EXHIBIT 181
(Rev. 148, Issued: 10-09-15, Effective: 10-09-15, Implementation: 10-09-15)

NOTICE TO HOSPITAL PROVIDER OF INVOLUNTARY TERMINATION

(**Date**)

Name/Title of Responsible Individual
Name of Hospital
Address
City, State, ZIP Code

Re: CMS Certification Number (CCN) ***[enter CCN assigned to the Facility]***

Dear _____:

The Centers for Medicare & Medicaid Services (CMS) *has evaluated (**insert name of hospital**) for its compliance with the hospital Conditions of Participation (CoPs) and* has determined that the (**name of *hospital***) no longer meets the requirements for participation as a Medicare provider established under Title/XVIII of the Social Security Act (the Act).

To continue to participate in the Medicare program, a hospital must meet all of the statutory provisions of section 1861(e) of the Act and be in compliance with the Conditions of Participation (CoPs) found at 42 CFR Part 482.

*CMS has determined that (**name of hospital**) does not meet the requirement(s) contained in (**insert specific requirements that have not been met and a brief explanation of the circumstances of noncompliance**).*

The date on which the agreement terminates is (*insert* **date of termination**). The Medicare program will not make payment for inpatient hospital services furnished to patients who are admitted on or after (**date of termination**). *However, in accordance with 42 CFR 489.55(a)(1), Medicare* payment*s* may continue for a maximum of 30 days *after the termination date for Medicare beneficiaries admitted prior to (**insert termination date**) for either inpatient acute care services or skilled nursing facility (SNF)-level swing bed services.*

***(Insert name of* hospital)** *should submit* a list of names and Medicare claim numbers of beneficiaries *receiving inpatient and SNF-level services in the* hospital on *the termination date to the CMS **(insert city of Regional Office here)** Regional Office as soon as possible* to facilitate payment for *the services the hospital has provided to* these *beneficiaries.*

CMS will publish a public notice in the (***insert name of* local newspaper**). You will be advised of the publication date for the notice.

***(If this is the first notice after the survey, add the following:** Termination can only be averted by correction of the deficiencies, through submission of an acceptable plan of*

*correction (PoC) and subsequent verification of compliance by (**State Agency)**. The Form CMS-2567 with your POC, dated and signed by your facility's authorized representative must be submitted to **(State Agency)** no later than **(enter date that is 10 calendar days after the date of this notice)**. Please indicate your corrective actions on the right side of the Form CMS-2567 in the column labeled "Provider Plan of Correction", and list the corresponding deficiency number in the column to its left, labeled "ID Prefix Tag". Additionally, indicate your anticipated completion dates in the column labeled "Completion Date".*

An acceptable PoC must contain the following elements:

1. The plan for correcting each specific deficiency cited;

2. The plan for improving the processes that led to the deficiency cited, including how the hospital is addressing improvements in its systems in order to prevent the likelihood of recurrence of the deficient practice;

3. The procedure for implementing the PoC, if found acceptable, for each deficiency cited;

4. A completion date for correction of each deficiency cited;

5. The monitoring and tracking procedures that will be implemented to ensure that the PoC is effective and that the specific deficiency(ies) cited remain corrected and in compliance with the regulatory requirements; and

6. The title of the person(s) responsible for implementing the acceptable PoC.

Copies of the Form CMS-2567, including copies containing the facility's PoC, are releasable to the public in accordance with the provisions of Section 1864(a) of the Act and 42 CFR 401.133(a). As such, the PoC should not contain personal identifiers, such as patient names, and you may wish to avoid the use of staff names. It must, however, be specific as to what corrective action the hospital will take to achieve compliance, as indicated above.

Your facility will be revisited to verify necessary corrections. If CMS determines that the reasons for termination remain, you will be informed in writing, including the effective date of termination. If corrections have been made and your facility is in substantial compliance, the termination procedures will be halted, and you will be notified in writing.)

If your Medicare agreement is terminated and 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 CMS is reasonably assured that you are able to sustain compliance.*

If you *disagree with* this termination *action,* you *or your legal representative* may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 CFR 498.40, et seq. *You must file your hearing request electronically by using the DAB's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov* no later than sixty (60) days *after receiving* this letter. *Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request must also be submitted electronically to:*

(INSERT REGIONAL OFFICE CONTACT INFORMATION)

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions *of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing,* you may be represented by counsel at your own expense.

*If you have any questions regarding this matter, please contact the CMS (**insert city**) Regional Office by phone at (**insert phone number**) or by e-mail at (**insert email address**).*

Sincerely,

Associate Regional Administrator/Equivalent

Enclosures: Form CMS-2567 Statement of Deficiencies
DAB E-filing Instructions

Cc:

State Survey Agency
Accrediting Organization (when applicable)