

EXHIBIT 135

(Rev. 30, 12-15-07)

**Model Letter Transmitting
Swing-Bed Approval Notification in a Critical Access Hospital (CAH)**

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

Dear _____:

We are pleased to notify you that (insert name of hospital) meets the requirements at 42 CFR Part 485 Subpart F for participation in the Medicare program as a CAH with swing-bed approval as of (effective date). This approval allows your facility to provide skilled nursing care to post-hospital patients.

Your new CMS Certification number (CCN) for your CAH swing-bed approval is (insert CAH CCN). This CCN should be used on all correspondence and billing for the Medicare program starting on (effective date).

Your fiscal intermediary is (name of fiscal intermediary/Medicare Administrative Contractor). Questions concerning billing and other fiscal matters should be directed to the FI/MAC. Questions related to the Conditions of Participation for CAHs should be referred to your SA (insert contact information).

Sincerely,

Associate Regional Administrator/Equivalent

cc:

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