EXHIBIT 82
(Rev. 30, 12-15-07)

Model Letter
Approval Notification for Swing-beds in a Hospital

Name/Title of Hospital Administrator, CEO, or Responsible Individual
Name of Hospital
Street Address
City, State, Zip Code

Dear_____:

We are pleased to notify you that (name of Hospital) meets the requirements at 42 CFR Part 482.66 for participation in the Medicare program as a hospital with swing-bed approval. The effective date of this approval is (effective date).

Effective with this approval (name of Hospital's) participation as an acute care hospital will use the current CMS Certification Number (CCN) (insert hospital CCN) for acute care patients. Your new CCN for swing-beds services is like your general Medicare CCN, except that the "third digit" is changed to the alpha-character "u". It is important that this sub-provider CCN (swing-bed CCN) be entered on all forms, claims, and correspondence relating to skilled nursing care services. You will continue to the use the general Medicare CCN (hospital CCN) on all forms, claims, and correspondence relating to hospital acute care services.

The swing-bed CCN should be used on all correspondence and billing for the Medicare program starting (effective date).

If deficiencies were found during the survey of your facility, it is expected that you will correct these citations as stated in your plan of correction. The State Agency will monitor progress made in correcting the identified deficiencies.

Your fiscal intermediary is (name of fiscal intermediary). Questions concerning billing and other fiscal matters should be directed to them at (contact number). Questions related to the Conditions of Participation for hospitals should be referred to your SA (SA contact information).

Sincerely,

(Associate Regional Administrator or Equivalent)

cc:
Fiscal Intermediary/Medicare Administrative Contractor
Regional Administrator
State Department of Health