RMS LIFELINE INC
Form 424B5
August 14, 2012
Table of Contents

As filed pursuant to Rule 424(b)(5)
Under the Securities Act of 1933
Registration No. 333-183285

The information in this preliminary prospectus is not complete and may be changed. A registration statement relating to the notes has become effective under the Securities Act of 1933, as amended. This preliminary prospectus supplement and the accompanying prospectus are not an offer to sell these securities and it are not soliciting an offer to buy these securities in any jurisdiction where the offer or sale is not permitted.

Subject to completion, dated August 13, 2012

Preliminary prospectus supplement

DaVita Inc.

$1,000,000,000

% Senior Notes due 2022

Issue Price %

Interest payable and

We are offering $ million aggregate principal amount of % senior notes due 2022, or the notes. The notes will mature on , 2022. We will pay interest on the notes on and of each year. Interest will accrue on the notes from , 2012 and the first interest payment date will be , 2013.

The notes are being offered to finance a portion of the cash consideration for our merger with HealthCare Partners Holdings, LLC, or HCP. Upon consummation of the offering of the notes, we will deposit the net proceeds (after deducting the underwriting discount) from this offering, together with additional amounts needed to redeem the notes at the special mandatory redemption price described below, into escrow as described in Description of Notes Escrow of proceeds; release conditions. If the conditions to our merger with HCP and certain other conditions are not satisfied on or prior to November 30, 2012, subject to up to three one-month extensions as described herein (which we sometimes refer to as the Escrow End Date), or if we notify the escrow agent that we will not pursue consummation of the merger, the amount deposited in escrow will be applied to redeem all of the notes offered hereby at a special mandatory redemption price equal to 100% of the issue price of the notes, plus accrued and unpaid interest from the date of initial issuance, or the most recent date to which interest has been paid or duly provided for, as the case may be, to but excluding the special mandatory redemption date. If the conditions to our merger with HCP and certain other conditions are satisfied on or before the Escrow End Date, the amounts deposited in escrow will be released to us and applied to finance a portion of the cash consideration for the merger. See Use of Proceeds and Description of Notes Escrow of proceeds; release conditions and Special mandatory redemption.

We may redeem some or all of the notes at any time on or after , 2017 at redemption prices described in this prospectus supplement and prior to such date at a make-whole redemption price described in this prospectus supplement. At any time prior to , 2015, we may also redeem up to 35% of the notes with the net cash proceeds we receive from certain equity offerings at the redemption price set forth in this prospectus supplement. If a change of control occurs as described in this prospectus supplement under the heading Description of Notes Change of control , we may be required to offer to purchase the notes from the holders.

Except as described under Description of Notes Escrow of proceeds; release conditions, the notes will be our unsecured senior obligations and will rank equally with our existing and future unsecured senior indebtedness. The notes will be guaranteed by certain of our domestic subsidiaries. The guarantees will rank equally with all existing and future unsecured senior indebtedness of the guarantors. The notes and guarantees will be effectively subordinated to all of our and the guarantors existing and future secured debt (including our senior secured credit facilities) to the extent of the value of the collateral securing such debt and structurally subordinated to all existing and future liabilities of any of our subsidiaries that do not guarantee the notes. The notes will be issued only in registered form in minimum denominations of $2,000 and integral multiples of $1,000 in excess thereof.

Investing in the notes involves risks. See Risk Factors beginning on page S-35.

	Public offering price(1)	Underwriting discount	Proceeds, before expenses, to us(1)
Per note	%	%	%
Total	$	$	$

(1) Plus accrued interest from , 2012, if settlement occurs after that date.

The notes will not be listed on any securities exchange or quotation system. Currently, there is no public market for the notes.

Neither the Securities and Exchange Commission nor any state securities commission has approved or disapproved of these securities or determined if this prospectus supplement or the accompanying prospectus is truthful or complete. Any representation to the contrary is a criminal offense.

The notes will be ready for delivery in book-entry form through the facilities of The Depository Trust Company for the accounts of its participants, including Euroclear Bank S.A./N.V. and Clearstream Banking, société anonyme, on or about , .

Joint Book-Running Managers

J.P. Morgan

Barclays

BofA Merrill Lynch

Credit Suisse

Goldman, Sachs & Co.

Morgan Stanley

SunTrust Robinson Humphrey

Wells Fargo Securities

Co-Managers

Credit Agricole CIB **Mitsubishi UFJ Securities** **Scotiabank** **SMBC Nikko**

, 2012.

Table of Contents

TABLE OF CONTENTS

Prospectus Supplement

Prospectus

Table of Contents

ABOUT THIS PROSPECTUS SUPPLEMENT

This document is in two parts. The first part is this prospectus supplement, which contains the terms of this offering of notes. The second part, the accompanying prospectus dated August 13, 2012, gives more general information, some of which may not apply to this offering.

This prospectus supplement and the information incorporated by reference in this prospectus supplement may add to, update or change the information in the accompanying prospectus. If information in this prospectus supplement is inconsistent with information in the accompanying prospectus, this prospectus supplement will apply and will supersede that information in the accompanying prospectus.

It is important for you to read and consider all information contained or incorporated by reference in this prospectus supplement and the accompanying prospectus in making your investment decision.

No person is authorized to give any information or to make any representations other than those contained or incorporated by reference in this prospectus supplement or the accompanying prospectus and, if given or made, such information or representations must not be relied upon as having been authorized. This prospectus supplement and the accompanying prospectus do not constitute an offer to sell or the solicitation of an offer to buy any securities other than the securities described in this prospectus supplement or an offer to sell or the solicitation of an offer to buy such securities in any circumstances in which such offer or solicitation is unlawful. Neither the delivery of this prospectus supplement and the accompanying prospectus, nor any sale made hereunder, shall under any circumstances create any implication that there has been no change in our affairs since the date of this prospectus supplement, or that the information contained or incorporated by reference in this prospectus supplement or the accompanying prospectus is correct as of any time subsequent to the date of such information.

The distribution of this prospectus supplement and the accompanying prospectus and the offering of the notes in certain jurisdictions may be restricted by law. This prospectus supplement and the accompanying prospectus do not constitute an offer, or an invitation on our behalf or on behalf of the underwriters or any one of them, to subscribe to or purchase any of the notes, and may not be used for or in connection with an offer or solicitation by anyone, in any jurisdiction in which such an offer or solicitation is not authorized or to any person to whom it is unlawful to make such an offer or solicitation. See Underwriting.

In this prospectus supplement, unless otherwise stated or the context otherwise requires:

- the terms we, us, our, DaVita and Company refer to DaVita Inc. and, in some instances, its consolidated subsidiaries;
- the term Financings refers to this offering of notes and the use of proceeds therefrom, and the expected amendment of and initial borrowings under our senior secured credit facilities;
- the term HCP refers to HealthCare Partners Holdings, LLC, together with its consolidated subsidiaries and affiliated physician groups (unless the context otherwise requires);
- the term Merger refers to DaVita s agreement to acquire HCP through a merger of Seismic Acquisition LLC, a California limited liability company and a wholly owned subsidiary of DaVita, with and into HCP, with HCP continuing as the surviving entity in the Merger;
- the term senior secured credit facilities means our existing senior secured credit facilities or our amended senior secured credit facilities that we expect will become effective, pursuant to an amendment to our existing senior secured credit facilities prior to the consummation of the Merger, or both, as the context requires.

If we use a capitalized term in this prospectus supplement and do not define the term in this document, it is defined in the accompanying prospectus.

Table of Contents

INDUSTRY AND HCP DATA

Industry and market data contained or incorporated by reference in this prospectus supplement were obtained through company research, surveys and studies conducted by third parties and industry and general publications or based on our experience in the industry. We have not independently verified market and industry data from third-party sources. While we believe internal company surveys and assumptions are reliable and market definitions are appropriate, neither these surveys and assumptions nor these definitions have been verified by any independent sources and we cannot assure that they are accurate. Our internal company reports have not been verified by any independent source. Statements as to our industry position are based on market data currently available to us. The information in this prospectus supplement concerning HCP is based on information provided to us by HCP s management. We have not independently verified this information, and, accordingly, the accuracy of this information is not guaranteed. While we are not aware of any misstatements regarding the industry data presented herein, this information involves risks and uncertainties and is subject to change based on various factors, including those discussed under the heading Risk Factors in this prospectus supplement.

Table of Contents

SPECIAL NOTE REGARDING FORWARD-LOOKING STATEMENTS

This prospectus supplement and the documents deemed to be incorporated by reference in this prospectus supplement contains or may contain statements that are forward-looking statements within the meaning of Section 27A of the Securities Act of 1933, as amended and Section 21E of the Securities Exchange Act of 1934, as amended. We intend these forward-looking statements to be covered by the safe harbor provisions for such statements contained in these documents. All statements that do not concern historical facts are forward-looking statements and include, among other things, statements about our expectations, beliefs, intentions and/or strategies for the future. These forward-looking statements include statements regarding anticipated refinancing transactions, our future operations, financial condition and prospects, expectations for treatment growth rates, revenue per treatment, expense growth, levels of the provision for uncollectible accounts receivable, operating income, cash flow, operating cash flow, estimated tax rates, capital expenditures, the development of new centers and center acquisitions, government and commercial payment rates, revenue estimating risk and the impact of our related level of indebtedness on our financial performance, including earnings per share. These statements can sometimes be identified by the use of forward looking words such as may, believe, will, should, could, would, expect, project, estimate, anticipate, plan, continue, seek, forecast, or intend or other similar word negative thereof.

These statements involve substantial known and unknown risks and uncertainties that could cause our actual results to differ materially from those described in the forward-looking statements, including, but not limited to:

- risks resulting from uncertainties associated with government regulations,
- general economic and other market conditions,
- competition,
- accounting estimates,
- variability of our cash flows,
- the concentration of profits generated from commercial payor plans,
- continued downward pressure on average realized payment rates from commercial payors, which may result in the loss of revenue or patients,
- a reduction in the number of patients under higher-paying commercial plans,
- a reduction in government payment rates under the Medicare end stage renal disease, or ESRD, program or other government-based programs,
- the impact of health care reform legislation that was enacted in the U.S. in March 2010,
- changes in pharmaceutical or anemia management practice patterns, payment policies, or pharmaceutical pricing,

our ability to maintain contracts with physician medical directors,

legal compliance risks, including our continued compliance with complex government regulations,

current or potential investigations by various governmental entities and related government or private-party proceedings,

continued increased competition from large and medium-sized dialysis providers that compete directly with us,

the emergence of new models of care introduced by the government or private sector, such as accountable care organizations, independent practice associations, or IPAs, and integrated delivery systems, and changing affiliation models for physician plans, such as employment by hospitals, that may erode our patient base and reimbursement rates,

Table of Contents

our ability to complete any acquisitions or mergers, including the consummation of the Merger, or dispositions that we might be considering or announce, or to integrate and successfully operate any business we may acquire, including the HCP business, or to expand our operations and services to markets outside the U.S., or to businesses outside of dialysis,

the risk that the Merger could compromise or diminish HCP s distinctive physician-owned, physician-led culture and business model, including the potential impact on current employees, affiliated physicians and physician groups and IPA consolidation opportunities,

the risk that the cost of providing services under HCP s agreements will exceed its compensation,

the risk that laws regulating the corporate practice of medicine could restrict the manner in which HCP conducts its business,

the risk that reductions in reimbursement rates and future regulations may negatively impact HCP s business, revenue and profitability,

the risk that HCP may not be able to successfully establish a presence in new geographic regions,

the risk that reductions in the quality ratings of health maintenance organization plan customers of HCP could have an adverse effect on HCP s business,

the fact that HCP faces certain competitive threats that could reduce its profitability,

the risk that health plans that acquire health maintenance organizations may not be willing to contract with HCP or may be willing to contract only on less favorable terms, and

the risk that a disruption in HCP s healthcare provider networks could have an adverse effect on HCP s operations and profitability.

The forward-looking statements included or incorporated by reference in this prospectus supplement are only made as of the date of this prospectus supplement or the respective document incorporated by reference herein, as applicable. Except as required by law, we undertake no obligation to update or revise these statements, whether as a result of changes in underlying factors, new information, future events or otherwise. See Where You Can Find More Information.

Table of Contents

SUMMARY

This summary may not contain all the information that may be important to you. You should read this entire prospectus supplement and the accompanying prospectus, together with the information incorporated by reference herein and therein, including our financial statements and related notes, before making an investment decision. In this summary, we have presented certain financial measures, such as free cash flow, net debt, pro forma Adjusted EBITDA, Adjusted EBITDA, total care dollars under management and metrics derived therefrom, that are non-GAAP financial measures. We are presenting these non-GAAP financial measures because we believe that they provide us and readers of this prospectus supplement with useful supplemental information. We do not intend for these non-GAAP financial measures to be a substitute for any GAAP financial information. See DaVita Summary Historical Financial and Operating Data and HCP Summary Historical Financial and Operating Data for a reconciliation of these non-GAAP financial measures to their most comparable measure calculated and presented in accordance with GAAP.

DaVita

We are a leading provider of kidney dialysis services in the U.S. for patients suffering from chronic kidney failure, also known as end stage renal disease, or ESRD. As of June 30, 2012, DaVita provided dialysis and other related services through a network of 1,884 outpatient dialysis centers located in the U.S. throughout 43 states and the District of Columbia, serving a total of approximately 149,000 patients. In addition, as of June 30, 2012, DaVita provided outpatient dialysis and administrative service to a total of 19 outpatient dialysis centers located in four countries outside the U.S. DaVita centers offer outpatient hemodialysis treatments and other ESRD-related services such as the administration of physician-prescribed pharmaceuticals, including erythropoietin, or EPO, vitamin D analogs and iron supplements. DaVita also provides services for home dialysis patients, vascular access, disease management services and laboratory services related to ESRD. As of June 30, 2012, DaVita also provides acute inpatient dialysis services in approximately 960 hospitals and related laboratory services throughout the U.S. DaVita is a Delaware corporation, incorporated in 1994.

DaVita s U.S. dialysis and related lab services business accounted for approximately 92% of DaVita s consolidated net operating revenues for the twelve months ended June 30, 2012. Other ancillary services and strategic initiatives accounted for approximately 8% of our consolidated net operating revenues for the same period and relate primarily to DaVita s core business of providing kidney dialysis services. For the twelve months ended June 30, 2012, DaVita generated consolidated net operating revenues of $7,365 million, Adjusted EBITDA of $1,585 million, and net income attributable to DaVita of $519 million. For an explanation of Adjusted EBITDA and a reconciliation of Adjusted EBITDA to net income, see DaVita Summary Historical Financial and Operating Data beginning on page S-30.

We provide our services through the following business segments:

Dialysis and Related Lab Services. Our network of 1,884 outpatient dialysis centers located in the U.S. and 19 outpatient dialysis centers located outside the U.S. are designed specifically for outpatient hemodialysis. In the twelve months ended June 30, 2012 our overall network of outpatient dialysis centers increased by 14% primarily as a result of acquisitions and the opening of new centers, net of center closures and divestitures. A large portion of this increase was driven from the acquisition of DSI Renal Inc., or DSI, a medium sized dialysis provider that we acquired in September 2011, that contributed a net 83 outpatient dialysis centers.

Throughout the U.S. we also provided hospital inpatient hemodialysis services, excluding physician services, to patients in approximately 960 hospitals as of June 30, 2012. 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. In the twelve months ended June 30, 2012 hospital inpatient hemodialysis services accounted for approximately 4.5% of our total U.S. dialysis treatments.

Table of Contents

We also own two separately incorporated, licensed, clinical laboratories, which specialize 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 U.S. 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 certain members of the dialysis centers staff and medical directors regarding critical outcome indicators.

As of June 30, 2012, we operated or provided management and administrative services to 24 outpatient dialysis centers located in the U.S. and three outpatient dialysis centers located outside of the U.S. in which we either own a minority equity investment or which 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. Our ancillary services and strategic initiatives consist of pharmacy services, infusion therapy services, disease management services, vascular access services, ESRD clinical research programs, physician services, direct primary care and our international dialysis operations.

DaVita s Industry

The loss of kidney function is normally irreversible. Kidney failure may be 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. Patients suffering from ESRD generally require dialysis at least three times a week for the rest of their lives. Treatment options that we provide for ESRD are hemodialysis and peritoneal dialysis. Hemodialysis, the most common form of ESRD treatment, uses an artificial kidney, called a dialyzer, to remove toxins, fluids and salt from the patient s blood. The procedure is typically performed at a freestanding center, a hospital-based outpatient center, or at the patient s home. Peritoneal dialysis uses the patient s peritoneal or abdominal cavity to eliminate fluid and toxins and is typically performed in the patient s home.

The dialysis industry is characterized by:

Stable and Growing Patient Base. The nature of ESRD allows for significant demand stability due to a lack of clinical need controversy and limited treatment alternatives for patients. In addition, patients require treatment at least three times a week for the rest of their lives, regardless of seasonality or macroeconomic conditions. According to U.S. Renal Data System, there were approximately 399,000 ESRD dialysis patients in the U.S. in 2009 and the underlying ESRD dialysis patient population grew at an approximate compound annual growth rate, or CAGR, of 3.9% from 2000 to 2009, 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.

Competitive Landscape. The dialysis industry has consolidated significantly over time, but still remains highly competitive. The two largest dialysis companies account for approximately 70% of the U.S. dialysis patient population based upon management estimates, with DaVita serving approximately 33% of that population. The remainder of the industry is highly fragmented, comprised of regional chains, local hospital based dialysis facilities and physician and other independently-owned centers.

Universal Medicare Reimbursement. 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

Table of Contents

first and only disease state eligible for dialysis and dialysis-related lab services and for all benefits available under the Medicare program. 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. For DaVita, revenue attributable to Medicare and Medicare-assigned plans represented 59% of dialysis and related lab services revenues for the twelve months ended June 30, 2012.

Significant Government Responsibility. Because of universal Medicare reimbursement for dialysis treatment, the federal government provides significant oversight and regulation of the dialysis sector on a federal, state and local level. A primary concern is the significant, yet fragmented, presence of approximately 825 independent providers of dialysis treatments, whose survival depends on adequate Medicare reimbursement rates. Given patient dependence on dialysis for sustaining life and the critical financial role undertaken by the government, we believe there is likely to be some protection from government rate cuts or any cuts that would make it difficult for small and regional providers to continue to offer dialysis services to their patients.

Bundled Reimbursement System. Since January 2011, ESRD payments have been 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 payment 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 Epogen®, or 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 bundled payment. The bundled payment rate is also adjusted for certain patient characteristics, a geographic usage index and certain other factors.

Also, beginning January 1, 2014, certain oral-only ESRD drugs (currently paid separately to pharmacies under Medicare Part D) will be included in the ESRD bundled payment to dialysis facilities. It is currently unclear how the Centers for Medicare and Medicaid Services, or CMS, will price the oral-only drugs for inclusion in the ESRD bundle in 2014.

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. For the twelve months ended June 30, 2012, 90% of our total patients were under government-based programs, with approximately 80% of our patients under Medicare and Medicare-assigned plans.

DaVita s Competitive Strengths

Superior Clinical Outcomes. We believe that the clinical outcomes of our patient population compare favorably with other dialysis providers and generally exceed the dialysis outcome quality indicators of the National Kidney Foundation. To better assess overall outcomes improvement we have developed our own index, which we refer to as the DaVita Quality Index, or DQI. DQI takes into account outcomes associated with adequacy of dialysis, anemia management, cardiovascular and bone disease, nutrition, and vascular access. The DQI methodology awards points for the percentage of patients exceeding a specified goal and deducts points for the percentage of patients falling below a certain level, providing an objective measure of our total patient care. We believe that DQI correlates with patient survival and likelihood of hospitalization. We believe that our strong clinical outcomes have led to improved quality of life for our patients, lower mortality rates, reduced hospitalizations, and greater satisfaction with care. We believe that this, in turn, has reduced overall patient costs for the payors. In addition, we have an active national physician council, consisting of twenty physicians across the country, that advises our senior management on all clinical issues impacting our operations. DaVita and its affiliated physicians collaborated to achieve outstanding clinical outcomes in 2011. As just one example, our patients 2010 gross mortality rate improved for the fifth straight year to 15%, a 16% improvement from our 2005 mortality rate of 19%.

Table of Contents

National scale. DaVita has a network of 1,884 outpatient dialysis and administrative centers located in the U.S. throughout 43 states and the District of Columbia, serving a total of approximately 149,000 patients. This scale allows DaVita to provide its patient base with convenient locations and access to a full range of services; benefit from economies of scale in purchases of pharmaceuticals and other medical supplies and services; enhance relationships with managed care payors by offering an extensive set of related services to lower the overall cost of patient care; leverage information technology and compliance systems; provide a greater depth and breadth of services; strengthen its medical director recruitment and retention initiatives; and develop the expertise and obtain the resources needed to continue to expand the business through denovo center expansion and selected acquisitions.

Strong operating track record. DaVita has demonstrated strong and resilient financial performance even through the recent macroeconomic downturn as demand for care is steady, predictable and independent of the many macroeconomic factors affecting the broader economy. DaVita s growth has been underpinned by the stable volume growth of the underlying dialysis patient population, which increased at a CAGR of 3.9% from 2000 through 2009, the latest period for which such data is available. Since June 30, 2009, DaVita s quarterly organic growth has ranged between 3.7% and 5.5%. From June 30, 2009 to June 30, 2012, DaVita s net operating revenue and Adjusted EBITDA have grown at CAGRs of 8.8% and 10.0%, respectively.

Strong and stable free cash flow. The stability of demand and reimbursement for DaVita s services, consistent historical Adjusted EBITDA margins of approximately 20% 22% since fiscal year ended December 31, 2009 and efficient management of working capital have resulted in strong operating cash flow. DaVita has increased its net cash provided by operating activities from $705 million in the twelve months ended June 30, 2009 to $1,180 million for the twelve months ended June 30, 2012, representing a CAGR of 19%. In addition, DaVita s centers require limited and predictable maintenance capital expenditures once they are operational, resulting in strong and stable free cash flow generation, which allows DaVita to fund its growth-related investments and reduce indebtedness. DaVita s maintenance capital expenditures have ranged from $104 $259 million, or approximately 2% 4% of consolidated net operating revenues, between the twelve months ended June 30, 2009 and the twelve months ended June 30, 2012. DaVita has increased its free cash flow from $527 million in the twelve months ended June 30, 2009 to $817 million for the twelve months ended June 30, 2012, representing a CAGR of 16%. For an explanation of free cash flow and a reconciliation to operating cash flow, see DaVita Summary Historical Financial and Operating Data beginning on page S-30.

Comprehensive compliance program. DaVita s dialysis operations are subject to extensive federal, state and local government regulations. Management has designed and implemented a company-wide, corporate compliance program as part of DaVita s commitment to comply fully with all applicable laws and regulations and to maintain the high standards of conduct DaVita expects from all of its employees, whom DaVita refers to as its teammates. To increase awareness of the necessity of complying with all applicable laws and regulations, DaVita has developed ongoing training programs for its teammates through its in-house training program, DaVita University. In addition, DaVita has well-established guidelines around physician roles and responsibilities and requires that its physicians attest to their adherence to these guidelines on a periodic basis. DaVita s compliance programs are overseen by the Chief Compliance Officer who reports directly to the Chief Executive Officer and to the Compliance Committee of the Board of Directors.

