EXHIBIT 219

MODEL AUDIT DISALLOWANCE LETTER - TITLE XVIII

CERTIFIED MAIL -- RETURN RECEIPT REQUESTED

(**Date**)

Director, State Health Department
(**State**) State Health Department
Address
City, State, ZIP Code

Dear (**Director Name**):

RE: Section 1864/1903(a) Audit ACN _____

This is the determination of the Centers for Medicare & Medicaid Services concerning unallowable costs identified through the HHS audit of provider survey and certification program activities of the (**State Agency**) during (**period**). The auditors identified the following questioned or unallowable costs:

Year	**Item**	**Amount Questioned or Unallowable**
_____	_____	$ _____
_____	_____	$ _____

This determination does not necessarily cover all the above questioned or unallowable items, since on (**date**) the (**State Agency**) and the Centers for Medicare & Medicaid Services Regional Administrator reached agreement on certain of the questioned and unallowable items. This determination refers only to the audit-questioned or unallowable items on which the agencies did not reach agreements.

(Recitation of Issues, Findings, and Conclusions. Insert paragraphs explaining how each disallowed item is determined. Refer to any worksheets or more detailed calculations attached to the determination, if necessary. If a full explanation is being given in the body of the text, it may be useful to offer additional review of RO worksheets, if the SA requests. Summarize net adjustments separately for Medicare and Medicaid, by the separate fiscal years.)

This notice concerns only the title XVIII trust fund disallowed amounts. A separate termination (**is being, has been**) made concerning title XIX aspects of this same subject audit and the disallowance of certain Federal financial participation for related title XIX survey activity costs.

You should make a complete repayment of the title XVIII disallowed amounts, (**amount -title XVIII only, to the extent actually spent by the State**), by the check made out to the Centers for Medicare & Medicaid Services, within 30 days. If, however, you prefer to have this amount offset from your annual award, notify this office promptly. If the amount is neither repaid nor offset within 30 days, interest must be charged by Centers for Medicare & Medicaid Services in accordance with the Federal claim collection standards. (4 CFR 101-105)

This is the final decision of the Centers for Medicare & Medicaid Services. This decision may be appealed to the Armed Services Board of Contract Appeals, Hoffman Building No. 2, 200 Stovall Street, Alexandria, Virginia 22332. If you decide to make such an appeal, you must mail or otherwise furnish written notice thereof to the Board of Contract Appeals within 90 days from the date you receive this decision. Simultaneously, mail a copy to this Regional Office. The notice should indicate that an appeal is intended and should reference this decision. Note that instead of appealing to the board, you may bring an action directly to the U.S. Claims Court within 12 month of the date you receive this decision. (Disallowance regulations may be found in 41 CFR 1 - 1.318

Citations: Social Security Act, sections 1864 and 1874; 45 CFR Part 74 (HHS Cost Principles); 41 CFR (Federal Procurement Regulations); PL 89-508 (Federal Claim Collection Act); 4 CFR 101 - 105 (Federal claim collection standards).

Sincerely yours,

Regional Administrator

Enclosures (if any)

cc:
Regional Audit Director
Division of Accounting/OMB
Audit Liaison Staff/OEO
Office of Intergovernmental Affairs