EXHIBIT 148

NOTIFICATION OF DEDUCTION OF CIVIL MONEY PENALTY FROM MONEY OWING TO THE PROVIDER

(**Date**)

Provider Name
Address
City, State, ZIP Code

Dear (**Provider Name**):

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

As a result of the survey findings on (**date**) the (**State Medicaid Agency or Centers for Medicare & Medicaid**) imposed a civil money penalty on (**facility name**) for noncompliance with the participation requirements in accordance with sections 1819(h) and/or 1919(h) of the Social Security Act and the enforcement regulations specified at 42 CFR Part 488. On (**date of notice of amount due and payable**) we informed you that the civil money penalty imposed on (**effective date of the penalty**) was due and payable on (**date**).

As of the above due date, we have not received payment of the civil money penalty. Consequently, we will deduct the civil money penalty amount and any accrued interest from the sums owing to you.

Sincerely yours,

Regional Office Official or
State Medicaid Agency Official