Experienced management team. DaVita s management team has extensive experience and expertise in the dialysis industry with an average of 15 years of industry experience. Under management s guidance, DaVita has enjoyed consistent improvements in clinical outcomes, improving contract negotiation results with managed care payors, strong organic growth and successful acquisition and denovo growth. DaVita s consolidated net operating revenues, Adjusted EBITDA and number of U.S. centers in operation grew from $1.3 billion, $188 million and 572, respectively, in 1999 when DaVita s current Chief Executive Officer, Kent Thiry, joined DaVita as CEO, to $7.4 billion, $1.6 billion and 1,884, respectively, as of and for the twelve months ended June 30, 2012.

Table of Contents

DaVita s Strategy

DaVita plans to continue to grow its business and improve its financial performance by implementing its business strategy, the key elements of which are:

Continuous improvement in patient care. DaVita believes its reputation for providing quality patient care is a key factor in attracting patients and qualified medical directors as well as in maintaining and building relationships with referring physicians and managed care and government payors. DaVita strives to deliver best-in-class clinical outcomes as well as increase patient involvement in their care. For example, DaVita s At Home Initiative is committed to leading the introduction and promotion of effective home hemodialysis and peritoneal dialysis solutions for healthier, more independent dialysis patients who prefer to dialyze at home. Moreover, DaVita is committed to continuous improvement in its medical and clinical processes through quality management programs to monitor and enhance the level of services it delivers. Through these quality management programs supervised by the Office of the Chief Medical Officer and the Directors of Clinical Services, DaVita continuously works to promote its high standards of patient care. These efforts include further development and implementation of patient care policies and procedures, clinical education and training programs, clinical guidelines and protocols and audits of the quality of services rendered at each of DaVita s centers. Although it is difficult to reliably measure clinical performance across the dialysis industry, DaVita believes its clinical outcomes compare favorably with other dialysis providers in the U.S.

Developing and maintaining strong relationships with physicians. DaVita continuously seeks to develop relationships with nephrologists. DaVita believes that collaborating with these physicians leads to enhanced quality of care, patient satisfaction and physician satisfaction. DaVita intends to sustain and strengthen its physician relationships by emphasizing DaVita s high quality of care and state-of-the-art centers, expanding its broad array of services and technologies, developing and offering quality training programs and continuing to involve DaVita s physicians in establishing clinical guidelines and protocols.

Expansion of operations. DaVita intends to continue to expand its operations by building out its existing centers, as well as developing and/or acquiring new centers both domestically and internationally. DaVita will continue to evaluate acquisition and denovo opportunities that it identifies as complementary to its existing base of operations or as compelling for new geographic expansion. DaVita believes that its enhanced geographic presence makes it a more attractive partner for national managed care payors.

Integrated kidney care. DaVita maintains an integrated approach to managing the overall health of kidney disease patients through the development and administration of DaVita s ancillary service offerings, including DaVita Rx, Lifeline and VillageHealth. DaVita Rx, DaVita s pharmacy services offering, provides oral medications to DaVita s ESRD patients with the main objectives of (i) providing patients a convenient way to fill their prescription needs by delivering the prescriptions to the center where they are treated and (ii) improving clinical outcomes by facilitating increased patient compliance. Lifeline, DaVita s vascular access services offering, provides management and administrative services to physician-owned vascular access clinics that provide surgical and interventional radiology services for dialysis patients. VillageHealth, DaVita s disease management services offering, provides advanced care management services to health plans and government agencies for employees/members diagnosed with ESRD.

Effective teammate retention and satisfaction. DaVita s dialysis business requires nurses and other teammates with specialized training for treating patients with complex care needs. Recruitment and retention of nurses are continuing concerns for health care providers due to short supply. DaVita has an active program of investing in its teammates. As a result of these efforts DaVita s teammate turnover has improved from 25% to 18% for the quarter ended June 30, 2012 compared to the quarter ended December 31, 2007. This has been a major contributor to DaVita s improving productivity and effective cost control. To meet DaVita s recruitment and retention targets, DaVita offers its teammates expanded training opportunities, tuition reimbursements and other incentives.

Table of Contents

HCP

HCP s Business

HCP is a patient- and physician-focused, integrated health care delivery and management company with nearly three decades of providing coordinated, outcomes-based medical care in a cost-effective manner. Through capitation contracts with some of the nation s leading health plans, as of June 30, 2012, HCP had approximately 669,400 current members under its care in southern California, central and south Florida and southern Nevada. Of these, approximately 190,700 individuals were patients enrolled in Medicare Advantage. The remaining approximately 478,700 individuals were managed care members whose health coverage is provided through their employer or who have individually acquired health coverage directly from a health plan or as a result of their eligibility for Medicaid benefits. In addition, during 2011, HCP provided care to over 412,000 fee-for-service patients.

The patients of HCP s affiliated physicians, physician groups and IPAs benefit from an integrated approach to medical care that places the physician at the center of patient care. As of June 30, 2012, HCP delivered services to its members via a network of over 1,800 affiliated group and other network primary care physicians, 139 network hospitals, and several thousand affiliated group and network specialists. Together with hundreds of case managers, registered nurses and other care coordinators, these medical professionals utilize a comprehensive data analysis engine, sophisticated risk management techniques and clinical protocols to provide high-quality, cost effective care to HCP s members.

Approximately 94% of HCP s revenues are derived from multi-year capitation contracts with health plans. Under these contracts, HCP s health plan customers delegate full responsibility for member care to physicians and health care facilities that are part of HCP s network. In return, HCP receives a per-member per-month, or PMPM, fee for each HCP member. As a result, HCP has financial and clinical accountability for a population of members. In California, HCP does not assume direct financial risk for institutional (hospital) services, but is responsible for managing the care dollars associated with both the professional (physician) and institutional services being provided for the PMPM fee attributable to both professional and institutional services. In those cases and as a result of its managed care-related administrative services agreements with hospitals, HCP recognizes the surplus of institutional revenues less institutional expense as HCP revenues. In addition to revenues recognized for financial reporting purposes, HCP measures its total care dollars under management which includes the PMPM fee payable to third parties for institutional (hospital) services where HCP manages the care provided to its members by hospitals and other institutional providers, which fees are not included in GAAP revenues. For the twelve months ended June 30, 2012, HCP s total consolidated operating revenues were $2.6 billion, total care dollars under management were $3.4 billion, net income was $450 million and Adjusted EBITDA was $561 million. Total care dollars under management and Adjusted EBITDA are non-GAAP measures. For a description of how HCP calculates total care dollars under management and Adjusted EBITDA and a reconciliation to revenues and net income, respectively, see HCP Summary Historical Financial and Operating Data beginning on page S-33.

We believe that HCP is well positioned to profitably leverage marketplace demands for greater provider accountability, measurable quality results and cost effective medical care. We believe that HCP s business model is likely to continue to be an attractive alternative for health plans looking for high quality, cost effective delivery systems, physicians seeking an attractive practice environment and patients interested in a highly integrated approach to managing their medical care. Additionally, we believe that the scale of HCP s business allows it to spread capitation risk over a large population of members, invest in comprehensive analytic and health care information tools as well as clinical and quality measurement infrastructure, and recognize administrative and operating efficiencies. For these reasons, we believe that HCP offers patients, physicians and health plans a proven platform for addressing many of the most pressing challenges facing the U.S. health care system, including rising medical costs.

Table of Contents

HCP Industry Overview

U.S. healthcare spending has increased steadily over the past twenty years. These increases have been driven, in part, by the aging population of the baby boomer generation, lack of healthy lifestyle both in terms of exercise and diet, rapidly increasing costs in medical technology and pharmaceutical research, and provider reimbursement structures that may promote volume over quality in a fee-for-service environment. These factors, as well as the steady growth of the U.S. population, have made the healthcare industry a growing market. In 2009, CMS reported that health care accounted for 17.3% of the U.S. economy. According to CMS the increase in health spending, from $2.3 trillion in 2008 to $2.5 trillion in 2009, was the largest one-year jump since 1960. Comprising an estimated 14% of the federal budget and more than one-fifth of total national health expenditures in 2010, Medicare is frequently the focus of discussions on how to moderate the growth of both federal spending and health care spending in the U.S.

Growth in Medicare spending is expected to continue due to demographics. According to the U.S. Census Bureau from 1970 through 2011, the overall U.S. population is expected to have grown 52% while the number of Medicare enrollees will have grown approximately 130% over that time period. As an increasing number of the baby boomers become eligible for Medicare, the senior market is expected to grow to 79 million by 2030, more than double the number in 2000. UnitedHealth estimates that over the next decade 10,000 people per day will become newly eligible for Medicare. This translates into a Medicare population that makes up more than 20% of the total U.S. population by the year 2025, compared to less than 15% currently.

Medicare Advantage is an alternative to the traditional fee-for-service Medicare program, which permits Medicare beneficiaries to receive benefits from a managed care health plan. Medicare Advantage plans contract with CMS to provide benefits at least comparable to those offered under the traditional fee-for-service Medicare program in exchange for a fixed monthly premium payment per member from CMS. The monthly premium varies based on the county in which the member resides, as adjusted to reflect the plan members demographics and the members risk scores. Individuals who elect to participate in the Medicare Advantage program typically receive greater benefits than traditional fee-for-service Medicare Part B beneficiaries, including additional preventive services, vision, dental and prescription drug benefits, and typically have lower deductibles and co-payments than traditional fee-for-service Medicare.

Managed care health plans were developed, primarily during the 1980s, in an attempt to mitigate the rising cost of providing healthcare benefits to populations covered by traditional health insurance. These managed care health plans enroll members through their employers, under federal Medicare benefits or through state Medicaid programs. As a result of the prevalence of these health plans, many seniors now becoming eligible for Medicare have been interacting with managed care companies through their employers for the last 30 years. Individuals turning 65 now are likely to be far more familiar with the managed care setting than previous Medicare populations. According to the Kaiser Family Foundation, in 2012, Medicare Advantage represents only 27% of total Medicare members, creating a significant opportunity for additional Medicare Advantage penetration of newly eligible seniors.

In an effort to reduce the number of uninsured and to begin to control healthcare expenditures, President Obama signed the Medicare and Medicaid regulations and the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010, or the Health Reform Acts, into law in March 2010, which were affirmed, in substantial part, by the U.S. Supreme Court in June 2012. The Health Reform Acts provide for a reduction of up to 32 million uninsured by 2019, while potentially increasing Medicaid coverage by up to 16 million and net commercial coverage by 16 million. CMS projects that the total number of uninsured Americans will fall to 24 million in 2019 from 52 million in 2011. These previously uninsured Americans and potentially newly eligible Medicaid beneficiaries represent a significant new market opportunity for health plans. We believe that health plans looking to cover these newly eligible individuals under fixed premium arrangements will seek provider arrangements that can effectively manage the cost and quality of the care being provided to these newly eligible individuals.

In 2006, Medicare began to pay Medicare Advantage health plans under a bidding process. Plans bid against county-level benchmarks established by Medicare based on the prior year s Medicare Advantage county payment rate and increased by the projected national growth rate in per capita Medicare spending. Those payment rates were at least as high as per capita fee-for-service Medicare spending in each county and often substantially higher because Congress set floors to raise the lowest rates to stimulate plan growth in areas where plans historically had not found it profitable to enter. If a plan s bid is higher than the benchmark, enrollees pay the difference in the form of a monthly premium. If the bid is lower than the benchmark, the Medicare program retains 25% of the difference as savings and the plan receives 75% as a rebate, which must be returned to enrollees in the form of additional benefits or reduced premiums. Plan payments are also adjusted based on enrollees risk profiles. The formula for base payment is a combination of the base rate for the enrollee s county of residence, multiplied by the enrollee s risk score.

One of the primary ways in which the Healthcare Reform Acts will fund increased health insurance coverage is through cuts in Medicare Advantage reimbursement. County benchmarks are transitioning to a system in which each county s benchmark in 2017 will be a certain percentage (ranging from 95% to 115%) of fee-for-service. Medicare Payment Advisory Commission, or MedPAC, estimated that 2012 Medicare Advantage benchmarks, bids, and payments will average 112%, 98%, and 107% of fee-for-service spending, respectively. As a result, plans on average would have to bid 36% lower than fee-for-service or 43% lower than the Medicare Advantage benchmark for CMS to begin to save money on Medicare Advantage. As result of the transition of county benchmarks to 95% to 115% of fee-for-service, Medicare Advantage benchmarks on average are expected to be reduced to parity with fee-for-service as compared to 112% of fee for-service today. Given that CMS will retain 25% of the difference of any plans bid below benchmark, the overall Medicare Advantage program should realize savings as compared to fee-for-service in 2017, which would result in lower payments to Medicare Advantage plans and to HCP.

Many health plans recognize both the opportunity for growth from senior members as well as the potential risks and costs associated with managing additional senior members. In California, Florida, Nevada and numerous other markets, many health plans subcontract a significant portion of the responsibility for managing patient care to integrated medical systems such as HCP. These integrated health care systems, whether medical groups or IPAs, offer a comprehensive medical delivery system and sophisticated care management know-how and infrastructure to more efficiently provide for the health care needs of the population enrolled with that health plan. While reimbursement models for these arrangements vary around the country, health plans in California, Florida and Nevada often prospectively pay the integrated health care system a fixed PMPM amount, or capitation payment, which is often based on a percentage of the amount received by the health plan. The capitation payment is for much and sometimes virtually all of the care needs of the applicable membership. Capitation payments to integrated health care systems, in the aggregate, represent a prospective budget from which the system manages care-related expenses on behalf of the population enrolled with that system. To the extent that these systems manage care-related expenses under the capitated levels, the system realizes an operating profit. On the other hand, if care-related expenses exceed projected levels, the system will realize an operating deficit. Since premiums paid represent a significant amount per person, there is a significant revenue opportunity for an integrated medical system like HCP that is able to effectively manage its costs under a capitated arrangement. This is particularly the case for Medicare Advantage members for which revenue to a system can be substantial given the higher expected morbidity and cost associated with a Medicare Advantage member.

Integrated medical systems, such as HCP, that have scale are positioned to spread an individual member s cost experience across a wider population and realize the benefits of pooling medical risk among large numbers. In addition, integrated medical systems with years of managed care experience can utilize their sizeable medical claims data to identify specific medical care and quality management strategies and interventions for potential high cost cases and aggressively manage them to improve the health of its population base and, thus, lower cost.

Table of Contents

Many integrated medical systems, like HCP, have also established physician performance metrics that allow them to monitor quality and service outcomes achieved by participating physicians in order to reward efficient, high quality care delivered to members and initiate improvement efforts for physicians whose results can be enhanced.

HCP s Competitive Strengths

We believe that HCP distinguishes itself through its ability to demonstrably improve medical outcomes and patient satisfaction while effectively managing costs. HCP achieves this result through the following key strengths:

Clinically based utilization management models. HCP s clinical leadership and affiliated group and network physicians devote significant efforts to ensuring that HCP s members receive the most appropriate care in the most appropriate setting. HCP believes this results in significant differences compared to a typical unmanaged patient population. For example, during fiscal 2010, HCP s inpatient acute bed days in California were 864 days per 1,000 members for its Medicare Advantage members, as compared to an average of 1,706 days per 1,000 patients for Medicare s fee-for-service program during the same period. Similarly, HCP s 30 day all cause hospital re-admission rate in California during fiscal 2010 was 14%, which HCP believes was lower than the Medicare fee-for-service benchmark. HCP has achieved similarly favorable outcomes in Nevada and Florida when compared to benchmarks.

Service commitment. HCP is committed to maximizing its patients satisfaction levels with HCP and their physicians. HCP regularly conducts comprehensive satisfaction surveys of its members and actively monitors survey results at the individual physician level. In its most recent survey conducted during the second quarter of 2012, 91.6% of patients surveyed gave their HCP physician top satisfaction scores. We believe that HCP s high rates of patient satisfaction lead to greater member retention. Because of the number of HCP commercial health plan customers, if an employer changes health plans, members can often move to another plan and still retain their participation with HCP. HCP believes the longevity of the patient-physician relationship provides it with additional leverage with the health plans and helps to ensure the stability of the relationship between the health plans and HCP.

Long standing relationships with health plans. We believe that HCP s scale, combined with its strong reputation and high quality patient care, makes it an attractive partner for health plans compared to smaller provider groups that may have a higher risk of default and may not have the same resources to devote to integrated care techniques. We believe that HCP is a leader in managing global capitation arrangements by assuming both professional (physician) and institutional (hospital) risk and has the critical mass necessary to diversify these risks across a large membership base. HCP s scale and resources enable it to invest in continuous innovation to improve the clinical outcomes of its members. We believe that health plans in the regions in which it operates appreciate HCP s ability to manage global risk because these arrangements eliminate the volatility of medical costs, the largest cost component for health plans. HCP, or its predecessor companies, have longstanding relationships with its health plan customers, with these relationships having an average tenure of approximately 20 years. For example, HCP has had a relationship spanning approximately 28 years with UnitedHealthcare, one of HCP s largest customers. HCP also provides care to a significant portion of Humana s Medicare Advantage membership in the central Florida region. HCP is not aware of any health plan customer that has not renewed its contract with HCP.

Proprietary database of long-tenured patient data. HCP has nearly three decades of experience in managing complex disease cases for its population of patients. As a result, HCP has developed a rich

Table of Contents

dataset of patient care experiences and outcomes which permits HCP to proactively monitor and intervene in improving the care of its members. HCP uses this proprietary database to:

identify patients with high-cost or high-utilization disease categories;

provide direct feedback to their physicians and other care-givers with point of care reminders and other notifications of patient s needs;

reduce variation in practice patterns, provide immediate feedback to physicians and improve the overall quality of care;

benchmark HCP s performance across its organization and against published metrics to establish a best practices approach to health care; and

accurately model historical utilization and cost patterns and, from that, seek to project future patterns, allowing HCP to better assess risk and negotiate health plan contracts.

Experienced management team. HCP s senior management team possesses substantial experience within the healthcare industry, with average experience of nearly 35 years. The management team has overseen significant growth in its business and demonstrated the ability to produce strong financial performance. HCP s senior management team is expected to continue with HCP after the Merger.

Strong financial performance. Consistent revenue and EBITDA growth over the prior 14 years, coupled with negative working capital and low maintenance capital expenditures over this period of less than one percent of revenue, have enabled HCP to achieve attractive historical cash flows. In the twelve months ended June 30, 2012, HCP generated cash flows from operating activities of $512 million. HCP s ability to generate strong and consistent cash flow from operations has enabled it to invest in its operations and pursue attractive growth opportunities.

Scalable and portable business model. We believe that HCP s strong clinical outcomes, reputation with health plans and health care providers and its ability to successfully manage complex regulatory, reimbursement, clinical and operating environments associated with practicing medicine are key reasons that medical groups and IPAs are interested in joining HCP s network. HCP has the capacity to extend its network and systems to encompass additional medical groups and IPAs with only limited incremental capital expenditures.

HCP s Strategy

HCP intends to continue to increase its membership, and generate incremental revenue and earnings opportunities in existing and new markets. HCP expects to accomplish this through pursuing the following activities:

Continue to Provide High Quality Care to Patients While Minimizing Costs. HCP intends to continue to improve quality care and strong medical outcomes for its patients while managing health care costs and minimizing the level of unnecessary care by investing in the following programs and initiatives:

Integrated care teams. HCP has re-engineered the patient care process to enhance the patient care experience through the use of integrated care teams. These include care teams of physicians, nurses and medical assistants who have direct contact with and deep personal knowledge of a panel of assigned patients. Patients have direct phone and/or email access to these teams for appointments

and information flow. Teams are supported by a multi-disciplined support center, 24 hours a day, seven days per week, that handles customer service issues, claims and benefit questions as well as medical questions and the triaging of medical conditions to the appropriate resource after office hours.

Table of Contents

Disease management programs. HCP proactively manages its patients with specific disease conditions, including chronic obstructive pulmonary disease, chronic kidney disease, ESRD and diabetes, among others, through a combination of direct clinical intervention and treatment, and patient education. These programs are designed to reduce the escalation of the severity of the medical conditions, thereby reducing hospital admissions and medical claims costs, as well as improving the overall quality of life for patients with these conditions.

Hospitalists. HCP utilizes hospitalists in all of its markets to more efficiently use HCP s primary care physicians and to provide more individualized and focused attention for hospitalized patients. These specifically trained physicians monitor and manage on a 24 hours a day, seven days per week basis all aspects of care during a patient s hospital stay, in many cases on-site at the hospital. We believe this results in more efficient, and generally shorter hospital stays, as well as reduced levels of readmissions.

Comprehensive care centers. HCP offers comprehensive care centers that are typically located within existing medical clinics and practice locations. These comprehensive care centers provide customized interventions for high-risk patients with multiple chronic diseases. These comprehensive services are designed to prevent these chronic disease conditions from becoming more severe.

Home care program. The most ill, highest risk patient population typically accounts for a disproportionate level of hospitalizations and emergency room visits. HCP s home care program brings personalized care to its most frail and ill patients in their home. This program is designed to reduce inpatient acute admissions and emergency room visits for the patients under HCP s care.

Same or next day access. Most physicians who depend on fee-for-service reimbursement have fully booked schedules so that when a patient calls with symptoms that are troublesome, but not life-threatening, the patient may be told to go to the emergency room, an extremely high cost and inefficient setting for delivery of care. To mitigate this problem, HCP keeps open a significant block of its physicians schedules for same or next day access. This allows patients with non life-threatening problems to be seen in a physician s office on the same or next day after they call. We believe this program not only improves the quality of care, but also enhances patient satisfaction and retention.

Urgent care centers. HCP owns and operates freestanding urgent care centers to provide access for patients who require immediate care. These centers create a more appropriate clinical alternative to emergency room visits, which are typically expensive and may lead to unnecessary inpatient admissions.

Organically Grow by Adding Physicians, Physician Groups and IPAs in Existing and Adjacent Markets. Consistent with HCP s historical growth model, HCP plans to continue to organically grow its network in and adjacent to its existing markets by adding physicians, physician groups and IPAs, particularly those with strong senior enrollment and an acceptance of integrated care management and evidence-based medicine techniques. We believe that HCP s strong relationships with many leading health plans, extensive provider networks, and reputation for providing quality care, make it an attractive partner for a wide range of physician groups and IPAs. We believe that there are many of these physician groups and IPAs in its existing and adjacent markets that have experience in managed care. As such, HCP believes that the growth opportunity from organically adding physician groups and IPAs is significant in its primary and adjacent markets.

Opportunistically Expand into New Markets. HCP intends to continue to expand its business model into new markets in a disciplined and opportunistic manner. HCP has acquired or has become affiliated with a number of medical groups, IPAs and physician practices in the past and is currently reviewing a number of acquisitions and affiliation candidates of various sizes both within and outside its existing geographic markets. If a significant portion of the opportunities currently being reviewed were consummated, HCP could be required to raise up to $1 billion in additional financing.

