**EXHIBIT 197**

**NOTICE TO ACCREDITED HOSPITAL ANNOUNCING APPROVAL OF PLAN OF CORRECTION AND COMPLETION SCHEDULE**

(**Date**)

Hospital Name
Address
City, State, ZIP Code

Dear (**Hospital Administrator**):

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

I am pleased to inform you that the (**name of hospital**)'s plan of correction for its Medicare deficiencies, and the time schedule for completion of the plan, has been found acceptable.

When (**name of hospital**)'s plan of correction has been implemented, its major Medicare deficiencies have been corrected, and we have concluded that it meets all the Medicare Conditions of Participation for hospitals, it will no longer be subject to State agency follow-up. Failure to correct deficiencies in a timely manner will result in termination of the Medicare provider agreement.

Copies of this letter are being forwarded to the (**State agency**) and the (**JCAHO**) (**AOA**).

We thank you for your cooperation and look forward to working with you on a continuing basis in the administration of the Medicare program.

Sincerely yours,

Associate Regional Administrator
(or its equivalent)

cc:
Central Office
JCAHO/AOA
State agency