INDEX OF EXHIBITS TO THE FIRST AMENDED COMPLAINT

UNITED STATES OF AMERICA, et al. *ex rel.* DAVID BARBETTA,
Plaintiffs
v.
DAVITA, INC. and TOTAL RENAL CARE, INC.,
Defendants

Case No. 09 cv 02175 WJM-KMT

Exhibit 1

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-K

For the Fiscal Year Ended

December 31, 2010

ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

Commission File Number: 1-14106

DAVITA INC.

1551Wewatta Street
Denver, Colorado 80202
Telephone number (303) 405-2100

Delaware	**51-0354549**
(State of incorporation)	**(I.R.S. Employer Identification No.)**

Securities registered pursuant to Section 12(b) of the Act:

Class of Security:	**Registered on:**
Common Stock, $0.001 par value	New York Stock Exchange
Common Stock Purchase Rights	New York Stock Exchange

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ¡ No ″

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Exchange Act. Yes ″ No ¡

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports) and (2) has been subject to such filing requirements for the past 90 days. Yes ¡ No ″

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ″

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ¡ No ″

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ¡ Accelerated filer ″ Non-accelerated filer ″ Smaller reporting company ″
(Do not check if a smaller reporting company)

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ″ No ¡

As of June 30, 2010, the number of shares of the Registrant's common stock outstanding was approximately 102.6 million shares and the aggregate market value of the common stock outstanding held by non-affiliates based upon the closing price of these shares on the New York Stock Exchange was approximately $6.4 billion.

As of January 31, 2011, the number of shares of the Registrant's common stock outstanding was approximately 96.0 million shares and the aggregate market value of the common stock outstanding held by non-affiliates based upon the closing price of these shares on the New York Stock Exchange was approximately $7.1 billion.

Documents incorporated by reference

Portions of the Registrant's proxy statement for its 2011 annual meeting of stockholders are incorporated by reference in Part

III of this Form 10-K.

PART I

Item 1. Business

We were incorporated as a Delaware corporation in 1994. Our annual report on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K and amendments to those reports filed or furnished pursuant to section 13(a) or 15(d) of the Exchange Act are made available free of charge through our website, located at http://www.davita.com, as soon as reasonably practicable after the reports are filed with or furnished to the Securities and Exchange Commission, or SEC. The SEC also maintains a website at http://www.sec.gov where these reports and other information about us can be obtained. The contents of our website are not incorporated by reference into this report.

Overview

DaVita is a leading provider of kidney dialysis services in the United States for patients suffering from chronic kidney failure, also known as end stage renal disease, or ESRD. As of December 31, 2010, we operated or provided administrative services to 1,612 outpatient dialysis centers located in 42 states and the District of Columbia, serving approximately 125,000 patients. We also provide acute inpatient dialysis services in approximately 750 hospitals and related laboratory services. Our dialysis and related lab services business accounts for approximately 94% of our consolidated net operating revenues. Our other ancillary services and strategic initiatives currently account for approximately 6% of our consolidated net operating revenues and relate primarily to our core business of providing kidney dialysis services.

The dialysis industry

The loss of kidney function is normally irreversible. Kidney failure is typically caused by Type I and Type II diabetes, high blood pressure, polycystic kidney disease, long-term autoimmune attack on the kidney and prolonged urinary tract obstruction. ESRD is the stage of advanced kidney impairment that requires continued dialysis treatments or a kidney transplant to sustain life. Dialysis is the removal of toxins, fluids and salt from the blood of ESRD patients by artificial means. Patients suffering from ESRD generally require dialysis at least three times a week for the rest of their lives.

According to United States Renal Data System, there were 382,000 ESRD dialysis patients in the United States in 2008 and the underlying ESRD dialysis patient population has grown at an approximate compound rate of 3.8% from 2000 to 2008, the latest period for which such data is available. The growth rate is attributable to the aging of the population, increased incidence rates for diseases that cause kidney failure such as diabetes and hypertension, lower mortality rates for dialysis patients and growth rates of minority populations with higher than average incidence rates of ESRD.

Since 1972, the federal government has provided health care coverage for ESRD patients under the Medicare ESRD program regardless of age or financial circumstances. ESRD is the first and only disease state eligible for Medicare coverage both for dialysis and dialysis-related services and for all benefits available under the Medicare program. Under this system, Congress established Medicare rates for dialysis treatments, related supplies, lab tests and medications. Although Medicare reimbursement limits the allowable charge per treatment, it provides industry participants with a relatively predictable and recurring revenue stream for dialysis services provided to patients without commercial insurance. Approximately 89% of our total patients are under government-based programs, with approximately 80% of our patients under Medicare and Medicare-assigned plans.

Prior to January 2011, dialysis providers operating under the Medicare ESRD program received a composite payment rate to cover routine dialysis treatments and certain supplies. There was a separate payment for laboratory testing and pharmaceuticals such as erythropoietin, or EPO, vitamin D analogs and iron supplements

that were not included in the composite payment rate. However, beginning in January 2011, Medicare implemented a new payment system in which all ESRD payments are now made under a single bundled payment rate that provides for an annual inflation adjustment based upon a market basket index, less a productivity improvement factor. The bundled payment rate provides a fixed rate to encompass all goods and services provided during the dialysis treatment, including pharmaceuticals that were historically separately reimbursed to the dialysis providers, such as EPO, vitamin D analogs and iron supplements, irrespective of the level of pharmaceuticals administered or additional services performed. Most lab services that used to be paid directly to laboratories are also included in the new payment bundle.

Treatment options for ESRD

Treatment options for ESRD are dialysis and kidney transplantation.

Dialysis Options

- *Hemodialysis*

Hemodialysis, the most common form of ESRD treatment, is usually performed at a freestanding outpatient dialysis center, a hospital-based outpatient center, or at the patient's home. The hemodialysis machine uses an artificial kidney, called a dialyzer, to remove toxins, fluids and salt from the patient's blood. The dialysis process occurs across a semi-permeable membrane that divides the dialyzer into two distinct chambers. While blood is circulated through one chamber, a pre-mixed fluid is circulated through the other chamber. The toxins, salt and excess fluids from the blood cross the membrane into the fluid, allowing cleansed blood to return into the patient's body. Each hemodialysis treatment that occurs in the outpatient dialysis centers typically lasts approximately three and one-half hours and is usually performed three times per week.

Some ESRD patients who are healthier and more independent may perform home-based hemodialysis in their home or residence through the use of a hemodialysis machine designed for home therapy that is portable, smaller and easier to use. Patients receive training, support and monitoring from registered nurses, in some cases in our outpatient dialysis centers, in connection with treatments. Home-based hemodialysis is typically performed with greater frequency than dialysis treatments performed in outpatient dialysis centers and on varying schedules.

Hospital inpatient hemodialysis services are required for patients with acute kidney failure resulting from trauma, patients in early stages of ESRD, and ESRD patients who require hospitalization for other reasons. Hospital inpatient hemodialysis is generally performed at the patient's bedside or in a dedicated treatment room in the hospital, as needed.

- *Peritoneal dialysis*

Peritoneal dialysis uses the patient's peritoneal or abdominal cavity to eliminate fluid and toxins and is typically performed at home. The most common methods of peritoneal dialysis are continuous ambulatory peritoneal dialysis, or CAPD, and continuous cycling peritoneal dialysis, or CCPD. Because it does not involve going to an outpatient dialysis center three times a week for treatment, peritoneal dialysis is an alternative to hemodialysis for patients who are healthier, more independent and desire more flexibility in their lifestyle. However, peritoneal dialysis is not a suitable method of treatment for many patients, including patients who are unable to perform the necessary procedures and those at greater risk of peritoneal infection.

CAPD introduces dialysis solution into the patient's peritoneal cavity through a surgically placed catheter. Toxins in the blood continuously cross the peritoneal membrane into the dialysis solution. After several hours, the patient drains the used dialysis solution and replaces it with fresh solution. This procedure is usually repeated four times per day.

CCPD is performed in a manner similar to CAPD, but uses a mechanical device to cycle dialysis solution through the patient's peritoneal cavity while the patient is sleeping or at rest.

- *Kidney transplantation*

Although kidney transplantation, when successful, is generally the most desirable form of therapeutic intervention, the shortage of suitable donors, side effects of immunosuppressive pharmaceuticals given to transplant recipients and dangers associated with transplant surgery for some patient populations limit the use of this treatment option.

Services we provide

Dialysis and Related Lab Services

Outpatient dialysis services

As of December 31, 2010, we operated or provided administrative services to 1,612 outpatient dialysis centers in the United States that are designed specifically for outpatient hemodialysis. In 2010, we added a net total of 82 outpatient dialysis centers primarily as a result of acquisitions and the opening of new centers, net of center closures and divestitures. This represented a total increase of approximately 5% to our overall network of outpatient dialysis centers.

As a condition of our enrollment in Medicare, we contract with a nephrologist or a group of affiliated nephrologists to provide medical director services at each of our centers. In addition, other nephrologists may apply for practice privileges to treat their patients at our centers. Each center has an administrator, typically a registered nurse, who supervises the day-to-day operations of the center and its staff. The staff of each center typically consists of registered nurses, licensed practical or vocational nurses, patient care technicians, a social worker, a registered dietician, biomedical technician support and other administrative and support personnel.

Many of our outpatient dialysis centers offer services for dialysis patients who prefer and are able to perform either home-based hemodialysis in their homes or peritoneal dialysis. Home-based hemodialysis services consist of providing equipment and supplies, training, patient monitoring, on-call support services and follow-up assistance. Registered nurses train patients and their families or other caregivers to perform either home-based hemodialysis or peritoneal dialysis.

Under Medicare regulations, we cannot promote, develop or maintain any kind of contractual relationship with our patients which would directly or indirectly obligate a patient to use or continue to use our dialysis services, or which would give us any preferential rights other than those related to collecting payments for our services. Our total patient turnover averaged approximately 30% per year for the last two years. However, in 2010 the overall number of patients to whom we furnished services increased by approximately 6%, primarily from continued growth within the industry, lower mortality rates and the opening of new centers and acquisitions.

Hospital inpatient hemodialysis services

We provide hospital inpatient hemodialysis services, excluding physician services, to patients in approximately 750 hospitals. We render these services for a contracted per-treatment fee that is individually negotiated with each hospital. When a hospital requests our services, we typically administer the dialysis treatment at the patient's bedside or in a dedicated treatment room in the hospital, as needed. Hospital inpatient hemodialysis services are required for patients as discussed above. In 2010, hospital inpatient hemodialysis services accounted for approximately 4% of our total dialysis treatments.

ESRD laboratory services

We own two separately incorporated, licensed, clinical laboratories specializing in ESRD patient testing. These specialized laboratories provide routine laboratory tests for dialysis and other physician-prescribed laboratory tests for ESRD patients. Our laboratories provide these tests predominantly for our network of ESRD patients throughout the United States. These tests are performed to monitor a patient's ESRD condition, including the adequacy of dialysis, as well as other medical conditions. Our laboratories utilize information systems which provide information to our dialysis centers regarding critical outcome indicators.

Management services

We currently operate or provide management and administrative services to 32 outpatient dialysis centers in which we either own a minority equity investment or are wholly-owned by third parties. These services are provided pursuant to management and administrative services agreements. Management fees are established by contract and are recognized as earned typically based on a percentage of revenues or cash collections generated by the centers.

Ancillary services and strategic initiatives

Ancillary services and strategic initiatives, which currently account for approximately 6% of our total consolidated net operating revenues, consist of the following:

- *Pharmacy services*. DaVita Rx is a pharmacy that provides oral medications to DaVita's patients with ESRD. The main objectives of the pharmacy are to improve clinical outcomes by facilitating increased patient compliance and to provide our patients a convenient way to fill their prescription needs by delivering the prescriptions to the center where they are treated. Revenues are recognized as prescriptions are filled and shipped to patients.
- *Infusion therapy services.* HomeChoice Partners provides personalized infusion therapy services to patients typically in their own homes as a cost-effective alternative to inpatient hospitalization. Intravenous and nutritional support therapies are typically managed by registered and/or board-certified professionals including pharmacists, nurses and dieticians in collaboration with the patient's physician in support of the patient's ongoing health care needs. Revenues are recognized in the period when infusion therapy services are provided.
- *Disease management services.* VillageHealth provides advanced care management services to health plans and government agencies for employees/members diagnosed with Chronic Kidney Disease (CKD) or ESRD. Through a combination of clinical coordination, medical claims analysis and information technology, we endeavor to assist our customers and patients in obtaining superior renal health care and improved clinical outcomes, as well as helping to reduce overall medical costs. Revenues are typically based upon an established contract fee and are recognized as earned over the contract period and can include additional fees for cost savings recognized by certain customers.
- *Vascular access services.* Lifeline provides management and administrative services to physician-owned vascular access clinics that provide surgical and interventional radiology services for dialysis patients. Lifeline also is the majority-owner of one vascular access clinic. Management fees generated from providing management and administrative services are recognized as earned typically based on a percentage of revenues or cash collections generated by the clinics. Revenues associated with the vascular access clinic that is majority-owned are recognized in the period when physician services are provided.
- *ESRD clinical research programs.* DaVita Clinical Research conducts research trials principally with dialysis patients and provides administrative support for research conducted by DaVita-affiliated nephrology practices. Revenues are based upon an established fee per study, as determined by contract with drug companies and other sponsors and are recognized as earned according to the contract terms.

- *Physician services.* DaVita Nephrology Partners offers practice management and administrative services to physicians who specialize in nephrology under management and administrative services agreements. Practice management and administrative services typically include operations management, IT support, billing and collections, credentialing and coding, and other support functions. Management fees generated from providing practice management and administrative services to physician practices are recognized as earned typically based upon cash collections generated by the practices.

Quality care

We employ 180 clinical service specialists. The primary focus of this group is assuring and facilitating processes that aim to achieve superior clinical outcomes at our centers.

Our physician leadership in the Office of the Chief Medical Officer (OCMO) includes eight senior nephrologists, led by our Chief Medical Officer, with a variety of academic, clinical practice, and clinical research backgrounds. Our Physician Council is an advisory body to senior management, composed of nine physicians with extensive experience in clinical practice in addition to the members of OCMO and five Group Medical Directors.

Sources of revenue—concentrations and risks

Our dialysis and related lab services business revenues represent approximately 94% of our consolidated net operating revenues for the year ended December 31, 2010, with the balance of our revenues from ancillary services and strategic initiatives. Dialysis and related lab services revenues are derived primarily from our core business of providing kidney dialysis services, the administration of pharmaceuticals, related laboratory services and to a lesser extent management fees generated from providing management and administrative services to certain outpatient dialysis centers.

The sources of our dialysis and related lab services revenues are principally from government-based programs, including Medicare and Medicare-assigned plans, Medicaid and Medicaid-assigned plans and commercial insurance plans.

The following table summarizes our dialysis and related lab services revenues by source for the year ended December 31, 2010:

	Revenue percentages
Medicare and Medicare-assigned plans	57%
Medicaid and Medicaid-assigned plans	6%
Other government-based programs	3%
Total government-based programs	66%
Commercial (including hospital inpatient dialysis services)	34%
Total dialysis and related lab services revenues	100%

The following table summarizes our dialysis and related lab services revenues by modality for the year ended December 31, 2010:

	Revenue percentages
Outpatient hemodialysis centers	83%
Peritoneal dialysis and home-based hemodialysis	12%
Hospital inpatient hemodialysis	5%
Total dialysis and related lab services revenues	100%

Medicare revenue

Under the Medicare ESRD program, payment rates for dialysis are established by the U.S. Congress. Prior to January 2011, the Medicare composite rate set by the Centers for Medicare and Medicaid Services, or CMS, paid dialysis providers for services furnished to Medicare beneficiaries in two parts: (1) the composite payment which included a base payment, adjusted for case-mix which linked payments more closely with illness severity and regional geography differences, and a drug add-on payment, which was updated annually to account for changes in drug prices and utilization and (2) separately billable reimbursement for certain drugs. Thus, dialysis providers received a composite payment rate per treatment to cover routine dialysis services, certain pharmaceuticals, routine lab work, and other supplies, as well as a separate payment for pharmaceuticals, which include EPO (a pharmaceutical used to treat anemia, a common complication associated with ESRD), vitamin D analogs and iron supplements that are not included in the composite payment rate. Pharmaceuticals were generally paid at average sale price, or ASP, plus 6% based upon prices set by Medicare. The Medicare payment rates that were paid to us, including payments for separately billable drugs, were not sufficient to cover our average cost of providing a dialysis treatment.

ESRD patients receiving dialysis services become eligible for primary Medicare coverage at various times, depending on their age or disability status, as well as whether they are covered by an employer group health plan. Generally, for a patient not covered by an employer group health plan, Medicare becomes the primary payor either immediately or after a three-month waiting period. For a patient covered by an employer group health plan, Medicare generally becomes the primary payor after 33 months, which includes a three month waiting period, or earlier if the patient's employer group health plan coverage terminates. When Medicare becomes the primary payor, the payment rate we receive for that patient shifts from the commercial insurance plan rate to the Medicare payment rate.

Medicare pays 80% of the amount set by the Medicare system for each covered treatment. The patient is responsible for the remaining 20%. In most cases, a secondary payor, such as Medicare supplemental insurance, a state Medicaid program or a commercial health plan, covers all or part of these balances. Some patients, who do not qualify for Medicaid but otherwise cannot afford secondary insurance, can apply for premium payment assistance from charitable organizations through a program offered by the American Kidney Fund. We and other dialysis providers support the American Kidney Fund and similar programs through voluntary contributions. If a patient does not have secondary insurance coverage, we are generally unsuccessful in our efforts to collect from the patient the 20% portion of the ESRD composite rate that Medicare does not pay. However, we are able to recover some portion of this unpaid patient balance from Medicare through an established cost reporting process by identifying these Medicare bad debts on each center's Medicare cost report.

The Medicare composite payment rates set by Congress for dialysis treatments that were in effect for 2010 were between $151 and $169 per treatment, with an average rate of $161 per treatment. Historically, Medicare payment rates for dialysis services have not been routinely increased to compensate for the impact of inflation, which negatively impacted our margins as patient care costs continued to rise. The Medicare Improvements for Patients and Providers Act for 2008, or MIPPA, provided dialysis providers with an increase in the composite rate of 1% that went into effect on January 1, 2009 and an additional 1% that went into effect on January 1, 2010. This legislation also changed the way Medicare pays for dialysis services beginning in January 2011, as further described below. The new payment system also provides for an annual inflation adjustment based upon a market basket index, less a productivity adjustment, beginning in 2012. Also beginning in 2012, the rule provides for up to a 2% annual payment withhold that can be earned back by facilities that meet certain defined clinical performance standards.

The new payment system reimburses providers based on a single bundled or average payment for each Medicare treatment provided. The new bundled payment amount is designed to cover all dialysis services that were historically included in the composite rate and all separately billable ESRD services such as pharmaceuticals and laboratory tests. This new bundled payment rate is adjusted for certain patient characteristics, a geographic wage

index and certain other factors. The initial 2011 bundled payment rate includes reductions of 2% and 3.1%, respectively, to conform to the provisions of MIPPA and to establish budget neutrality. Further, there is a 5.94% reduction tied to an expanded list of case mix adjustors which can be earned back based upon the presence of these certain patient characteristics and co-morbidities at the time of treatment. There are also other provisions which may impact payment including an outlier pool and a low volume facility adjustment. Historically, services that were separately billable accounted for approximately 30% of our total dialysis and related lab revenues. Now the dialysis providers are at risk for variations in pharmaceutical utilization since reimbursement set at a fixed average reimbursement rate. With regard to the expanded list of case-mix adjustors, these are difficult or, in some cases, have been impossible for our dialysis clinics to document and track, which could result in a reduction in the reimbursement amounts that we would otherwise be entitled to receive.

We are attempting to reduce our operating costs to minimize the overall negative financial impact from the reductions in reimbursement for services we provide to Medicare patients. However, certain operating expenditures, such as labor and supply costs, are subject to inflation, and without a compensating inflation-based increase in the new bundled payment rate system, could significantly impact our operating results.

We participated in two Medicare demonstration programs through a contract with CMS in 2010. One program was an ESRD demonstration program that started in January 2006 and terminated in December 2010. This program was converted into a full service health care plan for ESRD patients in 2011, which is referred to as a Medicare Advantage ESRD Special Needs Plan that works with CMS to provide ESRD patients full service health care. The revenue in 2010 was capitated for all medical services required by enrollees in the program. We are still at risk for all medical costs of the program in excess of the capitation payments. The other program is a CKD/ESRD demonstration program which started in November 2008 and will continue for three years. We are paid a management fee for program enrollees relating to CKD and ESRD disease states. Management fee revenues are subject to retraction if medical cost savings targets are not met.

Medicaid revenue

Medicaid programs are state-administered programs partially funded by the federal government. These programs are intended to provide health coverage for patients whose income and assets fall below state-defined levels and who are otherwise uninsured. These programs also serve as supplemental insurance programs for co-insurance payments due from Medicaid-eligible patients with primary coverage under Medicare. Some Medicaid programs also pay for additional services, including some oral medications that are not covered by Medicare. We are enrolled in the Medicaid programs in the states in which we conduct our business.

Commercial revenues

Before a patient becomes eligible to have Medicare as their primary payor for dialysis services, a patient’s commercial insurance plan, if any, is responsible for payment of such dialysis services. Although commercial payment rates vary significantly, average commercial payment rates are generally significantly higher than Medicare rates. The payments we receive from commercial payors generate nearly all of our profits. Payment methods from commercial payors include a single lump-sum per treatment, referred to as bundled rates, and in some cases separate payments for treatments and pharmaceuticals, if used as part of the treatment, referred to as fee for service rates. Commercial payment rates are typically the result of negotiations between us and insurers or third-party administrators. Our out-of-network payment rates are on average higher than in-network payment rates. In 2010, we entered into several new commercial contracts with certain commercial payors that will primarily pay us a single bundled payment rate for all dialysis services provided to patients covered by the commercial insurance plan. However, some of the contracts will pay us for certain other services and pharmaceuticals in addition to the bundled payment. These contracts contain annual escalators and effectively eliminate all payments for out-of-network patients. We are continuously in the process of negotiating agreements with our commercial payors and if our negotiations result in overall commercial rate reductions in excess of our commercial rate increases, our revenues and operating results could be negatively impacted. In addition, if there

are sustained or increased job losses in the United States as a result of current economic conditions, or depending upon changes to the healthcare regulatory system, we could experience a decrease in the number of patients covered under commercial plans.

Approximately 34% of our dialysis and related lab services revenues and approximately 11% of our patients were associated with commercial payors for the year ended December 31, 2010. Less than 1% of our dialysis and related lab services revenues are due directly from patients. No single commercial payor accounted for more than 5% of total dialysis and related lab services revenues for the year ended December 31, 2010.

Revenue from EPO and other pharmaceuticals

Approximately 26% of our total dialysis and related lab services revenues for the year ended December 31, 2010 are associated with the administration of physician-prescribed pharmaceuticals that improve clinical outcomes when included with the dialysis treatment. These pharmaceuticals include EPO, vitamin D analogs and iron supplements. However, as described above, the majority of these pharmaceuticals will no longer be separately billable as a result of the new Medicare single bundled payment rate system effective in January 2011 as well as some of our new commercial contracts that implemented a single bundled payment rate.

EPO is an erythropoiesis stimulating agent, or ESA, genetically-engineered form of a naturally occurring protein that stimulates the production of red blood cells. EPO is used in connection with all forms of dialysis to treat anemia, a medical complication most ESRD patients experience. The administration of EPO, which was separately billable under the Medicare payment program through 2010, accounted for approximately 18% of our dialysis and related lab services revenues for the year ended December 31, 2010.

Furthermore, EPO is produced by a single manufacturer, Amgen, who can unilaterally increase its price for EPO at any time during the term of our agreement with them. Any interruption of supply or product cost increases could adversely affect our operations. In 2010, we experienced an increase in the cost of EPO of approximately 2%. In December 2010, we entered into a new Dialysis Organization Agreement (the “Agreement”) with Amgen USA Inc., a wholly owned subsidiary of Amgen Inc. The Agreement sets forth the terms under which we and certain of our affiliates will purchase EPO. The Agreement, among other things, provides for discount pricing and rebates for EPO. Some of the rebates are subject to various qualification requirements based on a variety of factors including process improvement targets, patient outcome targets and data submission. The term of the Agreement commenced January 1, 2011 and ends June 30, 2011.