Table of Contents

Pursue New Product Offerings. HCP also intends to pursue new product offerings. In HCP s existing markets, HCP intends to contract with health plans that undertake to manage the care of members who are dually eligible for both Medicare and Medicaid benefits, and who are currently receiving care through a traditional fee-for-service model. Health plans receive a higher premium from CMS for dual-eligible patients under a Medicare Advantage program, as these patients typically have higher medical costs. For example, these patients experience 80% higher medical costs than the average Medicare patient and have a 47% higher rate of diabetes; over half of these patients are under treatment for five or more chronic conditions. As a result of CMS authorized demonstration projects, several states are exploring enrolling these dual-eligible patients in managed care plans, and California announced an intention to launch a demonstration project in 2013. Given the high level of chronic disease states among this population and the higher associated costs, HCP believes there is a sizeable new revenue opportunity to apply its integrated care management model to serving dual-eligible patients. In addition, HCP has been selected by CMS Innovation Center to be among the 32 Pioneer Accountable Care Organizations, or Pioneer ACO, in each of HCP s three markets. HCP is the only such Pioneer ACO in more than one state. Pioneer ACOs contract with CMS on a direct basis, not through health plans, to manage the care of Medicare fee-for-service patients attributable to these organizations. The Pioneer ACO program presents an opportunity for HCP to bring the benefit of its integrated care programs to a fee-for-service patient population. Because Medicare fee-for-service is not part of HCP s health plan customers business, this new product offering will not compete with HCP s customers.

Table of Contents

The Merger

Rationale for the Merger

DaVita believes that the Merger with HCP can open a large new market for DaVita the integrated healthcare services market that HCP serves offering considerable growth opportunities beyond domestic dialysis. The combination offers the potential to create an industry leading company that may be well positioned to capitalize on anticipated trends in U.S. healthcare, including growth in managed healthcare services, especially to the Medicare-eligible population.

As a significant participant in healthcare delivery with a proven track record, HCP is a recognized leader in its field and should allow DaVita to significantly expand the range of services it provides with only limited additional operational resources required. HCP s industry leadership provides it substantial credibility with governmental entities, physician groups, large hospital systems and payors across the U.S.

There are many similarities in the values and cultures of DaVita and HCP, including a strong common culture of putting the patient first. In the case of HCP, this is demonstrated by its commitment to and the success of its integrated care model, which has had high quality clinical outcomes and has been able to effectively manage its costs under capitated arrangements. DaVita believes that HCP s business model is in the right place to capitalize on long-term trends in healthcare in the U.S. the need to more effectively manage the cost of providing healthcare services, especially to the Medicare-eligible population, while continuing to deliver high quality care. In addition, DaVita believes that HCP s experience may be able to help DaVita achieve attractive reimbursement for globally capitated kidney care.

Merger Agreement

On May 20, 2012, we entered into a merger agreement, or Merger Agreement, providing for our acquisition of HCP pursuant to the Merger of a newly formed wholly owned subsidiary of DaVita into HCP. Under the Merger Agreement, HCP will be the surviving entity in the Merger and will become a wholly owned subsidiary of DaVita. Following the Merger, DaVita will be renamed DaVita HealthCare Partners Inc.

If the Merger is completed, the total merger consideration to be paid to the holders of HCP common units and vested and unvested options to purchase HCP common units, or the HCP options, is an aggregate of $3.6 billion in cash and approximately 9.4 million shares of DaVita common stock, subject to certain adjustments.

In addition to the merger consideration payable at the closing of the Merger and amounts that may be released over time from the escrow accounts as further described below in Merger Agreement Escrows , HCP members and holders of HCP options may receive up to $275.0 million of additional cash consideration in the form of two separate earn-out payments of $137.5 million in cash that are based on the financial performance of HCP and the achievement of certain financial targets for fiscal years 2012 and 2013.

The completion of the Merger is subject to various customary conditions, including, among others, (i) obtaining the approval of HCP s members, (ii) subject to certain materiality exceptions, the accuracy of the representations and warranties made by DaVita and HCP, respectively, and compliance by DaVita and HCP with their respective obligations under the Merger Agreement, and (iii) declaration of the effectiveness by the Securities and Exchange Commission of the registration statement on Form S-4 filed by DaVita regarding the shares of DaVita common stock to be issued in the Merger.

The Merger must be approved by a vote of the majority of the HCP members. The board of managers of HCP made a recommendation to the HCP members to approve the principal terms of the Merger and the Merger

Table of Contents

Agreement and the holders of approximately 74% of the outstanding HCP common units has entered into a voting agreement with DaVita pursuant to which it has agreed to vote in favor of the principal terms of the Merger and the Merger Agreement. Accordingly, pursuant to such voting agreement the HCP member approval is assured.

The Merger Agreement contains certain termination rights for each of DaVita and HCP and provides that DaVita is required to pay HCP a $125.0 million termination fee in the event that the Merger Agreement is terminated under certain circumstances. Specifically, in the event that DaVita cannot obtain the financing required for the Merger, each party to the Merger generally has the right to terminate the Merger Agreement and HCP may be entitled to the termination fee.

The Merger Agreement provides that at the closing the DaVita board of directors will be increased in size by one member, and Dr. Robert Margolis, Chairman and Chief Executive Officer of HCP, will be appointed to fill the newly created directorship as Co-Chairman . In addition, for a minimum period of four consecutive annual meetings of stockholders of DaVita, Dr. Margolis will hold the office of Co-Chairman until the expiration of his term of office or until his successor is duly elected and qualified, subject to his earlier death, resignation, disqualification, or removal in accordance with DaVita s bylaws and/or applicable law.

Merger Agreement Escrows

Approximately $575 million of the closing merger consideration will be withheld from payment and contributed to escrow accounts that support a potential working capital adjustment, certain indemnification obligations, certain contingent payments, and certain costs and expenses that may be incurred by the HCP member representative designated in the Merger Agreement. Beginning on the second anniversary of the closing, funds in escrow, to the extent not previously released or reserved for certain indemnity claims, will be released on various dates, with the final release to occur on or about October 15, 2017.

Employment Agreements

Concurrently with the execution of the Merger Agreement, each of Dr. Margolis, Mr. Mazdyasni, Dr. Chin, Dr. Thomas Paulsen, Executive Medical Director, California of HCP, Zan Calhoun, Chief Operating Officer of HCP, and Lorie Glisson, Chief Executive Officer JSA Healthcare, entered into an employment agreement with HCP and DaVita that will become effective upon the consummation of the Merger.

Financing of the Merger

We expect to finance the cash portion of the Merger consideration through a combination of available cash, the net proceeds of the notes offered hereby, and additional borrowings under our senior secured credit facilities, which senior secured credit agreement is expected to be amended to permit or facilitate, among other things, the additional borrowings under the senior secured credit facilities, the Merger and this note offering. There is no financing condition to the Merger; however, DaVita must use its reasonable best efforts to arrange and obtain the financing required to consummate the Merger.

We currently intend to enter into an amendment to our senior secured credit facilities to provide for additional borrowings in an aggregate principal amount of $3,000 million, comprised of:

- a new five year Term Loan A-3 facility in an aggregate principal amount of $1,350 million, and
- a new seven year Term Loan B-2 facility in an aggregate principal amount of $1,650 million.

The proceeds from these additional borrowings, together with available cash, will be used to finance a portion of the cash portion of the Merger consideration, to repay approximately $198 million of our Term Loan

Table of Contents

A-2 outstanding under our existing senior secured credit agreement, to repay the net amount of HCP indebtedness as a result of the Merger, and pay related fees and expenses.

We intend to borrow all $3,000 million of the term loans and issue $1,000 million of the notes offered hereby. Based upon the amount of available cash, and the proceeds of the notes and secured debt expected to be available to the Company, after giving pro forma effect to the Financing and the Merger as if they had occurred on June 30, 2012, we do not anticipate borrowing any amounts under our revolving credit facility.

The terms and conditions of the amended senior secured credit facilities have not been finalized and are subject to change. We may not finalize the terms until prior to the consummation of the Merger, but after the issuance of the notes offered hereby.

We expect that our amended senior secured credit facilities will be guaranteed by a substantial portion of our direct or indirect wholly owned domestic subsidiaries and will be secured by substantially all of our and our subsidiary guarantors assets. In particular, these facilities will be secured by first priority pledges of 100% of the equity interests owned by us and the subsidiary guarantors in our direct domestic subsidiaries and 65% of the equity interests of our and the subsidiary guarantors direct foreign subsidiaries, if any.

We expect that our amended senior credit facilities will contain limits and restrictions on certain of our business activities. In addition, we expect that the amended senior secured credit facilities will require compliance on a quarterly basis with certain financial covenants.

As a result of the borrowings that we will incur to finance the Merger, the aggregate amount of our indebtedness and annual debt expense will increase substantially following the Merger. See Risk Factors, Capitalization and DaVita Inc. and HealthCare Partners Holdings, LLC Unaudited Pro Forma Condensed Consolidated Financial Statements.

Sources and Uses

We estimate the net proceeds from this offering, after deducting the underwriting discount and other estimated expenses payable by us, will be approximately $983 million and will be deposited into an escrow account upon the closing of this offering. Funds held in escrow will be released upon the consummation of the Merger and satisfaction of customary conditions, and we intend to use the escrowed proceeds from this offering, together with proceeds from our anticipated amended senior secured credit facilities and cash on hand, to finance the aggregate cash consideration for the Merger and pay related fees and expenses. The following table illustrates the expected sources and uses of funds from the Financing. No assurances can be given that the information in the following table will not change depending on the nature of our financing arrangements and/or whether the Merger will be consummated in accordance with the anticipated timing or at all. See Risk Factors Risks Relating to the Merger.

Sources of Funds (in millions)	
Amended senior secured credit facilities[1]	$ 3,000
Notes offered hereby	1,000
Equity consideration[2]	907
Cash from balance sheet	67
Total sources	$ 4,974

Uses of Funds (in millions)	
Cash portion of purchase price[3]	$ 3,592
Equity portion of purchase price[2]	907
Repayment of Term Loan A-2	198
Repayment of HCP s existing debt[4]	187
Estimated fees and expenses	90
Total uses	$ 4,974

(1) Assumes that such amounts are obtained through the issuance of additional term loans under the amended senior secured credit facilities. The terms of the amended senior secured credit facilities have not yet been finalized and are subject to change.

Table of Contents

(2) Based upon the issuance of 9,380,312 shares of Davita Inc. common stock valued at the closing market price on August 10, 2012 as reported by the New York Stock Exchange, or NYSE.

(3) The cash portion of the purchase price for HCP consists of $3.66 billion in cash less an estimated negative working capital adjustment of $68 million.

(4) Represents HCP s debt to be repaid at the closing of the Merger (based upon HCP s existing debt net of available cash, in each case as of June 30, 2012).

Table of Contents

Combined Company Condensed Organizational Chart

The following condensed organizational chart shows our corporate structure after giving effect to the Merger. It does not show our actual corporate structure and is intended solely to illustrate the general ownership structure after the acquisition of HCP, including the subsidiaries and affiliates that serve as guarantors and non-guarantors of the notes.

(1) Following the Merger, DaVita will be renamed DaVita HealthCare Partners Inc.
(2) Non-owned, non-subsidiary, non-guarantor affiliates included in HCP consolidated financial statements and subject to management agreements.

Table of Contents

THE OFFERING

The summary below describes some of the terms of the notes and the related indenture and escrow agreement. Certain of the terms and conditions described below are subject to important limitations and exceptions. For a more detailed description of the terms and conditions of the notes and the related indenture and escrow agreement, see the section entitled Description of Notes. As used in this section, references to the we, us, our, DaVita and Company mean DaVita Inc. and not any of its subsidiaries, unless otherwise expressly stated or the contex otherwise requires.

Issuer	DaVita Inc.
Notes Offered	$1,000,000,000 aggregate principal amount of % Senior Notes due 2022.
Maturity Date	The notes will mature on , 2022.
Interest	The notes will bear interest at a rate of % per year. Interest will accrue from , 2012.
Interest Payment Dates	and of each year, commencing , 2013.
Guarantees	Except as described below under Escrow of Proceeds; Special Mandatory Redemption , the notes initially will be guaranteed by each of our domestic restricted subsidiaries that guarantee our senior secured credit facilities. Upon consummation of the Merger, HCP and each of its subsidiaries that guarantee our senior secured credit facilities will also guarantee the notes.
Ranking	Except as described under Description of Notes Escrow of proceeds; release conditions, the notes will be unsecured senior obligations of the Company and will rank senior in right of payment to all of the Company s existing and future unsecured debt, if any, that is expressly subordinated in right of payment to the notes. The notes will rank equally in right of payment with all of the Company s existing and future unsecured senior debt, will be effectively subordinated to all of the Company s existing and future secured debt (including its senior secured credit facilities) to the extent of the value of the collateral securing such debt and will be structurally subordinated to all existing and future liabilities of the Company s subsidiaries that do not guarantee the notes. The guarantees will be unsecured senior obligations of the guarantors and will rank senior in right of payment to all their existing and future unsecured debt, if any, that is expressly subordinated in right of payment to the guarantees. The guarantees will rank equally in right of payment with all of the guarantors existing and future unsecured senior debt, will be effectively subordinated to all of the guarantors existing and future secured debt (including their guarantees of our senior secured credit facilities) to the extent of the value of the collateral securing such debt and will be structurally subordinated to all existing and future liabilities of any of the guarantors subsidiaries that do not guarantee the notes.

Table of Contents

As of June 30, 2012, after giving pro forma effect to the Financings and the Merger as if they had occurred on that date, the Company and the guarantors would have had total secured debt of approximately $5,650 million and approximately $284 million of additional secured debt available to be borrowed under our amended senior secured credit facilities (after giving effect to outstanding letters of credit of approximately $66 million), and the notes and the guarantees would have been structurally subordinated to $510 million of liabilities, including $64 million of indebtedness and the rest being primarily trade payables, of non-guarantor subsidiaries.

HCP provides services to certain affiliated physician groups that are not owned by HCP, will not constitute Subsidiaries (as defined in the indenture governing the notes) and will not guarantee the notes, even though the accounts of these groups are consolidated with the financial statements of HCP and would be consolidated with the financial statements of the Company following the Merger. Pursuant to management agreements between HCP and these affiliated physician groups, a substantial portion of the aggregate net revenues of these groups is payable to subsidiaries of HCP and will be payable to entities that will be guarantors of the notes as compensation for management and administrative services under management services agreements. See HCP s Business Government Regulations Corporate Practice of Medicine and Fee Splitting. As of June 30, 2012, after giving pro forma effect to the Financing and the Merger as if they had occurred on that date, our consolidated balance sheet would have included third party liabilities of these affiliated physician groups, in the amount of approximately $305 million and assets of these affiliated physician groups in the amount of approximately $510 million after elimination of intercompany receivables (or approximately 3% of our pro forma consolidated total assets at that date). The pro forma consolidated net operating revenues and Adjusted EBITDA of DaVita for the twelve months ended June 30, 2012, giving effect to the Financing and the Merger as if they had occurred on July 1, 2011, would have been $9,929 million and $2,167 million, respectively. The pro forma consolidated net operating revenues and Adjusted EBITDA of DaVita, excluding HCP s affiliated physician groups and DaVita s existing non-guarantor Subsidiaries, for the twelve months ended June 30, 2012, giving effect to the Financing and the Merger as if they had occurred on July 1, 2011, would have been $6,623 million and $1,744 million, respectively. Substantially all of the difference between pro forma consolidated Adjusted EBITDA of $2,167 million and the pro forma consolidated Adjusted EBITDA excluding HCP s affiliated physician groups and DaVita s existing non-guarantor subsidiaries of $1,744 million for the twelve months ended June 30, 2012 is attributable to the exclusion of the existing non-guarantor subsidiaries of DaVita.

Table of Contents

	The consolidated net operating revenues and Adjusted EBITDA of HCP for the twelve months ended June 30, 2012 were $2,564 million and $561 million, respectively. Excluding HCP s affiliated physician groups, but inclusive of the management fees earned by HCP from the affiliated physician groups of $725 million, the net operating revenue and Adjusted EBITDA of HCP for the twelve months ended June 30, 2012 would have been $1,731 million and $557 million, respectively. Excluding the management fees earned by HCP from the affiliated physician groups, HCP net operating revenue for the twelve months ended June 30, 2012 would have been $1,006 million.
Escrow of Proceeds; Special Mandatory Redemption	Upon consummation of the offering of the notes, we will deposit the net proceeds from this offering (after deducting the underwriting discount), together with additional amounts needed to redeem the notes at the redemption price set forth below, into escrow as described in Description of Notes Escrow of proceeds; release conditions. If the conditions to our merger with HCP and certain other conditions are not satisfied on or prior to the Escrow End Date, or if we notify the escrow agent that we will not pursue consummation of the Merger, the amount deposited in escrow will be applied to redeem all of the notes offered hereby at a special mandatory redemption price equal to 100% of the issue price of the notes plus accrued and unpaid interest from the date of initial issuance, or the most recent date to which interest has been paid or duly provided for, as the case may be, to but excluding the special mandatory redemption date. See Description of Notes Special mandatory redemption. If the conditions to our merger with HCP and certain other conditions are satisfied on or before the Escrow End Date, the amounts deposited in escrow will be released to us and applied to finance a portion of the cash consideration for the Merger. See Use of Proceeds and Description of Notes Escrow of proceeds; release conditions.
Optional Redemption	At any time prior to , 2015, the Company may redeem up to 35% of the notes with the net cash proceeds of certain equity offerings at the redemption price set forth under Description of Notes Optional redemption. At any time prior to , 2017, the Company may also redeem the notes, in whole or in part, at a make whole redemption price, plus accrued and unpaid interest to the date of redemption, as set forth under Description of Notes Optional redemption. On and after , 2017, the Company may redeem the notes, in whole or in part, at the redemption prices set forth under Description of Notes Optional redemption .

Table of Contents

Change of Control

If specific kinds of changes of control occur and the Company has not previously exercised its right to redeem all of the outstanding notes as described under Description of Notes Optional redemption or Description of Notes Special mandatory redemption, the Company must offer to purchase the notes at a price equal to 101% of the principal amount thereof plus any accrued and unpaid interest. The amount required to be escrowed by the Company as described above under Escrow of Proceeds; Special Mandatory Redemption is less than the amount required to pay such price in full.

Covenants

The indenture governing the notes, which we refer to as the indenture, will, among other things, restrict our ability and the ability of our restricted subsidiaries (as defined) to:

- incur additional indebtedness and issue certain preferred stock;
- make certain distributions, investments and other restricted payments;
- sell certain assets;
- agree to restrictions on the ability of restricted subsidiaries to make payments to us;
- create certain liens;
- merge, consolidate or sell substantially all of our assets; and
- enter into certain transactions with affiliates.

These covenants are subject to important exceptions and qualifications described under the heading Description of Notes.

Use of Proceeds

Upon consummation of the Merger and satisfaction of certain other conditions, we intend to use the net proceeds from this offering, together with proceeds from our anticipated amended senior secured credit facilities and available cash, to finance the aggregate cash consideration for the Merger and pay related fees and expenses. Substantially simultaneously with the consummation of the Merger, we intend to use the proceeds from additional borrowings under our amended senior secured credit facilities and available cash to repay approximately $198 million of our Term Loan A-2 outstanding under our existing senior secured credit agreement, to repay the net amount of HCP indebtedness as a result of the Merger, and pay related fees and expenses. See Use of Proceeds. If the Merger is not consummated on or prior to the Escrow End Date or the Merger Agreement is terminated at any time prior thereto, we will be required to redeem all of the notes as described under Description of Notes Escrow of proceeds; release conditions and Description of Notes Special mandatory redemption. Pending such uses, the net proceeds may be invested in short-term, investment-grade, interest bearing securities. See Use of Proceeds.

Table of Contents

No Public Market	The notes are a new series of securities for which there is currently no established trading market. The underwriters have advised us that they presently intend to make a market in the notes. However, you should be aware that they are not obligated to make a market and may discontinue their market-making activities at any time without notice. As a result, a liquid market for the notes may not be available if you try to sell your notes. We do not intend to apply for a listing of the notes on any securities exchange or any automated dealer quotation system.
Form	The notes will be represented by registered global notes registered in the name of Cede & Co., the nominee of the depository, The Depository Trust Company, or DTC. Beneficial interests in the notes will be shown on, and transfers will be effected through, records maintained by DTC and its participants.
Risk Factors	See Risk Factors beginning on page S-35 of this prospectus supplement for important information regarding us, HCP and an investment in the notes.

Table of Contents

Summary Unaudited Pro Forma Financial and Other Data

The following summary unaudited pro forma condensed consolidated statements of income and balance sheet data were derived from DaVita s unaudited pro forma condensed consolidated financial information included elsewhere in this prospectus. The pro forma other financial data and operating data were derived from historical operating data of each of DaVita and HCP. The unaudited pro forma condensed consolidated statements of income and balance sheet data are based on the audited financial statements for the year ended December 31, 2011 of each of DaVita and HCP and unaudited financial information for the six months ended June 30, 2012 of DaVita and HCP included elsewhere and/or incorporated by reference in this prospectus, and the unaudited financial information for trailing twelve months ended June 30, 2012. The unaudited pro forma condensed consolidated financial information gives effect to the Merger and related borrowings as if each had occurred on January 1, 2011, in the case of income statement data and other financial data derived therefrom, and gives effect to the Merger and related borrowings on June 30, 2012, in the case of balance sheet data and other financial data derived therefrom. The unaudited financial data has been prepared on a basis consistent with DaVita s and HCP s annual audited financial statements. In the opinion of management, such unaudited financial data reflects all adjustments, consisting only of normal and recurring adjustments, necessary for a fair presentation of the results for those periods.

The summary unaudited pro forma condensed consolidated financial information has been derived from estimates and financial data that may change materially between the date of this prospectus supplement and the consummation of the Merger. The summary unaudited pro forma financial information below does not purport to represent what DaVita s results of operations or financial data would actually have been had the Merger and related borrowings in fact occurred on the dates specified, nor does it purport to project our results of operations or financial position for any future period or at any future date. Because the information below is a summary, you should read the following information in conjunction with the other information contained under the captions DaVita Inc. and HealthCare Partners Holdings, LLC Unaudited Pro Forma Condensed Consolidated Financial Statements, DaVita s and HCP s historical financial statements and the accompanying notes thereto, and other financial and statistical data included elsewhere or incorporated by reference in this prospectus. For information regarding the pro forma adjustments in the following summary unaudited pro forma condensed consolidated financial information, see DaVita Inc. and HealthCare Partners Holdings, LLC Unaudited Pro Forma Condensed Consolidated Financial Statements, DaVita Selected Historical Financial and Other Data and HCP Selected Historical Financial and Other Data beginning on page S-84 , page S-88 and page S-90, respectively.

