EXHIBIT 127

(Rev. 61, Issued: 07-23-10, Effective: 07-23-10 Implementation: 07-23-10)

ATTESTATION STATEMENT FOR EXCLUSION FROM PPS

FOR FISCAL YEAR BEGINNING: (DATE)

(**Date**)

State Agency Director Name
State Agency Name
Address
City, State, ZIP Code

Dear (**State Agency Director**):

This attestation must be signed by the Administrator/Chief Executive Officer of the hospital (including hospitals with excluded units).

ATTENTION: Read the following carefully before signing.

STATEMENTS OR ENTRIES GENERALLY: Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statement or representations, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than $10,000 or imprisoned not more than five years, or both. (18 U.S.C., Sec.1001)

Based upon my personal knowledge and belief, I attest that the responses on the attached prospective payment system (PPS) exclusion work sheet are true and correct, and that (**name of PPS-Excluded Hospital or Unit**) currently meets and will continue to meet the applicable requirements for exclusion from PPS for the period beginning (**first day of hospital's fiscal year**), as set out in Subpart B of 42 CFR Part 412. I agree that if the (**hospital or unit**) fails to meet any of these requirements between the date of attestation and the first day of the hospital's fiscal year, I will notify the Regional Office (**name and address of RO**) of the change immediately in order to permit a valid determination of distinct part status prior to the beginning of the fiscal year. (**Include the next sentence for units only**): The unit is located in (**enter building name, room numbers and address**), and consists of square feet.

I understand that the Centers for Medicare & Medicaid Services (CMS) or its representative has the right to conduct an on-site survey at any time to validate whether the statements made on the attached work sheet are true.

Signature_____
(Administrator/Chief Executive Officer of the hospital)

Title_____

Date_____

Fill in blanks before sending the form to the facility.