**EXHIBIT 188**

**NOTIFICATION: VOLUNTARY TERMINATION OF PROVIDER AGREEMENT APPROVED**

(**Date**)

Provider Name
Address
City, State, ZIP Code

Dear (**Provider Name**):

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

Your request to terminate your participation in Medicare as a provider of services has been accepted. Accordingly, your agreement with the Secretary of Heath and Human Services will be terminated effective (**date of termination**). Please notify your medical and administrative staff.

In accordance with your Health Insurance Benefits Agreement, public notice of termination of the agreement is necessary. Please publish a notice in the local newspaper with the widest circulation, as soon as possible, but at least 15 days before the effective termination date. The notice should be along the following lines:

> The (**name and address of institution**) will no longer participate in the Medicare Program (title XVIII of the Social Security Act) effective (**date of termination**). The agreement between the (**name of institution**) and the Secretary of Health and Human Services will be terminated on (**date of termination**) in accordance with the provisions of the Social Security Act.
>
> The Medicare program will not make payment for inpatient hospital services furnished to patients who are admitted on or after (**date of termination**). For patients admitted prior to (**date of termination**), payment may continue to be made for up to 30 days of inpatient services furnished on or after (**date of termination**).
>
> Name of authorized official
> Name of institution

Please send us a copy of the published notice. An envelope is enclosed for your convenience in replying.

Please note that payment for inpatient services rendered to Medicare beneficiaries admitted prior to the effective date of termination is specifically limited to 30 days from (**date of termination**). Please provide us with a list showing the names and health insurance claim numbers of beneficiaries in your facility on (**date of termination**) to facilitate the payment of bills for these individuals.

You should be in touch with (**name of fiscal intermediary**) to make arrangements for completing a final cost report and to adjust any outstanding current financing or accelerated emergency payments.

Sincerely yours,

Associate Regional Administrator
(or its equivalent)

Enclosure