Table of Contents

Unaudited Pro Forma Condensed Consolidated Statement of Income

	Pro forma year ended December 31, 2011	Pro forma six months ended June 30, 2012	Pro forma twelve months ended June 30, 2012
	(dollars in millions)		
Net dialysis patient service revenues, less provision for uncollectable accounts	$ 6,273	$ 3,465	$ 6,745
Integrated care revenue	2,375	1,294	2,511
Other revenues[1]	566	360	673
Net operating revenues	9,214	5,119	9,929
Operating expenses and charges:			
Patient care costs	6,402	3,515	6,802
General and administrative	896	513	993
Depreciation and amortization	425	234	453
Provision for uncollectible accounts	7	4	8
Equity investment income	(34)	(17)	(38)
Goodwill impairment charge	24		
Legal proceeding contingency accrual and related expenses[2]		78	78
Total operating expenses and charges	7,720	4,327	8,296
Operating income	1,494	792	1,633
Debt expense	(434)	(212)	(430)
Other income	11	5	11
Income from continuing operations before income taxes	1,071	585	1,214
Income tax expense	390	220	444
Income from continuing operations	681	365	770
Discontinued operations:			
Income from operations of discontinued operations, net of tax	1		1
Loss on disposal of discontinued operations, net of tax	(5)		(5)
Net income	677	365	766
Less: Net income attributable to noncontrolling interests	(95)	(49)	(104)
Net income attributable to DaVita Inc.	$ 582	$ 316	$ 662
Other financial data and ratios:			
Adjusted EBITDA[3]	2,063	1,052	2,167
Net debt[4]	8,062	8,157	8,167
Ratio of net debt to Adjusted EBITDA	3.91x		3.77x

(1) Other revenues for DaVita include revenues from our ancillary services and strategic initiatives and fees for providing management and administrative services. Other revenues for HCP include revenues primarily from consulting services and fees from providing management and administrative services.

(2) Represents a legal proceeding contingency accrual and related expenses that resulted from an agreement we reached in principle to settle the Woodard Private Civil Suit. See DaVita s Business Legal Proceedings beginning on page S-169.

(3) We present Adjusted EBITDA because it is one of the components used in the calculations of the leverage ratio that is included in the covenants contained in our existing senior secured credit agreement, and we expect similar covenants to be included in our amended senior secured credit agreement; however, the terms of the amended senior secured credit agreement have not yet been finalized. Adjusted EBITDA is defined as

Table of Contents

net income attributable to DaVita Inc. before income taxes, debt expense, depreciation and amortization, noncontrolling interests, and equity investment income, net and we further adjust for non-cash charges, stock-based compensation, pro forma amounts for acquisitions and asset sales as if they had been consummated on the first day of each period, and non-cash gains and credits. Management uses Adjusted EBITDA and similar calculations as measures to assess operating and financial performance including compliance with the financial covenants contained in its indentures and its senior secured credit agreement. Adjusted EBITDA is not a measure of financial performance computed in accordance with GAAP and should not be considered in isolation or as a substitute for operating income, net income, cash flows from operations, or other statement of operations or cash flow data prepared in conformity with GAAP, or as measures of profitability or liquidity. In addition the calculation of Adjusted EBITDA is susceptible to varying interpretations and calculation, and the amounts presented may not be comparable to similarly titled measures of other companies. Adjusted EBITDA may not be indicative of historical operating results, and we do not mean for it to be predictive of future results of operations or cash flows. The following table contains a reconciliation of Adjusted EBITDA to net income attributable to DaVita Inc.:

	Pro forma year ended December 31, 2011	Pro forma six months ended June 30, 2012	Pro forma twelve months ended June 30, 2012	Pro forma Guarantors twelve months ended June 30, 2012[d]
	(dollars in millions)			
Net income attributable to DaVita Inc.[a]	$ 582	$ 316	$ 662	$ 633
Debt expense[b]	434	212	430	407
Income taxes	390	220	444	382
Depreciation and amortization	425	234	453	255
Stock compensation expense	56	28	57	57
Goodwill impairment	24			
Noncontrolling interests and equity income, net	95	49	104	
Other items[c]	57	(7)	17	10
Adjusted EBITDA	$ 2,063	$ 1,052	$ 2,167	$ 1,744

(a) Net income attributable to DaVita Inc. for the six and twelve months ended June 30, 2012, includes an after-tax legal proceeding contingency accrual and related expenses of $78.0 million recorded in the second quarter of 2012.

(b) Debt expense includes interest expense, amortization of deferred financing costs and the amortization of debt discount.

(c) Represents pro forma acquisition EBITDA, non-cash gains or losses, other valuation adjustments and interest income.

(d) Pro forma amounts for DaVita, excluding HCP s affiliated physician groups and DaVita s existing non-guarantor subsidiaries, giving effect to the Merger and the Financings as if they had occurred on July 1, 2011.

(4) Net debt is defined as total debt, plus outstanding letters of credit, excluding debt discounts, or premiums and less cash and cash equivalents.

Table of Contents

DaVita Summary Historical Financial and Operating Data

The following summary historical financial information was derived from DaVita s audited historical financial statements for the years ended December 31, 2009, 2010, and 2011 and unaudited financial information for the six months ended June 30, 2011 and 2012 and the trailing twelve months ended June 30, 2012, incorporated by reference in this prospectus. Effective January 1, 2012, DaVita adopted FASB s ASU No 2011-07 *Health Care Entities Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts*. Upon adoption of this standard, DaVita was required to change the presentation of its provision for uncollectible accounts related to patient service revenue as a deduction from patient service operating revenues. These consolidated financial results have been revised for all prior periods presented to reflect the retrospective application of adopting these new presentation and disclosure requirements for the provision for uncollectible accounts. You should read the information set forth below in conjunction with DaVita s historical consolidated financial statements and related notes, incorporated herein by reference, and DaVita Selected Historical Financial and Other Data and Unaudited Pro Forma Condensed Consolidated Financial Information included in this prospectus beginning on pages S-88 and S-79, respectively.

	Year ended December 31,			Six months ended June 30,		Twelve months ended June 30,
	2009	2010 (audited)	2011	2011	2012 (unaudited)	2012
	(dollars in millions)					
Statement of operations data:						
Net dialysis patient service revenues, less provision for uncollectible accounts	$ 5,601	$ 5,877	$ 6,273	$ 2,992	$ 3,465	$ 6,745
Other revenue	343	395	519	232	332	620
Net operating revenues	5,944	6,272	6,792	3,224	3,797	7,365
Operating expenses and charges:						
Patient care costs	4,242	4,467	4,681	2,277	2,575	4,979
General and administrative	531	579	691	315	422	798
Depreciation and amortization	228	234	267	126	154	294
Provision for uncollectible accounts	5	4	7	3	4	8
Goodwill impairment charge[1]			24	24		
Legal proceeding contingency accrual and related expenses[2]					78	78
Equity investment income	(2)	(9)	(9)	(4)	(5)	(10)
Total operating expenses and charges	5,004	5,275	5,661	2,742	3,228	6,147
Operating income	940	997	1,131	482	569	1,218
Debt expense	(186)	(182)	(241)	(118)	(122)	(245)
Refinancing and debt redemption charges[3]		(74)				
Other income	4	3	3	1	2	3
Income from continuing operations before income taxes	758	744	893	365	449	976
Income tax expense	278	260	316	130	164	349
Income from continuing operations	480	484	577	235	285	627
Discontinued operations[4]			(4)	1		(4)
Net income	480	484	573	236	285	623
Less: Net income attributable to noncontrolling interests	(57)	(78)	(95)	(41)	(49)	(104)
Net income attributable to DaVita Inc.	$ 423	$ 406	$ 478	$ 195	$ 236	$ 519

Table of Contents

	2009	Year ended December 31, 2010 (audited)	2011	Six months ended June 30, 2011	2012 (unaudited)	Twelve months ended June 30, 2012
			(dollars in millions)			
Balance sheet data (at end of period):						
Cash and cash equivalents	$ 539	$ 860	$ 394	$ 730	$ 273	
Working capital	1,256	1,699	1,128	1,478	943	
Total assets	7,558	8,114	8,892	8,193	9,255	
Total debt	3,632	4,309	4,505	4,286	4,498	
Total shareholders equity[5]	2,135	1,978	2,141	1,881	2,379	
Other financial data:						
Adjusted EBITDA[6]	$ 1,225	$ 1,288	$ 1,534	$ 660	$ 740	$ 1,585
Net cash provided by operating activities	667	840	1,180	534	534	1,180
Net debt[7]	3,142	3,503	4,171	3,610	4,281	4,281
Ratio of net debt to Adjusted EBITDA[6][7]	2.56x	2.72x	2.72x			2.70x
Operating data:						
Maintenance capital expenditures[8]	114	159	224	88	122	259
Centers	1,530	1,612	1,820	1,669	1,903	1,903
Patients	118,000	125,000	143,000	131,000	150,000	150,000
U.S. Dialysis treatments	16,985,000	17,964,000	19,599,000	9,364,000	10,766,000	21,001,000

(1) Operating expenses and charges in 2011 include $24 million of a non-cash goodwill impairment charge related to our infusion therapy business.

(2) Represents a legal proceeding contingency accrual and related expenses that resulted from an agreement we reached in principle to settle the Woodard Private Civil Suit. See DaVita s Business Legal Proceedings beginning on page S-169.

(3) In 2010, we incurred $74 million of refinancing and debt redemption charges in conjunction with the extinguishment of our prior senior secured credit facilities and the redemption of $200 million of our previously outstanding 6 $^{5}/_{8}$% senior notes.

(4) During 2011, we divested a total of 28 outpatient dialysis centers in conjunction with a consent order issued by the Federal Trade Commission on September 30, 2011 in order for us to complete the acquisition of DSI. In addition, we also completed the sale of two additional centers that were previously pending state regulatory approval in conjunction with the acquisition of DSI on October 31, 2011. The operating results of the historical DaVita divested centers are reflected as discontinued operations in our consolidated financial statements for all periods presented. In addition, the operating results for the DSI divested centers are reflected as discontinued operation in our consolidated financial statements beginning September 1, 2011.

(5) Share repurchases consisted of 3,794,686 shares of DaVita common stock for $323 million in 2011, 8,918,760 shares of DaVita common stock for $618 million in 2010, 2,902,619 shares of DaVita common stock for $153 million in 2009, and 3,710,086 shares of DaVita common stock for $316 million in the first six months of 2011. Shares issued in connection with stock awards amounted to 1,260,259 in 2011, 1,771,384 in 2010 and 2,104,304 in 2009.

Table of Contents

(6) We present Adjusted EBITDA because it is one of the components used in the calculations of the leverage ratio that is included in the covenants contained in our existing senior secured credit agreement, and we expect similar covenants to be included in our amended senior secured credit agreement; however, the terms of the amended senior secured credit agreement have not yet been finalized. Adjusted EBITDA is defined as net income attributable to DaVita Inc. before income taxes, debt expense, depreciation and amortization, noncontrolling interests, and equity investment income, net, and we further adjust for non-cash charges, stock-based compensation, pro forma amounts for acquisitions and assets sales as if they had been consummated on the first day of each period, and non-cash gains and credits. Management uses Adjusted EBITDA and similar calculations as measures to assess operating and financial performance including compliance with the financial covenants contained in our indentures and our senior secured credit agreement. Adjusted EBITDA is not a measure of financial performance computed in accordance with GAAP and should not be considered in isolation or as a substitute for operating income, net income, cash flows from operations, or other statement of operations or cash flow data prepared in conformity with GAAP, or as measures of profitability or liquidity. In addition the calculation of Adjusted EBITDA is susceptible to varying interpretations and calculation, and the amounts presented may not be comparable to similarly titled measures of other companies. Adjusted EBITDA may not be indicative of historical operating results, and we do not intend for it to be predictive of future results of operations or cash flows. Adjusted EBITDA reconciled to net income attributable to DaVita is as follows:

	Year ended December 31,			Six months ended June 30,		Twelve months ended June 30,
	2009	2010	2011	2011	2012	2012
	(dollars in millions)					
Net income attributable to DaVita Inc[a].	$ 423	$ 406	$ 478	$ 195	$ 236	$ 519
Income tax expense	278	260	316	130	164	349
Debt expense[b]	186	182	241	118	122	245
Depreciation and amortization	228	234	267	126	154	294
Noncontrolling interests and equity investment income, net	55	75	95	41	49	104
Non-cash charges[c]	53	62	56	30	25	55
Non-cash goodwill impairment charge			24	24		
Debt refinancing and redemption charges		74				
Pro forma amounts for acquisitions and assets sales	9	22	89	18	22	62
Non-cash gains and credits	(7)	(27)	(32)	(22)	(32)	(43)
Adjusted EBITDA	$ 1,225	$ 1,288	$ 1,534	$ 660	$ 740	$ 1,585

(a) Net income for the quarter and twelve months ended June 30, 2012, includes an after-tax legal proceeding contingency accrual and related expenses of $78.0 million recorded in the second quarter of 2012.
(b) Debt expense is defined as interest expense plus the amortization of deferred financing costs and amortization of debt discounts or premiums.
(c) Includes stock-based compensation expense, impairments and valuation adjustments and other non-cash charges and losses.

(7) Net debt is defined as total debt, plus outstanding letters of credit, excluding debt discounts, or premiums and less cash and cash equivalents.

(8) Maintenance capital expenditures represent routine capital expenditures to maintain the current operations of the business and include such expenditures for system development, information technology equipment, and dialysis machines.

We have presented free cash flow in this prospectus supplement. Free cash flow represents net cash provided by operating activities less income distributions to noncontrolling interests and capital expenditures for routine maintenance and information technology. We believe free cash flow is a useful adjunct to cash flow from operating activities and other measurements under GAAP, since free cash flow is a meaningful measure of our ability to fund acquisition and development activities and meet our debt service requirements. In addition, free cash flow excluding income distributions to noncontrolling interests provides an investor with an understanding of free cash flows that are attributable to DaVita Inc. Free cash flow is not a measure of financial performance under GAAP and should not be considered as an alternative to cash flows from operating, investing or financing activities, as an indicator of cash flows or as a measure of liquidity.

	Twelve months ended	
	June 30, 2012	June 30, 2009
	(dollars in millions)	
Cash provided by operating activities	$ 1,180	$ 705
Less: Income distributions to noncontrolling interests	(105)	(58)

Cash provided by operating activities attributable to DaVita Inc.	1,075	647
Less: Expenditures for routine maintenance and information technology	(258)	(120)
Free cash flow	$ 817	$ 527

Table of Contents

HCP Summary Historical Financial and Operating Data

The following summary historical financial information was derived from HCP s audited historical financial statements for the years ended December 31, 2009, 2010, and 2011, unaudited financial information for the six months ended June 30, 2011 and 2012, and the unaudited financial information for the twelve months ended June 30, 2012. The unaudited pro forma financial information gives effect to the Financing and the Merger as if it had occurred on that date. You should read the information set forth below in conjunction with HCP s historical financial statements and related notes thereto included in this prospectus and the discussion under Management s Discussion and Analysis of Financial Condition and Results of Operations included in this prospectus beginning on page S-91. The combined statement of operations and balance sheet data presented below are derived from the consolidated financial statements of HCP.

	Year ended December 31,			Six months ended June 30,		Twelve Months ended June 30,
	2009	2010 (audited)	2011	2011	2012 (unaudited)	2012
	(dollars in millions, except operating data)					
Statement of operations data:						
Medical revenues	$ 1,731	$ 2,049	$ 2,375	$ 1,158	$ 1,294	$ 2,511
Other operating revenues	46	40	47	22	28	53
Total operating revenues	1,777	2,089	2,422	1,180	1,322	2,564
Operating expenses and charges:						
Medical expenses	930	1,034	1,165	569	620	1,216
Hospital expenses	212	222	248	121	155	282
Clinic support and other operating costs	226	263	308	148	165	325
General and administrative expenses	136	178	207	101	110	216
Depreciation and amortization	26	29	31	16	16	31
Total operating expenses	1,530	1,726	1,959	955	1,066	2,070
Equity earnings of unconsolidated joint ventures	12	15	25	9	12	28
Operating income	259	378	488	234	268	522
Interest income	6	6	7	3	4	8
Interest expense	(6)	(5)	(16)	(9)	(6)	(13)
Gain on sale of investments	2		1	1		
Total other income (expense)	2	1	(8)	(5)	(2)	(5)
Income before income taxes	261	379	480	229	266	517
Provision for income taxes	41	49	71	37	33	67
Net income	$ 220	$ 330	$ 409	$ 192	$ 233	$ 450
Balance sheet data (end of period):						
Cash and cash equivalents	358	361	395	183	355	
Working capital.	179	360	304	192	341	
Total assets.	911	1,286	1,366	1,188	1,415	
Total debt	220	218	556	571	542	
Member s equity.	340	566	188	29	248	
Other financial data:						
Total care dollars under management[1]	2,388	2,792	3,212	1,582	1,752	3,382
Adjusted EBITDA[2]	293	414	527	255	288	561
Capital expenditures	12	21	23	11	10	22
Net cash provided by operating activities	286	343	509	181	184	512
Operating data:						
Managed care members	589,900	658,000	667,700	659,200	669,400	

Medical clinic locations	99	129	152	138	157	
Full time physicians	570	715	794	734	818	
IPA Primary care physicians	1,268	1,291	1,458	1,414	1,454	
Ratio of operating income to total care dollars under management	10.8%	13.5%	15.2%	14.8%	15.3%	15.4%

Table of Contents

(1) In California, as a result of its managed care administrative services agreement with hospitals, HCP does not assume the direct financial risk for institutional (hospital) services, but is responsible for managing the care dollars associated with both the professional (physician) and institutional services being provided for the PMPM fee attributable to both professional and institutional services. In those cases, HCP recognizes the surplus of institutional revenue less institutional expense as HCP revenue. In addition to revenues recognized for financial reporting purposes, HCP measures its total care dollars under management, which includes the PMPM fee payable to third parties for institutional (hospital) services where HCP manages the care provided to its members by the hospitals and other institutions, which are not included in GAAP revenues. HCP uses total care dollars under management as a supplement to GAAP revenues as it allows HCP to measure profit margins on a comparable basis across both the global capitation model (where HCP assumes the full financial risk for all services, including institutional services) and the risk sharing models (where HCP operates under managed care administrative services agreements where HCP does not assume the full risk). HCP believes that presenting amounts in this manner is useful because it presents its operations on a unified basis without the complication caused by models that HCP has adopted in its California market as a result of various regulations related to the assumption of institutional risk. Total care dollars under management is not a measure of financial performance computed in accordance with GAAP and should not be considered in isolation or as a substitute for revenues calculated in accordance with GAAP. Total care dollars under management includes PMPM payments to third parties that are not recorded in HCP s accounting records and have not been reviewed and are not otherwise subject to procedures by HCP s independent auditors. The following table reconciles Total Care Dollars Under Management to medical revenues for the periods indicated. Total Care Dollars Under Management is a non-GAAP measure.

	Year ended December 31,			Six months ended June 30,		Twelve months ended June 30,
	2009	2010	2011	2011	2012	2012
	(in millions)					
Medical revenues	$ 1,731	$ 2,049	$ 2,375	$ 1,158	$ 1,294	$ 2,511
Less: Risk share revenue, net	(30)	(87)	(127)	(52)	(61)	(136)
Add: Institutional capitation amounts	687	831	964	476	519	1,007
Total care dollars under management	$ 2,388	$ 2,793	$ 3,212	$ 1,582	$ 1,752	$ 3,382

(2) HCP uses Adjusted EBITDA and similar calculations as measures to assess operating and financial performance, including compliance with the financial covenants contained in its senior secured credit agreement. Adjusted EBITDA is defined as net income attributable to HCP before income taxes, net debt expense, depreciation and amortization, stock-based compensation, and any impairment charges. Adjusted EBITDA is not a measure of financial performance computed in accordance with GAAP and should not be considered in isolation or as a substitute for operating income, net income, cash flows from operations, or other statement of operations or cash flow data prepared in conformity with GAAP, or as measures of profitability or liquidity. In addition, the calculation of Adjusted EBITDA is susceptible to varying interpretations and calculation, and the amounts presented may not be comparable to similarly titled measures of other companies. Adjusted EBITDA may not be indicative of historical operating results, and HCP does not mean for it to be predictive of future results of operations or cash flows. Adjusted EBITDA reconciled to net income to HCP is as follows:

	Year ended December 31,			Six months ended June 30,		Twelve months ended June 30,	Guarantors Twelve months ended June 30,[a]
	2009	2010	2011	2011	2012	2012	2012
	(dollars in millions)						
Net income	$ 220	$ 330	$ 409	$ 192	$ 233	$ 450	$ 451
Income tax expense	41	49	71	37	33	67	64
Debt expense	6	5	16	9	6	13	13
Depreciation and amortization	26	29	31	16	16	31	28
Stock-based compensation	6	7	7	4	4	8	8
Interest income	(6)	(6)	(7)	(3)	(4)	(8)	(7)
Adjusted EBITDA	$ 293	$ 414	$ 527	$ 255	$ 288	$ 561	$ 557

(a) This information consists of combined amounts for HCP, excluding HCP s affiliated physician groups, but inclusive of management fee revenue therefrom.

Table of Contents

RISK FACTORS

Any investment in the notes involves a high degree of risk. You should carefully consider the risks described below together with all the other information contained in, or incorporated by reference into, this prospectus supplement and the accompanying prospectus, before making a decision to invest in the notes. Some of these factors relate principally to our business. The risks and uncertainties described below are not the only ones facing us. Additional risks and uncertainties not presently known to us or that we currently deem immaterial may also have a material adverse effect on our business and operations.

If any of the matters included in the following risks were to occur, our business, financial condition, results of operations, cash flows or prospects could be materially adversely affected. In such case, you may lose all or part of your original investment.

Risks Relating to Our Business

If the average rates that commercial payors pay us decline significantly, it would have a material adverse effect on our revenues, earnings and cash flows.

Approximately 34% of our dialysis and related lab services revenues for the six months ended June 30, 2012 were generated from patients who have commercial payors as the primary payor. The majority of these patients have insurance policies that pay us on terms and at rates that are generally significantly higher than Medicare rates. The payments we receive from commercial payors generate nearly all of our profit and all of our nonacute dialysis profits come from commercial payors. We continue to experience downward pressure on some of our commercial payment rates and it is possible that commercial payment rates could be materially lower in the future. The downward pressure on commercial payment rates is a result of general conditions in the market, recent and future consolidations among commercial payors, increased focus on dialysis services and other factors.

We are continuously in the process of negotiating our existing or potentially new agreements with commercial payors who tend to be aggressive in their negotiations with us. Sometimes many significant agreements are up for renewal or being renegotiated at the same time. In the event that our continual negotiations result in overall commercial rate reductions in excess of overall commercial rate increases, the cumulative effect could have a material adverse effect on our financial results. Consolidations have significantly increased the negotiating leverage of commercial payors. Our negotiations with payors are also influenced by competitive pressures. Some of our contracted rates with commercial payors may decrease or we may experience decreases in patient volume as our negotiations with commercial payors continue. In addition to downward pressure on contracted commercial payor rates, payors have been attempting to impose restrictions and limitations on non-contracted or out-of-network providers. In some circumstances for some commercial payors, our centers are designated as out-of-network providers. Rates for out-of-network providers are on average higher than rates for in-network providers. We believe commercial payors have or will begin to restructure their benefits to create disincentives for patients to select or remain with out-of-network providers and to decrease payment rates for out-of-network providers. Decreases in out-of-network rates and restrictions on out-of-network access, our turning away new patients in instances where we are unable to come to agreement on rates, or decreases in contracted rates could result in a significant decrease in our overall revenues derived from commercial payors. If the average rates that commercial payors pay us decline significantly, or if we see a decline in commercial patients, it would have a material adverse effect on our revenues, earnings and cash flows.

If the number of patients with higher-paying commercial insurance declines, then our revenues, earnings and cash flows would be substantially reduced.

