EXHIBIT 191

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

NOTIFICATION TO SUPPLIER THAT HAS CEASED OR IS CEASING OPERATION

(**Date**)

Supplier Name
Address
City, State, ZIP Code

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

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

We have been notified that your (**facility type**) (**closed, will close**) on (**date of closing**). Therefore, your participation in the Medicare program (**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**)

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. The notice will give the effective date of termination and the state that payment for (***supplier type***) services will not be made on or after that date. This action will be made known to professional users of your services.

If your (***supplier type***) reopens and you again wish to be covered under the Medicare program, you *must submit a new application to enroll in the Medicare program.*

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

Sincerely yours,

Associate Regional Administrator
(or its equivalent)