

DATE

XXX, CEO
XXX Hospital
Street Address
City, State Zip code

Dear XXX:

A review has been completed of your application to be designated as a critical access hospital (CAH), authorized by the Medicare Rural Hospital Flexibility Program. This application is the first step in the process of becoming certified as a critical access hospital. The information you submitted documents the importance of the health care XXX Hospital provides to the residents of its primary service area in XXX County. The information identifies XXX Hospital and XXX County meets several of the requirements in the XXX STATE RURAL HEALTH PLAN to be designated as a CAH and is supported by the following statements.

- XXX Hospital is located in a rural area and is at least 35 miles from a hospital or another CAH or more than 15 miles in areas with mountainous terrain or only secondary roads. *(consider specifying how far the facility is from the nearest one)*
- XXX Hospital provides 24-hour emergency care services.
- Average length of stay at XXX Hospital is 96 hours or less. *(consider specifying the average length of stay for the facility of interest)*
- XXX Hospital operates up to 25 beds for acute inpatient care, subject to the 96-hour length of stay. *(consider specifying the number of beds for acute inpatient care for the facility of interest and if there are any swing beds to consider)*
 - For CAHs with swing bed agreements, any of its beds may be used to furnish either inpatient acute care or swing bed services.

We are notifying you of our approval of your facility to pursue CAH designation. We are pleased you are pursuing this opportunity for rural hospitals to maintain an array of services necessary for the well being of area residents and be reimbursed at a reasonable cost level through the Medicare program. Should you have any questions about your application, please contact XXXXX.

Sincerely,

NAME OF PERSON FROM STATE OFFICE