Exhibit 352

(Rev. 67, Issued: 10-18-10, Effective: 10-18-10, Implementation: 10-18-10)

NOTICE TO A PROVIDER/SUPPLIER THAT AGREEMENT WAS NOT ACCEPTED

*(**Date**)*

Provider/Supplier Name
Street Address
City, State, ZIP Code

*Dear (**Provider/Supplier Name**):*

*Your application for participation as a (**identify type of provider/supplier**) in the Medicare program has been denied by the Centers for Medicare & Medicaid Services (CMS). This decision was based on the recommendation received from (State Survey Agency or **Accreditation Organization**). That information indicated that you did not meet all Medicare (**identify provider/supplier type**) (**indicate Conditions of Participation, Conditions for Coverage, or Conditions for Certification).***

If you believe this determination is incorrect, you may ask that it be reconsidered in accordance with the provisions of 42 CFR 498.22. 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 yours,

Associate Regional Administrator
(or its equivalent)

*CC: Accreditation Organization **(if applicable)***
State Survey Agency
MAC