Received 6.29.2018

U.S. RENAL CARE

June 15, 2018

VIA UPS

Illinois Health Facilities and Services Review Board
525 W. Jefferson, Second Floor
Springfield, Illinois 62761
Attn: Courtney Avery

Re: Report of Final Realized Cost for U.S. Renal Care West Chicago Dialysis (Project 16-027)

Ms. Avery:

In accordance with the Health Facilities Planning Procedural Rules (77 Ill. Adm. Code 1130), USRC West Chicago, LLC respectfully submits this report of final realized costs for the approved project.

I. Current Status of the Project

At the time of the submission of this report, the project is complete. The U.S Renal Care West Chicago Dialysis center was completed on March 14, 2018.

I hereby certify that there have been no changes in the scope or size of the project or the approved services, and that the project is in compliance with all of the terms of the permit to date, including project cost.

II. Final Realized Costs

The approved permit amount is $4,381,822. The final realized costs associated with this project through completion total $2,778,504 covering costs associated with the in center hemodialysis center, including architectural fees, construction costs, equipment, and medical and business office supplies. See Table 1. These final realized costs are the total costs required to complete the project and there are no additional or associated costs or capital expenditures related to the project.

For informational purposes, an itemization of the costs that have been or will be submitted for reimbursement under Title XVIII or XIX are attached as Table 2. As USRC West Chicago, LLC will provide both in-center hemodialysis and home dialysis training and support under a single Provider Number, CMS requires USRC West Chicago, LLC to report the capital costs for both in-center hemodialysis and home dialysis training and support in one

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cost report. Similarly, USRC West Chicago, LLC has set forth the home dialysis training and support capital costs, which are separate and apart from the in-center hemodialysis capital costs, in the attached Table 2, as a separate line item.

All project costs funded through project completion were funded through cash and securities.

III. Final Application and Certification for Payment

In accordance with 77 Ill. Adm. Code 1130.770, please find the attached final Application and Certification for Payment (the "Certification"), attached as Exhibit 1. We note that page 2 of the Certification incorrectly notes "Period to: 9/1/2012" rather than "Period to: 10/1/2012" as indicated on page 1 of the Certification. This inconsistency is attributable to a typographical error on page 2 which should state "Period to: 10/1/2012." The accuracy of the data contained in the Certification is demonstrated through the consistent values of "Total Completed & Stored to Date" listed on Line 4 of page 1 and the total of Column G provided on page 2.

We appreciate the opportunity to present this information to you. Please do not hesitate to contact me at 870-336-4022 if you have any questions or require additional information.

Sincerely,

NAME: Jack Harrington
TITLE: Senior Vice President

Subscribed and Sworn to before me this 28th day of June, 2018

Notary

STATE OF ARKANSAS NOTARY PUBLIC
CYNTHIA L PHILLIPS
MY COMMISSION # 12698561
EXPIRES: July 30, 2026
Craighead County

Enclosures

TABLE 1
U.S. Renal Care West Chicago Dialysis (Project 16-027)
Project Completion Report – Project Costs

Use of Funds	Total Amount
Modernization Contracts	$1,824,646
Architecture Engineering Fees	$ 78,127
Movable or Other Equipment	$ 531,912
Fair Market Value of Lease or Equipment	$ 286,480
Other Costs to be Capitalized	$ 57,339
TOTAL COSTS	**$2,778,504**

TABLE 2
U.S. Renal Care West Chicago Dialysis (Project 16-027)
Project Completion Report – Costs that have been or will be submitted for reimbursement under Title XVIII or XIX

Use of Funds	Total Amount
Modernization Contracts	$1,824,646
Architecture Engineering Fees	$ 78,127
Movable or Other Equipment	$ 531,912
Fair Market Value of Lease or Equipment	$ 286,480
Other Costs to be Capitalized	$ 57,339
IN-CENTER HEMODIALYSIS COSTS	**$2,778,504**
HOME DIALYSIS TRAINING AND SUPPORT COSTS	**$333,420**

