

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO <i>Mells</i>	DATE <i>3-22-07</i>
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DIRECTOR'S USE ONLY		ACTION REQUESTED	
1. LOG NUMBER <i>000600</i>	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____	<input type="checkbox"/> Prepare reply for appropriate signature DATE DUE _____	<input type="checkbox"/> FOIA DATE DUE _____
2. DATE SIGNED BY DIRECTOR <i>CC: Singleton, Bowling</i>		<input checked="" type="checkbox"/> 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

CENTERS for MEDICARE & MEDICAID SERVICES



March 19, 2007

Ms. Erma Singleton, Administrator
Medical Center of North
4631 Savannah Highway
North, SC 29112

Dog- Wells
cc: Erma. Action
cc: Smyleton
cc: Bowling



MAR 22 2007

Department of Health & Human Services
OFFICE OF THE DIRECTOR

Re: RHC CMS Certification Number (CCN): 42-8965

Dear Ms. Singleton:

We have been notified of the change in the ownership of your facility effective **January 5, 2006**. The effective date of the previous owner was November 13, 2003. The fiscal year end date is **December 31** and **Riverbend Government Benefits Administrators (00390)** will continue to serve as the intermediary. They have been notified of this change by copy of this letter.

Please be advised that when there is a change of ownership, the new provider agreement between the Secretary of Health and Human Services and the former owner is automatically assigned to the new owner, who is subject to all the terms and conditions of the provider agreement, including correcting deficiencies previously cited, complying with health and safety requirements, and submitting the Ownership and Financial Interest Disclosure Statement to the Centers for Medicare and Medicaid Services.

Payment may be made for services rendered by your facility under the new ownership until your compliance with all Medicare requirements can be confirmed by an on-site survey. Payments will be discontinued upon the expiration of your provider agreement if certification requirements are not met.

You must take steps to maintain required records and information necessary to allocate the costs for furnishing services to beneficiaries. Payments made under Medicare are subject to a final cost report. Your fiscal intermediary will contact you shortly concerning the cost report. They will explain any records and information which will be needed to validate these costs.

Should you have any questions concerning this matter, please contact Willie Tucker at (404) 562-7470.

Sincerely,

/s/

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

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