EXHIBIT 189

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

NOTIFICATION: APPROVAL OF VOLUNTARY TERMINATION OF A SUPPLIER

(**Date**)

Supplier Name
Address
City, State, ZIP Code

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

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

Your request to terminate your Medicare coverage as a supplier of services has been accepted. Accordingly, your coverage under the program will be terminated effective (**date**).

Optional

Since this action may be of interest to the public, we will 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 will give the effective date of termination and state that payment for services will not be made on or after that date. This action will be made known to professional users of your services.

Sincerely yours,

Associate Regional Administrator
(or its equivalent)