There continues to be significant media discussion and government scrutiny regarding anemia management practices in the United States. In late 2006, the U.S. House of Representatives Ways and Means Committee held a hearing on the issue of the utilization of ESAs, which include EPO, and in 2007, the FDA required changes to the labeling of EPO and darbepoetin alfa, or Aranesp® to include a black box warning, the FDA’s strongest form of warning label. An FDA advisory panel on ESA use met in October 2010, which meeting was similar to the prior meeting held in 2007 in that there was significant discussion and concern about the safety of ESAs. The panel concluded it would not recommend a change in ESA labeling. However, the FDA is not bound by the panel’s recommendation. In addition, in June 2010, CMS opened a National Coverage Analysis (NCA) for ESAs. Further, in January 2011, CMS convened a meeting of the Medicare Evidence Development and Coverage Advisory Committee (MEDCAC) to evaluate evidence for the pending NCA. CMS expects to complete its decision memo in March 2011 and issue final guidance in June 2011. The foregoing congressional and agency activities and related actions could result in further restrictions on the utilization and reimbursement for ESAs. Commercial payors have also increasingly examined their administration policies for EPO and, in some cases, have modified those policies. Inclusion of EPO in the Medicare bundled payment rate, as well as in a bundled payment rate for several of our commercial payors, is expected to mitigate the effect of lower utilization of EPO. However, further changes in labeling of EPO and other pharmaceuticals in a manner that alters physician practice patterns or accepted clinical practices, changes in private and governmental payment criteria, including the introduction of EPO administration policies or the conversion to alternate types of administration of EPO or other pharmaceuticals that result in further decreases in utilization or reimbursement for EPO and other pharmaceuticals, could have a material adverse effect on our operating results.

Physician relationships

An ESRD patient generally seeks treatment at an outpatient dialysis center near his or her home where his or her treating nephrologist has practice privileges. Our relationships with local nephrologists and our ability to meet their needs and the needs of their patients are key factors in the success of our dialysis operations. Over 3,900 nephrologists currently refer patients to our outpatient dialysis centers. As is typical in the dialysis industry, one or a few physicians, including the outpatient dialysis center's medical director, usually account for all or a significant portion of an outpatient dialysis center's patient base. If a significant number of physicians, including an outpatient dialysis center's medical directors, were to cease referring patients to our outpatient dialysis centers, our business could be adversely affected.

Participation in the Medicare ESRD program requires that dialysis services at an outpatient dialysis center be under the general supervision of a medical director who is a licensed physician. We have engaged physicians or groups of physicians to serve as medical directors for each of our outpatient dialysis centers. At some outpatient dialysis centers, we also separately contract with one or more physicians to serve as assistant or associate medical directors or to direct specific programs, such as home dialysis training programs. We have contracts with approximately 1,400 individual physicians and physician groups to provide medical director services.

Medical directors enter into written contracts with us that specify their duties and fix their compensation generally for periods of ten years. The compensation of our medical directors is the result of arm's length negotiations and generally depends upon an analysis of various factors such as the physician's duties, responsibilities, professional qualifications and experience, among others.

Our medical director contracts generally include covenants not to compete. Also, when we acquire an outpatient dialysis center from one or more physicians or where one or more physicians own minority interests in our outpatient dialysis centers, these physicians have agreed to refrain from owning interests in other competing outpatient dialysis centers within a defined geographic area for various time periods. These agreements not to compete restrict the physicians from owning or providing medical director services to other outpatient dialysis centers, but do not prohibit the physicians from referring patients to any outpatient dialysis center, including competing centers. Many of these agreements not to compete continue for a period of time beyond expiration of the corresponding medical director agreements, although some expire at the same time as the medical director agreement. Occasionally, we experience competition from a new outpatient dialysis center established by a former medical director following the termination of his or her relationship with us.

Government regulation

Our dialysis operations are subject to extensive federal, state and local governmental regulations. These regulations require us to meet various standards relating to, among other things, government payment programs, dialysis facilities and equipment, management of centers, personnel qualifications, maintenance of proper records and quality assurance programs and patient care.

Because we are subject to a number of governmental regulations, our business could be adversely impacted by:

- Loss or suspension of federal certifications;
- Loss or suspension of licenses under the laws of any state or governmental authority from which we generate substantial revenues;
- Exclusion from government healthcare programs including Medicare and Medicaid;
- Significant reductions or lack of inflation-adjusted increases in payment rates or reduction of coverage for dialysis and ancillary services and related pharmaceuticals;
- Fines, damages and monetary penalties for anti-kickback law violations, Stark Law violations, submission of false claims, civil or criminal liability based on violations of law or other failures to meet regulatory requirements;

- Claims for monetary damages from patients who believe their protected health information has been used or disclosed in violation of federal and state patient privacy laws;
- Mandated changes to our practices or procedures that significantly increase operating expenses; or
- Refunds of payments received from government payors and government health care program beneficiaries because of any failures to meet applicable requirements.

We expect that our industry will continue to be subject to substantial regulation, the scope and effect of which are difficult to predict. Our activities could be reviewed or challenged by regulatory authorities at any time in the future. This regulation and scrutiny could have a material adverse impact on us.

Licensure and Certification

Our dialysis centers are certified by CMS, as is required for the receipt of Medicare payments. In some states, our dialysis centers also are required to secure additional state licenses and permits. Governmental authorities, primarily state departments of health, periodically inspect our centers to determine if we satisfy applicable federal and state standards and requirements, including the conditions of participation in the Medicare ESRD program.

To date, we have not experienced significant difficulty in maintaining our licenses or our Medicare and Medicaid authorizations. However, we have experienced delays in obtaining certifications from CMS.

CMS continues to study the regulations applicable to Medicare certification to provide dialysis services. On April 15, 2008, CMS issued new regulations for Medicare-certified ESRD facilities to provide dialysis services, referred to as Conditions for Coverage. The Conditions for Coverage were effective October 14, 2008, with some provisions having a phased in implementation date of February 1, 2009. The new regulations are patient, quality and outcomes focused. Among other things, they establish performance expectations for facilities and staff, eliminate certain procedural requirements, and promote continuous quality improvement and patient safety measures. We have established an interdisciplinary work group to facilitate implementation of the Conditions of Coverage and have developed comprehensive auditing processes to monitor ongoing compliance. We continue to assess the impact these changes will have on our operating results.

Federal anti-kickback statute

The “anti-kickback” statute contained in the Social Security Act imposes criminal and civil sanctions on persons who receive, make, offer or solicit payments in return for:

- The referral of a Medicare or Medicaid patient for treatment;
- The ordering or purchasing of items or services that are paid for in whole or in part by Medicare, Medicaid or similar federal and state programs; or
- Arranging for or recommending the ordering or purchasing of such items.

Federal criminal penalties for the violation of the anti-kickback statute include imprisonment, fines and exclusion of the provider from future participation in the Medicare and Medicaid programs. Violations of the anti-kickback statute are punishable by imprisonment for up to five years and fines of up to $250,000 or both. Larger fines can be imposed upon corporations under the provisions of the U.S. Sentencing Guidelines and the Alternate Fines Statute. Individuals and entities convicted of violating the anti-kickback statute are subject to mandatory exclusion from participation in Medicare, Medicaid and other federal healthcare programs for a minimum of five years. Civil penalties for violation of this law include up to $50,000 in monetary penalties per violation, repayments of up to three times the total payments between the parties and suspension from future participation in Medicare and Medicaid. Court decisions have also held that the statute is violated whenever one of the purposes of remuneration is to induce referrals.

Exhibit 2

Web Link: http://oig.hhs.gov/fraud/docs/safeharborregulations/acquisition122292.htm

December 22, 1992

Mr. T. J. Sullivan

Technical Assistant (Health Care Industries)

Office of the Associate Chief Counsel

(Employee Benefits and Exempt Organizations)

Internal Revenue Service

Washington, D.C. 20224

Dear Mr. Sullivan:

You have informally inquired about our views concerning the application of the Medicare and Medicaid anti-kickback statute, 42 U.S.C. 1320a-7b(b), to certain types of situations involving the acquisition of physician practices. In the situations in question, the physician practices would be acquired either by a hospital or by another entity which would also acquire one or more hospitals (and potentially other health care providers as well). The physicians from these practices would continue to treat patients and be affiliated (through an employment relationship or otherwise) with the hospital or other entity which acquired their practices. The acquisition of the physician practices could arise through a number of different methods or arrangements and the resulting or ensuing relationships or affiliations could vary. However, the end result in each case would be the common ownership or control of both hospitals and physician practices by a single entity. We are responding to your inquiry in general terms and not in reference to any specific fact pattern(s).

Typically, in the case of the acquisition of a physician practice by a hospital or other entity, there is a large, up front payment to the physician, often of many hundreds of thousands of dollars or more. This sum is asserted to be payment for the purchase of the assets of the practice. There are also payments made to the physician subsequent to the sale of the practice where the physician becomes employed by the hospital or entity or otherwise enters into a contract to provide services to patients. These payments are asserted to be compensation for services rendered to patients by the physician.

As you know, the anti-kickback statute provides for penalties against anyone who knowingly and willfully solicits, receives, offers or pays remuneration, in cash or in kind, to induce or in return for:

A. referring an individual to a person for the furnishing or arranging for the furnishing of any

item or service payable under the Medicare or Medicaid programs, or

B. purchasing, leasing or ordering or arranging for or recommending purchasing, leasing, or ordering any good, facility, service or item payable under the Medicare or Medicaid programs.

Persons who violate the anti-kickback statute are subject to criminal penalties and/or exclusion from participation in the Medicare and Medicaid programs. The anti-kickback statute sets forth certain specific exceptions to the general prohibition against remuneration, and specifically authorizes this Department to promulgate, by regulation, additional payment practices (known as "safe harbors") which will be immune from prosecution. The Department published final "safe harbor" regulations on July 29, 1991 (42 C.F.R. 1001.952, 56 Fed. Reg. 35,952) setting forth eleven regulatory exceptions to the anti-kickback statute. Among the safe harbors included in the regulations were provisions relating to employees and sale of practitioner practices. Additional safe harbor provisions relating to "managed care" entities were published as final regulations (with comment period) on November 5, 1992 (57 Fed. Reg. 52,723).

We have significant concerns under the anti-kickback statute about the type of physician practice acquisitions described in your inquiry to us. Frequently, hospitals seek to purchase physician practices as a means to retain existing referrals or to attract new referrals of patients to the hospital. Such purchases implicate the anti-kickback statute because the remuneration paid for the practice can constitute illegal remuneration to induce the referral of business reimbursed by the Medicare or Medicaid programs.(1)

We believe the same concerns raised by hospital purchases of physician practices could also arise where another entity (such as a foundation) purchases a physician practice, when such foundation also owns or operates a hospital which benefits from referrals from those physicians.

In particular, we are concerned that the remuneration paid in connection with or as a result of the acquisition of a physician's practice could serve to interfere with the physician's subsequent judgment of what is the most appropriate care for a patient. The remuneration could result in the delivery of inappropriate care to Medicare or Medicaid beneficiaries by inducing the physician to utilize the affiliated hospital rather than another hospital or less costly facility which may provide better or more appropriate care. It could also have the effect of inflating costs to the Medicare or Medicaid programs by causing physicians to overuse inappropriately the services of a particular hospital (or other affiliated provider). This higher cost could occur directly because of the higher rates of that hospital or the ordering of unnecessary serviced or indirectly as a result of lessened competition in the marketplace. Finally, these arrangements could significantly interfere with a beneficiary's freedom of choice of providers. All these considerations are the very abuses that the antikickback statute was designed to prevent. We recently addressed these same types of possible abuses in an Office of Inspector General Special Fraud Alert entitled "Hospital Incentives to Physicians". A copy of that Fraud Alert is enclosed for your information.

The following are specific aspects of physician practice acquisition or subsequent activities that may implicate or result in violations of the anti-kickback statute. Our comments focus primarily on two broad issue categories: (1) the total amount paid for the physician practice and the nature

and type of items for which the physician receives payment; and (2) the amount and manner in which the physician is subsequently compensated for providing services to patients.(2)

Under the anti-kickback statute, either of the above categories of payment could constitute illegal remuneration. This is because under the anti-kickback statute, the statute is violated if "one purpose" of the payment is to induce the referral of future Medicare or Medicaid program business. United States v. Greber, 760 F.2d 68, 69 (3rd Cir. 1985) cert. denied, 474 U.S. 988 (1985); United States v. Kats, 871 F.2d 105, 108 (9th Cir. 1989). Thus, it is necessary to scrutinize the payments (including the surrounding facts and circumstances) to determine the purpose for which they have been made. As part of this undertaking, it is necessary to consider the amounts paid for the practice or as compensation to determine whether they reasonably reflect the fair market value of the practice or the services rendered, in order to determine whether such items in reality constitute remuneration for referrals. Moreover, to the extent that a payment exceeds the fair market value of the practice or the value of the services rendered, it can be inferred that the excess amount paid over fair market value is intended as payment for the referral of program-related business. United States v. Lipkis, 770 F.2d 1447 (9th Cir. 1985).

When considering the question of fair market value, we would note that the traditional or common methods of economic valuation do not comport with the prescriptions of the anti-kickback statute. Items ordinarily considered in determining the fair market value may be expressly barred by the anti-kickback statute's prohibition against payments for referrals. Merely because another buyer may be willing to pay a particular price is not sufficient to render the price paid to be fair market value. The fact that a buyer in a position to benefit from referrals is willing to pay a particular price may only be a reflection of the value of the referral stream that is likely to result from the purchase.(3)

Accordingly, when attempting to assess the fair market value (as that term is used in an anti-kickback analysis) attributable to a physician's practice, it may be necessary to exclude from consideration any amounts which reflect, facilitate or otherwise relate to the continuing treatment of the former practice's patients. This would be because any such items only have value with respect to the on-going flow of business to the practice. It is doubtful whether this value may be paid by a party who could expect to benefit from referrals from that ongoing practice.(4) Such amounts could be considered as payments for referrals. Thus, any amount paid in excess of the fair market value of the hard assets of a physician practice would be open to question. Similarly, in determining the fair market value of services rendered by employee or contract physicians, it may be necessary to exclude from consideration any amounts which reflect or relate to past or future referrals or any amounts which reflect or are affected by the expectation or guarantee of a certain volume of business (by either the physician or the hospital). Specific items that we believe would raise a question as to whether payment was being made for the value of a referral stream would include, among other things:

-- payment for goodwill,

-- payment for value of ongoing business unit,

-- payment for covenants not to compete,

-- payment for exclusive dealing agreements,

-- payment for patient lists, or

-- payment for patient records.

Payments for the above types of assets or items are questionable where, as is the case here, there is a continuing relationship between the buyer and the seller and the buyer relies (at least in part) on referrals from the seller.

We believe a very revealing inquiry would be to compare the financial welfare of the physicians involved before and after the acquisition. (One can expect to find projections on this subject among materials given to prospective physician participants in these arrangements.) If the economic position of these physicians is expected to significantly improve as a result of the acquisition, it is likely that a purpose of the acquisition is to offer remuneration for the referrals which these physicians can make to the buyer. Another revealing inquiry would be to compare referral patterns before and after the acquisition, specifically, whether the sellers become increasingly "loyal" to the buyer. (Obviously, this inquiry would only occur if the acquisition took place, but it is a potential topic to study in the future to the extent acquisitions occur and are subject to audit or investigation by the Internal Revenue Service.)

In sum, these arrangements raise grave questions of compliance with the anti-kickback statute. We believe that many of these arrangements are merely sophisticated disguises to share the profits of business at a hospital with referring physicians, in order to induce the physicians to steer referrals to the hospital.

We hope this letter has provided helpful information in response to your informal inquiry.

Sincerely,

/s/

D. McCarty Thornton

Associate General Counsel

Inspector General Division

Enclosure

FOOTNOTES:

1. Since tax exempt hospitals are generally required to participate in the Medicare and-Medicaid

programs as a condition of obtaining or maintaining their tax exempt status, the antikickback statute is necessarily a significant issue to be addressed by them.

2. We would also note that while the anti-kickback statute contains a statutory exemption for payments made to employees by an employer, the exemption does not cover any and all such payments. Specifically, the statute exempts only payments to employees which are for "the provision of covered items or services". Accordingly, since referrals do not represent covered items or services, payments to employees which are for the purpose of compensating such employees for the referral of patients would likely not be covered by the employee exemption.

3. This deviation from the normal "economic" model was made expressly clear in the safe harbor provisions. For purposes of determining the value of space or equipment rentals, "fair market value" is specifically defined to exclude the "additional value one party . . . would attribute to the property [equipment] as a result of its proximity or convenience to sources of referrals or business otherwise generated". 42 C.F.R. 1001.952(b) and (c), 56 Fed. Reg. 35971-35973, 35985.

4. We note that these physician practice acquisitions do not fall within the parameters of the existing safe harbor provisions on the sale of practitioner practices. In the final safe harbor regulations, we expressly declined to expand the scope of the safe harbor to cover purchases of physician practices by hospitals or other types of entities or to situations where the seller remains in a continuing position to make referrals or influence referrals to the buyer because of our concerns that many of such purchases were in fact merely attempts to provide remuneration in return for a future stream of referrals. See Preamble to the final safe harbor regulations, 56 Fed. Reg. at 35975. We also attempted to deal with arrangements which have the potential to lock in a referral stream in the safe harbor provisions dealing with joint ventures. See 42 C.F.R. 1001.952(a), 56 Fed. Reg. 35,984-85.

Exhibit 3

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington, D.C. 20201

[*We redact certain identifying information and certain potentially privileged, confidential, or proprietary information associated with the individual or entity, unless otherwise approved by the requestor.*]

Issued: July 22, 2009

Posted: July 29, 2009

To: ATTACHED DISTRIBUTION LIST

Re: OIG Advisory Opinion No. 09-09

Ladies and Gentlemen:

We are writing in response to your request for an advisory opinion regarding a proposed joint venture involving ownership of an ambulatory surgery center by a hospital and physicians (the "Proposed Arrangement"). Specifically, you have inquired whether the Proposed Arrangement would constitute grounds for the imposition of sanctions under the exclusion authority at section 1128(b)(7) of the Social Security Act (the "Act"), or the civil monetary penalty provision at section 1128A(a)(7) of the Act, as those sections relate to the commission of acts described in section 1128B(b) of the Act, the Federal anti-kickback statute.

You have certified that all of the information provided in your request, including all supplemental submissions, is true and correct and constitutes a complete description of the relevant facts and agreements among the parties.

In issuing this opinion, we have relied solely on the facts and information presented to us. We have not undertaken an independent investigation of such information. This opinion is limited to the facts presented. If material facts have not been disclosed or have been misrepresented, this opinion is without force and effect.

Based on the facts certified in your request for an advisory opinion and supplemental submissions, we conclude that while the Proposed Arrangement could potentially generate prohibited remuneration under the anti-kickback statute, if the requisite intent to induce or reward referrals of Federal health care program business were present, the Office of

Inspector General ("OIG") would not impose administrative sanctions on [names redacted] (the "Requestors") under sections 1128(b)(7) or 1128A(a)(7) of the Act (as those sections relate to the commission of acts described in section 1128B(b) of the Act) in connection with the Proposed Arrangement. This opinion is limited to the Proposed Arrangement and, therefore, we express no opinion about any ancillary agreements or arrangements disclosed or referenced in your request letter or supplemental submissions.

This opinion may not be relied on by any persons other than the Requestors of this opinion, and is further qualified as set out in Part IV below and in 42 C.F.R. Part 1008.

I. FACTUAL BACKGROUND

[Name redacted] owns and operates a general acute care hospital, [name redacted], in [city redacted] [state redacted]. (For purposes of this opinion, both of these entities will be designated as the "Hospital.")

[Name redacted] (the "Surgeon LLC") is a limited liability company organized under the laws of the State of [state redacted], owned by seven orthopedic surgeons (the "Surgeon Investors") who are members of a single physician group practice. The Requestors have certified that each Surgeon Investor's ownership in the Surgeon LLC is proportional to his or her capital investment and that each Surgeon Investor received at least one-third of his or her medical practice income for the previous fiscal year or previous 12-month period from the performance of procedures payable by Medicare when performed in an ambulatory surgery center ("ASC").

The Surgeon Investors (through the Surgeon LLC) and the Hospital desire to enter into a joint venture to own and operate an ASC with two operating rooms in a medical office building (the "Building") owned by the Hospital and located on its campus.

The Requestors have certified that, under state law, the development of an ASC requires obtaining a certificate of need ("CON"), except in certain circumstances. They have devised the Proposed Arrangement, by which they plan to develop a single two-operating room ASC by first developing two separate and adjacent ASCs, each consisting of one operating room and neither requiring a CON, and subsequently merging the two into a single ASC.[1]

In furtherance of this goal, the Surgeon LLC has developed an outpatient operating room in the Building and is operating it as a Medicare-certified ASC (the "Surgeon ASC"). The

[1] We express no opinion with respect to whether the Proposed Arrangement complies with state law.

Requestors have certified that the Surgeon ASC occupies space in the Building pursuant to a lease agreement that complies with the requirements of the space rental safe harbor at 42 C.F.R. § 1001.952(b).

Under the Proposed Arrangement, the Hospital will develop a single hospital operating room (the "OR") in space within the Building adjacent to the Surgeon ASC. Upon receipt of necessary regulatory approvals, it will then contribute the assets used to operate the OR to [name redacted] (the "Company"), after which the OR will be operated as a Medicare-certified ASC (the "Hospital ASC"). The Hospital currently is the sole member of the Company, which at the present time has no tangible assets.

The Requestors have certified that, upon receipt of necessary regulatory approvals, the Surgeon LLC will purchase 50 percent of the membership units in the Company. The purchase price will consist, at least in part, of the Surgeon ASC, which the Surgeon LLC will contribute to the Company. Prior to this contribution, appraisals will be conducted to determine the fair market value of the Company (whose sole asset at that time will be the Hospital ASC) and the fair market value of the Surgeon ASC. The Requestors have certified that the appraisals will not take into account the volume or value of referrals made or business otherwise generated among the parties to the transaction, including past or anticipated referrals to the ASCs, but will be based solely on the fair market value of the tangible assets of the Company and the Surgeon ASC, which will consist for the most part of equipment, furnishings, and supplies. If the fair market value of the tangible assets of the Surgeon ASC is determined to be less than the fair market value of the tangible assets of the Company, the Surgeon LLC will make a cash contribution to the Company in the amount of the difference. If the fair market value of the tangible assets of the Surgeon ASC is determined to be more than the fair market value of the tangible assets of the Company, the Hospital will make a cash contribution to the Company in the amount of the difference. At the time of this transaction, the lease for the space occupied by the Surgeon ASC will be terminated, and the Hospital (as lessor) and the Company (as lessee) will execute a lease for the combined space. The Requestors have certified that this lease will comply with the requirements of the safe harbor for space rental at 42 C.F.R. § 1001.952(b).

At the conclusion of this transaction, the Hospital and the Surgeon LLC will jointly own the Company, which in turn will own and operate a two-operating room ASC (the "Hospital-Surgeon ASC"). The Requestors have certified that this ASC will comply with all the requirements of the safe harbor for hospital/physicians-owned ASCs at 42 C.F.R. § 1001.952(r)(4), except for the requirements that (1) the hospital not be in a position to make or influence referrals directly or indirectly to any investor or the ASC (see 42 C.F.R. § 1001.952(r)(4)(viii)); (2) physician investors in the ASC invest directly or through a group practice composed of physicians who meet the requirements of paragraphs (r)(1), (r)(2) or (r)(3) of 42 C.F.R. § 1001.952(r) (see 42 C.F.R. § 1001.952(r)(4)); and (3) the amount of

payment to an investor in return for the investment be directly proportional to the amount of the capital investment (including the fair market value of any pre-operational services rendered) of that investor (see 42 C.F.R. § 1001.952(r)(4)(iii)).

The Requestors have certified that any physicians employed by the Hospital or its affiliates will not make referrals to the Hospital-Surgeon ASC; the Hospital will not take any actions to require or encourage its medical staff to refer patients to the Hospital-Surgeon ASC or the Surgeon Investors; neither the Hospital nor the Company will track referrals to the Hospital-Surgeon ASC or the Surgeon Investors by the Hospital or members of its medical staff; any compensation the Hospital pays its medical staff will be at fair market value and will not take into account any referrals its medical staff may make to the Hospital-Surgeon ASC or to its Surgeon Investors; and the Hospital will inform its medical staff annually of these measures. In addition, the Hospital will continue to operate its own facilities for outpatient surgery.

II. LEGAL ANALYSIS

A. Law

The anti-kickback statute makes it a criminal offense knowingly and willfully to offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by a Federal health care program. See section 1128B(b) of the Act. Where remuneration is paid purposefully to induce or reward referrals of items or services payable by a Federal health care program, the anti-kickback statute is violated. By its terms, the statute ascribes criminal liability to parties on both sides of an impermissible "kickback" transaction. For purposes of the anti-kickback statute, "remuneration" includes the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind.

The statute has been interpreted to cover any arrangement where one purpose of the remuneration was to obtain money for the referral of services or to induce further referrals. United States v. Kats, 871 F.2d 105 (9th Cir. 1989); United States v. Greber, 760 F.2d 68 (3d Cir.), cert. denied, 474 U.S. 988 (1985). Violation of the statute constitutes a felony punishable by a maximum fine of $25,000, imprisonment up to five years, or both. Conviction will also lead to automatic exclusion from Federal health care programs, including Medicare and Medicaid. Where a party commits an act described in section 1128B(b) of the Act, the OIG may initiate administrative proceedings to impose civil monetary penalties on such party under section 1128A(a)(7) of the Act. The OIG may also initiate administrative proceedings to exclude such party from the Federal health care programs under section 1128(b)(7) of the Act.