Our revenue levels are sensitive to the percentage of our patients with higher-paying commercial insurance coverage. A patient s insurance coverage may change for a number of reasons, including changes in the patient s or a family member s employment status. Currently, for a patient covered by an employer group health plan,

Table of Contents

Medicare generally becomes the primary payor after 33 months, 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 employer group health plan rate to the lower Medicare payment rate. We have seen an increase in the number of patients who have government-based programs as their primary payors which we believe is largely a result of improved mortality and recent economic conditions which have a negative impact on the percentage of patients covered under commercial insurance plans. To the extent there are sustained or increased job losses in the U.S., independent of whether general economic conditions might be improving, we could experience a continued decrease in the number of patients covered under commercial plans. We could also experience a further decrease if changes to the healthcare regulatory system result in fewer patients covered under commercial plans or an increase of patients covered under more restrictive commercial plans with lower reimbursement rates. In addition, our continuous process of negotiations with commercial payors under existing or potentially new agreements could result in a decrease in the number of patients under commercial plans to the extent that we cannot reach agreement with commercial payors on rates and other terms, resulting in termination or non-renewals of existing agreements or our inability to enter into new ones. If there is a significant reduction in the number of patients under higher-paying commercial plans relative to government-based programs that pay at lower rates, it would have a material adverse effect on our revenues, earnings and cash flows.

Changes in the structure of, and payment rates under the Medicare ESRD program, including the Budget Control Act of 2011 and other healthcare reform initiatives, could substantially reduce our revenues, earnings and cash flows.

Approximately 49% of our dialysis and related lab services revenues for the six months ended June 30, 2012 was generated from patients who have Medicare as their primary payor. Prior to January 1, 2011, the Medicare ESRD program paid us for dialysis treatment services at a fixed composite rate. The Medicare composite rate was the payment rate for a dialysis treatment including the supplies used in those treatments, specified laboratory tests and certain pharmaceuticals. Certain other pharmaceuticals, including EPO, vitamin D analogs and iron supplements, as well as certain specialized laboratory tests, were separately billed.

In July 2008, the Medicare Improvements for Patients and Providers Act of 2008 was passed by Congress. This legislation introduced a new payment system for dialysis services beginning in January 2011 whereby payment for dialysis treatment and related services is now made under a bundled payment rate which 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, as well as laboratory testing. In August 2010, CMS published the final rule implementing the bundled payment in the Federal Register. The initial 2011 bundled rate included reductions of 2% from the prior reimbursement and further reduced overall rates by 5.94% tied to an expanded list of case-mix adjustors which can be earned back based upon the presence of 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.

Another important provision in the law is an annual adjustment, or market basket update, to the base ESRD Prospective Payment Rate, or PPS. Absent action by Congress the PPS base rate will be automatically updated by a formulaic inflation adjustment.

On November 1, 2011, CMS issued the final ESRD PPS rule for 2012, which increased the base rate by 2.1%, representing a market base of increase of 3.0% less a productivity adjustment of 0.9%. The increase in the final base rate for 2012 (2.1%) is slightly greater than the increase of 1.8% stated in the proposed 2012 ESRD PPS rule published in July 2011, and was made irrespective of the Medicare Payment Advisory Commission, or MedPAC, recommendation for a reduced increase. The MedPAC focus on such a reduction indicates further scrutiny of the annual update is possible.

On July 11, 2012, CMS issued the proposed ESRD PPS rule for 2013. As currently proposed, the base rate will increase by 2.5%, resulting from a market basket increase of 3.2% less a productivity adjustment of 0.7%.

Table of Contents

This increase in the ESRD PPS base rate will be further reduced by the Budget Control Act of 2011 sequestration, discussed below. The proposed rule implements the reduction in bad debt payments to dialysis facilities (as well as to all other providers eligible for bad debt payments) mandated under the Middle Class Tax Relief and Job Creation Act of 2012 and adds new quality reporting measures.

The new payment system presents operating, clinical and financial risks. For example, with regard to the expanded list of case-mix adjustors, there is a risk that our dialysis centers or billing and other systems may not accurately document and track the appropriate patient-specific characteristics, resulting in a reduction or overpayment in the amounts of the payments that we would otherwise be entitled to receive.

Beginning January 1, 2014, certain oral-only ESRD drugs (currently paid separately to pharmacies under Medicare Part D) will be included in the ESRD bundled payment to dialysis facilities. CMS delayed the inclusion of these oral only ESRD drugs until 2014 in order to assess how to reimburse for these oral drugs and services. It is currently unclear how CMS will price the oral-only drugs for inclusion in the ESRD bundle in 2014. Inadequate pricing could have a significant negative financial impact on our dialysis facilities given the volume and value of these drugs.

We expect to continue experiencing increases in operating costs that are subject to inflation, such as labor and supply costs, regardless of whether there is a compensating inflation-based increase in Medicare payment rates or in payments under the new bundled payment rate system.

On August 2, 2011, President Obama signed into law the Budget Control Act of 2011 (Public Law 112-25), which raised the debt ceiling and put into effect a series of actions to reduce the federal budget deficit over ten years. The law created a Joint Congressional Committee charged with producing legislation reducing federal spending by at least $1.2 trillion. As a result of the committee s failure to act, the federal government is facing a $1.2 trillion sequester (across-the-board cuts in discretionary programs). However, Medicare providers face a maximum of no more than a 2% reduction in reimbursements in fiscal year 2013.

We also cannot predict whether we will be able to comply with the CMS rules related to the bundled payment system as processes and systems are modified substantially to capture all required data. To the extent we are not able to adequately bill and collect for certain payment adjustors and are not able to offset the mandated reductions in reimbursement or if we face regulatory enforcement actions and penalties as a result of alleged improper billing of governmental programs, it could have a material adverse effect on our revenues, earnings and cash flows. For additional details regarding the risks we face for failing to adhere to our Medicare and Medicaid regulatory compliance obligations, see the risk factor below under the heading If we fail to adhere to all of the complex government regulations that apply to our business, we could suffer severe consequences that would substantially reduce our revenues, earnings and cash flows .

Health care reform could substantially reduce our revenues, earnings and cash flows.

In March 2010, broad health care reform legislation was enacted in the U.S. Although many of the provisions of the new legislation do not take effect immediately, and may be modified before they are implemented, the reforms could have an impact on our business in a number of ways. We cannot predict how employers, private payors or persons buying insurance might react to these changes or what form many of these regulations will take before implementation. In March 2012, the Department of Health and Human Services, or HHS, issued two final proposed rules related to the establishment of health care insurance exchanges due to be operating by 2014 that will provide a marketplace for eligible individuals to purchase health care insurance. The first relates to the standards and requirements applicable to the exchanges, employers and qualified health plans that are marketed in the exchange. The second rule finalizes the provisions governing the risk adjustment program that includes reinsurance, risk corridors and risk adjustment. The final exchange rules clarify the requirements related to implementation of such exchanges, outline areas of state flexibility in their implementation of such exchanges and provide standards for certain risk adjustment mechanisms. We believe the

establishment of health care insurance exchanges could result in a reduction in patients covered by commercial insurance or an increase of patients covered through the exchanges under more restrictive commercial plans with lower reimbursement rates. To the extent that the implementation of such exchanges results in a reduction in patients covered by commercial insurance or a reduction in reimbursement rates for our services from commercial and/or government payors, our revenues, earnings and cash flows could be adversely affected.

In October 2011, CMS issued a final rule concerning the Medicare Shared Savings Program established by the health care reform legislation, which under the statute was required to be implemented no later than January 1, 2012. The Medicare Shared Savings Program, which is now operational provides financial incentives to health care providers and suppliers that work together to furnish coordinated, high-quality care to Medicare beneficiaries through accountable care organizations, or ACOs.

The CMS Center for Innovation (Innovation Center) is in various stages of development in working with various healthcare providers to implement ACOs and other innovative models of care for Medicare and Medicaid beneficiaries. We are currently uncertain of the extent to which these models of care including ACOs, Bundled Payments for Care Improvement Initiative, the Comprehensive Primary Care Initiative, the Duals Demonstration, or other models, will impact the health care market. As a provider of dialysis services, we may choose to participate in one or several of these models either as a partner with other providers or independently. We are currently seeking a renal specific coordinated care pilot with the Innovation Center. Even if we do not participate in these programs, some of our patients may be assigned to a pilot, in which case the quality and cost of care that we furnish will be included in an ACO s or other program s calculations regardless of our participation in the program. As new models of care emerge, we may be at risk for losing our Medicare patient base, which would have a materially adverse effect on our revenues, earnings and cash flow. Furthermore, further initiatives in the government or private sector may arise, including the development of models similar to ACOs, independent practice associations and integrated delivery systems or evolutions of those concepts which could adversely impact our business.

In addition, the Health Reform Acts introduced severe penalties for the knowing and improper retention of overpayments collected from government payors. As a result, we made initial significant investments in additional resources to accelerate the time it takes to identify and process overpayments and we may be required to make additional investments in the future. Acceleration in our ability to identify and process overpayments could result in us refunding overpayments to government or other payors sooner than we have in the past, which could have a material adverse effect on our operating cash flows. The failure to return identified overpayments within the specified time frame is now a violation of the federal False Claims Act, or FCA.

The Health Reform Acts also reduced the timeline to file Medicare claims, which now must be filed with the government within one calendar year after the date of service. To comply with this reduced timeline, we must deploy significant resources and may change our claims processing methods to ensure that our Medicare claims are filed in a timely fashion. Failure to file a claim within the one year window could result in payment denials, adversely affecting our revenues, earnings and cash flows.

Effective March 2011, CMS instituted new screening procedures and a new $500 enrollment fee for providers enrolling and re-enrolling in government health care programs. A provider is subject to screening upon initial enrollment and each time the provider re-validates its enrollment application. Screening includes verification of enrollment information and review of various federal databases to ensure the provider has valid tax identification NPI numbers and is not excluded from participation in federal and state healthcare programs. We expect this screening process to delay the Medicare contractor approval process, potentially causing a delay in reimbursement. The enrollment fee is also applicable upon initial enrollment, re-validation, and each time an existing provider adds a new facility location. This fee is an additional expense that must be paid for each center every three years and could be more significant if other government and commercial payors follow this trend. Ultimately, we anticipate the new screening and enrollment requirements will require additional personnel and financial resources and will potentially delay the enrollment and revalidation of our centers which in turn will delay payment.

Table of Contents

Other reform measures allow CMS to place a moratorium on new enrollment of providers and to suspend payment to providers upon a credible allegation of fraud from any source. These types of reform measures, or others, depending upon the scope and breadth of the implementing regulations, could adversely impact our revenues, earnings and cash flows.

There are numerous steps required to implement the broad healthcare reform legislation adopted by Congress, and Congress may seek to alter or eliminate some of the provisions described above. Numerous legal challenges have also been raised to the healthcare reform legislation that could alter or eliminate certain provisions. The United States Supreme Court reviewed state actions challenging the constitutionality of the health insurance mandate and the Medicaid expansion program. The Court upheld the mandate under Congress taxing power and upheld the Medicaid expansion program. However, the Court found that the federal government cannot withhold all of a state s Medicaid funding for the state s failure or refusal to expand its Medicaid program as contemplated by the reform legislation, effectively leaving the Medicaid expansion decision up to the individual states. Several states have announced they do not intend to expand their Medicaid programs. Further, various health insurance reform proposals are also emerging at the state level. There is a considerable amount of uncertainty as to the prospective implementation of the federal healthcare reform legislation and what similar measures might be enacted at the state level. The enacted reforms as well as future legislative changes could have a material adverse effect on our results of operations, including lowering our reimbursement rates and increasing our expenses. The Healthcare Reform Acts added several new tax provisions that, among other things, impose various fees and excise taxes, and limit compensation deductions for health insurance providers and their affiliates. To date, the IRS has not issued regulations for many of these provisions. In the event that we, or any of our current or future subsidiaries, were to become subject to these rules, our cash flow and tax liabilities could be negatively impacted.

Changes in state Medicaid or other non-Medicare government-based programs or payment rates could reduce our revenues, earnings and cash flows.

Approximately 16% of our dialysis and related lab services revenues for the six months ended June 30, 2012 was generated from patients who have state Medicaid or other non-Medicare government-based programs, such as Medicare-assigned plans or the VA, as their primary coverage. As state governments and governmental organizations face increasing budgetary pressure, we may in turn face reductions in payment rates, delays in the timing of payments, limitations on eligibility or other changes to the applicable programs. For example, some programs, such as certain state Medicaid programs and the VA, have recently considered, proposed or implemented rate reductions.

On December 17, 2010, the Department of Veterans Affairs published a final rule in which it materially changed the payment methodology and ultimately the amount paid for dialysis services furnished to veterans in non-VA centers such as ours. In the final rule, the VA adopted the bundled payment system implemented by Medicare and estimated a reduction of 39% in payments for dialysis services to veterans at non-VA centers. Approximately 2% of our dialysis and related lab services revenues for the six months ended June 30, 2012 was generated by the VA. The new VA payment methodology will have a significant negative impact on our revenues, earnings and cash flows as a result of the reduction in rates or as a result of the decrease in the number of VA patients we serve. We recently executed contractual agreements with the VA and there is some uncertainty as to when this rule will take effect for the patients covered by these contracts. While at this time the contracts remain in force, these agreements provide for the right of the VA to terminate the agreement without cause on short notice. Further, patients who are not covered by the contractual arrangements will likely be reimbursed at Medicare rates beginning with the date of implementation of the rule. If the VA proceeds with payment rate reductions or fails to renew our existing contracts, we might have to cease accepting patients under this program and could even be forced to close centers.

State Medicaid programs are increasingly adopting Medicare-like bundled payment systems, but sometimes these new payment systems are poorly defined and could include all drugs (even those oral-only drugs that

Table of Contents

Medicare will not include in the bundled payment until 2014) and are implemented without any claims processing infrastructure, or patient or facility adjusters. If these new payment systems are implemented without any adjusters and claims processing changes, Medicaid payments will be substantially reduced and the costs to submit such claims may increase. In addition, some state Medicaid program eligibility requirements mandate that citizen enrollees in such programs provide documented proof of citizenship. If our patients cannot meet these proof of citizenship documentation requirements, they may be denied coverage under these programs. These Medicaid payment and enrollment changes, along with similar changes to other non-Medicare government programs could reduce the rates paid by these programs for dialysis and related services, delay the timing of payment for services provided, and further limit eligibility for coverage which could adversely affect our revenues, earnings and cash flows.

Changes in clinical practices, payment rates or regulations impacting EPO and other pharmaceuticals could reduce our revenues, earnings and cash flows.

Historically, Medicare and most Medicaid programs paid for EPO outside of the composite rate. This separate payment has long been the subject of discussions regarding appropriate dosing and payment in an effort to reduce escalating expenditures for EPO. Since January 1, 2011, Medicare has bundled EPO into the prospective payment system such that dosing variations will not change the amount paid to a dialysis facility. Although some Medicaid programs and other payors suggest movement towards a bundled payment system inclusive of EPO, some non-Medicare payors continue to pay for EPO separately from the treatment rate. The administration of EPO and other pharmaceuticals that are separately billable accounted for approximately 5% of our dialysis and related lab services revenues for the six months ended June 30, 2012, with EPO alone accounting for approximately 3% of our dialysis and related lab services revenues for the same period. Changes in physician clinical practices that result in further decreased utilization of prescribed pharmaceuticals or changes in payment rates for those pharmaceuticals could reduce our revenues, earnings and cash flows.

Since late 2006, there has been significant media discussion and government scrutiny regarding anemia management practices in the U.S. which has created confusion and concern in the nephrology community. 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 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 June 2011, the FDA required that the black box warning be slightly revised and also include more conservative dosing recommendations for patients with chronic kidney disease. In addition, in June 2011, CMS opened a National Coverage Analysis, or NCA, for ESAs. Further in January 2011, CMS convened a meeting of the Medicare Evidence Development and Coverage Advisory Committee, or MEDCAC, to evaluate evidence for the pending NCA. In June 2011, CMS determined not to issue a national coverage determination for ESAs due to a lack of available evidence to establish coverage criteria or limitations.

The forgoing 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. 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 of EPO for patients covered by commercial payors or increased utilization of EPO for patients for whom the cost of EPO is included in a bundled reimbursement rate, or further decreases in reimbursement for EPO and other pharmaceuticals that are not included in a bundled reimbursement rate, could have a material adverse effect on our revenues, earnings and cash flows.

Table of Contents

Changes in EPO pricing could materially reduce our earnings and cash flows and affect our ability to care for our patients.

In November 2011, we entered into a seven year Sourcing and Supply Agreement with Amgen USA Inc. Under the agreement we committed to purchase EPO in amounts necessary to meet no less than 90% of our requirements for erythropoiesis stimulating agents. The agreement replaces in its entirety the prior one-year supply agreement between us and Amgen that expired on December 31, 2011. As long as certain conditions are met by us, the agreement limits Amgen s ability to unilaterally decide to increase the price for EPO. Future increases in the cost of EPO without corresponding increases in payment rates for EPO from commercial payors and without corresponding increases in the Medicare bundled rate could have a material adverse effect on our earnings and cash flows and ultimately reduce our income. Our agreement with Amgen for EPO provides for discounted pricing and rebates for EPO. Some of the rebates are subject to various conditions including but not limited to future pricing levels of EPO by Amgen and data submission by us. In addition, the rebates are subject to certain limitations. We cannot predict whether, over the seven year term of the agreement, we will continue to receive the rebates for EPO that we have received in the past, or whether we will continue to achieve the same levels of rebates within that structure as we have historically achieved. In the initial years of the agreement, however, the total rebate opportunity is less than what was provided in the agreement that expired at the end of 2011, however, the opportunity for us to earn discounts and rebates increases over the term of the agreement. Factors that could impact our ability to qualify for rebates provided for in our agreement with Amgen in the future include, but are not limited to, our ability to track certain data elements. We cannot predict whether we will be able to meet the applicable qualification requirements for receiving rebates. Failure to meet certain targets and earn the specified rebates could have a material adverse effect on our earnings and cash flows.

We are the subject of a number of inquiries by the federal government and two private civil suits, any of which could result in substantial penalties or awards against us, imposition of certain obligations on our practices and procedures, exclusion from future participation in the Medicare and Medicaid programs and, in certain cases, criminal penalties.

We are the subject of a number of inquiries by the federal government. We have received subpoenas or other requests for documents from the federal government in connection with the 2005 U.S. Attorney investigation, the Woodard private civil suit, the Vainer private civil suit, the 2010 U.S. Attorney physician relationship investigation, the 2011 U.S. Attorney physician relationship investigation and the 2011 U.S. Attorney Medicaid investigation. Certain current and former members of the Board and executives have been subpoenaed to testify before the grand jury in Colorado, and other Company representatives may also receive subpoenas for testimony related to the 2011 U.S. Attorney physician relationship investigation. After investigation, the government did not intervene and is not actively pursuing either the Woodard or the Vainer private civil suits mentioned above. In each of these private civil suits, a relator has filed a complaint against us in federal court under the *qui tam* provisions of the FCA and is pursuing the claims independently. The parties are engaged in active litigation in the Vainer private civil suit. In the Woodward private civil suit, though we have reached an agreement in principle to settle all allegations relating to claims arising out of this suit, it is still subject to the parties being able to enter into a mutually acceptable settlement agreement and receive the requisite approval of the federal government and the court to fully and finally resolve this matter. We are cooperating with the OIG and those offices of the U.S. Attorney still actively pursuing the matters mentioned above and are producing the requested records. Although we cannot predict whether or when proceedings might be initiated by the federal government, the scope of such proceedings or when these matters may be resolved, it is not unusual for investigations such as these to continue for a considerable period of time through the various phases of document and witness requests and on-going discussions with regulators. Responding to the subpoenas or investigations and defending ourselves in the private civil suits will continue to require management s attention and significant legal expense. Any negative findings could result in substantial financial penalties or awards against us, imposition of certain obligations on our practices and procedures, exclusion from future participation in the Medicare and Medicaid programs and, in certain cases, criminal penalties (see the discussion below under the captions Management s Discussion and Analysis of Financial Condition and Results of Operations

Table of Contents

Operating expenses and charges Legal proceeding contingency accrual and related expenses and Legal Proceedings for additional details regarding these matters). To our knowledge, no proceedings have been initiated by the federal government against us at this time.

Continued inquiries from various governmental bodies with respect to our utilization of EPO and other pharmaceuticals will require management s attention, cause us to incur significant legal expense and could result in substantial financial penalties against us, repayment obligations or exclusion from future participation in the Medicare and Medicaid programs, and could have a material adverse effect on our revenues, earnings and cash flows.

In response to clinical studies which identified risks in certain patient populations related to the utilization of EPO and other ESAs, i.e., Aranesp®, and in response to changes in the labeling of EPO and Aranesp®, there has been substantial media attention and government scrutiny resulting in hearings and legislation regarding pharmaceutical utilization and reimbursement. Although we believe our anemia management practices and other pharmaceutical administration practices have been compliant with existing laws and regulations, as a result of the current high level of scrutiny and controversy, we may be subject to increased inquiries from a variety of governmental bodies and claims by third parties. Additional inquiries from or audits by various agencies and claims by third parties with respect to these issues would continue to require management s attention and significant legal expense and any negative findings could result in substantial financial penalties or repayments, imposition of certain obligations on our practices and procedures and the attendant financial burden on us to comply, or exclusion from future participation in the Medicare and Medicaid programs, and could have a material adverse effect on our revenues, earnings and cash flows.

If we fail to adhere to all of the complex government regulations that apply to our business, we could suffer severe consequences that would substantially reduce our revenues, earnings, cash flows and stock price.

Our dialysis operations are subject to extensive federal, state and local government regulations, including Medicare and Medicaid payment rules and regulations, federal and state anti-kickback laws, the Stark Law physician self-referral prohibition and analogous state referral statutes, Federal Acquisition Regulations, the FCA and federal and state laws regarding the collection, use and disclosure of patient health information and the storage, handling and administration of pharmaceuticals. The Medicare and Medicaid reimbursement rules related to claims submission, enrollment and licensing requirements, cost reporting, and payment processes impose complex and extensive requirements upon dialysis providers. A violation or departure from any of these requirements may result in government audits, lower reimbursements, significant fines and penalties, the potential loss of certification and recoupments or voluntary repayments.

The regulatory scrutiny of healthcare providers, including dialysis providers continues to increase. For example, CMS has indicated that after implementation of the Medicare bundled payment system, it will monitor the use of EPO and other pharmaceuticals. In addition, Medicare has increased the frequency and intensity of its certification inspections of dialysis centers. For example, we are required to provide substantial documentation related to the administration of pharmaceuticals, including EPO, and, to the extent that any such documentation is found insufficient, we may be required to refund to government or commercial payors any amounts received for such administration, and be subject to substantial penalties under applicable laws or regulations. In addition, Medicare contractors have increased their prepayment and post-payment reviews.

