EXHIBIT 210
(Rev. 30, 12-15-07)

MODEL LETTER FOR A PAST VIOLATION OF 42 CFR 489.24 AND/OR THE RELATED REQUIREMENTS OF 42 CFR 489.20: NO TERMINATION

(**Date**)

Hospital Administrator Name
Hospital Name
Address
City, State, ZIP Code

Re: CMS Certification Number (CCN)

Dear (**Hospital Administrator Name**):

In order to participate in the Medicare program, a hospital must meet the requirements established under title XVIII of the Social Security Act (the Act), and must also meet the additional requirements established by the Secretary of Health and Human Services under the authority contained in §1861(e) of the Act. Further, §1866(b) of the Act authorizes the Secretary to terminate the provider agreement of a hospital that fails to meet these provisions.

This office authorized the (**State**) State Agency to conduct a survey of (**hospital**) on (**date**). As a result of that survey, it was determined that your facility violated 42 CFR 489.24, "Responsibilities of Medicare Participating Hospitals in Emergency Cases," and/or the related provisions of 42 CFR 489.20. The deficiencies identified are cited in the enclosed Statement of Deficiencies *and Plan of Correction.*

The State agency found that*, prior to the survey,* you discovered the violation and implemented corrective action that has been effective *over* the long*er* term. Therefore*,* we are not *proceeding with a* termina*tion of* your Medicare provider agreement with the Secretary of Health and Human Services.

(NOTE: Only include the following paragraph if the requirements of 42 CFR 489.24 were violated.)

As the requirements for participation in the Medicaid program under 42 CFR 440.10(a)(3)(iii) include meeting Medicare requirements, we are notifying the appropriate State officials concerning your hospital's past violation of the requirements of 42 CFR 489.24. 9. ***(Add as appropriate:*** We are also notifying the Office of Inspector General *which* has responsibility for the enforcement of the civil monetary penalties prescribed by §1867 of the Act.***)*** (***Add as appropriate:*** In addition, we are notifying the Regional Office for Civil Rights, which may take action under the Hill-Burton Subpart G Community Service regulations at 42 CFR 124.603(b)(1). ***)***

If you have any questions or concerns about this matter, please contact (**name of contact**) at (**phone number**).

Sincerely yours,

Associate Regional Administrator
(or its equivalent)

Enclosure: Form CMS-2567, Statement of Deficiencies

cc:

State Survey Agency
State Medicaid Agency
OIG ***(if appropriate)***
OCR/FO ***(if appropriate)***
QIO
Accreditation Organization
Complainant
State Licensing Body
DHHS Congressional Liaison Office
CMS Office of Legislation