EXHIBIT 163
(Rev. 30, 12-15-07)

Model Letter
Termination *Letter* for Hospital Swing-bed Services

Name/Title of Hospital Administrator, CEO, or Responsible Individual
Name of Hospital
Street Address
City, State, Zip Code

Re: CMS Certification Number (CCN)

Dear_____:

After a careful review of the facts, the Centers for Medicare and Medicaid Services (CMS) has determined that the (name of Hospital) no longer meets the requirements for participation as a provider of hospital swing-bed services in the Medicare program under "Title XVIII of the Social Security Act.

To continue to participate in the Medicare swing-bed program, a hospital must meet the appropriate statutory provisions of §1820 of the Act and be in compliance with the Conditions of Participation (CoPs) at 42 CFR *Part 482*. Hospitals with swing-bed approvals must also comply with the skilled nursing facility requirements at 42 CFR §482.66.

The (name of State agency) certifies to CMS whether hospitals meet the CoPs at 42 CFR *Part* 482.66. Based on the record of the State agency's visits, findings, and recommendations, we find that (name of Hospital) does not meet the requirement(s) contained in (insert the specific requirement(s) that have not been met and a brief explanation of the circumstances of noncompliance).

The date on which the swing-bed agreement terminates is (date of termination). The Medicare program will not make payment for inpatient swing-bed services furnished for patients admitted *on or* after the (date of termination). For swing-bed patients receiving a SNF level of care that are admitted prior to (date of termination), payment may continue to be made for a maximum of 30 days 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 CMS regional office involved) to facilitate payment for these individuals.

We will publish a public notice of swing-bed termination in the (name of local newspaper). You will be advised of the publication date *for the* notice.

You may, of course, take steps to meet the participation requirements and establish the hospital's eligibility to participate as a provider of swing-bed services. The (State agency) is available to provide assistance you may need in order to accomplish this.

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 (insert number of days) consecutive days.

If you do not believe this determination is correct, you may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in the regulations at 42

CFR *498.40. et. seq.* A written request for a hearing must be *filed no later than 60 days from the* date of receipt of this letter. For expedited handling, such a request may be made to the following:

(Associate Regional Administrator or Equivalent)
(Street Address)
(City, State, Zip Code)

We will forward your request to the Chief Administrative Law Judge in the Office of Hearings and Appeals.

At your option, you may instead submit a hearing request directly (accompanied by a copy of this letter) to the following address. Send a copy of your request to this office also.

Departmental Appeals Board, Civil Remedies Division
Room G-644-Cohen Building
330 Independence Avenue, S.W.
Washington, D.C. 20201

ATTN: Director, Departmental Appeals Board

A request for a hearing should identify the specific issues, and the findings of fact and conclusions that you consider to be incorrect. You may be represented by counsel at a hearing at your own expense.

If you have any questions concerning this letter, please contact (name of contact) at (phone number).

Sincerely,

(Associate Regional Administrator or Equivalent)

Enclosure: Form CMS-2567, *Statement of Deficiencies*

cc:
Fiscal Intermediary*/Medicare Administrative Contractor*
State Department of Health
CMS Central Office