EXHIBIT 187

NOTIFICATION TO PREVIOUSLY APPROVED SUPPLIER OF A PENDING TERMINATION

(**Date**)

Provider/Supplier Name
Address
City, State, ZIP Code

Dear (**Provider/Supplier Name**):

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

In order to have its services reimbursed under the Medicare Program, a supplier of services must meet certain requirements established in accordance with the provisions of title XVIII of the Social Security Act. The (**State agency**) State agency, which assists us in the Medicare certification process, has advised us that you no longer meet the requirements for approval of services as a (**type of facility**) because:

(**List reasons**)

Accordingly, action has been initiated to terminate coverage of your (**type of service(s)**) in the Medicare program.

Following a careful review of all the facts, you will receive formal notice of our determination. If an adverse determination is made, you will receive written notice informing you of the date of termination, and of your appeal rights. At the same time, we will place a notice in the (**local newspaper**) to advise the community of the date of termination, and the reasons for termination.* This action, and the reasons therefore, will be made known to the professional users of your services.

If you have already taken steps to meet the requirements or if you have definitive plans for doing so, please get in touch with this office immediately.

Sincerely yours,

Assistant Regional Administrator
(or its equivalent)

Enclosure

*Newspaper notification optional