EXHIBIT 166

(Rev. 67, Issued: 10-18-10, Effective: 10-18-10, Implementation: 10-18-10)

NOTICE OF APPROVAL OF SUPPLIER OF SERVICES

(**Date**)

Supplier Name
Street Address
City, State, ZIP Code

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

Dear (***Supplier Name***):

Your request for approval as a supplier of (***list service(s)***) under the Medicare program has been approved. Your effective date of Medicare participation is (***date***).

Your Medicare Administrative Contractor (MAC) has been notified of your certification for Medicare participation. They will contact you shortly regarding billing procedures

You should report to the *Medicare Administrative Contractor* and the State Agency any changes in staffing, services or other characteristics which may affect your compliance with the Conditions *for* Coverage *or Conditions for Certification*, *as applicable*. The State *A*gency will survey you periodically to determine that the Conditions for Coverage *or Conditions for Certification* services are still met.

Please include the CCN shown above on all forms and correspondence relating to the Medicare program.

If you believe that this notice is incorrect in any aspect, you may request that it be reconsidered. The request for reconsideration must be submitted in writing to this office within sixty (60) days of receipt of this notice. You may submit any information that you believe has a bearing on the issue in question.

*If you have any questions, please contact (**Name and contact information of RO Staff**).*

We welcome your participation and look forward to working with you.

Sincerely yours,

Associate Regional Administrator
(or its equivalent)