EXHIBIT 154

NOTICE OF INITIAL APPROVAL OF
END-STAGE RENAL DISEASE (ESRD) FACILITY

(**Date**)

Provider Name
Address
City, State, ZIP Code

Dear (**Provider Name**):

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

We have carefully considered your request for approval as a supplier of renal services in the Medicare program under the (**ESRD**) regulations, and have determined that your facility meets program requirements and is eligible for payment under section 1881 of the Social Security Act.

Your facility has been approved as (**renal transplantation center**) (**renal dialysis center**) (**renal dialysis facility**) (**special purpose renal dialysis facility**) to furnish the following service(s). The total number of approved stations is (**number**).

	Services	**Number of Stations**
____	Transplantation	____
____	Staff Assisted Dialysis	____
	___ Hemodialysis	____
	___ Peritoneal	____
____	Self-Dialysis	____
____	Patient Dialysis Training	____
	___ Hemodialysis	____
	___ Peritoneal	____
____	Other (Specify)	____

Based upon the review of utilization data, your facility has been assigned the following minimal utilization rate classification status:

Transplantation

____ Conditional
____ Unconditional
____ Exception

(**Include as appropriate**)

l. If MUR classification is conditional, your facility has four calendar years following the current year in which to attain unconditional status. Conditional status cannot be renewed.

2. If MUR exception status is granted, it must be periodically reviewed and renewed.

3. (**New Applicant**)--Based upon projected utilization set forth in your proposed Plan of Operation, your participation is contingent upon attaining conditional status by the end of your second calendar year of participation following the current year, and unconditional status during the fourth calendar year.

4. In the recent survey of your facility for compliance with the Conditions for Coverage, the following items were not met:

   Please submit your Plan of Correction, Form CMS-2567, by (**date**) .

5. (**For former participants, add the following sentence**:) This determination supersedes all prior determinations made under the ESRD program regulations.

Your intermediary for payment of renal treatment procedures is (**name of intermediary**). You must maintain separate cost centers for all renal services. Your intermediary will contact you shortly and explain the special payment procedures to be followed. Enter your provider number, shown above, on all forms and correspondence relating to the Medicare renal treatment program.

If you contemplate any further expansion, relocations, renovation, change of ownership, or additions to your renal treatment services, including reuse, after the date of this approval, you must notify us as soon as possible, by filing a new application. Your application should include all pertinent information concerning the nature and effect of the proposed change. We will then determine whether the contemplated changes meet program requirements.

Should you have any questions in regard to your participation in the Medicare renal treatment program, please contact this office.

If you believe that this determination is not correct in any respect, you may request that the decision be reconsidered. The request must be submitted in writing to this office within 60 days of the date of this notice. You may submit any additional information that you feel may have a bearing on the determination with the reconsideration request.

Sincerely yours,

Associate Regional Administrator
(or its equivalent)