EXHIBIT 190

NOTIFICATION TO PROVIDER THAT HAS CEASED OR IS CEASING OPERATION

(**Date**)

Provider Name
Address
City, State, ZIP Code

Dear (**Provider Name**):

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

We have been notified that (**name of facility**) (**closed, will close**) on (**date of closing**). Under the provisions of regulations 42 CFR 489.52(b)(3), your provider agreement with the Secretary of Health and Human Services (**terminated, will terminate**) effective with that date. No payment can be made under the Medicare program for services rendered on or after (**date of closing**).

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. The notice should be along the following lines:

> The (**name and address of your institution**) will no longer participate in the Medicare Program (title XVIII of the Social Security Act) effective (**date of cessation of business**). The agreement between the (**name of institution**) and the Secretary of Health and Human Services (**will be, has been**) 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 agency

You should be in touch with your fiscal intermediary to make arrangements for completing a fiscal cost report and to make provision for the return of any outstanding current financing or emergency payment

If your (**hospital, provider of OPT, home health agency**) is reopened and you again wish to participate as a provider of services, you should contact the (**State agency**). They will assist you in taking action necessary to become certified for participation as a provider.

Please let us know if you have any questions concerning this action.

Sincerely yours,

Associate Regional Administrator
(or its equivalent)