EXHIBIT 41

STATE AGENCY'S LETTER TO MEDICARE ENTITY SEEKING READMISSION AFTER INVOLUNTARY TERMINATION

(**Date**)

Provider Name
Address
City, State, ZIP

Dear _____:

This is in response to your expression of interest in again becoming a provider of services under the Medicare program.

Under the provisions of section 1866(c) of the Social Security Act, a provider of services previously terminated for cause may not obtain a new agreement to participate in Medicare until it is found that the reason for termination of the previous provider agreement has been removed and there is reasonable assurance that it will not recur. In order to ensure reasonable assurance, the Centers for Medicare & Medicaid Services requires that two surveys must be conducted to verify that the reason for termination no longer exists and that you have maintained continuous compliance with the Medicare conditions or requirements.

Our records show that (**name of facility**) previously participated in the program as a (**type of facility**) and that its agreement was terminated effective (**date**). (**Name of facility**) was found (**cover reasons for termination of the prior agreement as stated in the notice of termination to the facility**).

In view of this, you are requested to forward to this office a written statement, signed by an authorized official, describing the steps taken to correct those deficiencies that led to the termination of your prior agreement, and the precautions that have been taken to assure that these deficiencies will not recur.

In addition to this statement please complete and return to this office the following forms:

1. Two copies of Request to Establish Eligibility in the Health Insurance for the Aged Program;

2. Two copies of the Health Insurance Benefits Agreement;

3. One copy of the Expression of Intermediary Preference; and

4. Two copies of the Assurance of Compliance.

You are also required to enroll with the fiscal intermediary by completing the Form CMS-855, Medicare General Enrollment Health Care Provider/Supplier Application. Any questions concerning the form should be directed to (**name**) at (**phone number**). After the Form CMS-855 verification and the surveys, this agency will recommend to the Centers for Medicare & Medicaid Services whether your facility should again be approved for participation.

When it is determined that the deficiencies upon which the prior termination was based have been corrected and we are reasonably assured they will not recur, the agreement will be countersigned effective with the date that these and all other requirements for participation are met.

In addition to enrollment and being in substantial compliance with the Conditions of Participation, to receive payments under Medicare you must meet the requirements of Title VI of the Civil Rights Act of 1964. Title VI prohibits discrimination on grounds of race, color, or national origin in any program or activity receiving Federal financial assistance. The Office for Civil Rights is responsible for determining whether a health facility meets the requirements of Title VI. If you are denied participation in the program, notification will be forwarded to that effect together with the reasons for the denial and information about your right to appeal the decision.

Please do not hesitate to communicate with this office if you have any questions.

Sincerely yours,

Enclosures