The Department of Health and Human Services has promulgated safe harbor regulations that define practices that are not subject to the anti-kickback statute because such practices would be unlikely to result in fraud or abuse. See 42 C.F.R. § 1001.952. The safe harbors set forth specific conditions that, if met, assure entities involved of not being prosecuted or sanctioned for the arrangement qualifying for the safe harbor. However, safe harbor protection is afforded only to those arrangements that precisely meet all of the conditions set forth in the safe harbor.

The safe harbor for investment income from physician/hospital-owned ASCs, 42 C.F.R. § 1001.952(r)(4), is potentially applicable to the Proposed Arrangement.

B. Analysis

Although joint ventures by physicians and hospitals are susceptible to fraud and abuse, the OIG recognizes that hospitals may be at a competitive disadvantage when they compete with ASCs owned by physicians, who principally control referrals. Thus, the OIG promulgated a safe harbor for investment income from ASCs jointly-owned by physicians and hospitals that meet certain conditions, 42 C.F.R. § 1001.952(r)(4). Among the ownership arrangements potentially protected by this safe harbor are ASCs jointly owned by hospitals and general surgeons or surgeons engaged in the same surgical specialty. Because all the Surgeon Investors in the ASC are engaged in the same surgical specialty (orthopedics), the safe harbor is potentially applicable to the Proposed Arrangement.

The Requestors acknowledge that the Proposed Arrangement does not qualify for protection by this safe harbor, however, for the reasons noted below. Because no safe harbor would protect the investment income from the Hospital-Surgeon ASC, we must determine whether, given all the relevant facts, the Proposed Arrangement poses a minimal risk under the anti-kickback statute.

First, safe harbor protection requires that the Hospital not be in a position to make or influence referrals directly or indirectly to any investor or the ASC. 42 C.F.R. § 1001.952(r)(4)(viii). Here, the Hospital is in a position to make or influence referrals to the ASC and to the Surgeon Investors. However, the Proposed Arrangement includes certain commitments limiting the ability of the Hospital to direct or influence such referrals. The Requestors have certified that employees of the Hospital will not refer patients to the Hospital-Surgeon ASC, and the Hospital will refrain from any actions to require or encourage any members of its medical staff to refer patients to the ASC or to its Surgeon Investors. The Hospital will not track referrals, if any, by its medical staff to the Hospital-Surgeon ASC or to its Surgeon Investors; any compensation the Hospital pays its medical staff will be at fair market value and will not take into account any referrals to the Hospital-Surgeon ASC or to its Surgeon Investors; and the Hospital will inform its medical staff

annually of these measures. Also, the Hospital will continue to operate its own facilities for outpatient surgery. In light of these safeguards, the ability of the Hospital to direct or influence referrals to the Hospital-Surgeon ASC or to its Surgeon Investors is significantly constrained.

Second, safe harbor protection requires physician investors to hold their investment interests in an ASC either directly or through a group practice composed entirely of physicians who are qualified to invest directly. See 42 C.F.R. § 1001.952(r)(4). Each of the Surgeon Investors is qualified to invest in the ASC directly without destroying its eligibility for safe harbor protection.[2] In the Proposed Arrangement, they would invest in the Hospital-Surgeon ASC indirectly, through the Surgeon LLC, which would own 50 percent of the Company. The Company, in turn, would own and operate the Hospital-Surgeon ASC. We have previously expressed concern that intermediate investment entities could be used to redirect revenues to reward referrals or otherwise vitiate the safeguards provided by direct investment, including distributions of profits in proportion to capital investment. However, in this case, the use of a "pass-through" entity does not substantially increase the risk of fraud or abuse. Each Surgeon Investor's ownership in the Surgeon LLC is proportional to his or her capital investment, and the individual Surgeon Investors will receive a return on their investments that is the same as if they had invested in the Hospital-Surgeon ASC directly.

Third, safe harbor protection requires that the amount of payment to an investor in return for the investment be directly proportional to the amount of capital invested by that investor. 42 C.F.R. § 1001.952(r)(4)(iii). This requirement helps ensure that referral sources are not rewarded for their referrals through investment returns that are disproportionate to the capital they invested. In this case, the Surgeon Investors, through the Surgeon LLC, have developed the Surgeon ASC, and the Hospital is to develop the Hospital ASC. The Requestors propose to value the respective contributions to the jointly-owned Hospital-Surgeon ASC by obtaining appraisals of the tangible assets of the ASCs at the time of their merger, with either party (the Surgeon LLC or the Hospital) contributing cash, if necessary, to equalize the value of their respective contributions. The Requesters have certified that the appraisals will not take into account the volume or value of referrals made or business otherwise generated among the parties to the transaction, including past or anticipated referrals to the ASCs, but will be based solely on the fair market value of tangible assets.[3]

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[2] The Surgeon Investors are qualified to invest in the ASC directly because each of them practices a single surgical specialty (orthopedic surgery) and receives at least one-third of his or her medical practice income from performing procedures that are payable by Medicare when performed in an ASC. See 42 C.F.R. § 1001.952(r)(1).

[3] We are not authorized to opine on whether fair market value shall be, or was, paid or received for any goods, services, or property. See section 1128D(b)(3) of the Act.

Depending upon the amounts originally invested in the separate ASCs and the value of the tangible assets at the time of the planned merger, it is possible that the Hospital and the Surgeon LLC (and through the Surgeon LLC, the Surgeon Investors) will receive different returns on their investments.[4]

Given the facts presented here, however, we conclude that the risk of abuse resulting from any differences in return on capital is low. There are a number of factors that might influence the degree of such differences, including amounts paid for, and depreciation of, tangible assets. Nothing in the facts presented to us, however, suggests that any differences in return on capital might be related to the investors' past or anticipated referrals.[5]

For these reasons, taken together, we conclude that, while the Proposed Arrangement would result in income to investors that would not be protected by any safe harbor, it involves minimal risk of fraud or abuse.

Therefore, we rely on the certification of the Requestors with regard to whether the valuations described will represent fair market value, without taking into account the volume and value of referrals.

[4] In the particular circumstances of the Proposed Arrangement, where the Hospital and the Surgeon Investors developed two separate ASCs as part of a plan to form a single, jointly-owned Hospital-Surgeon ASC, we consider each investor's investment to be the amount that the investor contributes to develop a separate ASC, plus any additional cash that the investor contributes at the time the two ASCs are merged. We would measure each investor's return on investment accordingly.

[5] Our conclusion might be different if the valuation of the respective contributions of the investors included intangible assets. For example, given the circumstances of the Proposed Arrangement, we might be concerned if the valuation were based on a cash flow analysis of the Surgeon ASC as a going concern. Because the Surgeon Investors are referral sources for the Surgeon ASC, a cash flow-based valuation of that business potentially would include the value of the Surgeon Investors' referrals over the time that their ASC was in existence prior to the merger with the Hospital ASC. The result might be that the Surgeon Investors would receive a greater return on their capital investment than the Hospital, which could reflect the value of their referrals to the Surgeon ASC. (In these circumstances, the Hospital ASC, being newly developed at the time of the proposed merger, may have little or no cash flow record, but we might be similarly concerned with a valuation based on a cash flow analysis of a hospital-owned ASC for which the hospital could influence referrals.) We do not assert that a cash flow-based valuation or other valuation involving intangible assets would necessarily result in a violation of the anti-kickback statute; the existence of a violation depends upon all the facts and circumstances of a particular case.

III. CONCLUSION

Based on the facts certified in your request for an advisory opinion and supplemental submissions, we conclude that while the Proposed Arrangement could potentially generate prohibited remuneration under the anti-kickback statute, if the requisite intent to induce or reward referrals of Federal health care program business were present, the OIG would not impose administrative sanctions on the Requestors under sections 1128(b)(7) or 1128A(a)(7) of the Act (as those sections relate to the commission of acts described in section 1128B(b) of the Act) in connection with the Proposed Arrangement. This opinion is limited to the Proposed Arrangement and, therefore, we express no opinion about any ancillary agreements or arrangements disclosed or referenced in your request letter or supplemental submissions.

IV. LIMITATIONS

The limitations applicable to this opinion include the following:

- This advisory opinion is issued only to the Requestors of this opinion. This advisory opinion has no application to, and cannot be relied upon by, any other individual or entity.

- This advisory opinion may not be introduced into evidence in any matter involving an entity or individual that is not a requestor of this opinion.

- This advisory opinion is applicable only to the statutory provisions specifically noted above. No opinion is expressed or implied herein with respect to the application of any other Federal, state, or local statute, rule, regulation, ordinance, or other law that may be applicable to the Proposed Arrangement, including, without limitation, the physician self-referral law, section 1877 of the Act.

- This advisory opinion will not bind or obligate any agency other than the U.S. Department of Health and Human Services.

- This advisory opinion is limited in scope to the specific arrangement described in this letter and has no applicability to other arrangements, even those which appear similar in nature or scope.

- No opinion is expressed herein regarding the liability of any party under the False Claims Act or other legal authorities for any improper billing, claims submission, cost reporting, or related conduct.

This opinion is also subject to any additional limitations set forth at 42 C.F.R. Part 1008.

The OIG will not proceed against the Requestors with respect to any action that is part of the Proposed Arrangement taken in good faith reliance upon this advisory opinion, as long as all of the material facts have been fully, completely, and accurately presented, and the Proposed Arrangement in practice comports with the information provided. The OIG reserves the right to reconsider the questions and issues raised in this advisory opinion and, where the public interest requires, to rescind, modify, or terminate this opinion. In the event that this advisory opinion is modified or terminated, the OIG will not proceed against the Requestors with respect to any action taken in good faith reliance upon this advisory opinion, where all of the relevant facts were fully, completely, and accurately presented and where such action was promptly discontinued upon notification of the modification or termination of this advisory opinion. An advisory opinion may be rescinded only if the relevant and material facts have not been fully, completely, and accurately disclosed to the OIG.

Sincerely,

/Lewis Morris/

Lewis Morris
Chief Counsel to the Inspector General

Exhibit 4

October 6, 1997

[Names and addresses of Requestors have been redacted]

Re: Advisory Opinion No. 97-5

Dear Sirs:

We are writing in response to your request for an advisory opinion on behalf of Radiology Group X and Hospital System A. The request asks whether an outpatient radiology imaging center joint venture owned by a medical group specializing in radiology and a hospital care provider (i) generates prohibited remuneration within the meaning of the anti-kickback statute, Section 1128B of the Social Security Act ("Act"); (ii) constitutes grounds for the imposition of an exclusion under Section 1128(b)(7) of the Act (as it applies to kickbacks); (iii) constitutes grounds for criminal sanctions under Section 1128B(b) of the Act; and/or (iv) satisfies the criteria set out in Section 1128B(b)(3) of the Act or associated regulations, 42 C.F.R. § 1001.952.

Radiology Group X and Hospital System A have certified that all of the information provided in the request, including all supplementary letters, is true and correct, and constitutes a complete description of the relevant facts and agreements among the parties regarding the joint venture ("Proposed Arrangement"). Radiology Group X and Hospital System A have also certified that upon our approval, they will undertake to effectuate the Proposed Arrangement.

In issuing this opinion, we have relied solely on the facts and information presented to us. We have not undertaken an independent investigation of such information. This opinion is limited to the facts presented. If material facts have not been disclosed, this opinion is without force and effect.

Based on the information provided and subject to certain conditions described below, we have determined that the Proposed Arrangement does not meet any of the statutory or regulatory safe harbors set out in Section 1128B(b)(3) of the Act or 42 C.F.R. § 1001.952. However, we also conclude that the Proposed Arrangement would not generate prohibited remuneration within the meaning of the anti-kickback statute, Section

1128B of the Act, and therefore, does not constitute grounds for the imposition of either an exclusion under Section 1128(b)(7) of the Act (as it applies to kickbacks) or criminal sanctions under Section 1128B(b) of the Act.

This opinion may not be relied on by any person or entity other than the addressees and is further qualified as set out in Part III below and in 42 C.F.R. Part 1008.

I. FACTUAL BACKGROUND

Radiology Group X and Hospital System A have made the following representations with respect to the Proposed Arrangement. Radiology Group X and Hospital System A are collectively the "Requestors".

A. Parties to the Proposed Arrangement.

Hospital System A. Hospital System A operates three hospitals in State C: Hospital 1, Hospital 2, and Hospital 3. Hospital 1, located in State C, is licensed for 351 beds and is the largest hospital in the several counties surrounding City D. Hospital 1 has a full range of radiological equipment at its facility, including a CT scanner, ultrasound equipment, fluoroscopic radiographic equipment, nuclear radiographic equipment, and magnetic resonance imaging ("MRI") equipment. Hospital 1 will continue to operate its radiology department after the Proposed Arrangement is implemented.

Hospital System A employs three physicians directly or through its subsidiary organizations. These physicians will not make referrals to the Proposed Arrangement's joint venture imaging center, nor will any such referrals be accepted if made.

Radiology Group X. Radiology Group X is a medical group specializing in radiology. It is a State C professional corporation owned and controlled by five radiologists. Dr. Y, serves as the President of Radiology Group X.

The shareholders of Radiology Group X are also the members of Radiology Group X's affiliate, Company Z. Ownership and control interests in Radiology Group X and Company Z are identical. Company Z is a newly-formed State C limited liability company and one of the members of the Proposed Arrangement's joint venture company, Imaging Center [defined below].

Current Relationship Between Radiology Group X and Hospital 1. Radiology Group X and Hospital 1 have represented that they have an informal, unwritten arrangement whereby Radiology Group X provides professional radiology services to the hospital, while hospital employees provide the technical services. The hospital owns all of the radiological equipment and is responsible for employing qualified technicians. As part of

this arrangement, Radiology Group X's president, Dr. Y, serves as Hospital 1's Director of the Department of Radiology. His duties are set forth in the hospital's Medical and Dental Staff By-Laws. In addition, Hospital 1 provides Radiology Group X with space in its facility to perform radiologic interpretations.[1]

While there is no written agreement, the hospital has certified that the fair market value of the space used by Radiology Group X is substantially equal to the fair market value for compensation of Dr. Y's duties as the Director of the Department of Radiology. Further, the arrangements whereby Radiology Group X and Dr. Y provide services to Hospital 1 and Hospital 1 provides Radiology Group X with space in its facility are separate from, and not dependent on, the terms and conditions of the Proposed Arrangement.

B. Proposed Arrangement.

Radiology Group X, through its affiliate Company Z, and Hospital System A have proposed to enter into a joint venture to establish an outpatient radiology imaging center ("Imaging Center"). The Imaging Center will be located in the Village of E, at the western edge of City D. The Imaging Center will offer a full range of state-of-the-art imaging techniques, including X-ray equipment, fluoroscope equipment, a superconducting open MRI system, a computerized tomography scanner, and an ultrasound system.

The Imaging Center will be owned and operated by a State C limited liability company, Company B. The members of Company B will be Company Z and Hospital System A. Company Z and Hospital System A will make capital contributions of $204,000 and $196,000, respectively. In return, each member will receive voting and distribution rights proportional to its investment. Additional capital contributions will be apportioned to Company Z and Hospital System A based upon their respective ownership interests.[2]

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[1] Radiology Group X does not have any non-hospital based office space.

[2] If either member of Company B is unable or unwilling to make any part of an additional capital contribution, the other member has a right to make up the difference, treat such amount as either an additional capital contribution or as a loan, and adjust the

The Imaging Center will be staffed by employees hired by Company B. Radiology Group X radiologists will be the exclusive providers of professional services to the Imaging Center. The president of Radiology Group X, or his designee, will be in charge of supervising and administering all aspects of the clinical services rendered at the Imaging Center, including quality assurance. The Radiology Group X radiologists will not be employees of the Imaging Center, but will enter into a service provider agreement with Company B. Under the service agreement, Radiology Group X will not receive any compensation from the Imaging Center. Radiology Group X will bill patients and third-party payers, including Medicare and Medicaid, for the professional component of radiological services directly. The Imaging Center will bill separately its technical component to patients and third-party payers.

II. LEGAL ANALYSIS

The anti-kickback statute makes it a criminal offense knowingly and willfully to offer, pay, solicit or receive any remuneration to induce referrals of items or services reimbursed by Federal health care programs. 42 U.S.C. § 1320a-7b(b). Where remuneration is paid purposefully in exchange for referrals of items or services paid for by a Federal health care program, the kickback statute is violated. By its terms, the statute ascribes criminal liability to parties on both sides of an impermissible "kickback" transaction.

The statute has been interpreted to cover any arrangement where one purpose of the remuneration is to obtain money for the referral of services or to induce further referrals. United States v. Kats, 871 F.2d 105 (9th Cir. 1989); United States v. Greber, 760 F.2d 68 (3d Cir.), cert. denied, 476 U.S. 988 (1985). Violations of the statute constitute a felony punishable by a maximum fine of $25,000, imprisonment up to five years or both. Conviction will also lead to automatic exclusion from Federal health care programs including Medicare and Medicaid.

The Office of Inspector General may also initiate an administrative proceeding to exclude an individual from Federal health care programs for fraud, kickbacks and other prohibited activities. Section 1128(b)(7) of the Act. Because both the criminal and administrative

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proportional percentages of ownership accordingly. For purposes of this opinion, we have assumed that any loan would be at fair market value.

sanctions related to the Proposed Arrangement are based on the anti-kickback statute, the analysis is the same under either provision.

Health care joint ventures in which investors are also sources of referrals or suppliers of items or services to the joint venture raise many questions under the anti-kickback statute. In 1989, the Office of Inspector General issued a "Special Fraud Alert" specifically discussing joint venture arrangements that may violate the anti-kickback statute.[3] In general, joint ventures between radiologists and health care providers in a position to order imaging services may be suspect, because distributions from the joint ventures may be disguised remuneration paid in return for referrals. Like any kickback scheme, these arrangements can lead to overutilization of such services, increased costs for Federal health care programs, corruption of professional judgment, and unfair competition.

A. The Proposed Joint Venture Does Not Meet the Safe Harbor For Investment Interests in Small Entities.

In 1991, the Department of Health and Human Services ("Department") published safe harbor regulations which define practices that are not subject to the anti-kickback statute because such arrangements would be unlikely to result in fraud or abuse. Failure to comply with a safe harbor provision does not make an arrangement per se illegal. Rather, the safe harbors set forth specific conditions that, if fully met, would assure the entities involved of not being prosecuted or sanctioned for the arrangement qualifying for the safe harbor. The only safe harbor regulation potentially available to the Proposed Arrangement addresses investment interests in small entities. See 42 C.F.R. § 1001.952(a)(2).[4]

The safe harbor for investments in small entities has eight elements, each of which must be satisfied in order for the arrangement to qualify for the exception. The eight elements address three areas of concern in abusive joint ventures: (i) how investors are selected and retained; (ii) the nature of the business structure; and (iii) the financing and profit distributions. The eight elements are:

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[3] See Special Fraud Alert, "Joint Venture Arrangements" (OIG-89-4), reprinted in 59 Fed. Reg. 65373 (December 19, 1994).

[4] The Requestors had suggested that the "shared risk" statutory exception to the anti-kickback statute added by Section 216 of the Health Insurance Portability and Accountability Act, Pub. Law No. 104-191 (Aug. 21, 1996), potentially applied. That provision, however, applies only to contractual arrangements where a person supplying items or services is at risk for the cost or utilization of such items or services and is obligated to provide them, as in some managed care contracts.

- no more than forty percent of the investment interests may be held by investors who are in a position to make or influence referrals, furnish items or services, or generate business ("Interested Investors");
- interests offered to passive investors who are Interested Investors cannot be made on terms different from those offered to other investors;
- the terms on which an investment is offered to Interested Investors cannot take into account any previous or expected volume of referrals, services furnished, or amount of business generated from such investors;
- there is no requirement that a passive investor make referrals to, or otherwise generate business for, the entity as a condition of remaining an investor;
- the entity cannot market or furnish the items or services differently to passive investors and non-investors;
- no more than forty percent of the gross revenue of the entity may come from Interested Investors;
- the entity cannot loan or guarantee funds to an Interested Investor if the loan or guarantee is used to obtain the investment interest; and
- an investor's return on investment must be directly proportional to the amount of capital investment of that investor.

Strict compliance with all elements is required. See 56 Fed. Reg. 35952, 35954 (July 29, 1991).

The Proposed Arrangement fails to meet at least one of the eight elements. More than 40% of the investment interest is owned by persons who furnish items or services to the new venture; Radiology Group X owns 51% of the entity and will provide the professional services to the venture. Accordingly, the Proposed Arrangement does not meet the only relevant safe harbor.

B. The Proposed Arrangement Will Not Result in Prohibited Remuneration.

Even though the Proposed Arrangement does not fall within a safe harbor, it does not necessarily violate the anti-kickback statute. With respect to joint ventures, the major concern is that the profit distributions to investors in the joint venture, who are also referral sources to the joint venture, may potentially represent remuneration for those referrals. A related concern is that, where the investing parties have a referral relationship wholly apart from the joint venture, distributions from the joint venture could potentially represent remuneration to one party for referrals to the other party based on those independent relationships. Accordingly, all aspects of all relationships between the parties must be examined.

1. There Is No Prohibited Remuneration For Referrals To The Imaging Center.

Our initial inquiry is whether the distributions from the joint venture may be "disguised" remuneration for referrals by the investors to the joint venture. Based upon the information and representations provided, we find that neither Radiology Group X nor Hospital System A will be able to generate referrals to the joint venture.

A threshold issue is the proper characterization of Hospital System A's role in relationship to the joint venture. In many instances, hospitals are capable of influencing, and do influence, referrals to other health care providers, such as through discharge planning with respect to post-discharge care. In addition, hospitals are in a position to influence the flow of radiology work performed at the hospital, because the hospital controls to whom radiologic interpretations are referred. See Financial Arrangements Between Hospitals and Hospital-Based Physicians, OEI-09-89-00330, 1991. In this instance, however, and subject to the conditions set out below, we do not believe that the Hospital System A hospitals will be able to generate referrals to the Imaging Center.

First, Hospital System A has represented that its employed physicians will make no referrals to the Imaging Center, and the Imaging Center will not accept any referrals from those physicians. Second, Hospital System A has agreed that it will take no actions, either overt or covert, financial or otherwise, to induce its medical staff (i.e., any physician with admitting or staff privileges) to use the Imaging Center. Third, Hospital System A has agreed that it will inform the medical staff of the preceding agreement. Fourth, physician referrals to the Imaging Center will not be tracked by Hospital System A, its hospitals, Company Z, or Radiology Group X. Fifth, Hospital System A hospitals will continue to operate and use their own radiology units. In these circumstances, referrals from physicians with admitting or staff privileges at the Hospital System A hospitals would not be attributable to Hospital System A.

Moreover, the Radiology Group X radiologists are also unlikely to be able to generate an appreciable number of referrals to the Imaging Center. In general, radiologists do not order the radiological tests they perform; such tests are ordered by a patient's attending

physician. Although there may be situations in which a radiologist can recommend additional testing to the attending physician during the course of a consultation and, as a practical matter, indirectly generate some additional business, those tests must be approved by the patient's attending physician.[5] In these limited circumstances -- the recommendation of additional testing by a radiologist to an attending physician with whom the radiologist has no financial arrangements and pursuant to a bona fide medical consultation -- we conclude that a Radiology Group X radiologist's recommendation is not prohibited under the anti-kickback statute.[6]

In sum, since neither Radiology Group X nor Hospital System A will be in a position to generate or influence an appreciable number of referrals to the Imaging Center, the

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[5] See 61 Fed. Reg. 59490, 59497 (November 22, 1996) (with respect to when Medicare will cover diagnostic tests, the Health Care Financing Administration has stated, "we believe that the physician interpreting the diagnostic tests has an obligation to discuss any changes in or additions to the original order with the patient's physician.").

[6] Radiology Group X radiologists receive no remuneration from patients' attending physicians, and none of the attending physicians which refer to Radiology Group X have any financial relationships with Radiology Group X.

distributions of any profits would not constitute illegal remuneration in exchange for referrals.

2. There Is No Prohibited Remuneration For Referrals Outside Of The Joint Venture.

Radiology Group X derives a substantial amount of its revenues from its position as the exclusive provider of professional radiology services for Hospital 1.[7] This raises the possibility that the joint venture may be a vehicle by which Radiology Group X may indirectly reward Hospital System A for revenues Radiology Group X receives as a result of its arrangement with Hospital 1.[8]

In determining whether the joint venture may be a vehicle for illegally remunerating one investor for referrals to another investor, we examine initially whether the party making the referrals receives a disproportionate return on its investment compared to the return on the investment of the party receiving the referrals. Any excess or disproportionate return on the investment may be remuneration for referrals. Based on the facts and circumstances as represented by Radiology Group X and Hospital System A, both parties have made substantial financial investments in the venture, and control of the venture and

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[7] Radiology Group X radiologists are not in a position to make referrals to the Hospital System A hospitals for the same reasons that they cannot make appreciable referrals to the Imaging Center. Accordingly, the potential profit distributions from the Imaging Center to the Radiology Group X radiologists would not represent disguised remuneration for any possible referrals to Hospital System A hospitals.

