

EXHIBIT 194

(Rev. 68 Issued: 11-24-10, Effective: 11-24-10, Implementation: 11-24-10)

MODEL LETTER ANNOUNCING *TO DEEMED, ACCREDITED PROVIDER/SUPPLIER* COMPLIANCE WITH ALL SURVEYED MEDICARE CONDITIONS OF PARTICIPATION, *COVERAGE OR CERTIFICATION* AFTER A SAMPLE VALIDATION OR SUBSTANTIAL ALLEGATION SURVEY

(Date)

Facility Administrator Name

Facility Name

Address

City, State, ZIP Code

RE: *CMS Certification Number (CCN) [enter CCN assigned to the facility]*

Dear (*Administrator Name*):

I am pleased to inform you that as a result of the (**State agency's**) (**sample validation**)(**substantial allegation**) survey, (**name of facility**) was found in compliance with all the (Medicare Conditions of Participation/*Medicare Conditions for Coverage or Certification*) and will continue to be “deemed” to meet applicable Medicare requirements based upon accreditation by the (*insert appropriate Accrediting Organization*).

The (**State agency**) advised you of the Medicare deficiencies noted during the (**sample validation**)(**substantial allegation**) survey of your *facility*, and we are enclosing a complete listing of all deficiencies found by the (**State agency**). We have forwarded a copy of this letter and our findings from this survey (optional -- and your plan and timetable for correcting the Medicare deficiencies cited) to the (*appropriate AO*) for its review. The (**State agency**) has also been sent a copy of this letter. The (**AO**) may be in touch with you to discuss the Medicare survey findings.

Since your *facility* has been found “in compliance,” you do not have to submit a plan for correcting any of the Medicare deficiencies cited by the (**State agency**). However, under Federal disclosure rules a copy of the findings of this Medicare survey must be publicly disclosed within 90 days of the completion. You may therefore wish to submit for public disclosure, if you have not already done so, your comments on the survey findings, and any plans you may have for correcting the cited deficiencies.

(Name)
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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)

Enclosure: Form CMS-2567

cc:

Central Office
Accrediting Organization
State Agency