EXHIBIT 149

(Rev. 30, 12-15-07)

MODEL LETTER
CRITICAL ACCESS HOSPITAL (CAH) DENIAL FOR MEDICARE PARTICIPATION

Name/Title of Responsible Individual
Name of Hospital
Street Address
City, State, Zip Code

Dear _____:

This letter is to inform you that your request for certification as a provider of Medicare services as a critical access hospital (CAH) has been denied. In order to participate in the Medicare program, a critical access hospital must comply with all regulatory requirements at 42 CFR Part 485 Subpart F and any additional State requirements. Based on the deficiencies identified, your hospital does not qualify for participation as a CAH.

Although your facility does not qualify as a provider of CAH services at this time, you may take steps to correct these deficiencies and reapply to establish Medicare eligibility.

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

Sincerely,

Associate Regional Administrator/Equivalent

cc:

Fiscal Intermediary/Medicare Administrative Contractor
Regional Administrator
State Department of Health