Ohio | Department of Medicaid

12/18/2018 **16NBAR0035**

0058577
Midwest Health Services #2
11 Lincoln Way West, Suite 5A
Massillon, OH 44647-6376

Re: Adjudication Order to be Effective: **01/17/2019**
Provider Number **0058577**
Period: **07/01/2015** through: **06/30/2016**

Dear Administrator:

Pursuant to its authority under Chapters 119 and 5164 of the Ohio Revised Code, the Ohio Department of Medicaid (ODM) is issuing this NOTICE OF PROPOSED ACTION. ODM proposes to enter an adjudication order to implement the enclosed audit. Based upon the audit, ODM has determined the provider owes ODM **$0.00**. The issuance of the proposed adjudication order does not prevent ODM from recovering Medicaid overpayments pursuant to Ohio Revised Code section 5164.57. A summary of the audit recovery calculation page follows which details the calculation leading to the amount determined to be owed and references enclosed reports of examination which support the summary.

If you are in agreement with the proposed action complete the enclosed waiver form indicating you are not requesting a Chapter 119 hearing and return to ODM within 30 days of this mailing date to: LTCAudits@medicaid.ohio.gov

If you wish to participate in an audit conference prior to requesting a Chapter 119 hearing or signing a waiver, you may do so by completing and submitting within 30 days of this mailing date the enclosed request for an audit conference form. If you request an audit conference, the mailing date of this Notice of Proposed Action is preserved as the effective date of the issuance of the audit. At the conclusion of the conference, you will be given another notice of your right to request a Chapter 119 hearing or, at that point, you may sign a waiver indicating the agreements reached at the audit conference and waiving your right to a Chapter 119 hearing. If you request an audit conference and fail to participate in the conference, a notice of a right to a Chapter 119 hearing, without an opportunity for a conference, will be issued.

Under Ohio Revised Code Chapter 119, you are entitled to a hearing on this matter if you request a hearing within thirty (30) days of the date of the mailing of this notice. An expanded explanation of how to compute the thirty (30) day deadline is provided in Ohio Administrative Code 5160-70. To request a hearing:

Email your request to : LTCAudits@medicaid.ohio.gov
Or
Mail your request to :

Ohio Department of Medicaid
Office of Legal Counsel
Attention: Litigation Coordinator
PO Box 182709
Columbus, Ohio 43218-2709

At the hearing, you may appear in person and/or be represented by an attorney. At the hearing you or your attorney may present evidence and examine witnesses appearing for and against you. You may also present your position, arguments, or contentions entirely in writing. The rules governing Chapter 119 hearings may be found in Chapter 5160-70 of the Ohio Administrative Code.

If you do not request a hearing, or your request is not timely, ODM will implement this proposed action by issuing a final and binding order of adjudication adopting and ratifying the findings of the final fiscal audit.

If you have any questions regarding this NOTICE OF PROPOSED ACTION, please contact Jeff Fukuda at (614) 752-2626 or jeffrey.fukuda@medicaid.ohio.gov

Sincerely,

Mark Graves
Bureau Of Program Integrity
Long-Term Care Audits
mark.graves@medicaid.ohio.gov

Enclosures

Hand delivery mail receipt

ODM AUDIT WAIVER

NBAR #: 16NBAR0035
Provider Name: Midwest Health Services #2
Medicaid Provider Number: 0058577 **Date Audit Finalized:** December 18, 2018
Audit Period: Fiscal Year 2016 **Amount Due from Provider : $**0.00

I request that the Ohio Department of Medicaid (ODM) implement the audit for the period July 01, 2015 through June 30, 2016. I acknowledge that the execution of this waiver does not prevent ODM from recovering Medicaid overpayments pursuant to ORC 5164.57. **In agreement with the above, I hereby waive my right to appeal this audit under Chapter 119 of the Ohio Revised Code.**

_____ _____
Signature of the Owner, Officer, or Authorized Representative — Date

_____ _____
Printed Name of the Owner, Officer, or Authorized Representative — Title

Provider Mailing Address (if diff. from Nursing Home Address)

_____ _____
Telephone Number

_____ _____
Prov.Rep. Email Address

PAYMENT TERMS

If payment is due to ODM, please indicate the way you would like to pay, below. **SEND NO MONEY NOW.**
If you do not indicate a choice, the full amount due will be deducted from your next vendor payment from ODM.

_____ I would like the full amount due deducted from my next monthly payment from ODM.
If amount is to be deducted from payment to another provider due to a successor liability agreement, indicate that provider number here: _____.

_____ I would like to pay in equal installments deducted from my monthly payments from ODM for the next (circle one) 2 3 4 5 6 months. I understand that interest will be added to the amount due.
If amounts are to be deducted from payments to another provider due to a successor liability agreement, indicate that provider number here: _____.

EMAIL THIS COMPLETED WAIVER TO : LTCAudits@medicaid.ohio.gov

Note: By completing and submitting this form to ODM, your organization is acknowledging notification of Medicaid overpayment, pursuant to Ohio Revised Code § 5164.57

Request for Audit Conference

Provider name: **Midwest Health Services #2**
Provider number: **0058577**
NBAR: **16NBAR0035**

Audit period: **FISCAL YEAR 2016**

This form must be completed and returned to ODM within 30 days of the mailing date.

You may request an audit conference by completing this form.

You may submit supporting dispute documents with this form. Alternatively, you and your assigned auditor may work together to arrive at a reasonable and agreed upon date.

I request the Ohio Department of Medicaid (ODM) to conduct an audit conference for the period of July 01, 2015 through June 30, 2016. I understand that by requesting this conference the effective date of the issuance of the audit is preserved. At the conclusion of the audit conference I will be given another notice of my right to request a Chapter 119 hearing or I will be given an opportunity to waive my right to a Chapter 119 hearing.

Authorized Provider Representative _____
(Please print name)

Title _____

Signature _____

Date _____

Provider representative

Name _____

Address _____

City, state, zip _____

Telephone number(___)-(_____) area code/number

Prov. Rep. Email Address _____

Other Business Email Address(es)_____

Total due ODM: **$0.00**

Please complete and Email this request to : LTCAudits@medicaid.ohio.gov

Note: By completing and submitting this form to ODM, your organization is acknowledging notification of Medicaid overpayment, pursuant to Ohio Revised Code § 5164.57.

Ohio | Department of Medicaid

RECEIPT 16NBAR0035

I, _____, was served with an original **Proposed Adjudication Order**
Print Name
for the period 07/01/2015 - 06/30/2016 on _____.

The Proposed Adjudication Order was hand-served by Ohio Department of Medicaid (ODM),

_____
ODM Employee

The Order was served at:
0058577
Midwest Health Services #2
11 Lincoln Way West, Suite 5A
Massillon, OH 44647-6376

Midwest Health Services #2 0058577
Provider Name and Number

_____ _____
Providers Signature Date

_____ _____
ODM Employee Date