EXHIBIT 1

U.S. Renal Care West Chicago Dialysis (Project 16-027)

Project Completion Report – Final Application and Certification for Payment

FAX

To: **Administrator 142834**
Company:
Fax: 708 831 2602
Phone:

From: **Lindsey Hoffman**
Fax: 443-380-7432
Phone: 312-353-5198
E-mail: lindsey.hoffman@cms.hhs.gov

NOTES:

Initial Approved

Date and time of transmission: Thursday, March 29, 2018 10:52:32 AM
Number of pages including this cover sheet: 04

Printed: 03/14/2018
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	ILESRD11218		03/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
US RENAL CARE WEST CHICAGO DIALYSIS	112 WEST 87TH STREET SUITE N CHICAGO, IL 60620

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An initial certification survey was conducted, in conjunction with Emergency Preparedness regulations, on 03/14/18. The Facility was in compliance with 42 CFR 494.62, Establishment of the Emergency Program, for this survey.	E 000		
V 000	INITIAL COMMENTS An initial certification survey was conducted on 3/14/18. The Facility was in compliance with 42 CFR 494.	V 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Midwest Division of Survey and Certification
Chicago Regional Office
233 North Michigan Avenue, Suite 600
Chicago, IL 60601-5519

CMS Certification Number (CCN): 142834
National Provider Identifier (NPI): 1851813216

March 29, 2018

Administrator
USRC West Chicago LLC
US Renal Care West Chicago Dialysis
112 West 87th Street, Suite N
Chicago, IL 60620

Dear Administrator:

The Centers for Medicare & Medicaid Services has accepted your request for approval as a supplier of renal services in the Medicare program. Your effective date of coverage is March 14, 2018.

Your unit has been approved as a renal dialysis facility. This approval is for a total of thirteen (13) maintenance stations.

Your facility is approved to provide the following services:

-In Center Hemodialysis
-Patient Training and Support for Continuous Ambulatory Peritoneal Dialysis (CAPD) and Continuous Cycling Peritoneal Dialysis (CCPD)

Your National Provider Identifier (NPI) is your primary identifier for all health insurance billing. The NPI should be entered on all forms and correspondence relating to the Medicare program. In addition, you have been assigned the CMS Certification Number (CCN) shown above; please provide it when contacting this office, when contacting the State agency, or any time it is requested.

Your Medicare Administrative Contractor (MAC) for reimbursement for renal treatment procedures will be National Government Services. You must maintain separate cost centers for all renal services. Your intermediary will contact you shortly to explain the special reimbursement procedures.

When you make general inquiries to your MAC, you will be prompted to give either your provider transaction access number (PTAN) or CCN. These identification numbers are used as authentication elements when inquiring about beneficiary- and claim-specific information. When prompted for your PTAN, give your CCN.

The Medicare Administrative Contractor (MAC) will now complete the final steps and will notify you of your enrollment or denial including the date when you may begin submitting claims for payment. Your CCN is contingent upon your enrollment into the Medicare program. If your enrollment is ultimately denied by the MAC, your CCN will be voided.

If you are dissatisfied with the effective date of Medicare participation indicated above, you may request that the determination of the effective date be reconsidered. The request must be submitted in writing to this office within 60 days of the date you receive this notice. The request for reconsideration must state the issues or the findings of fact with which you disagree and the reasons for disagreement.

Please inform the Illinois Department of Public Health if you wish to relocate your facility, change the services which you are currently providing, change the number of approved stations, or undergo a change in ownership.

We welcome your participation and look forward to working with you in the administration of the Medicare program. If you have any questions, please contact Lindsey Hoffman, Certification Specialist, in the Chicago Office at (312) 353-5198 or via email at Lindsey.hoffman@cms.hhs.gov.

Sincerely,

Maria Vergel de Dios
Principal Program Representative
Non-Long Term Care Certification
& Enforcement Branch

cc: Illinois Department of Public Health
Illinois Department of Health Care & Family Service
National Government Services
Renal Network #10