

EXHIBIT 150

(Rev. 30, 12-15-07)

***MODEL LETTER
CRITICAL ACCESS HOSPITAL (CAH) APPROVAL NOTIFICATION***

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

Dear _____:

We are pleased to notify you that (name of hospital) meets the requirements at *42 CFR Part 485 Subpart F* for participation in the Medicare program as a critical access hospital (CAH). The effective date of this approval is (effective date).

Effective with *this* approval (name of hospital's) participation as an acute care hospital under *CMS certification number (CCN)* has been canceled effective (CAH effective date). *Your new CCN for your CAH is (CAH CCN). This CCN should be used on all correspondence and billing for the Medicare program starting (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).

Welcome to the CAH program.

Sincerely,

Associate Regional Administrator/Equivalent

cc:

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