EXHIBIT 158

NOTICE - RECERTIFICATION OF ESRD FACILITY
(NOT USED FOR SPECIAL PURPOSE RENAL DIALYSIS FACILITIES)

(**Date**)

Facility Name
Address
City, State, ZIP Code

Dear _____________:

RE: Provider Number (**Provider Number**)

We have reviewed the recent State agency survey findings and recommendations relating to your End Stage Renal Disease (**center/facility**). We have determined that your facility continues to meet program requirements and is approved as a (**renal transplantation center**) (**renal dialysis center**) (**renal dialysis facility**) with (**number**) stations to furnish the following services:

____	Transplantation	____	CAPD
____	Staff assisted dialysis	____	CCPD
____	Self-care	____	Home Training

The State agency has furnished you with a report of the deficiencies found during the most recent survey. Your plan of correction for these deficiencies has been reviewed and found acceptable. The State agency may revisit your facility to assess the progress of corrective actions to confirm all corrections are being completed in accordance with the time schedules you have provided.

If you plan changes in ownership, location, or services (**including expansions**), you must notify the State agency as soon as possible. Failure to do so may result in the suspension of payment for covered services.

We look forward to working with you on a continued basis in the administration of the Medicare program.

Sincerely yours,

Associate Regional Administrator
(or its equivalent)

cc: State Agency

Central Office