EXHIBIT 255B

MODEL LETTER NOTIFICATION OF INVOLUNTARY TERMINATION BASED ON CHOW REVIEW OF THE MEDICARE GENERAL ENROLLMENT HEALTH CARE PROVIDER/SUPPLIER APPLICATION (FORM CMS-855)

(**Date**)

Provider Name
Address
City, State, ZIP Code

Dear (**Provider Name**):

Re: Provider Number (**Provider Number)**

Under the provisions of section 1866(b)(2)(A) and (C) of the Social Security Act (42 CFR 489.53) the Centers for Medicare & Medicaid Service (CMS) may terminate an agreement with a provider of services if it is determined that the provider: is not complying with the terms of the agreement or the provisions of title XVIII and regulations; fails to furnish information that CMS finds necessary for a determination as to whether payments are or were due under Medicare and the amounts due; refuses to permit examination of its fiscal or other records by, or on behalf of CMS, as necessary for verification of information furnished as a basis for claiming payment under Medicare; or fails to furnish ownership information.

The CMS has examined your application for a change of ownership, and after a careful review of the facts and circumstances has determined that under the new ownership, your facility does not meet the requirements for participation as a provider/supplier of services in the Medicare program for the following reason(s):

(**Select applicable sentence.**)

- (**Name (s) of excluded persons or organizations**) is/are currently excluded from participating in the Medicare program by the Office of the Inspector General.

- (**Name(s) of excluded persons or organizations**) is/are currently excluded from participating in the Medicare program because (he/she/it) is on the Federal Government's (General Service Administration) List of Parties Excluded from Federal Procurement and Nonprocurement Programs.

- You do not possess a current valid license that is required by Federal, State, or local government in order to furnish health care items or services of the type you purportedly furnish or intend to furnish to Medicare beneficiaries.

- You failed to furnish an address sufficient to readily identify the physical location at or from which you purportedly furnish or intend to furnish items or services to Medicare beneficiaries; or having furnished such an address, you do not appear (on the basis of extrinsic evidence) to be furnishing items or services or otherwise operating from such location; or, if you are an individual practitioner who does not furnish or does not intend to furnish items or services to Medicare beneficiaries at or from a location controlled by you (e.g., a physician practicing exclusively as an employee), you failed to furnish an address sufficient to readily identify the physical location at which you can be personally served with required notice in the event that proves necessary.

- Your license, and any other information or documentation furnished by you with respect to such license, failed to show that such license was issued by a governmental entity having jurisdiction over a practice, service-delivery, or operating location designated by you as a location at or from which you purportedly furnish or intend to furnish items or services to Medicare beneficiaries or that your license, if valid only for a specific physical location, is not valid for the physical location specified by you as the practice, service-delivery, or operating location at or from which you purportedly furnish or intend to furnish items or services to Medicare beneficiaries.

- Your (i) billing agreement, (ii) billing service contract, or (iii) other agreement that creates or maintains, directly or indirectly, a relationship between you and another entity for the purpose of billing, the sale or purchase or other transfer of accounts receivable, or other financial relationship effecting a transfer - directly or indirectly - of Medicare claims payment, or any other evidence, shows or furnishes substantial evidence that you are violating Medicare rules on assignment or reassignment of claims.

Based on the above information, it is necessary to terminate coverage of your services. Notice is hereby given that effective at the close of (**date of termination**), (**name of provider/supplier**) is no longer approved for participation as a provider/supplier in the Medicare program. The Medicare program will not make payment for (**type of facility**) services furnished to patients after the close of (**date of termination**)**.

A notice will be published in the (**name of local newspaper**) advising the public of the termination. You will be advised of the publication date for the notice.

If you believe this determination is incorrect, you may request a hearing before an administrative law judge as outlined in Title 42 or the Code of Federal Regulations, section 498.22 et. seq. To be effective a written request for a hearing must be filed not later than 60 days after the date you receive this letter. Such a request may be made to the Associate Regional Administrator for Division of Medicaid and State Operations, (**address**), who will forward your request to the Regional Chief Administrative Law Judge in the Office of Hearings and Appeals. The request for a hearing should state why the decision is considered incorrect, and should be accompanied by any evidence and arguments you may wish to bring to the attention of the Department of Health and Human Services. Evidence and arguments may be presented at the hearing, and you may be represented by counsel.

Sincerely yours,

Associate Regional Administrator
(or its equivalent)

** This sentence may be used for all provider types with the exception of hospitals, SNFs, HHAs or hospices. Remove this sentence and replace with the following sentences for the type of facility indicated:

Hospital or SNF:

The Medicare program will not make payment for inpatient hospital services (or post-hospital extended care services) furnished to patients who are admitted after the close of (**date of termination**). For patients admitted on (**date of termination**), or earlier, payment may continue for up to 30 days of inpatient hospital services (or post-hospital extended care services) furnished after (**date of termination**).

HHA or Hospice:

The Medicare program will not make payment for home health services or hospice care furnished to patients whose plan of treatment was established after the close of (**date of termination**). For patients whose plan of treatment was established before (**date of termination**), payment may be made for up to 30 days after (**date of termination**).