We endeavor to comply with all of the requirements for receiving Medicare and Medicaid payments, to structure all of our relationships with referring physicians to comply with state and federal anti-kickback laws and physician self-referral law (Stark Law), and for storing, handling and administering pharmaceuticals. However, the laws and regulations in these areas are complex, require considerable resources to monitor and implement and are subject to varying interpretations. For example, if an enforcement agency were to challenge the level of compensation that we pay our medical directors or the number of medical directors whom we engage, we could be required to change our practices, face criminal or civil penalties, pay substantial fines or otherwise

Table of Contents

experience a material adverse effect as a result of a challenge to these arrangements. In addition, amendments to the FCA impose severe penalties for the knowing and improper retention of overpayments collected from government payors. These amendments could subject our procedures for identifying and processing overpayments to greater scrutiny. We have made significant investments in additional resources to decrease the time it takes to identify and process overpayments and we may be required to make additional investments in the future. An acceleration in our ability to identify and process overpayments could result in us refunding overpayments to government or other payors sooner than we have in the past. A significant acceleration of these refunds could have a material adverse affect on our operating cash flows. Additionally, amendments to the federal anti-kickback statute in the health reform law make anti-kickback violations subject to FCA prosecution, including *qui tam* or whistleblower suits.

If any of our operations are found to violate these or other government regulations, we could suffer severe consequences that would have a material adverse effect on our revenues, earnings, cash flows and stock price, including:

- Suspension or termination of our participation in government payment programs;
- Refunds of amounts received in violation of law or applicable payment program requirements;
- Loss of required government certifications or exclusion from government payment programs;
- Loss of licenses required to operate health care facilities or administer pharmaceuticals in some of the states in which we operate;
- Reductions in payment rates or coverage for dialysis and ancillary services and related pharmaceuticals;
- Fines, damages or monetary penalties for anti-kickback law violations, Stark Law violations, FCA violations, civil or criminal liability based on violations of law, or other failures to meet regulatory requirements;
- Enforcement actions by governmental agencies and/or claims for monetary damages by patients who believe protected health information has been used or disclosed in violation of federal or state patient privacy laws, including the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA);
- Mandated changes to our practices or procedures that significantly increase operating expenses;
- Imposition of and compliance with Corporate Integrity Agreements that could subject us to ongoing audits, reporting, increased scrutiny of our billing and business practices and potential additional fines;
- Termination of relationships with medical directors; and
- Harm to our reputation, which could impact our business relationships, ability to obtain financing and access to new opportunities.

Delays in state Medicare and Medicaid certification of our dialysis centers could adversely affect our revenues, earnings and cash flows.

Before we can begin billing for patients treated in our outpatient dialysis centers who are enrolled in government-based programs, we are required to obtain state and federal certification for participation in the Medicare and Medicaid programs. As state agencies responsible for

surveying dialysis centers on behalf of the state and Medicare program face increasing budgetary pressure, certain states are having difficulty keeping up with certifying dialysis centers in the normal course resulting in significant delays in certification. If state governments continue to have difficulty keeping up with certifying new centers in the normal course and we continue to experience significant delays in our ability to treat and bill for services provided to patients covered under government programs, it could cause us to incur write-offs of investments or accelerate the recognition of

lease obligations in the event we have to close centers or our centers operating performance deteriorates, and it could have an adverse effect on our revenues, earnings and cash flows.

If our joint ventures were found to violate the law, we could suffer severe consequences that would have a material adverse effect on our revenues, earnings and cash flows.

As of June 30, 2012, we owned a controlling interest in numerous dialysis-related joint ventures, which represented approximately 19% of our dialysis and related lab services revenues for the six months ended June 30, 2012. In addition, we also owned minority equity investments in several other dialysis related joint ventures. We anticipate that we will continue to increase the number of our joint ventures. Many of our joint ventures with physicians or physician groups also have the physician owners providing medical director services to those centers or other centers we own and operate. Because our relationships with physicians are governed by the federal anti-kickback statute, we have sought to structure our joint venture arrangements to satisfy as many safe harbor requirements as we believe are reasonably possible. However, our joint venture arrangements do not satisfy all elements of any safe harbor under the federal anti-kickback statute (and possibly the Stark Law). The subpoena and related requests for documents we received from the U.S. Attorney s Office for the Eastern District of Missouri in the 2005 U.S. Attorney investigation, the OIG s Office in Dallas in the 2010 U.S. Attorney physician relationship investigation and the U.S. Attorney s Office for the District of Colorado in the 2011 U.S. Attorney physician relationship investigation, included requests for documents related to our joint ventures. We were advised by the U.S. Department of Justice that it is conducting civil and grand jury investigations into our financial relationships with physicians.

If our joint ventures are found to be in violation of the anti-kickback statute or the Stark Law provisions, we could be required to restructure the joint ventures or refuse to accept referrals for designated health services from the physicians with whom the joint venture centers have a financial relationship.

We also could be required to repay amounts received by the joint ventures from Medicare and certain other payors to the extent that these arrangements are found to give rise to prohibited referrals, and we could be subject to monetary penalties, exclusion from government healthcare programs and, if criminal proceedings are brought against us, criminal penalties. If our joint venture centers are subject to any of these penalties, we could suffer severe consequences that would have a material adverse effect on our revenues, earnings and cash flows.

There are significant estimating risks associated with the amount of dialysis revenues and related refund liabilities that we recognize and if we are unable to accurately estimate our revenues and related refund liabilities, it could impact the timing and the amount of our revenues recognition or have a significant impact on our operating results.

There are significant estimating risks associated with the amount of dialysis and related lab services revenues and related refund liabilities that we recognize in a reporting period. The billing and collection process is complex due to ongoing insurance coverage changes, geographic coverage differences, differing interpretations of contract coverage, and other payor issues. Determining applicable primary and secondary coverage for approximately 149,000 U.S. patients at any point in time, together with the changes in patient coverage that occur each month, requires complex, resource-intensive processes. Errors in determining the correct coordination of benefits may result in refunds to payors. Revenues associated with Medicare and Medicaid programs are also subject to estimating risk related to the amounts not paid by the primary government payor that will ultimately be collectible from other government programs paying secondary coverage, the patient s commercial health plan secondary coverage or the patient. Collections, refunds and payor retractions typically continue to occur for up to three years and longer after services are provided. We generally expect our range of dialysis and related lab services revenues estimating risk to be within 1% of revenues for the segment, which can represent as much as 6% of consolidated operating income. If our estimates of dialysis and related lab services revenues and related refund liabilities are materially inaccurate, it could impact the timing and the amount of our revenues recognition and have a significant impact on our operating results.

Table of Contents

The ancillary services we provide or the strategic initiatives, including our international dialysis operations, that we invest in now or in the future may generate losses and may ultimately be unsuccessful. In the event that one or more of these activities is unsuccessful, we may have to write off our investment and incur other exit costs.

Our ancillary services and strategic initiatives currently include pharmacy services, infusion therapy services, disease management services, vascular access services, ESRD clinical research programs, physician services and our international dialysis operations. We expect to add additional service offerings and pursue additional strategic initiatives in the future as circumstances warrant, which could include healthcare services not related to dialysis. Many of these initiatives require or would require investments of both management and financial resources and can generate significant losses for a substantial period of time and may not become profitable. There can be no assurance that any such strategic initiative will ultimately be successful. Any significant change in market conditions, or business performance, or in the political, legislative or regulatory environment, may impact the economic viability of any of these strategic initiatives. For example, during 2011 and 2010, several of our strategic initiatives generated net operating losses and some are expected to generate net operating losses in 2012. If any of our ancillary services or strategic initiatives, including our international dialysis operations, do not perform as planned, we may incur a material write-off or an impairment of our investment, including goodwill, in one or more of these activities or we could incur significant termination costs if we were to exit a certain line of business. As an example, during the second quarter of 2011 we recorded a goodwill impairment charge of $24 million related to a decrease in the implied fair value of goodwill below its carrying amount associated with our infusion therapy business.

If a significant number of physicians were to cease referring patients to our dialysis centers, whether due to regulatory or other reasons, it would have a material adverse effect on our revenues, earnings and cash flows.

We believe that physicians prefer to have their patients treated at dialysis centers where they or other members of their practice supervise the overall care provided as medical director of the center. As a result, the primary referral source for most of our centers is often the physician or physician group providing medical director services to the center. Neither our current nor former medical directors have an obligation to refer their patients to our centers. If a medical director agreement terminates, whether before or at the end of its term, and a new medical director is appointed, it may negatively impact the former medical director s decision to treat his or her patients at our center. If we are unable to enforce noncompetition provisions contained in the terminated medical director agreements, former medical directors may choose to provide medical director services for competing providers or establish their own dialysis centers in competition with ours. Also, if the quality of service levels at our centers deteriorates, it may negatively impact patient referrals and treatment volumes.

Our medical director contracts are for fixed periods, generally three to ten years, and at any given time a large number of them could be up for renewal at the same time. Medical directors have no obligation to extend their agreements with us, and there are a number of factors, including opportunities presented by our competitors or different affiliation models in the changing healthcare environment, such as an increase in the number of physicians becoming employed by hospitals, that could negatively impact their decisions to extend their agreements with us. In addition, we may take actions to restructure existing relationships or take positions in negotiating extensions of relationships to assure compliance with the anti-kickback statute, Stark Law and other similar laws. These actions also could negatively impact the decision of physicians to extend their medical director agreements with us or to refer their patients to us. If the terms of any existing agreement are found to violate applicable laws, we may not be successful in restructuring the relationship which could lead to the early termination of the agreement, or cause the physician to stop referring patients to our dialysis centers. If a significant number of physicians were to cease referring patients to our dialysis centers, whether due to regulatory or other reasons, then our revenues, earnings and cash flows would be substantially reduced.

Table of Contents

Current economic conditions as well as further disruptions in the financial markets could have a material adverse effect on our revenues, earnings and cash flows and otherwise adversely affect our financial condition.

Current economic conditions could adversely affect our business and our profitability. Among other things, the potential decline in federal and state revenues that may result from such conditions may create additional pressures to contain or reduce reimbursements for our services from Medicare, Medicaid and other government sponsored programs. Increasing job losses or slow improvement in the unemployment rate in the U.S. as a result of current or recent economic conditions has and may continue to result in a smaller percentage of our patients being covered by an employer group health plan and a larger percentage being covered by lower paying Medicare and Medicaid programs. Employers may also begin to select more restrictive commercial plans with lower reimbursement rates. To the extent that payors are negatively impacted by a decline in the economy, we may experience further pressure on commercial rates, a further slowdown in collections and a reduction in the amounts we expect to collect. In addition, uncertainty in the financial markets could adversely affect the variable interest rates payable under our credit facilities or could make it more difficult to obtain or renew such facilities or to obtain other forms of financing in the future, if at all. Any or all of these factors, as well as other consequences of the current economic conditions which cannot currently be anticipated, could have a material adverse effect on our revenues, earnings and cash flows and otherwise adversely affect our financial condition.

We may engage in acquisitions, mergers or dispositions, including the Merger, which may affect our results of operations, debt-to-capital ratio, capital expenditures or other aspects of our business.

We may engage in acquisitions, mergers or dispositions, including the Merger, which may affect our results of operations, debt-to-capital ratio, capital expenditures, or other aspects of our business. There can be no assurance that we will be able to identify suitable acquisition targets or merger partners or that, if identified, we will be able to acquire these targets on acceptable terms or agree to terms with merger partners. There can also be no assurance that we will be successful in completing any acquisitions, mergers or dispositions that we might be considering or announce, or integrating any acquired business into our overall operations or operate them successfully as stand-alone businesses, or that any such acquired business will operate profitably or will not otherwise adversely impact our results of operations. Further, we cannot be certain that key talented individuals at the business being acquired will continue to work for us after the acquisition or that they will be able to continue to successfully manage or have adequate resources to successfully operate any acquired business.

If we are not able to continue to make acquisitions, or maintain an acceptable level of non-acquired growth, or if we face significant patient attrition to our competitors or a reduction in the number of our medical directors, it could adversely affect our business.

The dialysis industry is highly competitive, particularly in terms of acquiring existing dialysis centers. We continue to face increased competition in the U.S. dialysis industry from large and medium-sized providers which compete directly with us for acquisition targets as well as for individual patients and medical directors. In addition, as we continue our international dialysis expansion into various international markets, we will face competition from large and medium-sized providers for these acquisition targets as well. Acquisitions, patient retention and medical director retention are an important part of our growth strategy. Because of the ease of entry into the dialysis business and the ability of physicians to be medical directors for their own centers, competition for growth in existing and expanding markets is not limited to large competitors with substantial financial resources. Occasionally, we have experienced competition from former medical directors or referring physicians who have opened their own dialysis centers. In addition, Fresenius, our largest competitor, manufactures a full line of dialysis supplies and equipment in addition to owning and operating dialysis centers. This may give it cost advantages over us because of its ability to manufacture its own products. If we are not able to continue to make acquisitions, continue to maintain acceptable levels of non-acquired growth, or if we face significant patient attrition to our competitors or a reduction in the number of our medical directors, it could adversely affect our business.

Table of Contents

If businesses we acquire have liabilities that we are not aware of, we could suffer severe consequences that would substantially reduce our earnings and cash flows.

Our business strategy includes the acquisition of dialysis centers and businesses that own and operate dialysis centers, as well as other ancillary and non-dialysis services and strategic initiatives, including the Merger. Businesses we acquire may have unknown or contingent liabilities or liabilities that are in excess of the amounts that we originally estimated. Although we generally seek indemnification from the sellers of businesses we acquire for matters that are not properly disclosed to us, we are not always successful. In addition, even in cases where we are able to obtain indemnification, we may discover liabilities greater than the contractual limits or the financial resources of the indemnifying party. In the event that we are responsible for liabilities substantially in excess of any amounts recovered through rights to indemnification, we could suffer severe consequences that would substantially reduce our earnings and cash flows.

Expansion of our operations to and offering our services in markets outside of the U.S. subjects us to political, legal, operational and other risks that could adversely affect our business, results of operations and cash flows.

We are undertaking an expansion of our operations and beginning to offer our services outside of the U.S., which increases our exposure to the inherent risks of doing business in international markets. Depending on the market, these risks include, without limitation, those relating to:

changes in the local economic environment;

political instability, armed conflicts or terrorism;

social changes;

intellectual property legal protections and remedies;

trade regulations;

procedures and actions affecting approval, production, pricing, reimbursement and marketing of products and services;

foreign currency;

repatriating or moving to other countries cash generated or held abroad, including considerations relating to tax-efficiencies and changes in tax laws;

export controls;

lack of reliable legal systems which may affect our ability to enforce contractual rights;

changes in local laws or regulations;

potentially longer payment and collection cycles;

financial and operational, and information technology systems integration; and

failure to comply with U.S. or local laws that prohibit us or our intermediaries from making improper payments to foreign officials for the purpose of obtaining or retaining business.

Additionally, some factors that will be critical to the success of our international business and operations will be different than those affecting our domestic business and operations. For example, conducting international operations requires us to devote significant management resources to implement our controls and systems in new markets, to comply with local laws and regulations and to overcome the numerous new challenges inherent in managing international operations, including those based on differing languages, cultures and regulatory environments, and those related to the timely hiring, integration and retention of a sufficient number of skilled personnel in an environment with which we are not familiar to carry out operations.

Table of Contents

We anticipate expanding our international operations through acquisitions of varying sizes or through organic growth, which could increase these risks. Additionally, though we might invest material amounts of capital and incur significant costs in connection with the growth and development of our international operations, there is no assurance that we will be able to operate them profitably anytime soon, if at all. As a result, we would expect these costs to be dilutive to our earnings over the next several years as we start-up or acquire new operations.

These risks could have a material adverse effect on our financial condition, results of operations and cash flows.

The level of our current and future debt could have an adverse impact on our business, and our ability to generate cash to service our indebtedness depends on many factors beyond our control.

We have substantial debt outstanding and we may incur additional indebtedness in the future. The high level of our indebtedness, among other things, could:

- make it difficult for us to make payments on our debt securities;
- increase our vulnerability to general adverse economic and industry conditions;
- require us to dedicate a substantial portion of our cash flow from operations to payments on our indebtedness, thereby reducing the availability of our cash flow to fund working capital, capital expenditures, acquisitions and investments and other general corporate purposes;
- limit our flexibility in planning for, or reacting to, changes in our business and the markets in which we operate;
- place us at a competitive disadvantage compared to our competitors that have less debt; and
- limit our ability to borrow additional funds.

Our ability to make payments on our indebtedness and to fund planned capital expenditures and expansion efforts, including any strategic acquisitions we may make in the future, will depend on our ability to generate cash. This, to a certain extent, is subject to general economic, financial, competitive, regulatory and other factors that are beyond our control.

We cannot provide assurance that our business will generate sufficient cash flow from operations in the future or that future borrowings will be available to us in an amount sufficient to enable us to service our indebtedness or to fund other liquidity needs. The borrowings under our amended senior secured credit facilities are guaranteed by a substantial portion of our direct and indirect wholly owned domestic subsidiaries and are secured by a substantial portion of DaVita s and its guarantors assets.

Increases in interest rates may increase our interest expense and adversely affect our earnings and cash flow and our ability to service our indebtedness.

A portion of our outstanding debt bears interest at variable rates. We are subject to LIBOR-based interest rate volatility from a floor of 1.50% to a cap of 4.00% on $1.25 billion notional amounts of our Term Loan B outstanding debt as a result of several interest rate cap agreements that were entered into in January 2011. The remaining $474 million of outstanding debt on the Term Loan B is subject to LIBOR-based interest rate volatility above a floor of 1.50%. At June 30, 2012, we were also subject to LIBOR-based interest rate volatility above a floor of 1.00% on $199 million of outstanding debt associated with our Term Loan A-2.

We also have approximately $350 million of additional borrowings available of which approximately $49 million was committed for outstanding letters of credit, under our amended senior secured credit facilities that are subject to LIBOR-based interest rate volatility. We may also incur additional variable rate debt in the

Table of Contents

future. Increases in interest rates would increase our interest expense of the variable portion of our indebtedness, which could negatively impact our earnings and cash flow and our ability to service our indebtedness which would be particularly significant in the event of rapid and substantial increases in interest rates.

At June 30, 2012, if interest rates were to hypothetically increase by 100 basis points it would increase our interest expense by approximately $0.5 million, which increase solely relates to our Term Loan A-2 that is subject to LIBOR-based interest rate volatility above a floor of 1.00%.

However, interest expense would not be impacted by any LIBOR-based interest rate volatility associated with our other Term Loans since all of our Term Loan A is economically fixed and our Term Loan B is subject to LIBOR-based interest rate volatility above a floor of 1.50%, as described above. The current LIBOR rate in effect, plus a hypothetical increase of 100 basis points, is currently less than our Term Loan B floor of 1.50%. Therefore, LIBOR-based interest rates would have to increase above a floor of 1.50% for the Term Loan B to have a negative impact on our financial results.

If there are shortages of skilled clinical personnel or if we experience a higher than normal turnover rate, we may experience disruptions in our business operations and increases in operating expenses.

We are experiencing increased labor costs and difficulties in hiring nurses due to a nationwide shortage of skilled clinical personnel. We compete for nurses with hospitals and other health care providers. This nursing shortage may limit our ability to expand our operations. In addition, changes in certification requirements or increases in the required staffing levels for skilled clinical personnel can impact our ability to maintain sufficient staff levels to the extent our teammates are not able to meet new requirements or competition for qualified individuals increases. If we are unable to hire skilled clinical personnel when needed, or if we experience a higher than normal turnover rate for our skilled clinical personnel, our operations and treatment growth will be negatively impacted, which would result in reduced revenues, earnings and cash flows.

Our business is labor intensive and could be adversely affected if we were unable to maintain satisfactory relations with our employees or if union organizing activities were to result in significant increases in our operating costs or decreases in productivity.

Our business is labor intensive, and our results are subject to variations in labor-related costs, productivity and the number of pending or potential claims against us related to labor and employment practices. If political efforts at the national and local level result in actions or proposals that increase the likelihood of union organizing activities at our facilities or if union organizing activities increase for other reasons, or if labor and employment claims, including the filing of class action suits, trend upwards, our operating costs could increase and our employee relations, productivity, earnings and cash flows could be adversely affected.

Upgrades to our billing and collections systems and complications associated with upgrades and other improvements to our billing and collections systems could have a material adverse effect on our revenues, cash flows and operating results.

We are continuously performing upgrades to our billing systems and expect to continue to do so in the near term. In addition, we continuously work to improve our billing and collections performance through process upgrades, organizational changes and other improvements. We may experience difficulties in our ability to successfully bill and collect for services rendered as a result of these changes, including a slow-down of collections, a reduction in the amounts we expect to collect, increased risk of retractions from and refunds to commercial and government payors, an increase in our provision for uncollectible accounts receivable and noncompliance with reimbursement regulations. The failure to successfully implement the upgrades to the billing and collection systems and other improvements could have a material adverse effect on our revenues, cash flows and operating results.

Table of Contents

Our ability to effectively provide the services we offer could be negatively impacted if certain of our suppliers are unable to meet our needs or if we are unable to effectively access new technology, which could substantially reduce our revenues, earnings and cash flows.

We have significant suppliers that are either the sole or primary source of products critical to the services we provide, including Amgen, Baxter Healthcare Corporation, NxStage Medical, Inc. and others or to which we have committed obligations to make purchases including Gambro Renal Products and Fresenius. If any of these suppliers are unable to meet our needs for the products they supply, including in the event of a product recall, or shortage, and we are not able to find adequate alternative sources, or if some of the drugs that we purchase are not reimbursed or not adequately reimbursed by commercial payors or through the bundled payment rate by Medicare, our revenues, earnings and cash flows could be substantially reduced. In addition, the technology related to the products critical to the services we provide is subject to new developments and may result in superior products. If we are not able to access superior products on a cost-effective basis or if suppliers are not able to fulfill our requirements for such products, we could face patient attrition which could substantially reduce our revenues, earnings and cash flows.

We may be subject to liability claims for damages and other expenses not covered by insurance that could reduce our earnings and cash flows.

The administration of dialysis and related services to patients may subject us to litigation and liability for damages. Our business, profitability and growth prospects could suffer if we face negative publicity or we pay damages or defense costs in connection with a claim that is outside the scope of any applicable insurance coverage, including claims related to adverse patient events, contractual disputes and professional and general liability claims. In addition, we have received several notices of claims from commercial payors and other third parties related to our historical billing practices and the historical billing practices of the centers acquired from Gambro Healthcare and other matters related to their settlement agreement with the Department of Justice. Although the ultimate outcome of these claims cannot be predicted, an adverse result with respect to one or more of these claims could have a material adverse effect on our financial condition, results of operations, and cash flows. We currently maintain programs of general and professional liability insurance. However, a successful claim, including a professional liability, malpractice or negligence claim which is in excess of our insurance coverage could have a material adverse effect on our earnings and cash flows.

In addition, if our costs of insurance and claims increase, then our earnings could decline. Market rates for insurance premiums and deductibles have been steadily increasing. Our earnings and cash flows could be materially and adversely affected by any of the following:

- the collapse or insolvency of our insurance carriers;
- further increases in premiums and deductibles;
- increases in the number of liability claims against us or the cost of settling or trying cases related to those claims; and
- an inability to obtain one or more types of insurance on acceptable terms.

Provisions in our charter documents, compensation programs and Delaware law may deter a change of control that our stockholders would otherwise determine to be in their best interests.

