



Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

September 21, 2018

Dear Administrator:

This letter provides information about your free-standing and hospital-based nursing facilities and associated Adult Day Health Care Programs Medicaid capital reimbursement rates for January 1, 2019. These preview rates reflect the 2019 capital component that is based upon the facility's 2017 cost report, as well as the latest approved mortgage(s). These rates are available on the Health Commerce System under the heading of **NH Rate Sheets 4/2009-Forward**, under the selection **2019 Capital Preview Rates**.

The attestation form attached to this letter provides the Department with the assurance that the capital component is accurate and complies with the Department's statutes, regulations and policies regarding capital reimbursement. For capital reimbursement guidance, please refer to the capital rate setting webinar and FAQ's posted on the HCS. The Department is requiring **ALL** nursing facilities to submit an attestation form stating they agree or disagree with the preview rate. If a provider does not agree with the preview rate, a narrative along with supporting documentation justifying the changes and an adjusted capital schedule must be submitted.

All attestation forms, and necessary documentation must be submitted via email to nfrates@health.ny.gov by **COB Friday, October 12, 2018**. The subject line of the email should state "2019 Capital Preview Attestation".

Sincerely,

A handwritten signature in black ink, appearing to read "Laura Rosenthal", written over a light blue horizontal line.

Laura Rosenthal, Director
Bureau of Residential Health Care Reimbursement
Division of Finance and Rate Setting
Office of Health Insurance Programs

New York State Department of Health
Office of Health Insurance Programs
Capital Reimbursement Certification

Facility _____
Operating Certificate Number _____
Capital Reimbursement Rate Year - 2019
Declaration Control Number (DCN) of corresponding RHCF-2 or 4 _____

Certification Statement

Misrepresentation or falsification of any information contained on this form may be punishable by fine and/or imprisonment under New York State Law and Federal Law.

Certification of Operator

☐ I hereby certify that the attached capital schedule **does** contain revisions to the Department's capital schedule provided to me. I am the signatory to the RHCF-2 or 4 for the attached capital reimbursement schedule and that I have the authority to bind the above listed facility. I certify that this revised schedule was completed, to the best of my knowledge and ability, in accordance with the New York State statutes, regulations and policies that govern Medicaid capital reimbursement for nursing facilities. I have attached a narrative explaining the revisions, along with supporting documentation.

☐ I hereby certify that the capital schedule provided by the Department, **does not** require revisions to the Department's capital schedule provided to me. I am the signatory to the RHCF-2 or 4 and that I have the authority to bind the above listed facility. I have read the above statements and I have examined the Department's capital reimbursement schedule, which serves as the basis for the capital per diem of the corresponding rates, based upon certified information contained in the DCN identified above, and that to the best of my knowledge and belief, it is true and complete and is in accordance with the New York State statutes, regulations and policies that govern Medicaid capital reimbursement for nursing facilities.

I will provide any supporting documentation as requested by the Department of Health, the Office of the Medicaid Inspector General and any other audit, enforcement or oversight agency and/or body.

I understand that this attestation is in lieu of an administrative appeal of the attested rate. Further, I understand that any challenge to the attested rate, through administrative action or otherwise, will result in forfeiture of the facility calculated attested rate and adoption of the Department's original reimbursement rate. I understand that this in no way limits the administrative appeal rights of the facility and that an administrative appeal may be pursued in accordance with applicable New York State statutes, regulations and policies, including any rights under 10 NYCRR 86-2.13 & 86-2.14.

I understand that the Department of Health's acceptance of the attached schedule, in no way precludes the Office of the Medicaid Inspector General from conducting audits and/or exercising its oversight capacity in any manner whatsoever, including, but not limited to, actions taken pursuant to 18 NYCRR Parts 517, 518 and 519.

I hereby certify that I have read the foregoing conditions and that I have the legal authority to bind the above listed facility to the terms herein.

Modifications of the terms contained herein shall render this attestation null and void.

DATE

SIGNATORY'S NAME (PRINTED)

SIGNATURE

SIGNATORY'S TITLE