[8] Specific problems with financial arrangements between hospital-based physicians, such as radiologists, and hospitals were discussed in a 1991 Management Advisory Report entitled Financial Arrangements Between Hospitals and Hospital-Based Physicians, OEI-09-89-00330 (1991).

distribution of profits will be in direct proportion to such investments. Thus, both parties' return on investment is commensurate with their undertakings and would not appear to include any "unearned" remuneration to Hospital 1 attributable to its arrangements with Radiology Group X. Accordingly, any profit distributions from the Proposed Arrangement would not appear to represent compensation to Hospital System A or Hospital 1 for their referrals to Radiology Group X.

Moreover, based on the representations by Radiology Group X and Hospital System A that the value of the premises and equipment provided to Radiology Group X are substantially equal to the value of Dr. Y's services to Hospital 1, we conclude that any profit distribution from the Imaging Center will not represent illegal remuneration for the use of space and equipment at Hospital 1.[9]

However, even in situations where each party's return is proportionate with its investment, the mere opportunity to invest (and consequently receive profit distributions) may in certain circumstances constitute illegal remuneration if offered in exchange for past or future referrals. Such situations may include arrangements where one or several investors in a joint venture control a sufficiently large stream of referrals to make the venture's financial success highly likely, or where one investor has an established track record with similar ventures or the financial investment required is so small that the investors have little or no real risk. By contrast, there are no such indicia that the Proposed Arrangement will generate any profits for its investors, since neither party is in a position to influence appreciable referrals to the joint venture nor has successfully operated a freestanding imaging center before. In light of the substantial financial investment being made by Hospital System A, we find no evidence that the mere opportunity to participate as an investor in the Imaging Center constitutes illegal remuneration to Hospital System A.

III. CONCLUSION

For the above reasons, we have determined that the Proposed Arrangement does not contain any prohibited remuneration within the meaning of the anti-kickback statute,

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[9] We are not, however, making any independent finding as to the legality of the current arrangement between Radiology Group X and Hospital 1.

1128B of the Social Security Act ("Act"), and consequently does not constitute grounds for the imposition of either an exclusion under section 1128(b)(7) of the Act (as it applies to kickbacks) or criminal sanction under 1128B(b) of the Act.

IV. LIMITATIONS

The limitations applicable to this opinion include the following:

- This advisory opinion is issued only to the Radiology Group X and Hospital System A, which are the Requestors of this opinion. This advisory opinion has no application, and cannot be relied upon, by any other individual or entity.

- This advisory opinion may not be introduced into evidence in any matter involving an entity or individual that is not a Requestor to this opinion.

- This advisory opinion is applicable only to the statutory provisions specifically noted above. No opinion is herein expressed or implied with respect to the application of any other Federal, state, or local statute, rule, regulation, ordinance, or other law that may be applicable to the Proposed Arrangement, including any laws relating to insurance or insurance contracts.

- This advisory opinion will not bind or obligate any agency other than the U.S. Department of Health and Human Services.

- This advisory opinion is prospective only. It has no application to conduct which precedes the date of this opinion.

- This advisory opinion does not make any determination as to whether any amounts paid by one party to another are representative of fair market value.

- This advisory opinion is limited in scope to the specific arrangement described in this letter and has no applicability to other arrangements, even those which appear similar in nature or scope.

This opinion is also subject to any additional limitations set forth at 42 C.F.R. Part 1008.

The OIG will not proceed against the Requestors with respect to any action taken in good faith reliance upon this advisory opinion as long as all of the material facts have been fully, completely, and accurately presented, and the arrangement in practice comports with the information provided. The OIG reserves the right to reconsider the questions

and issues raised in this advisory opinion and, where the public interest requires, modify or terminate this opinion. In the event that this advisory opinion is modified or terminated, the OIG will not proceed against the Requestors with respect to any action taken in good faith reliance upon this advisory opinion, where all of the relevant facts were fully, completely, and accurately presented and where such action was promptly discontinued upon notification of the modification or termination of this advisory opinion.

Sincerely,

/S/

D. McCarty Thornton
Chief Counsel to the Inspector General

Exhibit 5

MEDICARE ENROLLMENT APPLICATION

Clinics/Group Practices and Certain Other Suppliers

CMS-855B

SEE PAGE 1 TO DETERMINE IF YOU ARE COMPLETING THE CORRECT APPLICATION.

SEE PAGE 2 FOR INFORMATION ON WHERE TO MAIL THIS APPLICATION.

SEE PAGE 34 TO FIND A LIST OF THE SUPPORTING DOCUMENTATION THAT MUST BE SUBMITTED WITH THIS APPLICATION.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

SECTION 15: CERTIFICATION STATEMENT

An **AUTHORIZED OFFICIAL** means an appointed official (for example, chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner) to whom the organization has granted the legal authority to enroll it in the Medicare program, to make changes or updates to the organization's status in the Medicare program, and to commit the organization to fully abide by the statutes, regulations, and program instructions of the Medicare program.

A **DELEGATED OFFICIAL** means an individual who is delegated by an authorized official the authority to report changes and updates to the supplier's enrollment record. A delegated official must be an individual with an "ownership or control interest" in (as that term is defined in Section 1124(a)(3) of the Social Security Act), or be a W-2 managing employee of, the supplier.

Delegated officials may not delegate their authority to any other individual. Only an authorized official may delegate the authority to make changes and/or updates to the supplier's Medicare status. Even when delegated officials are reported in this application, an authorized official retains the authority to make any such changes and/or updates by providing his or her printed name, signature, and date of signature as required in Section 15B.

NOTE: Authorized officials and delegated officials must be reported in Section 6, either on this application or on a previous application to this same Medicare fee-for-service contractor. **If this is the first time an authorized and/or delegated official has been reported on the CMS-855B, you must complete Section 6 for that individual.**

By his/her signature(s), an authorized official binds the supplier to all of the requirements listed in the Certification Statement and acknowledges that the supplier may be denied entry to or revoked from the Medicare program if any requirements are not met. All signatures must be original and in ink. Faxed, photocopied, or stamped signatures will not be accepted.

Only an authorized official has the authority to sign (1) the initial enrollment application on behalf of the supplier or (2) the enrollment application that must be submitted as part of the periodic revalidation process. A delegated official does not have this authority.

By signing this application, an authorized official agrees to immediately notify the Medicare fee-for-service contractor if any information furnished on the application is not true, correct, or complete. In addition, an authorized official, by his/her signature, agrees to notify the Medicare fee-for-service contractor of any future changes to the information contained in this form, after the supplier is enrolled in Medicare, in accordance with the timeframes established in 42 C.F.R. 424.520(b). (IDTF changes of information must be reported in accordance with 42 C.F.R. 410.33.)

The supplier can have as many authorized officials as it wants. If the supplier has more than two authorized officials, it should copy and complete this section as needed.

EACH AUTHORIZED AND DELEGATED OFFICIAL MUST HAVE AND DISCLOSE HIS/HER SOCIAL SECURITY NUMBER.

SECTION 15: CERTIFICATION STATEMENT (Continued)

A. ADDITIONAL REQUIREMENTS FOR MEDICARE ENROLLMENT

These are additional requirements that the supplier must meet and maintain in order to bill the Medicare program. Read these requirements carefully. By signing, the supplier is attesting to having read the requirements and understanding them.

By his/her signature(s), the authorized official(s) named below and the delegated official(s) named in Section 16 agree to adhere to the following requirements stated in this Certification Statement:

1. I authorize the Medicare contractor to verify the information contained herein. I agree to notify the Medicare contractor of any future changes to the information contained in this application in accordance with the timeframes established in 42 C.F.R. § 424.516. I understand that any change in the business structure of this supplier may require the submission of a new application.

2. I have read and understand the Penalties for Falsifying Information, as printed in this application. I understand that any deliberate omission, misrepresentation, or falsification of any information contained in this application or contained in any communication supplying information to Medicare, or any deliberate alteration of any text on this application form, may be punished by criminal, civil, or administrative penalties including, but not limited to, the denial or revocation of Medicare billing privileges, and/or the imposition of fines, civil damages, and/or imprisonment.

3. I agree to abide by the Medicare laws, regulations and program instructions that apply to this supplier. The Medicare laws, regulations, and program instructions are available through the Medicare contractor. I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), and on the supplier's compliance with all applicable conditions of participation in Medicare.

4. Neither this supplier, nor any five percent or greater owner, partner, officer, director, managing employee, authorized official, or delegated official thereof is currently sanctioned, suspended, debarred, or excluded by the Medicare or State Health Care Program, e.g., Medicaid program, or any other Federal program, or is otherwise prohibited from supplying services to Medicare or other Federal program beneficiaries.

5. I agree that any existing or future overpayment made to the supplier by the Medicare program may be recouped by Medicare through the withholding of future payments.

6. I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare, and I will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.

7. I authorize any national accrediting body whose standards are recognized by the Secretary as meeting the Medicare program participation requirements, to release to any authorized representative, employee, or agent of the Centers for Medicare & Medicaid Services (CMS) a copy of my most recent accreditation survey, together with any information related to the survey that CMS may require (including corrective action plans).

SECTION 15: CERTIFICATION STATEMENT (Continued)

B. 1ST AUTHORIZED OFFICIAL SIGNATURE

I have read the contents of this application. My signature legally and financially binds this supplier to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete and I authorize the Medicare fee-for-service contractor to verify this information. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Medicare fee-for-service contractor of this fact immediately.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE (mm/dd/yyyy)			

Authorized Official's Information and Signature

First Name	Middle Initial	Last Name	Suffix *(e.g., Jr., Sr.)*

Telephone Number	Title/Position
Authorized Official Signature *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*	Date Signed *(mm/dd/yyyy)*

(blue ink preferred)

C. 2ND AUTHORIZED OFFICIAL SIGNATURE

I have read the contents of this application. My signature legally and financially binds this supplier to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete and I authorize the Medicare fee-for-service contractor to verify this information. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Medicare fee-for-service contractor of this fact immediately.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

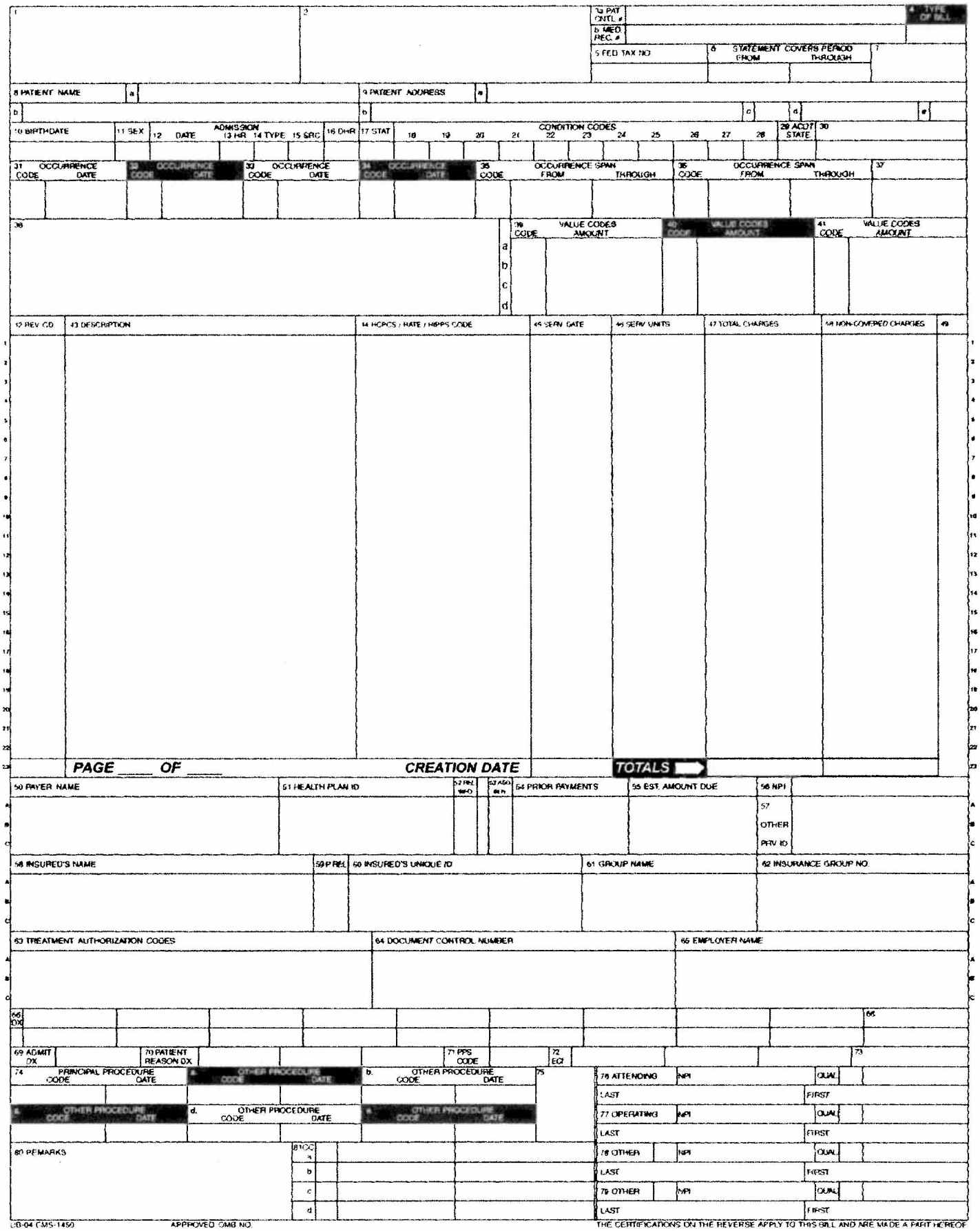
CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE (mm/dd/yyyy)			

Authorized Official's Information and Signature

First Name	Middle Initial	Last Name	Suffix *(e.g., Jr., Sr.)*

Telephone Number	Title/Position
Authorized Official Signature *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*	Date Signed *(mm/dd/yyyy)*

All signatures must be original and signed in ink (blue ink preferred). Applications with signatures deemed not original will not be processed. Stamped, faxed or copied signatures will not be accepted.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08-04 CMS-1450
APPROVED OMB NO.
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF
NUBC
UC9213257

UB-04 NOTICE: THE SUBMITTER OF THIS FORM UNDERSTANDS THAT MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION AS REQUESTED BY THIS FORM, MAY SERVE AS THE BASIS FOR CIVIL MONETARY PENALTIES AND ASSESSMENTS AND MAY UPON CONVICTION INCLUDE FINES AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW(S).

Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this Bill:

1. **If third party benefits are indicated, the appropriate assignments by the insured /beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the patient or the patient's legal representative.**
2. **If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.**
3. **Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.**
4. **For Religious Non-Medical facilities, verifications and if necessary re-certifications of the patient's need for services are on file.**
5. **Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal Law and Regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 through 1086, 32 CFR 199) and any other applicable contract regulations, is on file.**
6. **The provider of care submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.**
7. **For Medicare Purposes: If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance which is responsible to pay for the services for which this Medicare claim is made.**
8. **For Medicaid purposes: The submitter understands that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.**
9. **For TRICARE Purposes:**

   (a) **The information on the face of this claim is true, accurate and complete to the best of the submitter's knowledge and belief, and services were medically and appropriate for the health of the patient;**
   (b) **The patient has represented that by a reported residential address outside a military medical treatment facility catchment area he or she does not live within the catchment area of a U.S. Public Health Service medical facility, or if the patient resides within a catchment area of such a facility, a copy of Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;**
   (c) **The patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverage, and that all such coverage is identified on the face of the claim except that coverage which is exclusively supplemental payments to TRICARE-determined benefits;**
   (d) **The amount billed to TRICARE has been billed after all such coverage have been billed and paid excluding Medicaid, and the amount billed to TRICARE is that remaining claimed against TRICARE benefits;**
   (e) **The beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,**
   (f) **Any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent employees, but excluding contract surgeons or other personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.**
   (g) **Based on 42 United States Code 1395cc(a)(1)(j) all providers participating in Medicare must also participate in TRICARE for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987; and**
   (h) **If TRICARE benefits are to be paid in a participating status, the submitter of this claim agrees to submit this claim to the appropriate TRICARE claims processor. The provider of care submitter also agrees to accept the TRICARE determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. The provider of care will accept the TRICARE-determined reasonable charge even if it is less than the billed amount, and also agrees to accept the amount paid by TRICARE combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. The provider of care submitter will not attempt to collect from the patient (or his or her parent or guardian) amounts over the TRICARE determined reasonable charge. TRICARE will make any benefits payable directly to the provider of care, if the provider of care a participating provider.**

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS

NOTICE: Any person who knowingly files a statement of claim containing an, misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties

REFERS TO GOVERNMENT PROGRAMS ONLY

BLACK LUNG AND FECA CLAIMS

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION

FOR MEDICARE CLAIMS:

FOR OWCP CLAIMS:

FOR CHAMPUS CLAIMS:

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

SIGNATURE OF PHYSICIAN (OR SUPPLIER)

Exhibit 6

Deal Name	Date of Close	State	Market Segment	Purchase Price (b)	Patients (a)	Centers	IRR	Year 3 Cash on Cash	EBITDA Year 1 (b)	Price/Pt
2002 Acquisitions										
Slidell	Mar-02	LA	A (9.0%)	$ 2,840,000	62	1	21.2%	13.9%	$ 689,315	$ 45,679
Vainer	Jul-02	GA	E (4.5%)	3,990,000	102	4	17.0%	16.6%	637,915	39,118
Imperial	Aug-02	CA	H (2.4%)	2,500,000	93	1	16.2%	13.9%	583,821	26,882
Methodist	Sep-02	MN	B (6.1%)	3,840,000	123	1	17.5%	14.7%	985,036	31,135
Covington	Oct-02	LA	A / C (9.0% / 5.7%)	4,927,500	130	3	16.8%	15.7%	789,616	37,985
Yakima	Dec-02	WA	A (9.0%)	1,650,000	103	1	16.0%	13.3%	756,240	16,064
Total				**$ 19,747,500**	**613**	**11**	**17.5%** (d)	**15.0%** (d)	**$ 4,441,943**	**$ 34,751** (d)
2002 JVs										
Irvine (JV DeNovo)	Jul-02	CA	H (2.4%)	N/A	53	1				
Denver Nephrology (HS / JV DeNovo) (c)	Closed 9/23/02, Effective 6/15/02	CO	E (4.5%)	N/A	150	5				
Sapulpa & South Crest Hospital (HS / JV DeNovo) (f)	Oct-02	OK	B (6.1%)	N/A	60	2				
Soledad (JV DeNovo)	Oct-02	CA	B (6.1%)	N/A	45	1				
Total					**308**	**9**				
2002 Other										
Pasadena Purchase Rights (HS) (e)	Apr-02	CA	H (2.4%)	$ 60,000	60	1				

(a) Includes acute equivalent patients. JV census represents 100% ownership.
(b) Purchase Price and EBITDA reflect DaVita's pro rata proportionate ownership interest in the deal.
(c) Resolved hot spot by renewing 6 centers and approximately 700 patients (saved pre G&A EBITDA of $9.5MM). JV denovo for 5 new centers. Total patients saved plus new JV patients was 850.
(d) Weighted average based on Purchase Price.
(e) Acquisition of Purchase Rights. Option exercisable from 36 to 48 months after Medicare certification date.
(f) Resolved hot spot with Tulsa Nephrology saving 275 patients, 4 centers, and $3.5MM in pre G&A EBITDA. Forecasted Yr. 1 census reflects Sapulpa and Southcrest units. Partners have identified 3 additional potential JV locations.

Deal Name	Date of Close	State	Market Segment	Purchase Price	(b)	Patients	(a)	Centers	IRR	Year 3 Cash on Cash	EBITDA Year 1	(b)	Price/Pt	
2003 Acquisitions														
Rockford - Midway	May-03	Midwestern US	G (3.5%)	$ 23,000,000		437		5	21.3%	15.8%	$ 4,831,784		$ 52,632	
Bon Secours	May-03	VA	B (6.1%)	$4,000,000		172		2	16.0%	15.0%	1,388,153		23,234	
Atri - Saginaw	May-03	MI	A (9.0%)	2,000,000		54		1	16.7%	15.4%	490,418		37,037	
Hurley	Jun-03	MI	A (9.0%)	17,300,000		360		3	17.1%	15.3%	3,501,953		48,100	
Washington Parish	Jul-03	LA	C (5.7%)	850,000		19		1	9.0%	12.8%	109,592		44,737	
Dr. Pierce - Franklin Dialysis Center	Aug-03	MI	E (4.5%)	1,350,000		38		1	18.6%	15.3%	326,609		35,526	
SWORC	Sep-03	OH	B (6.1%)	2,550,000		72		1	17.0%	16.0%	711,989		35,212	
Owensboro & Tell City	Oct-03	KY	A (9.0%)	6,430,000		142		2	11.4%	13.6%	1,246,784		45,173	
Vainer (c)	Oct-03	GA	E (4.5%)	1,500,000		33		0	NA	NA	NA		45,045	
HRG St. Louis	Oct-03	MO	H (2.4%)	700,000		26		1	17.3%	14.6%	83,375		26,923	
Eaton Canyon (c)	Oct-03	CA	H (2.4%)	1,133,400		22		0	NA	NA	NA		50,939	
Nebraska Health System	Nov-03	NE / IA	A / B (9.0% / 6.1%)	12,250,000		292		5	24.8%	19.1%	3,494,085		41,904	
Dr. Handelsman - North Georgia	Nov-03	GA	E (4.5%)	800,000		18		1	16.1%	14.4%	182,362		44,444	
Kidney Care Maryland	Dec-03	MD	E (4.5%)	7,400,000		181		2	17.4%	15.0%	1,916,444		40,884	
DIALYassist	Dec-03	AZ	B (6.1%)	1,250,000		45		0	15.1%	26.4%	338,646		28,077	
Total				**$ 82,513,401**		**1,912**		**25**	**18.3%**	(g) **15.5%**	(g) **$ 18,622,193**		**$ 44,921**	(g)
2003 JVs														
Tustin (JV DeNovo)	Mar-03	CA	H (2.4%)	NA		44		2						
Riverside (HS / JV DeNovo) (f)	Mar-03	CA	H (2.4%)	NA		225		4						
Rockford (JV DeNovo)	May-03	Midwestern US	G (3.5%)	NA		60		2						
Dr. Buchsbaum (JV DeNovo)	May-03	IA	B (6.1%)	NA		33		1						
Sun City (JV DeNovo)	May-03	AZ	B (6.1%)	NA		67		1						
Cleveland Clinic (Weston Dialysis) (JV DeNovo)	Sep-03	FL	F (2.2%)	NA		42		1						
Michigan (HS / Partial divestiture / JV) (e)	Oct-03	MI	B (6.1%)	2,850,000		69		2						
East Ft. Lauderdale (JV DeNovo)	Oct-03	FL	F (2.2%)	NA		40		1						
Lawrenceburg (Partial divestiture / JV)	Nov-03	IN	B (6.1%)	800,000		44		1						
Southern Hills (JV DeNovo)	Dec-03	NV	B (6.1%)	NA		42		1						
Total				**$ 3,650,000**		**666**		**16**						
2003 Other														
Lifeline (d)	Jul-03	IL	NA	NA		NA		13						
Children's Hospital (MSA)	Jul-03	Washington D.C.	F (2.2%)	NA		25		1						
Gonzales/Alvarado (HS / PD carve-out) (i)	Apr-03	CA	H (2.4%)	175,000		NA		NA						
Total				**$ 175,000**		**25**		**14**						
2003 Divestitures														
Salt Lake City (h)	Jul-03	UT	B (6.1%)	NA		NA		3						

Total Acquisitions Purchase Price by Quarter	
First Quarter	$ -
Second Quarter	47,150,001
Third Quarter	3,900,000
Fourth Quarter	31,463,400

(a) Includes acute equivalent patients. JV census represents 100% ownership.

(b) Purchase Price and EBITDA reflect DaVita's pro rata proportionate ownership interest in the deal.

(c) Vainer and Eaton Canyon are buy-outs of the minority interest in the JV. For this analysis, pro-rata patients are included - however center numbers are not counted as facilities were already owned by DVA (Vainer and Eaton Canyon included 2 and 1 facilities, respectively). Purchase price and census reflects DVA purchasing remaining 30% minority interest in Vainer and 12.5% interest in Eaton Canyon. The Eaton Canyon transaction was completed pursuant to the seller's put option.

(d) Acquisition of Baxter's Vascular Access Program

(e) Includes pro rata interest of 11 existing facilities and buildout costs of 2 additional de novo facilites. Resolved hot spot saved $17.1MM in pre G&A EBITDA, 11 facilities, and renewed 1,076 DaVita patients. 69 patients reflect Year 1 census of the 2 de novo facilities (38 at Oak Park and 31 at Southfield West). Detroit facilities in E (4.5%) market segment, Ypsilanti and Jackson facilities in C (5.7%) market segment, and Grand Blanc facility in A (9.0%) market segment.