Our charter documents include provisions that may deter hostile takeovers, delay or prevent changes of control or changes in our management, or limit the ability of our stockholders to approve transactions that they may otherwise determine to be in their best interests. These include provisions prohibiting our stockholders from acting by written consent; requiring 90 days advance notice of stockholder proposals or nominations to our Board of Directors; and granting our Board of Directors the authority to issue preferred stock and to determine the rights and preferences of the preferred stock without the need for further stockholder approval.

Table of Contents

Most of our outstanding employee stock options include a provision accelerating the vesting of the options in the event of a change of control. We also maintain a change of control protection program for our employees who do not have a significant number of stock awards, which has been in place since 2001, and which provides for cash bonuses to the employees in the event of a change of control. Based on the market price of our common stock and shares outstanding on June 30, 2012, these cash bonuses would total approximately $364 million if a change of control transaction occurred at that price and our Board of Directors did not modify this program. These change of control provisions may affect the price an acquirer would be willing to pay for our Company.

We are also subject to Section 203 of the Delaware General Corporation Law that, subject to exceptions, would prohibit us from engaging in any business combinations with any interested stockholder, as defined in that section, for a period of three years following the date on which that stockholder became an interested stockholder.

These provisions may discourage, delay or prevent an acquisition of our Company at a price that our stockholders may find attractive. These provisions could also make it more difficult for our stockholders to elect directors and take other corporate actions and could limit the price that investors might be willing to pay for shares of our common stock.

Risks Relating to HCP

As a healthcare company, HCP is subject to many of the same risks to which DaVita is subject.

As a participant in the healthcare industry, HCP is subject to many of the same risks that DaVita is subject to as described in the DaVita risk factors, included elsewhere in or incorporated by reference into this prospectus supplement, any of which could materially and adversely affect HCP s revenues, earnings or cash flows. Among these risks are the following:

- the healthcare business is heavily regulated and changes in laws, regulations, or government programs could have a material impact on HCP s business;
- failure to comply with complex governmental regulations could have severe consequences to HCP, including, without limitation, exclusion from governmental payor programs like Medicare and Medicaid;
- HCP could become the subject of governmental investigations, claims, and litigation;
- HCP may be unable to continue to make acquisitions or to successfully integrate such acquisitions into its business, and such acquisitions may include liabilities of which HCP was not aware; and
- as a result of the broad scope of HCP s medical practice, including its affiliated physician groups in California and Nevada, HCP is exposed to medical malpractice claims, as well as claims for damages and other expenses, that may not be covered by insurance.

Under most of HCP s agreements with health plans, HCP assumes some or all of the risk that the cost of providing services will exceed its compensation.

Substantially all of HCP s revenue is derived from PMPM fees, paid by health plans under capitation agreements with HCP or its affiliated physician groups. In Florida, HCP contracts directly with health plans under global capitation arrangements to assume financial responsibility for both professional and institutional services. In Nevada, HCP contracts directly with health plans under capitation arrangements to assume financial responsibility for professional services, but does not generally assume institutional risk. Under such contracts, the health plan establishes pools for both professional services and institutional services based on a contractual PMPM fee, and the health plan then pays both professional and institutional expenses and remits the residual amounts to HCP. In California, HCP utilizes a capitation model in several different forms. While there are variations specific to each arrangement, HealthCare Partners Affiliates Medical Group, or HCPAMG, generally

Table of Contents

contracts with health plans to receive a PMPM fee for professional services and assumes the financial responsibility for professional services only. In some cases, the health plans separately enter into capitation contracts with third parties (typically hospitals) who receive directly a portion of the PMPM fee and assume contractual financial responsibility for hospital services. In other cases, the health plan does not pay any portion of the PMPM fee to the hospital, but rather administers claims for hospital expenses itself. In both scenarios, HCP enters into managed care-related administrative services agreements or similar arrangements with those third parties (hospitals) under which HCP agrees to be responsible for utilization review, quality assurance, and other managed care-related administrative functions. As compensation for such administrative services, HCP is entitled to share up to 100% of the amount by which the hospital capitation revenue exceeds hospital expenses; any such risk-share amount to which HCP is entitled is recorded as medical revenues.

To the extent that members require more care than is anticipated, aggregate PMPM payments may be insufficient to cover the costs associated with treatment. If medical expenses exceed estimates, except in very limited circumstances, HCP will not be able to increase the PMPM fee received under these risk agreements during their then-current terms.

If HCP or its affiliated physician groups enter into capitation contracts with unfavorable economic terms, or a capitation contract is amended to include unfavorable terms, HCP could, directly or indirectly through its contracts with HCPAMG, suffer losses with respect to such contract. Since HCP does not negotiate with CMS or any health plan regarding the benefits to be provided under their Medicare Advantage or other managed care plans, HCP often has just a few months to familiarize itself with each new annual package of benefits it is expected to offer.

Relatively small changes in HCP s or HCPAMG s ratio of medical expense to revenue can create significant changes in HCP s financial results. Accordingly, the failure to adequately predict and control medical expenses and to make reasonable estimates and maintain adequate accruals for incurred but not reported claims, may have a material adverse effect on HCP s financial condition, results of operations or cash flows.

Historically, HCP s and HCPAMG s medical expenses as a percentage of revenue have fluctuated. Factors that may cause medical expenses to exceed estimates include:

- the health status of members;
- higher than expected utilization of new or existing healthcare services or technologies;
- an increase in the cost of healthcare services and supplies, including pharmaceuticals, whether as a result of inflation or otherwise;
- changes to mandated benefits or other changes in healthcare laws, regulations, and practices;
- periodic renegotiation of provider contracts with specialist physicians, hospitals, and ancillary providers;
- periodic renegotiation of contracts with HCP s affiliated primary care physicians;
- changes in the demographics of the participating members and medical trends;
- contractual or claims disputes with providers, hospitals, or other service providers within a health plan s network; and
- the occurrence of catastrophes, major epidemics, or acts of terrorism.

Table of Contents

Risk-sharing arrangements that HCP-affiliated physician groups (including HCPAMG) have with health plans and hospitals could result in their costs exceeding the corresponding revenues, which could reduce or eliminate any shared risk profitability.

Most of the agreements between health plans and HCP and its affiliated physician groups, including HCPAMG, contain risk-sharing arrangements under which the physician groups can earn additional compensation from the health plans by coordinating the provision of quality, cost-effective healthcare to members. However, such arrangements may require the physician group to assume a portion of any loss sustained from these arrangements, thereby reducing HCP s net income. Under these risk-sharing arrangements, HCP and its affiliated physician groups are responsible for a portion of the cost of hospital services or other services that are not capitated. The terms of the particular risk-sharing arrangement allocate responsibility to the respective parties when the cost of services exceeds the related revenue, which results in a deficit, or permit the parties to share in any surplus amounts when actual costs are less than the related revenue. The amount of non-capitated and hospital costs in any period could be affected by factors beyond the control of HCP, such as changes in treatment protocols, new technologies, longer lengths of stay by the patient, and inflation. To the extent that such non-capitated and hospital costs are higher than anticipated, revenue may not be sufficient to cover the risk-sharing deficits the health plans and HCP are responsible for, which could reduce HCP s revenues and profitability. Certain of HCP s agreements with health plans stipulate that risk-sharing pool deficit amounts are carried forward to offset any future years surplus amounts HCP would otherwise be entitled to receive. HCP accrues for any such risk-sharing deficits.

Health plans often insist on withholding negotiated amounts from professional PMPM payments, which the health plans are permitted to retain, in order to cover HCP s share of any risk-sharing deficits. Whenever possible, HCP seeks to contractually reduce or eliminate its liability for risk-sharing deficits. Notwithstanding the foregoing, risk-sharing deficits could have a significant impact on future profitability.

Renegotiation, renewal, or termination of capitation agreements with health plans could have a significant impact on HCP s future profitability.

Under most of HCP s and its affiliated physician groups , including HCPAMG s, capitation agreements with health plans, the health plan is generally permitted to modify the benefit and risk obligations and compensation rights from time to time during the terms of the agreements. If a health plan exercises its right to amend its benefit and risk obligations and compensation rights, HCP and its affiliated physician groups, including HCPAMG, are generally allowed a period of time to object to such amendment. If HCP or its affiliated physician group so objects, under some of the risk agreements, the relevant health plan may terminate the applicable agreement upon 60 to 90 days written notice. In addition, in connection with the Merger, HCP must obtain the consent of certain health plans to assign certain capitation agreements, which could result in health plans attempting to renegotiate or threatening to cancel such contracts. Depending on the health plan at issue and the amount of revenue associated with the health plan s risk agreement, the renegotiated terms or termination may have a material adverse effect on HCP s and DaVita s future revenues and profitability.

Laws regulating the corporate practice of medicine could restrict the manner in which HCP is permitted to conduct its business and the failure to comply with such laws could subject HCP to penalties or require a restructuring of HCP.

Some states have laws that prohibit business entities, such as HCP, from practicing medicine, employing physicians to practice medicine, exercising control over medical decisions by physicians (also known collectively as the corporate practice of medicine) or engaging in certain arrangements, such as fee-splitting, with physicians. In some states these prohibitions are expressly stated in a statute or regulation, while in other states the prohibition is a matter of judicial or regulatory interpretation. Of the three states in which HCP currently operates, California and Nevada prohibit the corporate practice of medicine.

In California and Nevada, HCP operates by maintaining long-term contracts with its affiliated physician groups, including HCPAMG, which are each owned and operated by physicians and which employ or contract

with additional physicians to provide physician services. Under these arrangements, HCP provides management services, receives a management fee for providing non-medical management services, does not represent that it offers medical services, and does not exercise influence or control over the practice of medicine by the physicians or the affiliated physician groups.

In addition to the above management arrangements, HCP has certain contractual rights relating to the orderly transfer of equity interests in certain of its California and Nevada affiliated physician groups through succession agreements and other arrangements with their physician equityholders. However, such equity interests cannot be transferred to or held by HCP or by any non-professional organization. Accordingly, neither HCP nor HCP s subsidiaries directly own any equity interests in any physician groups in California and Nevada. In the event that any of these affiliated physician groups fails to comply with the management arrangement or any management arrangement is terminated and/or HCP is unable to enforce its contractual rights over the orderly transfer of equity interests in its affiliated physician groups, such events could have a material adverse effect on HCP s business, financial condition or results of operations.

HCP may be required to restructure its relationship with its affiliated physician groups if HCP s management services agreements with such affiliated physician groups or HCP s succession agreements and other related arrangements with equityholders of any such affiliated physician groups are deemed invalid under prohibitions against the corporate practice of medicine in California and Nevada.

Some of the relevant laws, regulations, and agency interpretations relating to the corporate practice of medicine have been subject to limited judicial and regulatory interpretation. Moreover, state laws are subject to change and regulatory authorities and other parties, including HCP s group physicians, may assert that, despite these arrangements, HCP is engaged in the prohibited corporate practice of medicine.

In light of the above, it is possible that a state regulatory agency or a court could determine that HCP s agreements with physician equityholders of certain managed California and Nevada affiliated physician groups as described above, either independently or coupled with the management services agreements with such affiliated physician groups, confer impermissible control over the business and/or medical operations of such affiliated physician groups, that the management fee payable under such arrangements results in profit sharing or that HCP is the beneficial owner of the affiliated physician groups equity interests in violation of the corporate practice of medicine doctrine. If there were a determination that a corporate practice of medicine violation existed or exists, these arrangements could be deemed invalid, potentially resulting in a loss of revenues and results of operations derived from such affiliated physician groups. In addition, HCP s California and Nevada affiliated physician groups and HCP, as well as those physician equityholders of affiliated physician groups who are subject to succession agreements with HCP, could be subject to criminal or civil penalties or an injunction for practicing medicine without a license or aiding and abetting the unlicensed practice of medicine.

A determination that a corporate practice of medicine violation existed could also force a restructuring of HCP s management arrangements with affiliated physician groups in California and/or Nevada. Such a restructuring might include revisions of the management services agreements, which might include a modification of the management fee, and/or establishing an alternative structure, such as obtaining a California Knox-Keene license (a managed care plan license issued pursuant to the California Knox-Keene Health Care Service Plan Act of 1975, or Knox-Keene Act) or its Nevada equivalent, which would permit HCP to contract with a physician network without violating the corporate practice of medicine prohibition. There can be no assurance that such a restructuring would be feasible, or that it could be accomplished within a reasonable time frame without a material adverse effect on HCP s operations and financial results.

Table of Contents

If HCP s agreements or arrangements with any physician equityholder(s) of affiliated physicians, physician groups, or IPAs are deemed invalid under state law, including laws against the corporate practice of medicine, or Federal Law, or are terminated as a result of changes in state law, or if there is a change in accounting principles or the interpretation thereof by the Financial Accounting Standards Board, or FASB, affecting consolidation of entities, it could impact HCP s consolidation of total revenues derived from such affiliated physician groups.

HCP s financial statements are consolidated and include the accounts of its majority-owned subsidiaries and certain non-owned HCP-affiliated physician groups, which consolidation is effectuated in accordance with applicable accounting rules. In the event of a change in accounting principles promulgated by FASB or in FASB s interpretation of its principles, or if there were an adverse determination by a regulatory agency or a court or if there were a change in state or federal law relating to the ability to maintain present agreements or arrangements with such physician groups, HCP may not be permitted to continue to consolidate the total revenues of such organizations. A change in accounting for consolidation with respect to HCP s present agreement or arrangements would diminish HCP s reported revenues but would not adversely affect its results of operations, while regulatory or legal rulings or changes in law interfering with HCP s ability to maintain its present agreements or arrangements could diminish both revenues and results of operations.

If HCPAMG and HCP s affiliated physician groups are not able to satisfy the California Department of Managed Health Care s financial solvency requirements, HCP could become subject to sanctions and its ability to do business in California could be limited or terminated.

The California Department of Managed Health Care, or DMHC, has instituted financial solvency regulations. The regulations are intended to provide a formal mechanism for monitoring the financial solvency of capitated physician groups. Under the regulations, HCPAMG and HCP s affiliated physician groups are required to, among other things:

- Maintain, at all times, a minimum cash-to-claims ratio (where cash-to-claims ratio means the organization s cash, marketable securities, and certain qualified receivables, divided by the organization s total unpaid claims liability). The regulations currently require a cash-to-claims ratio of 0.75.

- Submit periodic reports to the DMHC containing various data and attestations regarding performance and financial solvency, including incurred but not reported calculations and documentation, and attestations as to whether or not the organization was in compliance with the Knox-Keene Act requirements related to claims payment timeliness, had maintained positive tangible net equity (i.e., at least $1.00), and had maintained positive working capital (i.e., at least $1.00).

In the event that a physician organization is not in compliance with any of the above criteria, the organization would be required to describe in a report submitted to the DMHC the reasons for non-compliance and actions to be taken to bring the organization into compliance. Further, under these regulations, the DMHC can make public some of the information contained in the reports, including, but not limited to, whether or not a particular physician organization met each of the criteria. In the event HCP or its affiliated physician groups are not able to meet certain of the financial solvency requirements, and fail to meet subsequent corrective action plans, HCP could be subject to sanctions, or limitations on, or removal of, its ability to do business in California.

Reductions in Medicare Advantage health plan reimbursement rates stemming from recent healthcare reforms and any future related regulations may negatively impact HCP s business, revenue and profitability.

A significant portion of HCP s revenue is directly or indirectly derived from the monthly premium payments paid by CMS to health plans for medical services provided to Medicare Advantage enrollees. As a result, HCP s business and results of operations are, in part, dependent on government funding levels for Medicare Advantage programs. Any changes that limit or reduce Medicare Advantage reimbursement levels,

Table of Contents

such as reductions in or limitations of reimbursement amounts or rates under programs, reductions in funding of programs, expansion of benefits without adequate funding, elimination of coverage for certain benefits, or elimination of coverage for certain individuals or treatments under programs, could have a material adverse effect on HCP s business.

The Health Reform Acts contain a number of provisions that negatively impact Medicare Advantage plans, including the following:

- Medicare Advantage benchmarks for 2011 were frozen at 2010 levels. Beginning in 2012, Medicare Advantage benchmark rates are being phased down from current levels to levels that are between 95% and 115% of fee-for-service costs, depending on a plan s geographic area. Medicare Advantage plans receiving certain quality ratings by CMS will be eligible for bonus rate increases.

- Rebates received by Medicare Advantage plans that underbid based on payment benchmarks will be reduced, with larger reductions for plans failing to receive certain quality ratings.

- The Secretary of the Department of Health and Human Services, or HHS, is granted explicit authority to deny Medicare Advantage plan bids that propose significant increases in cost sharing or decreases in benefits.

- Beginning in 2014, Medicare Advantage plans with medical loss ratios below 85% will be required to pay a rebate to the Secretary of HHS. The Secretary of HHS will halt enrollment in any plan failing to meet this ratio for three consecutive years, and terminate any plan failing to meet the ratio for five consecutive years. If an HCP-contracting Medicare Advantage plan experiences a limitation on enrollment or is otherwise terminated from the Medicare Advantage program, HCP may suffer materially adverse consequences to its business or financial condition.

- Since January 1, 2011, cost-sharing for certain services (such as chemotherapy and skilled nursing care) has been limited to the cost-sharing permitted under the original fee-for-service Medicare program.

- Prescription drug plans are now required to cover all drugs on a list developed by the Secretary of HHS, and the Medicare Part D premium subsidy for high-income beneficiaries has been reduced by 25%.

- Beginning in 2014, CMS is required to increase coding intensity adjustments for Medicare Advantage plans, which is expected to reduce CMS payments to Medicare Advantage plans, which in turn will likely reduce the amounts payable to HCP and its affiliated physicians, physician groups, and IPAs under its capitation agreements.

In addition to the above, the Health Reform Acts establish a new Independent Payment Advisory Board, or IPAB, to recommend ways to reduce Medicare spending if the increase in Medicare costs per capita exceeds certain targets, which will be implemented unless Congress passes alternative legislation that achieves the same savings. The Health Reform Acts mandate that if targets are not met, the IPAB s recommendations are to include ways to reduce payments to Medicare Advantage plans and Medicare Part D prescription drug plans related to administrative expenses (including profits) and performance bonuses. Also, the Budget Control Act of 2011, or BCA, mandates a 2% decrease in Medicare Advantage spending in order to bring Medicare spending for Medicare Advantage beneficiaries more in line with Medicare fee-for-service spending. Additional steps could be taken by government agencies and plan providers to further restrict, directly or indirectly, the reimbursements available to plan service providers like HCP.

Finally, it is possible that the impact of the Health Reform Acts could cause a reduction in enrollment in Medicare Advantage plans, which, in turn, would reduce HCP s revenues and net income. For example, the Congressional Budget Office, or CBO, expects that, after reaching a high of 25% participation in Medicare Advantage plans in 2012, such participation will decline to 17% in 2020. The CBO predicts that this, together with other changes under the Reform Act, will result in reductions in Medicare Advantage spending by CMS of up to an aggregate of $131.9 billion over 10 years.

Although the Health Reform Acts provide for reductions in payments to Medicare Advantage plans, the Health Reform Acts also provide for bonus payments to Medicare Advantage plans rated four or five stars based on quality measures. In November 2011, CMS announced a three-year demonstration project with an alternative bonus structure that awards bonuses to plans with three or more stars. The Government Accountabilty Office, or GAO, and MedPAC have criticized the demonstration project. If Congress acts to curb the CMS initiated bonus structure, HCP s revenues would decrease.

HCP s operations are dependent on competing health plans and, at times, their and HCP s economic interests may diverge.

For the year ended December 31, 2011, 70% of HCP s consolidated medical revenues was earned through contracts with three health plans.

HCP expects that, going forward, substantially all of its revenue will continue to be derived from these and other health plans. Each health plan may immediately terminate any of HCP s contracts and/or any individual credentialed physician upon the occurrence of certain events. They may also amend the material terms of the contracts under certain circumstances. Failure to maintain the contracts on favorable terms, for any reason, would materially and adversely affect HCP s results of operations and financial condition. A material decline in the number of members could also have a material adverse effect on HCP s results of operations.

Notwithstanding each health plan s and HCP s current shared interest in providing service to HCP s members who are enrolled in the subject health plans, the health plans may have different and, at times, opposing economic interests from those of HCP. The health plans provide a wide range of health insurance services across a wide range of geographic regions, utilizing a vast network of providers. As a result, they and HCP may have different views regarding the proper pricing of services and/or the proper pricing of the various service providers in their provider networks, the cost of which HCP bears to the extent that the services of such service providers are utilized. These health plans may also have different views than HCP regarding the efforts and expenditures that they, HCP, and/or other service providers should make to achieve and/or maintain various quality ratings. In addition, several health plans have purchased or announced their intent to purchase IPAs or HMOs. If health plans with which HCP contracts make significant purchases, they may not continue to contract with HCP or contract on less favorable terms. Similarly, as a result of changes in laws, regulations, consumer preferences, or other factors, the health plans may find it in their best interest to provide health insurance services pursuant to another payment or reimbursement structure. In the event HCP s interests diverge from the interests of the health plans, HCP may have limited recourse or alternative options in light of its dependence on these health plans. There can be no assurances that HCP will continue to find it mutually beneficial to work with the health plans. As a result of various restrictive provisions that appear in some of the managed care agreements with health plans, HCP may, at times, have limitations on its ability to cancel an agreement with a particular health plan and immediately thereafter contract with a competing health plan with respect to the same service area.

HCP and its affiliated physicians, physician groups, including HCPAMG, and IPAs and other physicians may be required to continue providing services following termination or renegotiation of certain agreements with health plans.

There are circumstances under federal and state law pursuant to which HCP and its affiliated physician groups, including HCPAMG, IPAs, and other physicians could be obligated to continue to provide medical services to HCP members in their care following a termination of their applicable risk agreement with health plans and termination of the receipt of payments thereunder. In certain cases, this obligation could require the physician group or IPA to provide care to such member following the bankruptcy or insolvency of a health plan. Accordingly, the obligations to provide medical services to HCP members (and the associated costs) may not terminate at the time the applicable agreement with the health plan terminates, and HCP may not be able to recover its cost of providing those services from the health plan, which could have a material adverse effect on HCP s financial condition, results of operations, and/or cash flows.

Table of Contents

HCP operates only in Florida, California, and Nevada. HCP may not be able to successfully establish a presence in new geographic regions.

HCP derives substantially all of its revenue from operations exclusively in California, Nevada, and Florida (California, Nevada, and Florida are hereinafter referred to as, the Existing Geographic Regions). As a result, HCP s exposure to many of the risks described herein are not mitigated by a greater diversification of geographic focus. Furthermore, due to the concentration of HCP s operations in the Existing Geographic Regions, HCP s business may be adversely affected by economic conditions, natural disasters (such as earthquakes or hurricanes), or acts of war or terrorism that disproportionately affect the Existing Geographic Regions as compared to other states and geographic markets.

To expand the operations of its network outside of the Existing Geographic Regions, HCP must devote resources to identifying and exploring such perceived opportunities. Thereafter, HCP must, among other things, recruit and retain qualified personnel, develop new offices, establish potentially new relationships with one or more health plans, and establish new relationships with physicians and other healthcare providers. The ability to establish such new relationships may be significantly inhibited by competition for such relationships and personnel in the health care marketplace in the targeted new geographic regions. In addition, if HCP were to seek expansion outside of the Existing Geographic Regions, HCP would be required to comply with laws and regulations of states that may differ from the ones in which it currently operates, and could face competitors with greater knowledge of such local markets. HCP anticipates that any geographic expansion may require it to make a substantial investment of management time, capital, and/or other resources. There can be no assurance that HCP will be able to establish profitable operations or relationships in any new geographic markets.

