EXHIBIT 180
(Rev. 30, 12-15-07)

NOTICE TO ACCREDITED PSYCHIATRIC HOSPITAL OF INVOLUNTARY TERMINATION

(**Date**)

Psychiatric Hospital Name
Address
City, State, ZIP Code

Re: CMS Certification Number (CCN)

Dear _____:

Section 1865 of the Social Security Act (the Act) and pursuant regulations provide that a hospital accredited by The Joint Commission (***JC)*** *or the American Osteopathic Association (**AOA***) is "deemed" to meet all of the Medicare Conditions of Participation for hospitals, with the exception of *those relating to* utilization review and the special staffing and medical record requirements for psychiatric hospitals. Section 1864 of the Social Security Act authorizes the Secretary of *the Department of* Health and Human Services ***(the Secretary)*** to conduct surveys of accredited hospitals participating in the Medicare program.

When a hospital, regardless of its accreditation status, is found to be out of compliance with the special staffing or medical record requirements for psychiatric hospitals, a determination must be made that the facility no longer meets the requirements for participation as a provider of services in the Medicare program. Such a determination has been made in the case of (**hospital name**) and accordingly, the Medicare provider agreement between (**hospital name**) and the Secretary is being terminated.

A survey conducted at (**name of hospital**) on (**date**) found that the hospital was not in compliance with the Medicare health and safety requirements *(indicate* **Special Medical Record Requirement (42 CFR 482.61) and/*or* Special Staff requirement (42 CFR 482.62**)) for psychiatric hospitals.

A listing of all deficiencies found *is* enclosed. These deficiencies have been determined to be of such a serious nature as to substantially limit the hospital's capacity to provide adequate care.

The date on which the agreement terminates is (**date**). The Medicare program will not make payment for inpatient hospital services furnished to patients who are admitted on or after (**date of termination**). For patients admitted prior to (**date of termination**), payment may continue to be made for a maximum of 30 days of inpatient hospital

services furnished on or after (**date of termination**). You should submit as soon as possible, a list of names and Medicare claim numbers of beneficiaries in your hospital on (**date of termination**) to the (**name and address of the RO involved**) to facilitate payment for these individuals.

We will publish a public notice in the (**local newspaper**). You will be advised of the publication date for the notice. If you feel that these findings are incorrect, you have 15 days from the date of this notice to request an informal review of the findings by this office as provided by 42 CFR 488.456(c)(2). Include in the request any evidence and arguments which you may wish to bring to the attention of the Centers for Medicare & Medicaid Services (CMS). *[Public notice language is optional]*

Termination can only be averted by correction of the deficiencies within 45 days of your receipt of this letter. Your plan of correction (written on the enclosed statement of Deficiency and Plan of Correction forms) should be returned to us as soon as possible.

An acceptable plan of correction must contain the following elements:

1) *The plan for correcting each specific deficiency cited;*

2) *The plan should address improving the processes that led to the deficiency cited;*

3) *The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;*

4) *A completion date for correction of each deficiency cited must be included;*

5) *All plans of correction must demonstrate how the hospital has incorporated its improvement actions into its Quality Assessment and Performance Improvement (**QAPI**) program, addressing improvements in its systems in order to prevent the likelihood of the deficient practice reoccurring. The plan must include the monitoring and tracking procedures to ensure the plan of correction is effective and that specific deficiencies cited remain corrected and/or in compliance with the regulatory requirements; and*

6) *The plan must include the title of the person responsible for implementing the acceptable plan of correction.*

After termination if you wish to be readmitted to the program, you must demonstrate to the (**State agency**) and CMS that you are able to maintain compliance. Readmission to the program will not be approved until you are able to demonstrate compliance for a period of not less than (**number of days**) consecutive days.

If you do not believe this termination decision is correct, you may request a hearing before an Administrative Law Judge (**ALJ**) as outlined in Title 42 of the Code of Federal Regulations, Section *498.5(b)* et. seq. To be effective, a written request for a hearing must be filed not later than 60 days after the date you receive this letter. Such a request may be made to the *Consortium Survey and Certification Officer*, (**address**) who will forward your request to the *Civil Remedies Division* ALJ in the *Departmental Appeals Board*. The request for a hearing should state why the decision is considered incorrect, and should be accompanied by any evidence and arguments you may wish to bring to the attention of the Department of Health and Human Services. Evidence and arguments may be presented at the hearing, and you may be represented by counsel *at your own expense.*

Sincerely yours,

Consortium Survey and Certification Officer
(or its equivalent)

Enclosures