(f) Transaction contemplated denovos in Riverside, Norco, Hemet, Chino, Banning, and Lake Elsinore. To date, Lake Elsinore opened; Norco, Riverside, and Yucaipa denovos in process. Census figures represent Lake Elsinore census as of 7/04 + Year 1 estimate for 3 denovos. Includes a 10 year (+1 year tail) MDA renewal. Also includes 750 renewed DVA patients and $11.4MM saved pre G&A EBITDA.

(g) Weighted average based on Purchase Price.

(h) Legal settlement whereby 2 of the 3 facilities were closed down

(i) Resolved hot spot saving 217 patients and $1.9MM in pre G&A EBITDA. DaVita PD program had 35 patients at the time of transaction

Deal Name	Date of Close	State	Market Segment	Purchase Price	(a)	Patients	(b)	Centers	IRR	Year 3 Cash on Cash	EBITDA Year 1	(a)	Incremental Unit Mix (By # of Facilities) CMLs	Political	High Hipper Mix	Price/Pt
2004 Acquisitions																
Kidney Care Iowa	Mar-04	IA	A/B (9.0%/6.1%)	$ 14,000,000		246		9	21.7%	14.2%	$ 3,125,518		2	5	5	$ 56,968
Long Beach Memorial (Acutes)	Mar-04	CA	H (2.4%)	500,000	(c)	23		0	(d) 15.7%	33.7%	208,237		0	0	0	21,283
Battle Creek	Apr-04	MI	A (9.0%)	5,400,000		100		1	15.2%	13.4%	777,633		0	0	0	53,821
Dr. Bravo	Apr-04	TX	B (6.1%)	2,400,000		53		1	16.0%	14.0%	415,024		0	0	1	45,283
Cuero	May-04	TX	NA	503,993		NA		1	NA	NA	NA		NA	0	0	NA
Bogalusa	May-04	LA	C (5.7%)	1,120,000		55		1	17.6%	14.9%	284,913		0	0	0	20,364
Big Sandy (e)	Jun/Dec-04	KY and WV	A/C (9.0%/5.7%)	5,224,000		154		4	16.7%	14.9%	1,289,708		0	0	3	33,971
Reidsville	Jun-04	NC	D (4.4%)	732,000		30		1	31.2%	23.7%	203,184		1	0	0	24,400
Hillmed	Jul-04	OH	B (6.1%)	25,750,000		305		3	16.1%	14.2%	4,245,379		0	0	3	84,426
RCM	Jul-04	MD	B/E (6.1%/4.5%)	17,500,000		268		3	12.4%	12.2%	2,362,339		0	0	1	65,299
Innovative	Jul-04	NE	A/B (9.0%/6.1%)	13,100,000		199		5	11.9%	13.1%	1,960,073		1	0	4	65,829
Gambro Inland Empire (f)	Aug-04	CA	H (2.4%)	1,590,000		116		2	23.2%	19.0%	428,458		0	0	0	13,707
Savannah/Statesboro (g)	Aug/Nov-04	GA	B/D (6.1%/4.4%)	9,156,597		188		2	14.7%	15.5%	2,189,955		1	0	1	48,705
Chicago Heights (Partial Acquisition/JV) (h)	Aug-04	IL	B (6.1%)	2,754,000		100		1	26.2%	19.3%	831,697		0	0	1	27,540
Eastmont (Acquisition of Remaining Interest) (i)	Sep-04	CA	H (2.4%)	1,137,380		100		1	NA	NA	NA		0	0	0	11,374
Physicians Dialysis, Inc. (j)	Sep-04	AL, CT, MA, MI, PA, TX	NA	150,000,000		1,757		24	8.4%	11.0%	15,949,362		4	0	16	85,373
New Orleans Metropolitan Dialysis	Oct-04	LA	G (3.5%)	792,000		0		1	16.0%	17.2%	(19,633)		0	0	0	NA
Contract Dialysis (Acutes) (k)	Oct-04	TX	B (6.1%)	281,500		54		0	17.0%	NA	509,451		NA	NA	NA	5,174
Comprehensive Renal Care of Northlake (SpectraCare)	Nov-04	GA	B (High B) / 6.1%	2,400,000		61		1	18.3%	15.3%	425,289		0	0	1	39,663
Down River Kidney Center	Nov-04	MI	E (Med B) / 4.5%	9,500,000		148		1	17.4%	14.2%	1,902,176		0	0	0	64,189
Total				**$ 263,841,470**		**3,957**		**62**	**11.7%**	(l) **12.3%**	(l) **$ 37,088,761**		**9**	**5**	**36**	**$ 74,566** (l)
2004 JVs																
Brighton (Western Nephrology) (JV DeNovo)	Feb-04	CO	C (5.7%)	NA		30		1								
Kannapolis (Partial Divestiture/JV)	Feb-04	NC	B (6.1%)	300,000		70		1								
DPC Iowa (JV DeNovo)	Mar-04	IA	A/B (9.0%/6.1%)	NA		121		2								
North Tulsa/Greenwood (JV DeNovo)	Mar-04	OK	B (6.1%)	NA		43		1								
Summit/Dr. Hagstrom (JV DeNovo)	Jun-04	TX	C (5.7%)	NA		36		1								
Tidewater Kidney Services (HS/JV DeNovo)	Jun-04	VA	B (6.1%)	NA		40		1								
Dr. Magnus-Lawson (Downtown Houston) (JV DeNovo) (m)	Jun-04	TX	C (5.7%)	NA		36		1								
Sapulpa (Partial Divestiture/JV)	Jul-04	OK	B (6.1%)	NA		30		1								
Fadem (JV DeNovo) (m)	Aug-04	TX	B (6.1%)	NA		20		1								
Dr. Hines (JV / MDA Renewal)	Nov-04	TX	B (6.1%)	NA		275		3								
Durango (JV DeNovo)	Nov-04	CO	B (6.1%)	NA		40		1								
Elk Grove (JV DeNovo) (n)	Dec-04	CA	H (2.4%)	NA		54		1								
Muskogee (Partial Divestiture)	Dec-04	OK	A (9.0%)	NA		NA		1								
Southcrest (Partial Divestiture/JV)	Dec-04	OK	B (6.1%)	NA		NA		NA								
Total				**$ 300,000**		**795**		**16**								
2004 Divestitures / Other																
North Philly	Mar-04	PA	G (3.5%)	$ 1,300,000		107		1								
Panama City (Management Agreement)	Feb-04	FL	D (4.4%)	1,600,000		200		2								
Conmed (Acute Contract)	Jun-04	CA	C (5.7%)	NA		36		1								
Nephrology & Hypertension Assc. (MDA only)	Oct-04	MO	B (6.1%)	NA		51		1								
Provo (Hotspot)	Nov-04	UT	D (4.4%)	NA		90		1								
East Dearborn (Partial Divestiture and JV DeNovo)	Nov-04	MI	E (4.5%)	602,116		80		2								
Los Prados - Pharma (Acquisition)	Dec-04	CA	NA	181,011		NA		NA								
Atlanta Divestiture / Dr. Cleveland (Hotspot / MDA) (o)	Dec-04	GA	E / 4.5%	NA		368		NA								
Harbor UCLA (MDA Renewal)	Dec-04	CA	H (2.4%)	NA		NA		NA								

- *CMLs and Political deals are defined by Transaction Directors*
- *High Hipper Mix is defined as facilities which fall within the Bain A or B (9.0% or 6.1%) rating.*
- *Iowa and Montana are the primary political states.*

Total Acquisitions Purchase Price by Quarter

	Purchase Price	Price/Pt
First Quarter	$ 14,500,000	$ 55,738
Second Quarter	15,379,993	$ 40,146
Third Quarter	220,987,977	$ 79,378
Fourth Quarter	12,973,500	$ 54,453

(a) Purchase Price and EBITDA reflect DaVita's pro rata proportionate ownership interest in the deal.
(b) Includes acute equivalent patients. JV census represents 100% ownership.
(c) Purchase price based over an earnout paid over time assuming contract is not terminated. The maximum amount payable is $660K.
(d) Long Beach Memorial was an acquisition of an acute program at a hospital. Therefore, no center was included in totals.
(e) Three of the four Big Sandy facilities closed in June 2004, whereas the Whitesburg facility closed in December 2004. The numbers for this deal are inclusive of all four Big Sandy facilities.
(f) Acquired through DaVita-Riverside, LLC (60%/40% JV with NAMG).
(g) The two facilities of this deal were closed in separate transactions in which Savannah closed in August 2004 and Statesboro was closed in November 2004.
(h) Made partial acquisition of Chicago Heights, resulting in a JV partnership whereby DaVita owns 51% and partners own 49%.
(i) Resolution of threatened litigation.
(j) Metrics (IRR, Cash on Cash, Yr 1 EBITDA) include economics associated with lab business.
(k) Acquisition of 75% of business associated with 9 acute contracts. Patient and Year 1 EBITDA reflect 100% of business.
(l) Weighted average based on Purchase Price.
(m) Magnus-Lawson invested in the East Houston de novo and Fadem and his 2 partners invested in the Downtown Houston de novo. Each of the 4 doctors signed new 15-mile non-compete agreements.
(n) As a separate transaction, included resolution of hotspot with Capital Nephrology via extention of MDAs for 10 wholly-owned centers.
(o) Resolution of hotspot via signed MDA. Total census of the 5 facilities is 420 patients, of which DVA's share is 368 patients. Physicians have an opportunity to purchase up to 12.5% equity interest in the centers.

Deal Name	Date of Close	State	Market Segment	Purchase Price	(a)	Patients	(b)	Centers	IRR	Year 3 Cash on Cash	EBITDA Year 1	(a)	Incremental Unit Mix (By # of Facilities) CMLs	Political	High Hipper Mix	Price/Pt	Tx in FY05
2005 Acquisitions																	
LAPD	Jan-05	CA	H (2.4%)	$ 1,575,000		38		1	21.5%	16.3%	$ 342,499		0	0	0	$ 41,447	5,472
Sparta	Mar-05	GA	D (4.4%)	350,000		15		1	16.6%	14.5%	$ 300,122		0	0	0	$ 23,333	1,800
Seneca (Partial Acquisition / JV)	Apr-05	OH	A (9.0%)	1,690,000		50		1	25.5%	18.7%	$ 601,841		0	0	1	$ 33,800	5,400
Alamosa (c)	Apr-05	CO	C (5.7%)	50,000		40		1	22.2%	17.6%	$ (42,089)		1	0	0	$ 1,250	4,320
Liberty Dialysis (Santelli) (d)	Apr-05	TX	D (4.4%)	1,962,931		11		1	20.4%	14.1%	$ 12,916		0	0	0	$ 178,448	1,188
Tennessee Kidney Clinics	May-05	TN	A (9.0%) / B (6.1%)	27,200,000		432		11	9.4%	12.3%	$ 3,300,931		3	0	11	$ 62,963	41,472
Moses Taylor	May-05	PA	C (5.7%)	5,350,000		234		5	20.7%	17.6%	$ 1,807,783		0	0	0	$ 22,863	22,464
Evansville	May-05	IN, KY	A (9.0%) / B (6.1%)	37,000,000		423		5	14.3%	12.2%	$ 5,594,266		1	0	5	$ 87,470	40,608
Renal Care of Illinois	Jun-05	IL	B (6.1%)	7,550,000		105		1	17.1%	13.5%	$ 1,361,847		0	0	1	$ 71,621	8,855
Good Samaritan	Jul-05	IN/IL	A (9.0%)	9,000,000		130		2	16.4%	14.0%	$ 1,525,098		2	0	2	$ 69,142	9,372
Spring Dialysis	Jul-05	TX	B (6.1%)	7,000,000		86		1	18.2%	14.1%	$ 1,169,531		0	0	1	$ 81,395	6,192
Dr. MacLaurin -- Nelsonville	Aug-05	OH	A (High A) / 9.0%	4,900,000		47		1	17.7%	14.5%	$ 925,360		0	0	5	$ 104,255	2,538
Pensacola	Sep-05	FL	All segments	19,000,000		371		7	13.9%	14.1%	$ 3,695,427		0	0	4	$ 51,213	17,808
Royce Lin & Bay Area PD	Oct-05	WI	B (High B) / A (High A)	8,475,000		164		3	18.1%	14.3%	$ 1,836,255		0	0	3	$ 51,677	5,904
Charleston	Oct-05	SC	D (4.4%)	12,000,000		183		3	21.3%	15.0%	$ 2,866,023		0	0	0	$ 65,574	6,588
Wilmington	Nov-05	OH	A (High A) / 9.0%	4,511,000		55		1	16.5%	12.6%	$ 806,249					$ 82,018	1,320
New Braunsfel (m)	Nov-05	TX	D (High C) / 4.4%	2,300,000		56		1	18.9%	15.0%	$ 416,000					$ 41,071	1,344
Castroville (m)	Nov-05	TX	D (High C) / 4.4%	590,000		13		1	19.0%	15.5%	$ 22,000					$ 45,385	312
East Bay Acutes	Nov-05	CA	B (Low B)	4,600,000		52		5	10.3%	14.1%	$ 827,000					$ 88,462	1,248
Winchester	Dec-05	VA	B (6.1%) / D (4.4%)	11,000,000		154		2	16.0%	12.5%	$ 1,353,762		1	0	1	$ 71,236	1,853
Total				**$ 166,103,931**		**2,660**		**54**	**15.3%**	(e) **13.5%**	(e) **$ 28,722,820**		**8**	**0**	**34**	**$ 70,290**	(e) **186,058**
Total (excluding Tennessee Kidney Clinics)				**$ 138,903,931**		**2,228**		**43**	**16.4%**	(e) **13.7%**	(e) **$ 25,421,889**		**5**	**0**	**23**	**$ 71,725**	(e) **144,586**
2005 JVs																	
Louisville (Partial Divestiture / JV DeNovo)	Jan-05	KY	E (4.5%)	NA		44		1									
Fullerton (JV DeNovo)	Jan-05	CA	H (2.4%)	NA		41		1									
NE El Paso (JV DeNovo)	Feb-05	TX	D (4.4%)	NA		50		1									
Memorial Dialysis (Partial Divestiture)	Mar-05	TX	B (6.1%)	$ 1,680,000		120		1									
Marysville (JV DeNovo)	Mar-05	CA	G (3.5%)	NA		62		1									
Dr. Provenzano / St. Claire (JV De Novo/Lifeline)	May-05	MI	B (6.1%)	NA		40		1									
Central Kentucky (Partial Divestiture)	May-05	KY	A (9.0%)	NA		30		1									
Wilshire (JV Restructuring) (f)	May-05	CA	H (2.4%)	NA		394		3									
Macon Martinez (Partial Acquisition) (g)	Jun-05	GA	D (4.4%)	630,000		43		1									
Dr. Agraharkar (JV DeNovo)	Jun-05	TX	C (5.7%)	NA		30		1									
San Antonio Kidney Disease Center (JV De Novo)	Jun-05	TX	D (4.4%)	NA		357		5									
East New Orleans (Partial Divestiture) (h)	Jul-05	LA	G (3.5%)	NA		31		1									
Hillsboro (JV DeNovo/MDA) (i)	Sep-05	TX	B(6.1%)	NA		82		3									
Willowbrook (JV DeNovo)	Sep-05	TX	B(6.1%)	NA		17		1									
Rochester JV	Dec-05	MI	B(6.1%)	NA		20		1									
Woodland/Letchfield JV	Dec-05	KY	A (9.0%)	NA		115		1									
Long Beach JV	Dec-05	CA	B (2.4%)	NA		45		1									
Total				**$ 2,310,000**		**1,521**		**25**									
2005 Divestitures / Other																	
Harbor UCLA (Research Grant)	Jan-05	CA	H (2.4%)	NA		NA		NA									
Pacific Coast Dialysis (Minority Partner Buyout) (j)	Jan-05	CA	H (2.4%)	$ 280,000		105		1									
Garey Refinancing	Mar-05	CA	C (5.7%)	NA		NA		NA									
Macon Martinez (Divestiture) (g)	Jun-05	GA	D (4.4%)	NA		76		1									
Apothecary Shop	Aug-05	FL	NA	408,000		NA		1									
PDI-Alabama[k]	Aug-05	AL	A (9.0%)	1,424,512		251		4									
Atlantic City (Divestiture)	Sep-05	NJ	B (6.1%)	NA		NA		1									
USC [l]	Oct-05	CA	G (Low A)	3,550,000		277		1									
Wichita Hot Spot	Oct-05	KS	B (6.1%)	NA		604		10									

- *CMLs and Political deals are defined by Transaction Directors*
- *High Hipper Mix is defined as facilities which fall within the Bain A or B (9.0% or 6.1%) rating*
- *Iowa and Montana are the primary political states*

(a) Purchase Price and EBITDA reflect DaVita's pro rata proportionate ownership interest in the deal
(b) Includes acute equivalent patients. JV census represents 100% ownership
(c) No acquisition model made for this deal. IRR, Cash on Cash and EBITDA numbers are based on de novo model.
(d) This is a JV acquisition transaction where DaVita owns 60%.
(e) Weighted average based on Purchase Price.
(f) Recapitalized existing JVs (3 centers) to resolve compliance hot spot.
(g) Pertains to acquisition of 70% interest of Perry. No cash expended as transaction also includes the divestiture of 70% of East Macon ($2.1 million)
(h) Partial divestiture of 20% in East New Orleans facility.
(i) DVA closed a deal for 2 de novo centers and a MDA for the third facility. The centers are located in Arlington, Grapevine, and Hillsboro, TX.
(j) Acquisition of remaining 7% interest from DVA JV partner resulting in a wholly-owned entity.
(k) DVA exercised call option and acquired the ~17% ownership of 3 non-physician partners
(l) USC paid 40% of $3.55MM plus working capital
(m) Per D. Finn, DVA paid for 51% of the center and SAKDC paid the remaining 49%

Deal Name	Date of Close	State	Market Segment	Transaction Value		Patients		Centers	IRR	Year 3 Cash on Cash	EBITDA Year 1		Incremental Unit Mix (By # of Facilities) CMLs	Political	High Hipper Mix	Price/Pt	Tx in FY06
2006 Acquisitions																	
Nephroplex	Jan-06	IL	A (9.0%)	$ 13,900,000		222		4	18.1%	14.5%	$ 2,810,873		1	0	4	$ 62,764	31,896
Diamond Dialysis	Feb-06	IL	B (6.1%)	$ 9,150,000		96		2	14.3%	11.4%	$ 2,600,260		0	0	2	$ 95,313	12,672
SANC Idaho	Apr-06	ID	D (4.4%) / A (9.0%)	$ 44,000,000		534		6	16.2%	13.8%	$ 7,239,870		6	0	4	$ 82,397	57,672
Fresno (Pacific Family Health, Inc.)	Apr-06	CA	G (Low A) / 3.5%	$ 600,000		18		-	TBD	TBD	TBD		0	0	0	$ 33,333	1,944
Las Vegas Summerlin	Jun-06	NV	B (6.1%)	$ 7,680,000	(d)	124		1	15.3%	13.3%	$ 3,028,000		0	0	0	$ 61,935	10,416
FMC Concord	Jun-06	NC	B (6.1%)	$ 700,000		52		1	17.4%	10.2%	$ 250,747		0	0	1	$ 13,462	4,368
Cobb Paulding	Jul-06	GA	B (6.1%)	$ 3,000,000		141		3	17.1%	13.1%	$ 617,606		3	0	3	$ 21,277	10,152
Eastern Connecticut	Sep-06	CT	A (9.0%)	$ 2,500,000		135		2	17.1%	14.1%	$ 498,804		2	0	2	$ 18,477	6,494
Grand Junction	Oct-06	CO	G (Low A) / 3.5%	$ 3,740,000		89	(m)	1	16.7%	14.1%	$ 529,935		0	0	0	$ 42,253	3,187
Dyersburg	Nov-06	TN	A (9.0%)	$ 1,150,000		29		1	14.7%	13.4%	$ 94,074		0	0	1	$ 39,655	696
Amelia Island	Nov-06	FL	C(5.7%)	$ 1,300,000		38		1	16.6%	10.7%	$ (180,320)	(l)	0	0	0	$ 34,211	912
Virginia Beach	Nov-06	VA	B (6.1%)	$ 2,300,000		49		1	21.3%	15.4%	$ 193,102		0	0	1	$ 46,939	1,176
Atlanta Dialysis	Dec-06	GA	B (6.1%)	$ 3,250,000		52		1	9.5%	11.4%	$ 391,477			0	1	$ 62,500	624
Total				**$ 93,270,000**		**1,578**		**24**	**16.1%**	(c) **13.4%**	(c) **$ 18,074,427**		**12**	**0**	**19**	**$ 70,164**	(c) **142,209**
2006 JVs																	
Sugarloaf/Buford (Partial Divestiture/JV De Novo)	Mar-06	GA	B (6.1%)	$ 671,290		20		2									
Security (JV De Novo)	Apr-06	CO	B (6.1%)	$ 2,310,907		62	Yr 3	1									
La Grange (Partial Divestiture/JV De Novo)	May-06	KY	Med B (4.5%)	$ 1,050,000		33	Yr 3	1									
Anadarko (JV De Novo)	May-06	OK	A (9.0%)	$ 975,129		26	Yr 3	1									
Upper Valley (JV De Novo)	May-06	TX	D (4.4%)	De Novo Price		57		1									
Las Vegas Partnership (Partial Divestiture / JV)	Jun-06	NV	B (6.1%)	$ 7,240,000	(d)	408		3									
Strongsville (JV De Novo)	Jun-06	OH	B (6.1%)	De Novo Price		48	Yr 1	1									
Natomas (JV De Novo)	Jul-06	CA	H (2.4%)	De Novo Price		32		1									
Bear Creek (JV De Novo)	Aug-06	TX	B (6.1%)	De Novo Price		32	Yr 3	1									
Henderson (JV De Novo)	Aug-06	NV	B (6.1%)	De Novo Price		34	Yr 1	1									
Ionia (JV DeNovo)	Aug-06	MI	A (9.0%)	De Novo Price		26	Yr1	1									
Commerce Township (JV DeNovo)	Oct-06	MI	B (6.1%)	De Novo Price		26	Yr1	1									
East El Paso (JV DeNovo)	Oct-06	TX	C(4.4%)	DeNovo Price		70	Yr1	1									
Johnson City (JV DeNovo)	Oct-06	TN	A (9.0%)	DeNovo Price		17	Yr1	1									
Riverside II (JV DeNovo)	Oct-06	CA	H (2.4%)	DeNovo Price		106	Yr1	2									
The Woodlands (JV DeNovo)	Nov-06	TX	B (6.1%)	DeNovo Price		34	Yr1	1									
East Bay Vascular Access(JV DeNovo)	Nov-06	CA	H (2.4%)	DeNovo Price			Yr1	1									
Mena(JV DeNovo)	Dec-06	OK		DeNovo Price			Yr1	1									
Total				**$ 12,247,326**		**1,031**		**22**									
2006 Divestitures / Other																	
UAB Hotspot (Buyout / Change of Control)	Feb-06	AL	B (6.1%)	$ 5,000,000		533		7									
Kilmarnock (Divestiture)	Feb-06	VA	C (4.4%) / A (9.0%)	$ 153,495		30		1									
Tuscaloosa (MDA)	Feb-06	AL	A (9.0%)	NA		450		4									
Johns Hopkins Hotspot (Buyout / Change of Control)	Apr-06	MD	B (6.1%)	$ 5,000,000		644		8									
Capital Nephrology Hotspot	Apr-06	CA	H (2.4%)	NA		1,192		13									
University - Sacramento, CA (Partial Divestiture)	May-06	CA	H (2.4%)	$ 588,000		65		1									
PDI Alabama (Buyout)	May-06	AL	B (6.1%)	$ 1,332,125	(e)	243		4									
Woodstock / Elijay (Buyout)	Jun-06	GA	B (6.1%) / D (4.4%)	$ 675,000	(f)	47		2									
American Access (Divestiture/Hot Spot Resolution) (g)	Jun-06	PA	G (Low A) / 3.5%	$ 4,000,000		NA		NA									
Muskogee (Partial Divestiture)	Jun-06	OK	A (9.0%)	$ 429,000	(h)	51		1									
HRG (Bankruptcy)	Jul-06	Various	H (2.4%)	NA		270	(i)	6	(i)								
Floresville (Partial Divestiture)	Aug-06	TX	B (6.1%)	$ 100,000	(j)	35		1									
DC Lifeline (Access Acquisition)	Sep-06	MD	NA	$ 1,200,000		na		1									
SAKDC (Loan)	Sep-06	TX	D(4.2%)	$ 3,500,000	(k)	493		8									
				$ 21,977,620		**4,053**		**57**									

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(a) Transaction Value and EBITDA reflect DaVita's pro rata proportionate ownership interest in the deal.
(b) Includes acute equivalent patients. JV census represents 100% ownership
(c) Weighted average based on Transaction Value
(d) DaVita contributed the South Las Vegas, North Las Vegas, and West Las Vegas clinics to the partnership. The owners of the Summerlin clinic contributed the Summerlin clinic to the partnership. Cash outflow from DVA to Summerlin owners in the amount of $440k to result in a 60%/40% joint venture
DaVita acquired a 60% interest in Summerlin for $7.68M DaVita sold a 40% interest in South Las Vegas, North Las Vegas, and West Las Vegas for $7.24M. Valuation done by D&P.
(e) DaVita bought out its partner's 40% interest in PDI Alabama for $1.3mm.
(f) Involves the buyout of 30% interest in Woodstock and Elijay centers, which are fully-valued at a $2.25mm. The appraisal was performed by Applied Economics The valuation methodology was on a multiple-basis and not a DCF-basis
(g) Divested 1/3 interest in three Gambro-legacy access centers in greater Philadelphia for $4mm.
(h) DaVita divested 11% of its 72.5% stake in Muskogee. Full valuation was $3.9mm.
(i) Involves a total of 270 patients. 26 in the one acquired by DVA, and a total of six centers, of which one center is DVA's
(j) DaVita divested 100% of its interest in Floresville to SAKDC-DaVita Dialysis Partners, L.P., which is 51% owned by DaVita.
(k)Total Loan Amount to SAKDC JV is $3.5M -- $1.5M in term loan and $2.0M in revolving line of credit.
(l) Year 3 EBITDA is $237,699
(m) Includes 1370 acute treatments which is the equivalent of 9.5 hemo patients Therefore total number of patients is 79 plus 9.5 (hemo equivalent) which is 88.5.

