DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Wells	10-1-07

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000172	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR cc: Singleton, Myers	[ ] Prepare reply for appropriate signature DATE DUE _____ [ ] FOIA DATE DUE _____ [X] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth St, Suite 4T20
Atlanta, Georgia 30303-8909

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

*Amending letter of 8/31/07

September 24, 2007

RECEIVED
SEP 28 2007
Department of Health & Human Services
OFFICE OF THE DIRECTOR

Mr. William A. Jackson, Administrator
Healthsouth Rehabilitation Hospital SNF
1795 Frank Gaston Boulevard
Rock Hill, SC 29732

RE: SNF CMS Certification Number (CCN): **42-5371**

Dear Mr. Jackson:

Your request to withdraw from the Health Insurance for the Aged and Disabled Program (Medicare) as a provider of services has been accepted. Accordingly, your agreement with the Secretary of Health and Human Services terminated effective **June 30, 2007.**

In accordance with your Health Insurance Benefits agreement, public notice of this voluntary termination is necessary. Please publish a notice in the local newspaper with the widest circulation as soon as possible. The notice should be along the following lines:

> *Healthsouth Rehabilitation Hospital SNF will no longer participate in the Medicare Program (Title XVIII of the Social Security Act) effective **June 30, 2007**. The agreement between *Healthsouth Rehabilitation Hospital SNF and the Secretary of Health and Human Services terminated on **June 30, 2007** in accordance with the provisions of the Social Security Act.
>
> The Medicare program will not make payment for Skilled Nursing Facility services furnished to patients who were admitted on or after **June 30, 2007**. For patients admitted prior to **June 30, 2007**, payment may continue to be made for up to 30 days of inpatient services furnished on or after **June 30, 2007**.

Name of authorized official
Name of institution

Please provide our office with a copy of the newspaper notice. Send to: Atlanta Federal Center, CMS, Region IV, 61 Forsyth Street, S.W., Suite 4T20, Atlanta, Georgia 30303-8909.

You should contact **BC/BS of Alabama (00010)** to make arrangements for completing a final cost report and to adjust any outstanding current financing or accelerated emergency payments. They have been notified of this action by copy of this letter.

Should you have any questions concerning this matter, please contact Patricia Pearson (404) 562-7441.

Sincerely,

/s/

Sandra M. Pace
Associate Regional Administrator
Division of Survey and Certification

NOTE TO THE FISCAL INTERMEDIARY:
THIS LETTER REPLACES THE CMS-2007, PROVIDER TIE-IN NOTICE.

***Amended to show the correct facility name.**

Wells
c: Singleton
Myers