EXHIBIT 145

NOTIFICATION OF CHANGE IN THE AMOUNT OF THE CIVIL MONEY PENALTY

(**Date**)

Provider Name
Address
City, State, ZIP Code

Dear (**Provider Name**):

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

On (**date**) (**the State Medicaid Agency or the Centers for Medicare & Medicaid Services**) imposed a civil money penalty in the amount of (**dollar amount**) per day on (**facility name and provider number**). The civil money penalty was imposed after it was determined through a survey conducted by (**name of the State survey agency or regional office**) on (**date of survey**) that (**facility name**) was not in substantial compliance with the Medicare/Medicaid participation requirements that are specified at §§1819(b), (c), (d), and (e) and 1919(b), (c), (d), and (e) of the Social Security Act and the corresponding regulations in 42 CFR Part 483.

The amount of the civil money penalty is (**increased or decreased**) as a result of (**include detail regarding one of the following**):

Specific findings during a revisit, such as:

- The removal of immediate jeopardy although the noncompliance continues, or

- A change in noncompliance from a situation in which immediate jeopardy did not exist to a situation in which immediate jeopardy exists.

The revised amount of the civil money penalty is (**dollar amount**) per day and the effective date for the accrual of this adjusted amount is (**date substantiating the change in the noncompliance**).

The civil money penalty will continue to accrue in the amount of (**new adjusted dollar amount**) until the necessary corrections have been made to bring (**facility name**) into substantial compliance with the requirements or the provider agreement is terminated. When

the necessary corrections have been made, please contact (**person in the State survey agency**) so that the survey agency can verify that (**facility name**) is in substantial compliance with the requirements.

Sincerely yours,

Regional Office Official or
State Medicaid Agency Official