New York State Department of Health
Office of Health Insurance Programs
2022 Capital Preview Rate Attestation

Facility_____
Operating Certificate Number_____
Declaration Control Number (DCN) of corresponding RHCF-1, 2 or 4_____

Attestation 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.

Attestation of Operator

☐ I hereby attest that the capital preview rate schedule provided by the Department, **DOES NOT** require revisions. I am the signatory to the RHCF-1, 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 preview rate 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 hereby attest that the capital preview rate schedule **DOES** require revisions to the Department's capital preview rate schedule provided to me. I am the signatory to the RHCF-1, 2 or 4 for the attached capital preview rate attestation and that I have the authority to bind the above listed facility. I attest that this capital preview rate attestation 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 certify that this revised schedule **does not** include non-allowable items including but not limited to: real property rentals, changes to useful life not associated with an approved CON, reinstatement of residual equity payments, long-term WCI interest, or ADHC transportation expenses billed outside the rate. I have attached a narrative explaining the revisions, along with supporting documentation.

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 attest 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