Deal Name	Date of Close	State	Market Segment	Transaction Value		Patients		Centers	IRR	Year 3 Cash on Cash	EBITDA Year 1		Incremental Unit Mix (By # of Facilities) CMLs	Political	High Hipper Mix	Price/Pt		Tx in FY07	x EBITDA
2007 Acquisitions																			
Little Rock	Apr-07	AR	High B(6.1%)	$ 300.000		50		2	69.5%	27.0%	$ 535.923		0	0	2	$ 6.000		7.200	0.6 x
Florida Hemo	May-07	FL	Low B(2.4%)	$ 1.977.000		30		1	19.0%	17.8%	$ 59.066		0	0	0	$ 65.900		2.880	33.5 x
South Valley	Jun-07	CA	Low B(2.4%)	$ 4.000.000		145		1	19.0%	14.8%	$ 935.429		0	0	0	$ 27.586		12.180	4.3 x
Leesburg	Jul-07	FL	Med A (5.7%)	$ 3.000.000		50		1	17.4%	12.7%	$ 443.227		0	0	0	$ 60.000		3.600	6.8 x
St. Cloud(Partial Acquisition)	Aug-07	FL	Med C (2.2%)	$ 3.585.000	(j)	126		1	18.3%	14.0%	$ 645.987		0	0	0	$ 28.452		7.560	5.5 x
Hilimed(Partial Acquisition)	Aug-07	OH	High B(6.1%)	$ 1.200.000	(k)	55		1	17.3%	14.5%	$ 209.099		0	0	1	$ 21.818		3.300	5.7 x
RCP Hialeah	Aug-07	FL	Low B(2.4%)	$ 1.100.000		29		1	17.6%	14.3%	$ (161.454)		0	0	0	$ 37.931		1.740	NA
Turlock(Partial Acquisition)	Aug-07	CA	Low A(3.5%)	$ 879.000	(l)	37		1	20.4%	15.3%	$ 123.436		0	0	0	$ 23.757		2.220	7.1 x
Hialeah	Sep-07	FL	Low B(2.4%)	$ 800.000		12		1	18.5%	14.5%	$ (47.130)		0	0	0	$ 66.667		576	NA
Bakersfield	Oct-07	CA	Low A(3.5%)	$ 17.700.000		377		1	14.2%	13.2%	$ 2.341.001		1	0	0	$ 46.950		13.572	7.6 x
Erie	Nov-07	PA	High A(9.0%)	$ 8.125.000		199		2	16.6%	14.4%	$ 781.687		2	0	2	$ 40.829	#	4.776	10.4 x
SKI(Partial Acquisition)	Dec-07	AZ	High B(6.1%)	$ 18.300.000		311		3	11.8%	11.2%	$ 2.323.875			0	0	$ 58.842		3.732	7.9 x
Total				$ 15.750.000		443		8	18.2%	15.0%	$ 1.227.508			0	8	$ 35.553		5.316	12.8 x
				$ 78.716.000		**1.884**		**24**	**16.8%**	(c) **13.6%**	(c) **$ 9.417.654**		**3**	**0**	**13**	**$ 45.181**	(c)	**68.652**	**8.1 x**
2007 JVs																			
Dr Handler (JV DeNovo)	Jan-07	FL	C(5.7%)	DeNovo Price		28 (Yr 1)		1											
Wyandotte Central (JV De Novo)	Feb-07	KS	High B(6.1%)	DeNovo Price				1											
Riddle Dialysis (JV De Novo)	Mar-07	PA	High B(6.1%)	DeNovo Price				1											
West Broadway (JV De Novo)	Mar-07	KY	Med B(4.5%)	DeNovo Price		33 (Yr 1)		1											
Hopkins (JV De Novo)	Mar-07	MD	High B(6.1%)	DeNovo Price		50 (Yr 1)		1											
Montefiore (JV De Novo)	Mar-07	NY	Med B(4.5%)	DeNovo Price				2											
West Sacramento (JV De Novo)	May-07	CA	Low B(2.4%)	DeNovo Price		33 (Yr 1)		1											
Silverton(JV De Novo)	May-07	OH / KY		DeNovo Price	(q)	134 (Yr 1)		5											
Desert Springs(JV De Novo)	May-07	NV	High B(6.1%)	DeNovo Price		27 (Yr 1)		1											
Sun City West(JV De Novo)	Aug-07	AZ	High B(6.1%)	DeNovo Price		45 (Yr 1)		1											
Grand Home(JV De Novo)	Aug-07	AZ		DeNovo Price	(i)			1											
Riverside III (JV De Novo)	Sep-07	CA	Low B(2.4%)	DeNovo Price		96 (Yr 1)		2											
Fargo JV (JV De Novo)	Oct-07	ND		DeNovo Price		35 (Yr 1)		1											
Sandusky (JV De Novo)	Nov-07	OH	A(9.0%)	DeNovo Price		20 (Yr 1)		1											
REA (JV De Novo)	Nov-07	PA		DeNovo Price		478 (Yr 1)		4											
Sommerville (JV De Novo)	Dec-07	TN		DeNovo Price		26 (Yr 1)		1											
Total				**$ -**		**1.005**		**25**											
2007 Divestitures / Other																			
Dr Mark Lee (Physician Practice -Divestiture)	Jan-07	CA	H(2.4%)	$ 70.000		NA		1											
SAKDC(Partial Divestiture)	Apr-07	TX	High C(4.4%)	$ 560.000	(e)	122		3											
Reading (100% Divestiture)	May-07	PA	High B(6.1%)	$ 200.000		42		1											
KHC Silverton (Partial Divestiture)	May-07	OH	Med B(4.5%)	$ 505.000	(d)	53		1											
Little Rock (Partial Divestiture)	May-07	AR	High B(6.1%)	$ 120.000	(f)	50		2											
Central Kentucky (Partial Divestiture)	Jun-07	KY		$ 1.520.000	(h)			2											
IMS (Partial Divestiture)	Aug-07	FL	Med C (2.2%)	$ 3.075.000	(m)	211		3											
Home Choice Partners(Partial Acquistion)	Sep-07	VA/GA	NA	$76.000.000	(n)	2.000		NA											
Ionia (Partial Divestiture)	Oct-07	MI				26		1											
				$ 82.050.000		**2.504**		**13**											

- *CMLs and Political deals are defined by Transaction Directors*
- *High Hipper Mix is defined as facilities which fall within the Bain A or B (9.0% or 6.1%) rating.*

(a) Transaction Value and EBITDA reflect DaVita's pro rata proportionate ownership interest in the deal.
(b) Includes acute equivalent patients. JV census represents 100% ownership.
(c) Weighted average based on Transaction Value.
(d) This transaction involves the partial divestiture of one center (with 53 pts and currently 80.5% DVA). 100% valuation is $3,000,000. Silverton deal also includes 5 JV De Novos - White Oak, Anderson, Lebanon(Warren County), Turfway, and Cold Springs. All centers are in OH, except Turfway and Cold spring, which are in KY
(e) This transaction involves partial divestiture of 3 centers in San Antonio, TX. 100% valuation is $1,400,000
(f) This transaction involved acquisition of the center first and then divesting 40% of the center. Total vale is $300,000
(q) Silverton deal includes 5 JV De Novos - White Oak, Anderson, Lebanon(Warren County), Turfway and Cold Springs. All centers are in OH, except Turfway and Cold spring, which are in KY
(h) The transaction involves the doctor group buying in an additional 16% in the Woodland and Bardstown centers. Total Valuation is $9.5M
(i) This is a PD/HHD JV De Novo as an off shoot of Sun City West
(j) DVA Acquired interest is 60%. Net cash impact is $3,585,000
(k) DVA Acquired interest is 60%. Net cash impact is $1,200,000
(l) DVA Acquired interest is 60%. Net cash impact is $879,000
(m) Centers divested include Orlando(Hunters Creek), Kissimmee and Celebration. DVA Interest divested is 40%. Net cash impact $1,230,000
(n) Involves acquisition of 85% interest in a infusion business

Deal Name	Date of Close	State	Est % HIPPERS	Transaction Value	(a)	Patients	(b)	Centers	IRR	Year 3 Cash on Cash	EBITDA Year 1	(a)	Incremental Unit Mix (By # of Facilities) CMLs	Political	High Hipper Mix	Price/Pt	Tx in FY08	x EBITDA
2008 Acquisitions																		
Fayetteville	1-Feb-08	AR	8.3%	$ 3.790.000		110		4	16.6%	14.8%	$ (423.233)		1	0	0	$ 34.455	14.520	-9.0 x
Decatur	1-Apr-08	GA	7.7%	$ 8.000.000		168		2	16.2%	14.2%	$ 1.209.252		0	0	0	$ 47.619	18.144	6.6 x
Coastal	1-May-08	FL	1.0%	$ 5.400.000		111		1	12.5%	12.0%	$ 749.078		0	0	0	$ 48.649	10.656	7.2 x
Kansas	1-Jun-08	KS	9.1%	$ 18.750.000		189		3	14.0%	12.3%	$ 2.887.596		0	0	0	$ 99.206	15.876	6.5 x
Vidalia	1-Aug-08	GA	5.9%	$ 514.000		23		1					0	0	0	$ 22.348	1.380	
Cuero	1-Aug-08	TX	5.1%	$ 300.000		18		1					0	0		$ 16.667	1.080	
Trover	1-Aug-08	KY	8.3%	$ 1.100.000		87		1	15.5%	13.3%	$ 220.739		0	0	0	$ 12.644	5.220	5.0 x
Peyton	30-Sep-08	OH	9.8%	$ 28.275.000		295		3	14.5%	10.7%	$ 4.306.975		0	0	0	$ 95.847	14.160	6.6 x
Port Lavaca	1-Oct-08	TX	5.6%	$ 600.000		39		1	2.0%	10.1%	$ 114.411		0	0	0	$ 20.513	1.404	7.0 x
Stemmer	1-Dec-08	FL	6.0%	$ 10.000.000		111		1	17.4%	11.5%	$ 1.288.987		0	0	0	$ 90.090	1.332	7.8 x
Caucus	1-Dec-08	IA	9.8%	$ 14.000.000		170		2	13.3%	12.5%	$ 1.148.410		0	0	0	$ 82.319	2.041	12.2 x
Total				**90.929.000**		**1.321**		**20**	**14.4%**	(c) **11.9%**	(c) **11.502.216**		**1**	**0**	**0**	**$ 81.873**	(c) **85.813**	**7.9 x**
2008 JVs																		
American Fork(JV De Novo)	1-Jan-08	UT	12.2%	DeNovo Price		28 (Yr 1)		1										
Centennial (JV De Novo)	1-Feb-08	NV	12.3%	DeNovo Price				1										
Corydon (JV De Novo)	5-Feb-08	IN	11.1%	DeNovo Price		24 (Yr 1)		1										
Galleria PD/HHD (JV De Novo)	22-Feb-08	TN	8.6%	DeNovo Price		19 (Yr 1)		1										
RNA (JV DeNovo)	1-Apr-08	OH	8.3%	DeNovo Price		52 (Yr 1)		2										
Wauseon (JV DeNovo)	1-Apr-08	OH	5.8%	DeNovo Price		22 (Yr 1)		1										
MANA (JV DeNovo)	5-May-08	MD	13.4%	DeNovo Price		38 (Yr 1)		1										
Delhi (JV DeNovo)	1-May-08	OH	10.8%	DeNovo Price		50 (Yr 1)		1										
Las Vegas Pediatrics(JVDeNovo)	1-Jun-08	NV	10.2%	DeNovo Price		16 (Yr 1)		1										
N Austin (JV DeNovo)	1-Jul-08	TX	11.2%	DeNovo Price		30 (Yr 1)		1										
San Marcos (JV DeNovo)	1-Jun-08	TX		DeNovo Price		91(Yr 1)		1										
Sealy (JV DeNovo)	1-Nov-08	TX		DeNovo Price														
Five Star (JV DeNovo)	1-Dec-08	NV		DeNovo Price														
Sunset (JV DeNovo)	1-Dec-08	CA		DeNovo Price														
Total				**$ -**		**279**		**12**										
2008 Divestitures / Other																		
Houston Acutes (JV BUYOUT)	1-Jan-08	TX		$ 80.579				2										
Hemet (Partial Divestiture - 40%)	1-Feb-08	CA	7.4%	$ (250.000)		92		1										
PDI Middlesex (JV Buyout)	1-Feb-08	CT	12.9%	$ 2.380.677		100		1										
Manzanita - At Home(Partial Divestiture - 49%)	1-Feb-08	CA	7.3%	$ (143.898)				1										
Columbus (Partial Divestiture - 40%)	1-Mar-08	OH	13.0%	$ (4.208.177)	(d)	297		3										
Turlock (JV BUYOUT)	1-Mar-08	AR		$ 704.639				1										
*Miami / FL - Open Access Vascular Center	1-May-08	FL	4.30%	$ 10.979.364				1										
TRC Colorado (Partial Divestiture - 49%)	31-May-08	CO		$ (1.396.757)														
Rocky Mountain Dialysis (JV BUYOUT)	1-Jun-08	CO	7.20%	$ 19.353.368		230		3										
Mountain West Dialysis,LLC (Partial Divestiture - 49%)	1-Jun-08	CO		$ (2.412.786)														
Capital Dialysis (Partial Acquisition - 2.495%)	1-Jun-08	CA		$ 369.437														
TRC Petersburg (JV BUYOUT)	1-Jul-08	VA		$ 19.530														
Waynesboro (DIVESTITURE)	1-Jul-08	GA		$ (139.769)				1										
Soledad / CA (JV BUYOUT) - Soledad Dialysis Center, LLC	1-Aug-08	CA	8.30%	$ 1.100.000		79		1										
Shadow Dialysis (Partial Divestiture - 49%)	1-Oct-08			$ (1.296.338)														
Wauseon (Partial Divestiture - 10%)	1-Nov-08	OH		$ (223.150)														
Shadow Dialysis (Partial Divestiture - 10%)	14-Nov-08																	
Mainplace (Partial Divestiture - 36%)	1-Dec-08	CA		$ (504.000)														
				$ 24.906.719		**795**		**15**										

- *CMLs and Political deals are defined by Transaction Directors*
- *High Hipper Mix is defined as facilities with estimated % HIPPER greater than 10%*

(a) Transaction Value and EBITDA reflect DaVita's pro rata proportionate ownership interest in the deal
(b) Includes acute equivalent patients JV census represents 100% ownership
(c) Weighted average based on Transaction Value
(d) Involves Columbus($5,402,000); Columbus East($139,000) and Columbus Downtown($1,002,000) centers

Deal Name	Date of Close	State	Est % HIPPERS	Transaction Value (a)	Patients (b)	Centers	IRR	IRR with Lab	Year 3 COC	Yr 3 COC with Lab	EBITDA Year 1 (a)	Implied Price/Pt	Tx in FY08	x EBITDA	Physicians
2009 Acquisitions															
Dialysis Services of Central Florida	1-Feb-09	FL	10.3%	$ 32,800,000	474	5	12.2%	14.0%	9.9%	10.5%	$ 3,173,219	$ 69,198	62,568	10.3 x	11
Renown	1-Feb-09	NV	13.2%	$ 1,024,000	94	3	16.2%	27.4%	9.2%	10.5%	$ 242,087	$ 10,940	12,355	4.2 x	4
Bakersfield Acutes	1-Feb-09	CA	6.7%	$ 400,000	21	NA	47.7%	47.7%	46.5%	46.5%	$ 495,401	$ 18,701	2,823	0.8 x	NA
Klamath Falls	1-Mar-09	OR	7.5%	$ 3,500,000	51	1	16.1%	17.5%	12.1%	12.6%	$ 648,614	$ 68,627	6,120	5.4 x	4
Timpanogos PD	1-Mar-09	UT	10.7%	$ 1,050,000	8	1	14.3%	15.6%	10.6%	11.1%	$ 359,332	$ 131,250	960	2.9 x	3
Muskogee(JV Buyout - 38.5%)	1-Mar-09	OK	6.2%	$ 1,424,500	18	1	19.1%	20.4%	12.7%	12.7%	$ 243,623	$ 77,083	2,218	5.8 x	1
TKS(JV Buyout-40%)	1-Apr-09	VA	5.9%	$ 3,280,000	70	2	8.3%	10.7%	10.2%	10.2%	$ 561,880	$ 46,857	7,560	5.8 x	9
Wheaton	1-Jun-09	IA	9.0%	$ 3,500,000	84	2	22.3%	24.0%	14.4%	15.6%	$ 356,115	$ 41,667	7,056	9.8 x	4
Total				46,978,500	820	15	**13.8%**	**15.6%** (c)	**10.8%** (c)	**12.1%** (c)	6,080,271	$ 65,471 (c)	101,660	**7.7 x**	**36**
2009 JVs															
Wesley Chapel (JV DeNovo)	1-Jan-09	FL	6.7%	NA	NA										
Kennestone - Royale Dialysis (JV DeNovo)	1-Jan-09	GA	11.2%	NA	NA										
Fields Forest Fair (JV)	1-Mar-09	OH	11.5%	NA	NA										
Blue Grass/Williamstown (JV)	1-Mar-09	KY	9.2%	NA	NA										
Fields (JV)	1-Mar-09	OH	11.5%	NA	NA										
Cypress Woods (JV)	1-Mar-09	TX	5.6%	NA	NA										
Pryor (JV)	1-Apr-09	OK	6.0%	NA	NA										
District Heights (JV DeNovo)	1-May-09	MD	15.3%	NA	NA										
Total				$ -	0	0									
2009 Divestitures / Other															
East LA (Partial Divestiture - 20%)	1-Feb-09	CA		$ (770,000)		2									
Zephyrhills (Partial Divestiture - 46%)	1-Feb-09	FL		$ (690,000)		1									
Hennepin (Full Divestiture)	1-Feb-09	MN		$ (170,000)		1									
New Springs (Partial Divestiture - 15%)	1-Feb-09	IN		$ (173,339)		1									
La Grange (Partial Divestiture - 20%)	1-Feb-09	KY		$ (244,872)		1									
NW Tucson (Partial Divestiture - 50%)	1-Mar-09	AZ		$ (875,000)		1									
Sparks and Sierra Rose (Partial Divestiture - 60%)	1-Feb-09	NV		$ (1,570,800)		2									
Monroe (Full Divestiture)	1-Apr-09	LA		$ (1,475,199)		3									
Amery (Partial Divestiture - 25%)	1-Apr-09	WI		$ (416,282)		1									
West Elk Grove (Partial Divestiture - 49%)	1-Apr-09	CA		$ (1,078,000)		1									
				$ (7,463,491)	0	14									

(a) Transaction Value and EBITDA reflect DaVita's pro rata proportionate ownership interest in the deal.
(b) Includes acute equivalent patients. JV census represents pro rata ownership.
(c) Weighted average based on Transaction Value.

Exhibit 7

DaVita Acquisition Transactions

Transaction	Closed	State	Interest Purchased	Purchase Price	Centers	Patients	Proj. Yr 1 EBITDA	EBITDA Multiple	IRR	Assumptions: Hipper comp.	Assumptions: Plugged Or Bus?	Valuation @ $18 G&A
Nephroplex	Jan-06	IL	100%	$ 13,900,000	4	222	$ 2,810,873	4.9x	18.1%	NA	no	$ 13,000,000
Diamond Dialysis	Feb-06	IL	100%	9,150,000	2	96	2,600,260	3.5x	14.3%	750	no	8,600,000
SANC Idaho	Apr-06	ID	100%	44,000,000	6	534	7,239,870	6.1x	16.2%	NA	no	41,300,000
Las Vegas Summerlin	Jun-06	NV	60%	7,680,000	1	124	3,028,000	2.5x	15.3%			
FMC Concord	Jun-06	NC	100%	700,000	1	52	250,747	2.8x	17.4%	NA	no	500,000
Cobb Paulding	Jul-06	GA	100%	3,000,000	3	141	617,606	4.9x	17.1%	750	no	2,350,000
Eastern Connecticut	Sep-06	CT	100%	2,500,000	2	135	498,804	5.0x	17.1%	NA	287 vs 245	1,900,000
Grand Junction	Oct-06	CO	100%	3,740,000	1	89	505,116	7.4x	16.7%	750	5 @ 1,015	3,350,000
Dyersburg	Nov-06	TN	100%	1,150,000	1	29	94,074	12.2x	14.7%			
Amelia Island	Nov-06	FL	100%	1,300,000	1	38	(180,320)	NM	16.6%	750	14 @ 450	1,100,000
Virginia Beach	Nov-06	VA	100%	2,300,000	1	49	193,102	11.9x	21.3%	NA	300 vs 252	2,050,000
Atlanta Dialysis	Dec-06	GA	100%	3,250,000	1	52	391,477	8.3x	9.5%	NA	staffing	2,900,000
Little Rock	Apr-07	AR	100%	$ 300,000	2	50	$ 535,923	0.6x	69.5%	750	4 @ 1250	$ 225,000
Florida Hemo	May-07	FL	100%	1,977,000	1	30	59,066	33.5x	19.0%	750	253 vs 239	1,550,000
South Valley	Jun-07	CA	100%	4,000,000	1	145	935,429	4.3x	19.0%	750	EPO	3,300,000
Leesburg	Jul-07	FL	100%	3,000,000	1	50	443,227	6.8x	17.4%	750	12 @ 450	2,700,000
St. Cloud	Aug-07	FL	60%	3,585,000	1	126	645,987	5.5x	18.3%	750	265 vs 245	2,880,000
Hillmed	Aug-07	OH	60%	1,200,000	1	55	209,099	5.7x	17.3%	750	6 @ 455	900,000
RCP Hialeah	Aug-07	FL	100%	1,100,000	1	29	(161,454)	NM	17.6%	750	1 @ 750	850,000
Hialeah	Sep-07	FL	100%	800,000	1	12	(47,130)	NM	18.5%	750	4 @ 305	600,000
Bakersfield	Oct-07	CA	100%	17,700,000	1	377	2,341,001	7.6x	14.2%	750	294 vs 262	14,400,000
Erie	Nov-07	PA	100%	8,125,000	2	199	781,687	10.4x	16.6%	750	279 vs 262	7,300,000
Dr Dahhan	Dec-07	CA	100%	18,300,000	3	311	2,323,875	7.9x	11.8%	750	staffing	16,400,000
SKI	Dec-07	AZ	50%	15,750,000	8	443	1,227,508	12.8x	18.2%	750	306 vs 260	13,500,000
Fayetteville	Feb-08	AR	100%	$ 3,790,000	4	110	$ (423,233)	NM	16.6%	750	10 @ 1050	$ 3,100,000
Decatur	Apr-08	GA	100%	8,000,000	2	168	1,209,252	6.6x	16.2%	750	277 vs 269	7,100,000
Coastal	May-08	FL	100%	5,400,000	1	111	749,078	7.2x	12.5%	750	260 vs 239	4,800,000
Kansas	Jun-08	KS	100%	18,750,000	3	189	2,887,596	6.5x	14.0%	750	350 vs 310	17,750,000
Trover	Aug-08	KY	100%	1,100,000	1	87	220,739	5.0x	15.5%	750	1 @ 780	600,000
Payton	Sep-08	OH	100%	28,275,000	3	295	4,306,975	6.6x	14.5%	950	WACC - g	26,100,000
Stemmer	Dec-08	FL	100%	10,000,000	1	111	1,288,987	7.8x	17.4%	2,500	2 Aetna OON	9,400,000
Caucus	Dec-08	IA	100%	14,000,000	2	170	1,148,410	12.2x	13.3%	750	320 vs 303	13,000,000
Central Florida	Feb-09	FL	100%	$ 32,800,000	5	474	$ 3,173,219	10.3x	12.2%	2,500	WACC, HC	$ 29,800,000
Timpanogos PD	Mar-09	UT	100%	1,050,000	1	8	359,332	2.9x	14.3%	750	290 vs NA	990,000
Kant Tucker (proposed)	Jun-09	CA	100%	71,000,000	13	1,145	6,305,764	11.3x	6.1%	2,500	WACC & g	
Totals				362,672,000	83	6,255	48,569,947	7.5x				254,295,000
Totals (2007-2008)				165,152,000	40	3,068	20,682,023	8.0x				146,455,000

