EXHIBIT 83
(Rev. 30, 12-15-07)

Model Letter
Denial for Swing-bed Approval in a Hospital

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

Dear_____:

This letter is to inform you that your request for approval as a provider of swing-bed services is being denied. In order to participate in the Medicare swing-bed program, a hospital must comply with all regulatory requirements at 42 CFR Part 482 .66. Based on the deficiencies identified on the CMS Form-2567, your hospital does not qualify for participation.

Although your facility does not qualify as a provider of swing-bed services at this time, you may take steps to correct these deficiencies and reapply to establish Medicare eligibility.

If you believe this determination is incorrect, you may ask that it be reconsidered. Your request must be submitted in writing to this office within 60 days from the date of receipt of this letter. You may submit with your request for reconsideration any additional information you believe to be pertinent to this decision.

Sincerely,

(Associate Regional Administrator or Equivalent)

Enclosures: (list as appropriate)