DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Wells	8-1-06

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 060125	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR cc: Singleton, Bowling	[ ] 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

Log (4) Wells
" Nec. Action"
CC: Singleton
Bowling

July 31, 2006

RECEIVED
JUL 31 2006
Department of Health & Human Services
OFFICE OF THE DIRECTOR

Dr. Paul T. Kovacks
Wildewood Downs Nursing & Rehabilitation Center
1215 Wildewood Downs Circle
Columbia, SC 29223

Re: SNF Provider No.: **42-5385**

Dear Dr. Kovacks:

This letter is to inform you that your skilled nursing facility has been found to meet the Requirements for Participation in the Health Insurance for the Aged and Disabled Program (Medicare).

The effective date of certification is **June 30, 2006,** and the fiscal year end date is **December 31.** The Medicare provider number is shown above. This number should be entered on all forms and correspondence pertaining to the Medicare Program.

It is most important to note that this certification is contingent upon your obtaining approval from the Office for Civil Rights (OCR). If this approval is not obtained, Medicare reimbursement will be recouped as of the effective date of certification.

The State Survey Agency previously advised you of any deficiencies found during the latest survey. If any deficiencies were cited, your plan of correction was considered in making the determination of compliance. In accordance with established Program procedures, the Survey Agency will verify that your plan of correction was implemented, and that compliance was achieved and maintained.

This Medicare certification is for:
32 Number of beds - The entire skilled nursing facility:
____ Number of beds - The Medicare distinct part located in rooms:

Palmetto Government Benefits Administration (00380) will serve as your fiscal intermediary. They have been notified of your certification by copy of this letter.

You are advised to report any major changes in staffing, services, or other significant characteristics, which potentially could affect your facility's compliance, to the State Survey Agency for action as deemed necessary. Pursuant to this, Section 1819(d)(B) of the Social Security Act requires you to report any changes involving ownership, Management Company, Director of Nursing, and administrator.

If you believe that this determination is incorrect in any respect, you may ask that it be reconsidered. Your request must be submitted in writing to this office within 60 days of receipt of this letter. You may submit with your request for reconsideration any information you believe to be pertinent to the determination.

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.