DaVita Divestiture Transactions

Divestitures	Closed	State	Transaction Director	Analyst	Location #	Interest Divested	Valuation *	Centers	Patients
SAKDC	Apr-07	TX	David Finn				$560,000	3	122
Reading	May-07	PA	David Finn			100%	$200,000	1	42
KHC Silverton	May-07	OH	Paul Dorsa		LOC_3443		$505,000	1	53
Little Rock	May-07	AR			LOC_1864 & 3615		$120,000	2	50
Central Kentucky	Jun-07	KY	Giles Caver		LOC_0555 & 2055		$1,520,000	2	
IMS / St. Cloud	Aug-07	FL		Chris Pannell	LOC_0170, 0178, 4013	40%	$3,075,000	3	211
Ionia	Oct-07	MI	Giles Caver		LOC_2252			1	26
Hemet	Feb-08	CA	Ken Leidner		LOC_0878	40%	$260,000	1	92
Manzanita - At Home	Feb-08	CA			LOC_6016	49%	$143,898	1	
Columbus	Mar-08	OH	Finn / Menezes	Chris Pannell	LOC_2318, 3354, 3454, 3566	40%	$4,208,177	3	297
TRC Colorado	May-08	CO	Ken Leidner	Ben Chiu		49%	$1,396,757	2	
Mountain West Dialysis,LLC	Jun-08	CO	Ken Leidner	Ben Chiu		49%	$2,412,786	6	628
Waynesboro	Jul-08	GA	Giles Caver				$139,769	1	31
Shadow Dialysis	Oct-08	CA			LOC_1930	49%	$1,296,338	1	
Wauseon	Nov-08	OH	John Walcher		LOC_2254	10%	$223,150	1	
Shadow Dialysis	Nov-08	CA			LOC_1930	10%		1	
Mainplace	Dec-08	CA	John Walcher	Ben Chiu	LOC_0884	36%	$1,400,000	1	
East LA	Feb-09	CA			LOC_2541	20%	$3,850,000	2	
Zephyrhills	Feb-09	FL	Demetrius Menezes	Sheila Bruch	LOC_4068	46%	$1,500,000	1	
Hennepin	Feb-09	MN	John Walcher		LOC_0244	100%	$170,000	1	
New Springs	Feb-09	IN				15%	$1,155,592	1	
La Grange	Feb-09	KY			LOC_2148	20%	$1,224,358	1	
NW Tucson	Mar-09	AZ		Ben Chiu	LOC_2325	50%	$1,750,000	1	
Sparks and Sierra Rose	Feb-09	NV	Ken Leidner	David Barbetta	LOC_0844, 2015	60%	$2,618,000	2	162
Monroe	Apr-09	LA	Ben Jacobs			100%	$1,475,199	3	
Amery	Apr-09	WI	John Walcher		LOC_1966 or 4305	25%	$1,665,128	1	
West Elk Grove	Apr-09	CA	John Walcher	Alan Zhang	LOC_2343	49%	$2,200,000	1	

* It remains to be determined which of these are 100% valuations and which are the proceeds received for the pro rata interest sold.

Exhibit 8

Rocky Mountain
Colorado

Transaction Summary

Acquisition Metrics

Total Purchase Price		**$ 39,496,669**
Total IRR		3.5%
Total IRR, Including Lab		4.4%
Mult. of Yr 1 EBITDA		10.3x
Mult. of Yr 1 EBITA		11.4x
Mult. of Yr 1 EBIT		12.8x
Mult. of Yr 1 EBITDA - Recur. Outpt. Capex		10.6x
Mult. of Yr 1 Net Income	(1)	21.5x
Yr 3 Cash on Cash Return	(2)	8.9%

Forecasted Closing Date: May-06

Outpatient Business Only

Outpatient Purchase Price		**$ 39,496,669**
Outpatient IRR		3.5%
Outpatient IRR, Including Lab		4.4%
Mult. of Yr 1 EBITDA		10.3x
Mult. of Yr 1 EBITA		11.4x
Mult. of Yr 1 EBIT		12.8x
Mult. of Yr 1 EBITDA - Recur. Outpt. Capex		10.6x
Mult. of Yr 1 Net Income	(1)	14.5x
Yr 3 Cash on Cash Return	(2)	8.9%

Acute Business Only

Acute Purchase Price	**$ -**
Length of Contract	NA
Revenue Per Acute Tx	NA
Required IRR	NA
Yr 3 Cash on Cash Return	NA

Finance adjustments?	**Yes**
MSP Extension?	**No**
Likelihood of Extension	**80.0%**
Months of Extension	**6 Months**
Year Extension Begins	**2**

Purchase Price Sensitivity

	Required IRR							
	12%	**13%**	**14%**	**15%**	**16%**	**17%**	**18%**	**19%**
Outpatient Business	$ 39,496,669	$ 39,496,669	$ 39,496,669	$ 39,496,669	$ 39,496,669	$ 39,496,669	$ 39,496,669	$ 39,496,669
Acute Contract	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Purchase Price	**$ 39,496,669**	**$ 39,496,669**	**$ 39,496,669**	**$ 39,496,669**	**$ 39,496,669**	**$ 39,496,669**	**$ 39,496,669**	**$ 39,496,669**
Year 1 & 2 Non-Recurring Capex	$ 120,000	$ 120,000	$ 120,000	$ 120,000	$ 120,000	$ 120,000	$ 120,000	$ 120,000
Mult. of DVA Yr 1 EBITDA	10.3x	10.3x	10.3x	10.3x	10.3x	10.3x	10.3x	10.3x

Summary Financials

			Modeled Projections					
	2004	**2005**	**Base Year**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Avg. Patients	-	230	230	235	244	254	264	274
Treatments	-	33,126	33,126	33,789	35,140	36,546	38,007	39,528
Tx Growth				*2.0%*	*4.0%*	*4.0%*	*4.0%*	*4.0%*
Net Revenue	$ -	$ 4,887,202	$ 10,443,853	$ 10,652,730	$ 11,189,627	$ 11,753,585	$ 12,223,728	$ 12,712,677
Per Tx		$ 147.53	$ 315.28	$ 315.28	$ 318.43	$ 321.61	$ 321.61	$ 321.61
EBITDA	$ -	$ 1,549,047	$ 3,817,503	$ 3,823,176	$ 4,024,118	$ 4,223,103	$ 4,311,389	$ 4,397,692
Per Tx		$ 46.76	$ 115.24	$ 113.15	$ 114.52	$ 115.56	$ 113.44	$ 111.26
% of Revenue		31.7%	36.6%	35.9%	36.0%	35.9%	35.3%	34.6%
Pre-Tax Income				$ 3,077,336	$ 3,266,705	$ 3,349,976	$ 3,426,691	$ 3,501,423
Taxes				$ 1,243,244	$ 1,319,749	$ 1,353,390	$ 1,384,383	$ 1,414,575
Book Net Income				$ 1,834,092	$ 1,946,956	$ 1,996,586	$ 2,042,308	$ 2,086,848
EPS				$ 0.017	$ 0.018	$ 0.019	$ 0.019	$ 0.019
Fully Diluted Shares Outstanding				107.2 MM	107.2 MM	107.2 MM	107.2 MM	107.2 MM
Capex				$ 201,000	$ 81,000	$ 810,000	$ 81,000	$ 81,000

(1) Purchase Price/(Net Income + Tax Affected Interest Expense)
(2) After-tax C/F to Capital divided by Total Capital Expended (yrs 1-3).
Model created by: NAME

Exhibit 9

Denver Transaction Summary

Component	Valuation	Centers	Valuation per Center	EBITDA (1)	EBITDA Multiple	Patients	Price per Patient
Acquired Centers (2)	$ 38,571,400	3	**$ 12,857,133**	$ 2,423,878	15.9x	225	**$ 171,428**
Divested Centers (3)	$ 3,865,000	6	**$ 644,167**	$ 3,598,929	1.1x	556	**$ 6,951**

(1) Twelve month period 6/1/2008-5/31/2009.

(2) Valuation figure represents 100% of value. Amount attributable to the 49% ownership interest which DaVita purchased from Denver Nephrology was $18,899,986.

(3) Valuation figure represents 100% of value. Amount attributable to the 49% ownership interest which DaVita sold to Denver Nephrology was $1,893,850.

Exhibit 10

REDACTED

From: Chet Mehta
Sent: Tuesday, May 19, 2009 11:44 PM
To: Richard Whitney; Bob Badal; Tom Usilton; David Finn
Cc: Javier Rodriguez; Doug Saqui; Theresa Benson; Susan Dynes
Subject: RE: Acquisition Revenue Build Up Assumptions

Wow. Mike Staffieri, Bryan Parker, Dave Barbetta and I have been talking about the exact same issue on Number 3 (Hipper Compression). Mike/Bryan/I have been talking about an idea to retain Hipper compression but much different way than in current model. And then David Barbetta refined it to be something very similar to what Rich/Bob are talking about. I will be talking to Cassie to see what the right threshold for compression is to produce aggregate results comparable to Total SNIPER hit. A bunch of people on this email have been invited to a 7am call (Pacific) on THursday. Please try to participate if you can. (Rich/Tom/Bob mandatory or we will have to reschedule the call.....again)

From: Richard Whitney
Sent: Tue 5/19/2009 9:43 PM
To: Bob Badal; Tom Usilton; David Finn
Cc: Javier Rodriguez; Doug Saqui; Chet Mehta; Theresa Benson; Susan Dynes
Subject: Re: Acquisition Revenue Build Up Assumptions

1. Assumption should be the contracted increases.

2. Uhc. I think using the 2x rate penalty (ie 2/3 of what they owe us contractually) is appropriate for now. This should be consistent w what is in system rev (double check pls).

3. If all of our private pay compresses to 750 without increases in the lower rate biz or mcare...we are out of business. In other words this is not a realistic assumption. I would say for sure you shouldn't lower the rate for plans where we have long term contracts. Then instead of just assuming all of the high rate biz comes down we instead may want to assume a certain % reduction in avg non gov rate or assume avg non gov rate drops to something like 750 (if the acq asset has avg non gov rates above 750)

4. Depending on how we end up on 3 above this may not be relevant bc you just have an overall assumption for non gov whether contracted or not. If we don't go that way then we should consider having rates decline to 70% of charges over time.

Thx for bringing this up. We need to get these assumptions closer to our best (conservative) cut rather than something that is so conservative that it loses its usefulness.

From: Bob Badal
To: Tom Usilton; David Finn
Cc: Javier Rodriguez; Doug Saqui; Richard Whitney; Chet Mehta; Theresa Benson; Susan Dynes; Bob Badal
Sent: Tue May 19 21:07:16 2009
Subject: Acquisition Revenue Build Up Assumptions

TU,

Not sure if you are aware, but I have a standing call every week (sometimes 2x per week) with Theresa Benson, Doug Saqui, and Susan Dynes to discuss current acquisition revenue build up models. During these calls, we review all private payor revenue data for deals in play...both pre due diligence and post due diligence assumptions.

For pre due diligence, it is rare to have complete and accurate private payor data (contracts, rates, cash,

contract terms, etc) from sellers. As such, we make educated decisions on what rates would be appropriate to include in the model. These rate build up assumptions, at the payor level, can be set at 1) sellers rates, 2) DVA's contracted rates with that payor, 3) DVA's non-k rates, 4) % of DVA's billed charge, 5) Medicare...or some combination thereof.

For post due diligence (after DVA has been selected as a finalist), we typically receive more complete and accurate data from the seller re: private payor rates/contract information. During these post due diligence calls, the team evaluates any changes that are necessary to the pre due diligence rate assumptions.

The purpose of this email is to highlight a couple of the revenue assumption practices that we are using in these models, and, where appropriate, recommend changes to those assumptions. Here are a few questions that I would like your input on:

- Currently, the model assumes flat 1% increases on contracts instead of actual contract set increases - we propose that this change to more accurately reflect contract increases; this will add some extra work to the process however.
- For United Healthcare we are assuming booked revenue - this includes penalty amounts that were effective 1/1/09; these penalty increases have not yet been realized and will be tied up in legal arbitration for a while; should we continue to include these penalties in our rate build up for acquisitions
- For all contracted and noncontracted payors, the model compresses revenue to $750 all in for years 3 and beyond. Does this rate compression policy still hold true, given the success (though limited) that we have had in fighting ONR? Also, the logic of compressing contracted revenue that is currently above $750 RPT is overly conservative for select payors like Multiplan, BCBS IL, Med Mutual of Ohio, etc - payors whose current $750+ contracted RPT is not expected to drop anytime soon.
- Should we consider establishing a general rule that when there is noncontracted payment history in excess of 70% of billed charges, that we cap the revenue at 70% of billed charges in the model (ie., if we are currently getting paid at 90% of billed charge, it seems a bit bold to assume that we will continue to get that much...so should we discount it to a more conservative 70% figure)

Please provide your thoughts to the above 4 items. Thanks

Bob

Exhibit 11

Wauseon Valuation Summary

Projection	Year 1	Year 2	Year 3	Year 4	Year 5
With HIPPER Compression					
Net Cash Flow	$ 14,590	$ 890,240	$ 280,015	$ 184,598	$ 1,743,717
Minimum Fair Market Value	**$ 1,744,814**				
Without HIPPER Compression					
Net Cash Flow	$ 14,590	$ 890,240	$ 529,306	$ 585,480	$ 5,697,874
Minimum Fair Market Value	**$ 3,940,163**				

HIPPER Compression artifically depressed the supposed fair market value of this center by more than 50%.

Exhibit 12

Atlanta Dialysis Center, LLC
Atlanta, GA

Staffing Projections

Benefits	35%
Annual SWC Increase	3%
Overtime	5%
Profit Sharing	4%
Year 1 SWB Transition Buffer	10%

Hemo Patients

	Annual Yr 1 Salary	Projected Year 1 Headcount per Quarter				Projected Headcount					Year 1 SWBs per Quarter				SWBs per Year				
		Q 1	Q 2	Q 3	Q 4	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Q 1	Q 2	Q 3	Q 4	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5
Hemo Patients		54	54	54	54	54	56	58	61	63									
Treatments		1,864	1,947	1,983	1,993	7,788	8,099	8,423	8,760	9,110									
							4.0%	*4.0%*	*4.0%*	*4.0%*									
FA	$ 73,000	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	$ 18,250	$ 18,250	$ 18,250	$ 18,250	$ 73,000	$ 75,190	$ 77,446	$ 79,769	$ 82,162
RN	$ 56,160	1.00	1.00	1.00	1.00	1.00	1.25	1.50	1.50	1.50	$ 14,040	$ 14,040	$ 14,040	$ 14,040	$ 56,160	$ 72,306	$ 89,370	$ 92,051	$ 94,813
LPN	$ 41,600	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	$ 10,400	$ 10,400	$ 10,400	$ 10,400	$ 41,600	$ 42,848	$ 44,133	$ 45,457	$ 46,821
PCT	$ 30,500	4.80	4.80	4.80	4.80	4.80	2.31	2.36	2.90	3.46	$ 36,600	$ 36,600	$ 36,600	$ 36,600	$ 146,399	$ 72,419	$ 76,445	$ 96,693	$ 118,769
Reuse	$ 29,120	0.65	0.65	0.65	0.65	0.65	0.65	0.65	0.65	0.65	$ 4,732	$ 4,732	$ 4,732	$ 4,732	$ 18,928	$ 19,496	$ 20,081	$ 20,683	$ 21,304
Admin Assist	$ 23,795	0.90	0.90	0.90	0.90	0.90	0.90	0.90	0.90	0.90	$ 5,354	$ 5,354	$ 5,354	$ 5,354	$ 21,416	$ 22,058	$ 22,720	$ 23,401	$ 24,104
Dietician	$ 56,160	0.75	0.75	0.75	0.75	0.75	0.75	0.75	0.75	0.75	$ 10,530	$ 10,530	$ 10,530	$ 10,530	$ 42,120	$ 43,384	$ 44,685	$ 46,026	$ 47,406
MSW	$ 56,160	0.75	0.75	0.75	0.75	0.75	0.75	0.75	0.75	0.75	$ 10,530	$ 10,530	$ 10,530	$ 10,530	$ 42,120	$ 43,384	$ 44,685	$ 46,026	$ 47,406
Biomed	$ 37,440	0.40	0.40	0.40	0.40	0.40	0.40	0.40	0.40	0.40	$ 3,744	$ 3,744	$ 3,744	$ 3,744	$ 14,976	$ 15,425	$ 15,888	$ 16,365	$ 16,856
Overtime											$ 8,563	$ 8,563	$ 8,563	$ 8,563	$ 34,254	$ 30,488	$ 32,659	$ 34,985	$ 37,473
Overtime Ptx											$ 4.59	$ 4.40	$ 4.32	$ 4.30	$ 4.40	$ 3.76	$ 3.88	$ 3.99	$ 4.11
Transition Buffer											$ 24,549	$ 14,729	$ 9,819.44	$ -	$ 49,097				
Transition Buffer Allocation											50%	30%	20%	0%					
Total SWC		11.25	11.25	11.25	11.25	11.25	9.01	9.31	9.85	10.41	$ 147,292	$ 137,472	$ 132,562	$ 122,743	$ 540,069	$ 436,998	$ 468,112	$ 501,457	$ 537,114
SWC Ptx											$ 79.02	$ 70.59	$ 66.85	$ 61.58	$ 69.35	$ 53.96	$ 55.58	$ 57.24	$ 58.96
Profit Sharing (1)											$ -	$ -	$ 5,302	$ 4,910	$ 10,212	$ 17,480	$ 18,724	$ 20,058	$ 21,485
Profit Sharing Ptx											$ -	$ -	$ 2.67	$ 2.46	$ 1.31	$ 2.16	$ 2.22	$ 2.29	$ 2.36
Total SWB											$ 190,252	$ 180,432	$ 180,825	$ 170,613	$ 722,122	$ 607,427	$ 650,675	$ 697,025	$ 746,589
SWB Ptx											$ 102.07	$ 92.65	$ 91.19	$ 85.60	$ 92.73	$ 75.00 (2)	$ 77.25	$ 79.57	$ 81.95

PD Patients

	Annual Yr 1 Salary	Projected Year 1 Headcount per Quarter				Projected Headcount					Year 1 SWBs per Quarter				SWBs per Year				
		Q 1	Q 2	Q 3	Q 4	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Q 1	Q 2	Q 3	Q 4	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5
PD Patients		-	-	-	-	-	-	-	-	-									
Hemo Equivalent Treatments		-	-	-	-	-	-	-	-	-									
CC	$ -	-	-	-	-	-	-	-	-	-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
RN	$ -	-	-	-	-	-	-	-	-	-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
PCT	$ -	-	-	-	-	-	-	-	-	-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Reuse	$ -	-	-	-	-	-	-	-	-	-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
FA	$ -	-	-	-	-	-	-	-	-	-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Admin Assist	$ -	-	-	-	-	-	-	-	-	-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Dietician	$ -	-	-	-	-	-	-	-	-	-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
MSW	$ -	-	-	-	-	-	-	-	-	-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Biomed	$ -	-	-	-	-	-	-	-	-	-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Overtime											$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Overtime Ptx																			
Transition Buffer											$ -	$ -	$ -	$ -	$ -				
Transition Buffer Allocation											50%	30%	20%	0%					
Total SWC		-	-	-	-	-	-	-	-	-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
SWC Ptx											NM	NM	NM	NM	NM	NM	NM	NM	NM
Profit Sharing (1)											$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Profit Sharing Ptx											NM	NM	NM	NM	NM	NM	NM	NM	NM
Total SWB											$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
SWB Ptx											NM	NM	NM	NM	NM	NM	NM	NM	NM

(1) Per HR department, profit sharing expenses are delayed 12 months after beginning the program.
(2) Assumed SWB/tx of $75, which is consistent with that of DVA comps', growing at 3% annually thereafter.

Exhibit 13

Dr. Dahhan

Location

Consolidated Income Statement

Outpatient Business Only

	Actual DaVita DVA Fac #1 LTM 5/31/2004	PER TX	Actual DaVita DVA Fac #2 LTM 5/31/2004	PER TX	Seller Adjusted Base Year	PER TX	Pro Forma Year 1 Quarterly P&L Q1	Q2	Q3	Q4	Pro Forma Projected YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	
TREATMENTS:																
In Center	17,012	99.4%	11,412	93.6%	41,760	100.0%	10,627	10,485	10,890	11,025	43,026	45,983	48,016	51,368	54,977	
PD	102	0.6%	780	6.4%	-	0.0%	-	-	-	-	-	-	-	-	-	
Acute	-		-		-	0.0%	-	-	-	-	-	-	-	-	-	
Total Treatments	17,114	100.0%	12,192	100.0%	41,760	100.0%	10,627	10,485	10,890	11,025	43,026	45,983	48,016	51,368	54,977	
												3.0%	6.9%	4.4%	7.0%	7.0%
REVENUES:																
In Center Revenue	$ 2,986,225	$ 175.54	$ 2,240,058	$ 196.29	$ 7,532,492	$ 180.38	$ 1,916,908	$ 1,891,517	$ 1,964,646	$ 1,989,226	$ 7,762,297	$ 8,415,977	$ 8,821,697	$ 9,519,656	$ 10,277,600	
PD Revenue	21,613	211.89	152,144	195.02	-	-	-	-	-	-	-	-	-	-	-	
EPO Revenue	803,522	46.95	729,433	59.83	2,310,771	55.33	588,068	580,297	602,752	610,316	2,381,433	2,559,969	2,633,745	2,834,917	3,052,994	
Pharmacy & Other	442,838	26.03	414,796	36.35	1,160,247	27.78	295,193	291,177	302,325	305,996	1,194,691	1,285,599	1,324,626	1,425,084	1,533,842	
Acute	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Gross Revenue	$ 4,254,198	$ 248.58	$ 3,536,432	$ 290.06	$ 11,003,510	$ 263.49	$ 2,800,170	$ 2,762,991	$ 2,869,724	$ 2,905,537	$ 11,338,421	$ 12,261,545	$ 12,780,067	$ 13,779,658	$ 14,864,437	
Less:																
Contractual Allowanc	$ 603,842	$ 35.28	$ (44,245)	$ (3.63)												
EPO Contractual	-	-	-	-												
Total other Income	(0)	(0.00)	0	0.00			-	-	-	-	-	-	-	-	-	
Net Revenue	$ 4,858,040	$ 283.86	$ 3,492,186	$ 286.43	$ 11,003,510	$ 263.49	$ 2,800,170	$ 2,762,991	$ 2,869,724	$ 2,905,537	$ 11,338,421	$ 12,261,545	$ 12,780,067	$ 13,779,658	$ 14,864,437	
Net Revenue/Tx	$ 283.86		$ 286.43		$ 263.49		$ 263.50	$ 263.52	$ 263.53	$ 263.54	$ 263.52	$ 266.65	$ 266.16	$ 268.26	$ 270.37	Rev/tx
Total SW&B/Tx	$ 83.48		$ 87.55		$ 82.84	(1)	$ 88.36	$ 84.93	$ 81.78	$ 76.38	$ 82.79	$ 76.84	$ 77.90	$ 76.68	$ 75.47	Total SWB/Tx
EXPENSES:																
SW&B - Chronic	$ 1,428,630	$ 83.98	$ 1,057,049	$ 92.63	$ 3,459,368	$ 82.84	$ 938,982	$ 890,518	$ 890,518	$ 842,054	$ 3,562,072	$ 3,533,225	$ 3,740,447	$ 3,939,061	$ 4,148,895	Varies
SW&B - PD	-	-	10,373	13.30	-	-	-	-	-	-	-	-	-	-	-	Varies
SW&B - Acute	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	2.0% per tx
Medical Supplies - Chron	221,836	13.04	148,012	12.97	466,929	11.18	112,093	112,261	125,881	131,251	481,486	563,297	588,191	629,252	673,470	stable per tx
Medical Supplies -PD	1,058	10.37	45,832	58.75	-	-	-	-	-	-	-	-	-	-	-	stable per tx
Medical Supplies - Acute	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	stable per tx
Dialyzers - Chronic	-	-	-	-	340,920	8.16	86,849	80,151	52,279	40,243	259,523	114,959	120,039	128,419	137,443	stable per tx
Dialyzers - PD	-	#DIV/0!	-	#DIV/0!	-	-	-	-	-	-	-	-	-	-	-	stable per tx
Dialyzers - Acute	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	stable per tx
EPO	696,995	40.73	498,185	40.86	1,757,750	42.09	447,297	441,336	458,361	464,058	1,811,052	1,969,392	2,092,414	2,277,659	2,480,369	1.8%/tx in yrs 2-5
Pharmacy & Other	278,792	16.39	73,134	6.41	739,866	17.72	188,275	185,766	192,932	195,330	762,302	814,693	850,697	910,084	974,035	0.0% per tx
Lab Services	38,502	2.25	23,355	1.92	20,880	0.50	5,313	5,243	5,445	5,512	21,513	22,992	24,008	25,684	27,489	stable per tx
Bad Debt	315,948	18.46	71,876	5.90	220,070	5.27	56,003	55,260	57,394	58,111	226,768	245,231	255,601	275,593	297,289	2.0%
Maintenance and Repair	49,155	2.89	66,394	5.82	107,712	2.58	27,410	27,046	28,091	28,443	110,991	118,964	125,279	134,445	144,358	0.0% per tx
Utilities and Telephone	75,362	4.43	55,835	4.89	194,656	4.66	50,124	50,124	50,124	50,124	200,496	206,511	212,706	219,087	225,660	3.0%
Insurance	36,954	2.16	24,658	2.02	83,520	2.00	21,891	21,599	22,433	22,711	88,634	97,568	104,936	115,629	127,467	3.0% per tx
Taxes and Licenses	27,426	1.60	6,533	0.54	41,760	1.00	10,649	10,649	10,649	10,649	42,595	43,447	44,316	45,202	46,106	2.0%
Office &Other Sup.	26,566	1.55	20,989	1.72	68,357	1.64	17,395	17,163	17,825	18,047	70,430	75,270	78,597	84,084	89,992	0.0% per tx
Other Expenses	87,715	5.13	86,329	7.08	208,800	5.00	(2) 62,802	57,777	55,537	56,227	232,342	239,206	254,773	278,009	303,496	2.0% per tx
Professional Fees	1,130	0.07	1,145	0.09	3,340	0.08	835	835	835	835	3,340	3,507	3,682	3,866	4,059	5.0%
Medical Director Fees	120,000	7.01	65,000	5.33	340,000	8.14	85,000	85,000	85,000	85,000	340,000	340,000	340,000	340,000	340,000	0.0%
Mach. Oper. Lease	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.0%
Rent	175,792	10.27	80,366	6.59	500,325	11.98	128,834	128,834	128,834	128,834	515,335	530,795	546,719	563,120	580,014	3.0%
G&A Allocations	525,227	30.69	391,641	32.12	563,760	13.50	143,461	141,549	147,009	148,836	580,856	620,776	648,210	693,462	742,191	$13.50 per tx
Total Expenses	$ 4,107,089	$ 239.98	$ 2,726,706	$ 223.64	$ 9,118,013	$ 218.34	$ 2,383,212	$ 2,311,110	$ 2,329,148	$ 2,286,265	$ 9,309,734	$ 9,539,831	$ 10,030,614	$ 10,662,656	$ 11,342,334	
Total Expenses/Tx							$ 224.27	$ 220.42	$ 213.89	$ 207.37	$ 216.37	$ 207.46	$ 208.90	$ 207.58	$ 206.31	
EBITDA	**$ 750,951**	**$ 43.88**	**$ 765,481**	**$ 62.78**	**$ 1,885,497**	**$ 45.15**	**$ 416,958**	**$ 451,881**	**$ 540,576**	**$ 619,272**	**$ 2,028,687**	**$ 2,721,714**	**$ 2,749,453**	**$ 3,117,002**	**$ 3,522,103**	
EBITDA/Tx	$ 43.88		$ 62.78		$ 45.15		$ 39.24	$ 43.10	$ 49.64	$ 56.17	$ 47.15	$ 59.19	$ 57.26	$ 60.68	$ 64.06	
EBITDA Margin	15.5%		21.9%		17.1%		14.9%	16.4%	18.8%	21.3%	17.9%	22.2%	21.5%	22.6%	23.7%	
Depreciation	$ 155,634	$ 9.09	$ 43,560	$ 3.57	172,864	$ 4.14	43,216	43,216	43,216	43,216	172,864	255,444	271,515	287,586	303,658	
Amortization	-	-	-	-	170,530	4.08	42,633	42,633	42,633	42,633	170,530	170,530	170,530	170,530	170,530	
EBIT	$ 595,317	$ 34.79	$ 721,921	$ 59.21	$ 1,542,103	$ 36.93	$ 331,109	$ 366,033	$ 454,727	$ 533,424	$ 1,685,293	$ 2,295,740	$ 2,307,408	$ 2,658,885	$ 3,047,915	
EBIT/Tx	$ 34.79		$ 59.21		$ 36.93		$ 31.16	$ 34.91	$ 41.76	$ 48.38	$ 39.17	$ 49.93	$ 48.06	$ 51.76	$ 55.44	

(1) SW&Bs include all benefits, payroll taxes, profit sharing (deferred for six months in Year 1), and bonuses. SWB projections in Year 1 includes a 10% buffer, 50% of which is allocated to Q1, 30% in Q2 and 20% in Q3

(2) Includes RO Supplies, T&E, Other Purchase Services, Freight/Postage, Equipment Rental, Laundry & Linen, and Misc. & Other expenses in year 1, includes travel buffer of $0.30/tx, allocated 2/3 in Q1 and 1/3 in Q2.

Exhibit 14

Regional Kidney Centers
NW Arkansas

Transaction Summary

Acquisition Metrics

Total Purchase Price		**$ 3,790,000**
Total IRR		16.6%
Total IRR, Including Lab		19.5%
Mult. of Yr 1 EBITDA		-9.0x
Mult. of Yr 1 EBITA		-5.8x
Mult. of Yr 1 EBIT		-5.4x
Mult. of Yr 1 EBITDA - Recur. Outpt. Capex		-8.4x
Mult. of Yr 1 Net Income	(1)	-9.1x
Yr 3 Cash on Cash Return	(2)	14.8%

Forecasted Closing Date: Feb-08

Outpatient Business Only

Outpatient Purchase Price		**$ 3,790,000**
Outpatient IRR		16.6%
Outpatient IRR, Including Lab		19.5%
Mult. of Yr 1 EBITDA		-9.0x
Mult. of Yr 1 EBITA		-5.8x
Mult. of Yr 1 EBIT		-5.4x
Mult. of Yr 1 EBITDA - Recur. Outpt. Capex		-8.4x
Mult. of Yr 1 Net Income	(1)	-11.9x
Yr 3 Cash on Cash Return	(2)	14.8%

Acute Business Only

Acute Purchase Price	**$ -**
Length of Contract	NA
Revenue Per Acute Tx	NA
Required IRR	NA
Yr 3 Cash on Cash Return	NA

Finance adjustments?	**Yes**
MSP Extension?	**Yes**
Likelihood of Extension	**80.0%**
Months of Extension	**6 Months**
Year Extension Begins	**2**

Purchase Price Sensitivity

	Required IRR							
	12%	**13%**	**14%**	**15%**	**16%**	**17%**	**18%**	**19%**
Outpatient Business	$ 3,790,000	$ 3,790,000	$ 3,790,000	$ 3,790,000	$ 3,790,000	$ 3,790,000	$ 3,790,000	$ 3,790,000
Acute Contract	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Purchase Price	**$ 3,790,000**	**$ 3,790,000**	**$ 3,790,000**	**$ 3,790,000**	**$ 3,790,000**	**$ 3,790,000**	**$ 3,790,000**	**$ 3,790,000**
Year 1 & 2 Non-Recurring Capex	$ 818,124	$ 818,124	$ 818,124	$ 818,124	$ 818,124	$ 818,124	$ 818,124	$ 818,124
Mult. of DVA Yr 1 EBITDA	-9.0x	-9.0x	-9.0x	-9.0x	-9.0x	-9.0x	-9.0x	-9.0x

Summary Financials

			Modeled Projections					
	2004	2005	**Base Year**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Avg. Patients	-	-	110	118	137	153	170	188
Treatments	-	-	15,840	17,032	19,693	21,987	24,421	27,036
Tx Growth				*7.5%*	*15.6%*	*11.7%*	*11.1%*	*10.7%*
Net Revenue	$ 4,457,575	$ 3,725,963	$ 4,012,963	$ 4,314,820	$ 5,912,172	$ 6,576,565	$ 7,304,537	$ 8,086,556
Per Tx			$ 253.34	$ 253.34	$ 300.22	$ 299.11	$ 299.11	$ 299.11
EBITDA	$ (558,818)	$ (595,634)	$ (425,218)	$ (423,233)	$ 807,796	$ 1,082,260	$ 1,381,531	$ 1,501,631
Per Tx			$ (26.84)	$ (24.85)	$ 41.02	$ 49.22	$ 56.57	$ 55.54
% of Revenue	-12.5%	-16.0%	-10.6%	-9.8%	13.7%	16.5%	18.9%	18.6%
Pre-Tax Income				$ (697,379)	$ 525,793	$ 790,218	$ 1,081,631	$ 1,193,874
Taxes				$ (281,741)	$ 212,420	$ 319,248	$ 436,979	$ 482,325
Book Net Income				$ (415,638)	$ 313,373	$ 470,970	$ 644,652	$ 711,549
EPS				$ (0.004)	$ 0.003	$ 0.004	$ 0.006	$ 0.007
Fully Diluted Shares Outstanding				107.2 MM	107.2 MM	107.2 MM	107.2 MM	107.2 MM
Capex				$ 845,624	$ 55,000	$ 70,276	$ 55,000	$ 55,000

(1) Purchase Price/(Net Income + Tax Affected Interest Expense)
(2) After-tax C/F to Capital divided by Total Capital Expended (yrs 1-3).
Model created by: Jeff Young

Exhibit 15

Johnson County, Wyandotte County and Leavenworth Dialysis — Transaction Summary

Lenexa, Kansas

Acquisition Metrics

Total Purchase Price		**$ 18,750,000**
Total IRR		14.1%
Total IRR, Including Lab		15.1%
Mult. of Yr 1 EBITDA		6.5x
Mult. of Yr 1 EBITA		7.3x
Mult. of Yr 1 EBIT		7.8x
Mult. of Yr 1 EBITDA - Recur. Outpt. Capex		6.5x
Mult. of Yr 1 Net Income	(1)	13.2x
Yr 3 Cash on Cash Return	(2)	12.3%

Forecasted Closing Date: Jun-08

Outpatient Business Only

Outpatient Purchase Price		**$ 18,750,000**
Outpatient IRR		14.1%
Outpatient IRR, Including Lab		15.1%
Mult. of Yr 1 EBITDA		6.5x
Mult. of Yr 1 EBITA		7.3x
Mult. of Yr 1 EBIT		7.8x
Mult. of Yr 1 EBITDA - Recur. Outpt. Capex		6.5x
Mult. of Yr 1 Net Income	(1)	10.0x
Yr 3 Cash on Cash Return	(2)	12.3%

Acute Business Only

Acute Purchase Price	**$ -**
Length of Contract	NA
Revenue Per Acute Tx	NA
Required IRR	NA
Yr 3 Cash on Cash Return	NA

Finance adjustments?	**Yes**
MSP Extension?	**No**
Likelihood of Extension	**80.0%**
Months of Extension	**6 Months**
Year Extension Begins	**2**

Purchase Price Sensitivity

	Required IRR							
	12%	13%	14%	15%	16%	17%	18%	19%
Outpatient Business	$ 18,775,000	$ 18,775,000	$ 18,775,000	$ 18,775,000	$ 18,775,000	$ 18,775,000	$ 18,775,000	$ 18,775,000
Acute Contract	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Purchase Price	**$ 18,775,000**	**$ 18,775,000**	**$ 18,775,000**	**$ 18,775,000**	**$ 18,775,000**	**$ 18,775,000**	**$ 18,775,000**	**$ 18,775,000**
Year 1 & 2 Non-Recurring Capex	$ 1,842,927	$ 1,842,927	$ 1,842,927	$ 1,842,927	$ 1,842,927	$ 1,842,927	$ 1,842,927	$ 1,842,927
Mult. of DVA Yr 1 EBITDA	6.5x	6.5x	6.5x	6.5x	6.5x	6.5x	6.5x	6.5x

Summary Financials

			Modeled Projections					
	2006	2007	Base Year	Year 1	Year 2	Year 3	Year 4	Year 5
Avg. Patients	-	189	189	192	198	204	210	216
Treatments	-	27,266	27,216	27,624	28,453	29,307	30,186	31,091
Tx Growth				*1.5%*	*3.0%*	*3.0%*	*3.0%*	*3.0%*
Net Revenue	$ -	$ 7,656,848	$ 8,454,667	$ 9,668,484	$ 9,958,539	$ 10,257,295	$ 10,565,014	$ 10,881,964
Per Tx		$ 280.82	$ 310.65	$ 350.00	$ 350.00	$ 350.00	$ 350.00	$ 350.00
EBITDA	$ -	$ 1,459,712	$ 1,934,663	$ 2,887,596	$ 3,463,764	$ 3,532,848	$ 3,622,631	$ 3,682,594
Per Tx		$ 53.54	$ 71.09	$ 104.53	$ 121.74	$ 120.55	$ 120.01	$ 118.44
% of Revenue		19.1%	22.9%	29.9%	34.8%	34.4%	34.3%	33.8%
Pre-Tax Income				$ 2,388,909	$ 2,962,220	$ 3,028,448	$ 3,115,373	$ 3,172,480
Taxes				$ 965,119	$ 1,196,737	$ 1,223,493	$ 1,258,611	$ 1,281,682
Book Net Income				$ 1,423,790	$ 1,765,483	$ 1,804,955	$ 1,856,762	$ 1,890,798
EPS				$ 0.013	$ 0.016	$ 0.017	$ 0.017	$ 0.018
Fully Diluted Shares Outstanding				107.2 MM	107.2 MM	107.2 MM	107.2 MM	107.2 MM
Capex				$ 1,862,927	$ 20,000	$ 20,000	$ 20,000	$ 20,000

(1) Purchase Price/(Net Income + Tax Affected Interest Expense)
(2) After-tax C/F to Capital divided by Total Capital Expended (yrs 1-3).
Model created by: SHEILA D. BRUCH

Exhibit 16

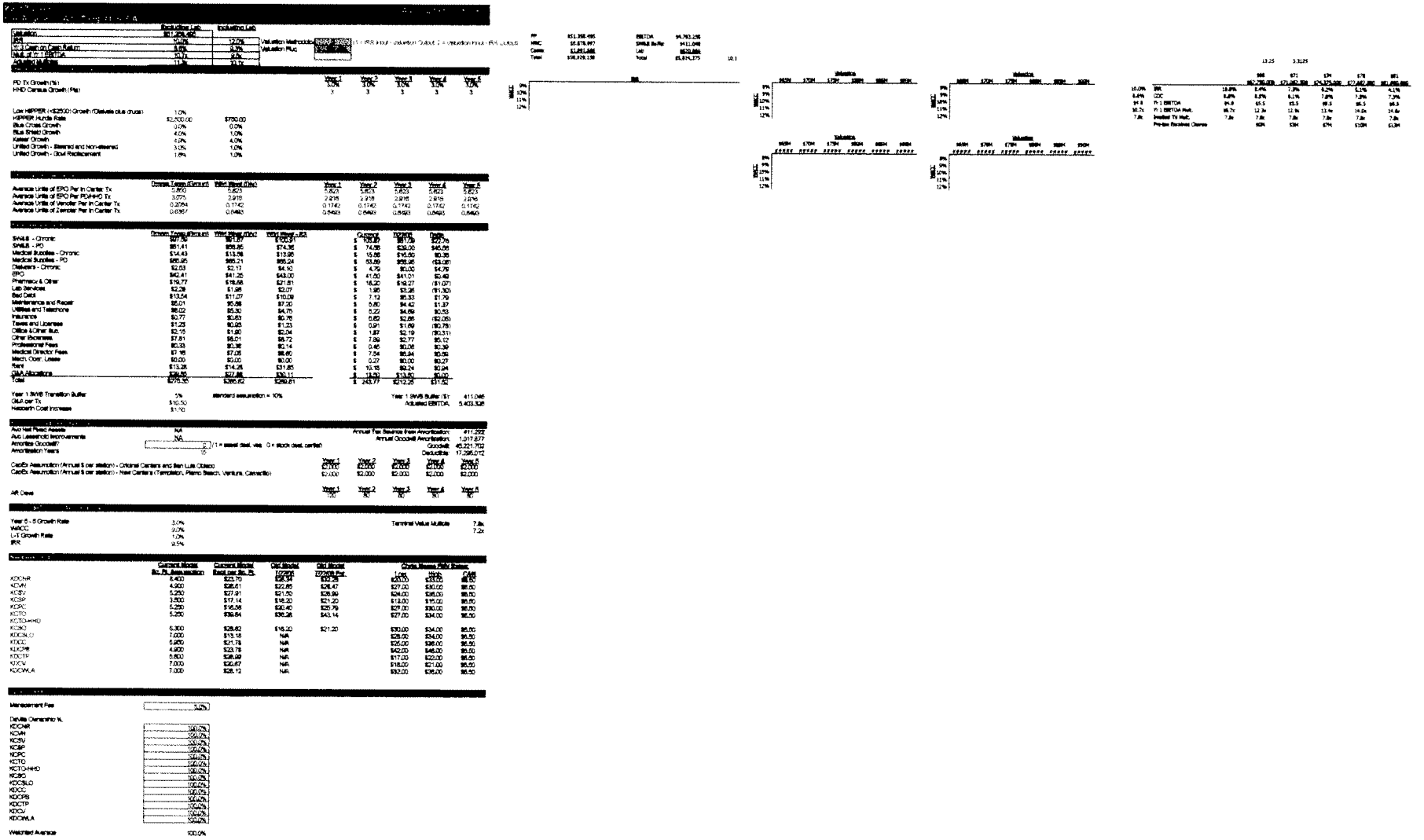

Exhibit 17

REDACTED

REDACTED

From: Bryan Parker
Sent: Friday, July 24, 2009 8:51 PM
To: Chet Mehta; David Barbetta
Cc: Queenie Nguyen; Steve Williams (Team Genesis); Bruce Ware; Mike Staffieri
Subject: RE: DeNovo Model

I do. Thanks Chet.

Bryan R. Parker
Vice President
Special Projects

Casa DaVita
601 Hawaii Street
El Segundo, CA 90245
Tel: 650.696.8970
Fax: 866.319.2440
Cell: 650.714.7494
Email: bryan.parker@davita.com

Our Mission: To be the Provider, Partner and Employer of Choice

Our Core Values: Service Excellence, Integrity, Team, Continuous Improvement, Accountability, Fulfillment, Fun

From: Chet Mehta
Sent: Friday, July 24, 2009 8:50 PM
To: Bryan Parker; David Barbetta
Cc: Queenie Nguyen; Steve Williams (Team Genesis); Bruce Ware; Mike Staffieri
Subject: Re: DeNovo Model

Bryan - you mean "gaming" the model, right?

Chet Mehta
VP, Finance
DaVita Inc.
601 Hawaii St.
El Segundo, CA 90245
Phone: 310-536-2634
Email: chet.mehta@davita.com

From: Bryan Parker
To: David Barbetta
Cc: Queenie Nguyen; Steve Williams (Team Genesis); Chet Mehta; Bruce Ware; Mike Staffieri
Sent: Fri Jul 24 20:45:17 2009
Subject: DeNovo Model

David

Sorry to hear you are leaving us, but do wish you the best.

I was hopeful before you leave you, or you and Queenie, can give us a list of the most common things

one could do within the model to make sure it passes the COC and IRR hurdles. As we redesign the model I would like to be mindful of these.

Best,

Bryan R. Parker
Vice President
Special Projects

Casa DaVita
601 Hawaii Street
El Segundo, CA 90245
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Fax: 866.319.2440
Cell: 650.714.7494
Email: bryan.parker@davita.com

Our Mission: To be the Provider, Partner and Employer of Choice

Our Core Values: Service Excellence, Integrity, Team, Continuous Improvement, Accountability, Fulfillment, Fun

Exhibit 18

From: Mik e Staffieri
Sent: Friday, July 25, 2008 11:24 AM
To: John Walcher; John Westover
Cc: Marsha Dodd; David Barbetta
Subject: RE: Klamath Falls MDA Question

John –

I am less concerned about whether or not RCC sells its centers to us or not. The important thing is that they sign a 10-year MDA with a 25 mile non-compete around Klamath Falls. If they will not sign that agreement, then we are wasting our time and money. All the patients in Klamath Falls are theirs. Without the agreement and non-compete, they will simply build a DeNovo and move their referrals to the center and we will be left with nothing.

Call me if you want to discuss. I will not approve closing without RCC signing an MDA.

Michael Staffieri
Division Vice President
North Star Division
2615 SW Trenton Street
Seattle, WA 98126-3745
206-935-5423(o) 949-233-4310(c) 866-309-3548(f)

From: John Walcher
Sent: Friday, July 25, 2008 10:12 AM
To: Mike Staffieri; John Westover
Cc: Marsha Dodd; David Barbetta
Subject: Klamath Falls MDA Question
Importance: High

Mike & John,

We're strategizing on the MDA and need to clarify a key issue.

One possible scenario is:
- DVA buys Sky Lakes;
- DVA hires RCC to be medical director (with a 15-20 mile non-compete radius); and
- RCC sells its centers to FMC.

Another possible scenario is:
- DVA buys Sky Lakes;
- DVA hires our Grant's Pass doctor to be medical director (with a 15-20 mile non-compete radius); and
- RCC sells its centers to FMC.

Do you want us to proceed with the acquisition in the event RCC sells their centers to FMC or some other competitor (whether or not RCC is the Sky Lakes medical director)?

Our concern is being able to close the Sky Lakes acquisition prior to knowing if RCC will sell to us or FMC. If you two are comfortable closing the Sky Lakes acquisition as long as RCC is the medical director (and is bound by a reasonable non-compete clause), we will push both Sky Lakes and RCC for a quick resolution to this issue. If we aren't willing to close Sky Lakes until we know whether or not we're buying

RCC's centers, we'll need to delay the Sky Lakes close (thereby potentially putting the deal in jeopardy) until we have closure on RCC.

Thanks in advance for your input.

John

John Walcher
Transaction Director
Mergers & Acquisitions / Corporate Development
DaVita, Inc.
15253 Bake Pkwy
Irvine, CA 92618
Direct: 949.930.4424
eFax: 866.442.3585

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Exhibit 19

From: David Finn
Sent: Tuesday, May 05, 2009 11:18 AM
To: David Barbetta
Subject: RE: RCC sensitivity

how abt 70/30, with klamath save and without?

From: David Barbetta
Sent: Tue 5/5/2009 11:16 AM
To: David Finn
Subject: RE: RCC sensitivity

Fixed it. Here are the tables for wholly owned & JV:

Sensitivity -- IRR with Lab -- 100% acquisition

Klamath CF Saved	Purchase Price $18M	$19M	$20M	$21M
20%	7.5%	6.0%	4.7%	3.5%
30%	8.2%	6.8%	5.4%	4.1%
40%	9.0%	7.5%	6.1%	4.7%
50%	9.9%	8.3%	6.8%	5.4%

Sensitivity -- IRR with Lab -- 60/40 JV

Klamath CF Saved	Purchase Price $18M	$19M	$20M	$21M
20%	9.7%	8.4%	7.2%	6.1%
30%	10.4%	9.1%	7.8%	6.6%
40%	11.2%	9.8%	8.5%	7.2%
50%	11.8%	10.3%	9.0%	7.7%

Klamath Cash Flow

Cash flow decline	Decline in PV*
20%	$ (1,017,442)
30%	(1,526,508)
40%	(2,037,966)
50%	(2,546,925)

* at 12% discount rate

From: David Finn
Sent: Tuesday, May 05, 2009 10:52 AM
To: David Barbetta
Subject: RE: RCC sensitivity

definitely not right...

From: David Barbetta
Sent: Tue 5/5/2009 10:45 AM
To: David Finn
Subject: RCC sensitivity

David,

Here is the new table based on changes to the model that Ben made this morning. This is for 100% owned again. I'd send the 60% JV scenario too but the returns are lower than wholly-owned, which doesn't seem right. I'm waiting for Ben to review.

Sensitivity -- IRR with Lab

Klamath CF Saved	Purchase Price $18M	$19M	$20M	$21M
20%	7.5%	6.0%	4.7%	3.5%
30%	8.2%	6.8%	5.4%	4.1%
40%	9.0%	7.5%	6.1%	4.7%
50%	9.9%	8.3%	6.8%	5.4%

Exhibit 20

REDACTED

REDACTED

From: D avid Finn
Sent: Wednesday, October 08, 2008 6:25 AM
To: Jo hn Walcher
Cc: D avid Barbetta
Subject: klamath falls

assuming we get joinders from all docs in the med dir group (4?), you can go up to 3.5mm

thx