Reductions in the quality ratings of the health plans HCP serves could have an adverse effect on its results of operations, financial condition, and/or cash flow.

As a result of the Health Reform Acts, HCP anticipates that the level of reimbursement each health plan receives from CMS will be dependent, in part, upon the quality rating of the Medicare plan that such health plan serves. Such ratings are expected to impact the percentage of any cost savings rebate and any bonuses earned by such health plan. Since a significant portion of HCP s revenue for 2012 is expected to be calculated as a percentage of CMS reimbursements received by these health plans with respect to HCP members, reductions in the quality ratings of a health plan that HCP serves could have an adverse effect on its results of operations, financial condition, and/or cash flows. In addition, CMS has announced its intention to terminate any plan that has a rating of less than three stars for three consecutive years. Medicare Advantage plans with five stars are permitted to conduct enrollment throughout the year and enrollees in plans with 4.5 or fewer stars are permitted to change plans during the year. None of the plans with which HCP contracts are five-star plans. Given each health plan s control of its plans and the many other providers that serve such plans, HCP believes that it will have limited ability to influence the overall quality rating of any such plan. Accordingly, since low quality ratings can potentially lead to the termination of a plan that HCP serves, HCP may not be able to prevent the potential termination of a contracting plan or a shift of patients to other plans based upon quality issues which could, in turn, have an adverse effect on HCP s results of operations, financial condition, and/or cash flows.

HCP s records and submissions to a health plan may contain inaccurate or unsupportable information regarding risk adjustment scores of members, which could cause HCP to overstate or understate its revenue and subject it to various penalties.

HCP, on behalf of itself and its affiliated physicians, physician groups, including HCPAMG, and IPAs, submits to health plans claims and encounter data that support the risk adjustment factor, or RAF, scores attributable to members. These RAF scores determine, in part, the revenue to which the health plan and, in turn, HCP is entitled for the provision of medical care to such members. The data submitted to CMS by each health plan is based on medical charts and diagnosis codes prepared and submitted by HCP. Each health plan generally relies on HCP to appropriately document and support such RAF data in HCP s medical records. Each health plan also relies on HCP to appropriately code claims for medical services provided to members. HCP may

Table of Contents

periodically review medical records and may find inaccurate or unsupportable coding or otherwise inaccurate records. Erroneous claims and erroneous encounter records and submissions could result in inaccurate PMPM fee revenue and risk adjustment payments, which may be subject to correction or retroactive adjustment in later periods. This corrected or adjusted information may be reflected in financial statements for periods subsequent to the period in which the revenue was recorded. HCP might also need to refund a portion of the revenue that it received, which refund, depending on its magnitude, could damage its relationship with the applicable health plan and could have a material adverse effect on HCP s results of operations, financial condition or cash flows.

CMS audits Medicare Advantage plans for documentation to support RAF-related payments for members chosen at random. The Medicare Advantage plans ask providers to submit the underlying documentation for members that they serve. It is possible that claims associated with members with higher RAF scores could be subject to more scrutiny in a CMS audit. HCP has experienced increases in RAF scores attributable to its members, and thus there is a possibility that a Medicare Advantage plan may seek repayment from HCP as a result of CMS payment adjustments to the Medicare Advantage plan. The plans also may hold HCP liable for any penalties owed to CMS for inaccurate or unsupportable RAF scores provided by HCP.

CMS has indicated that, starting with payment year 2011, payment adjustments will not be limited to RAF scores for the specific Medicare Advantage enrollees for which errors are found but may also be extrapolated to the entire Medicare Advantage plan subject to a particular CMS contract. Although CMS has described its audit process as plan-year specific and has stated that it will not extrapolate audit results for plan years prior to 2011, CMS has not specifically stated that payment adjustments as a result of one plan year s audit will not be extrapolated to prior plan years. There can be no assurance that a health plan will not be randomly selected or targeted for review by CMS or that the outcome of such a review will not result in a material adjustment in HCP s revenue and profitability, even if the information HCP submitted to the plan is accurate and supportable. Since the CMS rules, regulations, and statements regarding this audit program are still not well defined and, in some cases, have not been published in final form, there is also a risk that CMS may adopt new rules and regulations that are inconsistent with their existing rules, regulations, and statements.

A failure to estimate incurred but not reported medical benefits expense accurately could adversely affect HCP s profitability.

Medical claims expense includes estimates of future medical claims that have been incurred by the patient but for which the provider has not yet billed HCP. These claim estimates are made utilizing actuarial methods and are continually evaluated and adjusted by management, based upon HCP s historical claims experience and other factors. Adjustments, if necessary, are made to medical claims expense when the assumptions used to determine HCP s claims liability changes and when actual claim costs are ultimately determined.

Due to the inherent uncertainties associated with the factors used in these estimates and changes in the patterns and rates of medical utilization, materially different amounts could be reported in HCP s financial statements for a particular period under different conditions or using different, but still reasonable, assumptions. It is possible that HCP s estimates of this type of claim may be inadequate in the future. In such event, HCP s results of operations could be adversely impacted. Further, the inability to estimate these claims accurately may also affect HCP s ability to take timely corrective actions, further exacerbating the extent of any adverse effect on HCP s results.

HCP faces certain competitive threats which could reduce HCP s profitability and increase competition for patients.

HCP faces certain competitive threats based on certain features of the Medicare programs, including the following:

As a result of the direct and indirect impacts of the Health Reform Acts, many Medicare beneficiaries may decide that an original fee-for-service Medicare program is more attractive than a Medicare Advantage plan. As a result, enrollment in the health plans HCP serves may decrease.

Table of Contents

Managed care companies offer alternative products such as regional preferred provider organizations, or PPOs, and private fee-for-service plans. Medicare PPOs and private fee-for-service plans allow their patients more flexibility in selecting physicians than Medicare Advantage health plans, which typically require patients to coordinate care with a primary care physician. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 has encouraged the creation of regional PPOs through various incentives, including certain risk corridors, or cost-reimbursement provisions, a stabilization fund for incentive payments, and special payments to hospitals not otherwise contracted with a Medicare Advantage plan that treat regional plan enrollees. The formation of regional Medicare PPOs and private fee-for-service plans may affect HCP s relative attractiveness to existing and potential Medicare patients in their service areas.

The payments for the local and regional Medicare Advantage plans are based on a competitive bidding process that may indirectly cause a decrease in the amount of the PMPM fee or result in an increase in benefits offered.

The annual enrollment process and subsequent lock-in provisions of the Health Reform Acts may adversely affect HCP s level of revenue growth as it will limit the ability of a health plan to market to and enroll new Medicare beneficiaries in its established service areas outside of the annual enrollment period.

Commencing in 2012, CMS will allow Medicare beneficiaries who are enrolled in a Medicare Advantage plan with a quality rating of 4.5 stars or less to enroll in a five-star rated Medicare Advantage plan at any time during the benefit year. None of the plans HCP serves are five-star rated. Therefore, HCP may face a competitive disadvantage in recruiting and retaining Medicare beneficiaries.

In addition to the competitive threats intrinsic to the Medicare programs, competition among health plans and among healthcare providers may also have a negative impact on HCP s profitability. For example, California, Nevada, and Florida have become increasingly attractive to health plans that may compete with HCP, including the health plans with which HCP and its affiliated physicians, physician groups, and IPAs currently compete. HCP may not be able to continue to compete profitably in the healthcare industry if additional competitors enter the same market. If HCP cannot compete profitably, the ability of HCP to compete with other service providers that contract with competing health plans may be substantially impaired. Similarly, California, Nevada, and Florida have also become increasingly attractive to HCP s competitors due to the large populations of Medicare beneficiaries. HCP may not be able to continue to compete effectively if additional competitors enter the same regions.

HCP competes directly with various regional and local companies that provide similar services in HCP s Existing Geographic Regions. HCP s competitors vary in size and scope and in terms of products and services offered. HCP believes that some of its competitors and potential competitors may be significantly larger than HCP and have greater financial, sales, marketing, and other resources. Furthermore, it is HCP s belief that some of its competitors may make strategic acquisitions or establish cooperative relationships among themselves.

A disruption in HCP s healthcare provider networks could have an adverse effect on HCP s operations and profitability.

In any particular service area, healthcare providers or provider networks could refuse to contract with HCP, demand higher payments, or take other actions that could result in higher healthcare costs, disruption of benefits to HCP s members, or difficulty in meeting applicable regulatory or accreditation requirements. In some service areas, healthcare providers or provider networks may have significant market positions. If healthcare providers or provider networks refuse to contract with HCP, use their market position to negotiate favorable contracts, or place HCP at a competitive disadvantage, then HCP s ability to market products or to be profitable in those service areas could be adversely affected. HCP s provider networks could also be disrupted by the financial insolvency of a large provider group. Any disruption in HCP s provider networks could result in a loss of members or higher healthcare costs.

Table of Contents

HCP s revenues and profits could be diminished if HCP fails to retain and attract the services of key primary care physicians.

Key primary care physicians with large patient enrollment could retire, become disabled, terminate their provider contracts, get lured away by a competing independent physician association or medical group, or otherwise become unable or unwilling to continue practicing medicine or contracting with HCP or its affiliated physicians, physician groups, or IPAs, including as a result of HCP no longer being physician-owned after the Merger. Moreover, given limitations relating to the enforcement of post-termination noncompetition covenants in California, it would be difficult to restrict a primary care physician from competing with HCP s affiliated physicians, physician groups, or IPAs. As a result, members who have been served by such physicians could choose to enroll with competitors physician organizations or could seek medical care elsewhere, which could reduce HCP s revenues and profits. Moreover, HCP may not be able to attract new physicians to replace the services of terminating physicians or to service its growing membership.

HCP regularly explores potential acquisitions, which if consummated could affect its financial condition, results of operations or other aspects of its business.

HCP regularly explores potential acquisitions, which if consummated could affect its financial condition, results of operations or other aspects of its business. There can be no assurance that HCP will be able to identify suitable acquisition candidates or that, if identified, HCP would be able to consummate an acquisition on acceptable terms. There can also be no assurance that HCP will be successful in completing any acquisitions that it might be considering, or integrating any acquired business into its overall operations, or that any such acquired business will operate profitably or will not otherwise adversely impact HCP s results of operations.

Participation in Accountable Care Organization programs is subject to federal regulation, is new and subject to evolving regulatory development, and supervision and may result in financial liability.

The Health Reform Acts establish a Medicare shared savings program for ACOs, which took effect in January 2012. Participating ACOs that meet specified quality performance standards will be eligible to share in any savings below a specified benchmark amount. The Secretary of HHS is also authorized, but not required, to use capitation payment models with ACOs. The continued development and expansion of ACOs will have an uncertain impact on HCP s business, revenue, and profitability.

As an initial step in the formation and development of ACOs, CMS has issued contracts for participation in a Pioneer ACO program. HCP, through certain of its subsidiaries, was awarded contracts to participate as a Pioneer ACO in California, Nevada, and Florida. HCP is in the process of implementing such operations. The Pioneer ACO program provides for a three-year participation with opportunities for upside incentives and downside risk liability for an assigned population of Medicare fee-for-service patients. It is the responsibility of HCP s subsidiary ACOs to provide care to, and manage the health of, a patient population in California, Nevada, and Florida drawn from the traditional Medicare fee-for-service program, using a panel of specified physicians and healthcare facilities. The Pioneer ACO program requires participants to report on ACO operations, utilize healthcare information technology, and attempt to improve the quality of patient care.

The ACO programs are new and therefore operational and regulatory guidance is limited. It is possible that the operations of HCP s subsidiary ACOs may not fully comply with current or future regulations and guidelines applicable to ACOs, may not achieve quality targets or cost savings, or may not attract or retain sufficient physicians or patients to allow HCP to meet its objectives. Additionally, poor performance could put the HCP ACOs at financial risk and obligation to CMS. Traditionally, other than fee-for-service billing by the medical clinics and healthcare facilities operated by HCP, HCP has not directly contracted with CMS and has not operated any health plans or provider sponsored networks. Therefore, HCP may not have the necessary experience, systems, or compliance to successfully achieve a positive return on its ACOs investment or to avoid financial or regulatory liability. To date, demonstration projects using healthcare delivery models substantially similar to an ACO have not resulted in savings. HCP believes that its historical experience with fully delegated managed care will be applicable to operation of its subsidiary ACOs, but there can be no such assurance.

Table of Contents

California hospitals may terminate their agreements with HCPAMG or reduce the fees they pay to HCP.

In California, HCPAMG maintains significant hospital arrangements designed to facilitate the provision of coordinated hospital care with those services provided to members by HCPAMG and its affiliated physicians, physician groups, and IPAs. Through contractual arrangements with certain key hospitals, HCPAMG provides utilization review, quality assurance, and other management services related to the provision of patient care services to members by the contracted hospitals and downstream hospital contractors. In the event that any one of these key hospital agreements is amended in a financially unfavorable manner or is otherwise terminated, such events could have a material adverse effect on HCP s business, financial condition, and results of operations.

HCP s professional liability and other insurance coverages may not be adequate to cover HCP s potential liabilities.

HCP maintains professional liability insurance and other insurance coverage through California Medical Group Insurance Company, Risk Retention Group, an Arizona corporation in which HCP is a part owner. HCP believes such insurance is adequate based on industry standards. Nonetheless, potential liabilities may not be covered by insurance, insurers may dispute coverage or may be unable to meet their obligations, or the amount of insurance coverage and/or related reserves may be inadequate. There can be no assurances that HCP will be able to obtain insurance coverage in the future, or that insurance will continue to be available on a cost-effective basis, if at all. Moreover, even if claims brought against HCP are unsuccessful or without merit, HCP would have to defend itself against such claims. The defense of any such actions may be time-consuming and costly and may distract HCP management s attention. As a result, HCP may incur significant expenses and may be unable to effectively operate HCP s business.

Changes in the rates or methods of third-party reimbursements may adversely affect HCP operations.

HCP derives a substantial portion of its revenue from direct billings to governmental healthcare programs, such as Medicare and Medicaid, and private health insurance companies and/or health plans, including but not limited to those participating in the Medicare Advantage program. As a result, any negative changes in governmental capitation or fee-for-service rates or methods of reimbursement for the services HCP provides could have a significant adverse impact on HCP s revenue and financial results.

Medicare program reimbursements for physician services as well as other services to Medicare beneficiaries who are not enrolled in Medicare Advantage plans are based upon the fee-for-service rates set forth in the Medicare Physician Fee Schedule, which relies, in part, on a target-setting formula system called the Sustainable Growth Rate, or SGR. Each year, on January 1st, the Medicare program updates the Medicare Physician Fee Schedule reimbursement rates. Many private payors use the Medicare Physician Fee Schedule to determine their own reimbursement rates. Based on the SGR, the annual fee schedule update is adjusted to reflect the comparison of actual expenditures to target expenditures. Because one of the factors for calculating the SGR is linked to the growth in the U.S. gross domestic product, or GDP, the SGR formula may result in a negative payment update if growth in Medicare beneficiaries use of services exceeds GDP growth, a situation which has occurred every year since 2002 and the reoccurrence of which HCP cannot predict.

CMS determined that, effective January 1, 2012, the SGR formula results in a payment cut of approximately 27 percent. Congress, however, enacted the Temporary Payroll Tax Cut Continuation Act of 2011, which blocked this cut through the end of February 2012. In February 2012, Congress passed the Middle Class Tax Relief and Job Creation Act of 2012, or Tax Relief Act, which blocks the cut through the end of 2012. While Congress has repeatedly intervened to mitigate the negative reimbursement impact associated with the SGR formula, there is no guarantee that Congress will continue to do so in the future. Moreover, the existing methodology may result in significant yearly fluctuations in the Medicare Physician Fee Schedule amounts, which may be unrelated to changes in the actual costs of providing physician services. Unless Congress enacts a change to the SGR methodology, the uncertainty regarding reimbursement rates and fluctuation will continue to

exist. Moreover, if Congress does change the SGR methodology or substitute a new system for physician fee-for-service payments, it may require reductions in other Medicare programs including Medicare Advantage to offset such additional costs.

Another provision that affects physician payments under the Medicare Physician Fee Schedule is an adjustment under the Medicare statute to reflect the geographic variation in the cost of delivering physician services, by comparing those costs to the national average. Medicare payments to physicians under the Medicare Physician Fee Schedule are geographically adjusted to reflect the varying cost of delivering physician services across areas. The adjustments are made by indices, known as the Geographic Practice Cost Indices, or GPCI, that reflect how each geographic area compares to the national average. In 2003, Congress established that for three years there would be a floor of 1.0 on the work component of the Medicare Physician Fee Schedule formula used to determine physician payments, which meant that physician payments would not be reduced in a geographic area just because the relative cost of physician work in that area fell below the national average. Congress extended the GPCI work floor several times since its enactment in 2003. The Tax Relief Act provides another extension through 2012. Although Congress has extended the GPCI work floor several times, there is no guarantee that Congress will block the adjustment in the future, which could result in a decrease in payments HCP receives for physician services.

Congress has a strong interest in reducing the federal debt, which may lead to new proposals designed to achieve savings by altering payment policies. The BCA established a Joint Select Committee on Deficit Reduction, which had the goal of achieving a reduction in the federal debt level of at least $1.2 trillion. As a result of the Joint Select Committee s failure to draft a proposal by the BCA s deadline, automatic cuts in various federal programs will commence in January 2013. Although the Medicaid program is exempt from these cuts, Medicare payments to providers are not exempt. The BCA does, however, provide that the Medicare cuts to providers may not exceed 2%. At this time it is unclear how this automatic reduction may be applied to various Medicare healthcare programs, including physician reimbursement. Therefore it is not possible at this time to estimate what impact, if any, the BCA will have on HCP s business or results of operations.

As noted, the cuts described above will occur automatically as a matter of law. Certain members of Congress, however, want to achieve even greater reductions in the federal debt, and they want to change entitlement programs, such as Medicare. It is difficult to assess whether and to what extent Congress will alter Medicare payment policies.

Because governmental healthcare programs generally reimburse on a fee schedule basis rather than on a charge-related basis, HCP generally cannot increase its revenues from these programs by increasing the amount it charges for its services. Moreover, if HCP s costs increase, HCP may not be able to recover its increased costs from these programs. Government and private payors have taken and may continue to take steps to control the cost, eligibility for, use, and delivery of healthcare services as a result of budgetary constraints, cost containment pressures and other reasons. HCP believes that these trends in cost containment will continue. These cost containment measures, and other market changes in non-governmental insurance plans have generally restricted HCP s ability to recover, or shift to non-governmental payors, any increased costs that HCP experiences. HCP s business and financial operations may be materially affected by these developments.

HCP s business model depends on numerous complex management information systems, and any failure to successfully maintain these systems or implement new systems could materially harm HCP s operations and result in potential violations of healthcare laws and regulations.

HCP depends on a complex, specialized, and integrated management information system and standardized procedures for operational and financial information, as well as for HCP s billing operations. HCP may be unable to enhance its existing management information systems or implement new management information systems where necessary. Additionally, HCP may experience unanticipated delays, complications, or expenses in implementing, integrating, and operating its systems. HCP s management information systems may require modifications, improvements, or replacements that may require both substantial expenditures as well as

interruptions in operations. HCP s ability to implement these systems is subject to the availability of information technology and skilled personnel to assist HCP in creating and implementing these systems.

HCP s failure to successfully implement and maintain all of its systems could have a material adverse effect on its business, financial condition, and results of operations. For example, HCP s failure to successfully operate its billing systems could lead to potential violations of healthcare laws and regulations. If HCP is unable to handle its claims volume, or if HCP is unable to pay claims timely, HCP may become subject to a health plan s corrective action plan or de-delegation until the problem is corrected, and/or termination of the health plan s agreement with HCP. This could have a material adverse effect on HCP s operations and profitability. In addition, if HCP s claims processing system is unable to process claims accurately, the data HCP uses for its IBNR estimates could be incomplete and HCP s ability to accurately estimate claims liabilities and establish adequate reserves could be adversely affected. Finally, if HCP s management information systems are unable to function in compliance with applicable state or federal rules and regulations, including, without limitation, medical information confidentiality laws such as the Health Insurance Portability and Accountability Act of 1996, or HIPAA, possible penalties and fines as a result of this lack of compliance could have a material adverse effect on HCP s business, financial condition, and results of operations.

Federal and state privacy and information security laws are complex, and HCP may be subject to government or private actions due to privacy and security breaches.

HCP must comply with numerous federal and state laws and regulations governing the collection, dissemination, access, use, security and privacy of protected health information, or PHI, including the Health Insurance Portability and Accountability Act of 1996 and its implementing privacy and security regulations, as amended by the federal Health Information Technology for Economic and Clinical Health Act, or HITECH Act and collectively referred to as HIPAA. In the event that HCP s non-compliance with existing or new laws and regulations related to PHI results in privacy or security breaches, HCP could be subject to monetary fines, civil suits, civil penalties or criminal sanctions and requirements to disclose the breach publicly.

HCP may be impacted by eligibility changes to government and private insurance programs.

Due to potential decreased availability of healthcare through private employers, the number of patients who are uninsured or participate in governmental programs may increase. The Health Reform Acts will increase the participation of individuals in the Medicaid program in states that elect to participate in the expanded Medicaid coverage. A shift in payor mix from managed care and other private payors to government payors or the uninsured may result in a reduction in the rates of reimbursement or an increase in uncollectible receivables or uncompensated care, with a corresponding decrease in net revenue. Changes in the eligibility requirements for governmental programs such as the Medicaid program under the Health Reform Acts and state decisions on whether to participate in the expansion of such programs also could increase the number of patients who participate in such programs or the number of uninsured patients. Even for those patients who remain with private insurance, changes in those programs could increase patient responsibility amounts, resulting in a greater risk for uncollectible receivables. These factors and events could have a material adverse effect on HCP s business, financial condition, and results of operations.

Negative publicity regarding the managed healthcare industry generally or HCP in particular could adversely affect HCP s results of operations or business.

Negative publicity regarding the managed healthcare industry generally, or the Medicare Advantage program or HCP in particular, may result in increased regulation and legislative review of industry practices that further increase HCP s costs of doing business and adversely affect HCP s results of operations or business by:

- requiring HCP to change its products and services;
- increasing the regulatory, including compliance, burdens under which HCP operates, which, in turn, may negatively impact the manner in which HCP provides services and increase HCP s costs of providing services;

Table of Contents

adversely affecting HCP s ability to market its products or services through the imposition of further regulatory restrictions regarding the manner in which plans and providers market to Medicare Advantage enrollees; or

adversely affecting HCP s ability to attract and retain members.

Risks Relating to the Merger

Under the accounting rules applicable to the contingent consideration, DaVita must determine the fair value of the contingent consideration on a quarterly basis, which could result in DaVita recording changes in the fair value as an expense in its financial statements, and any such expense may have an adverse impact on DaVita s earnings and DaVita s ability to predict the amount of earnings.

A portion of the merger consideration is contingent upon HCP s performance following the closing of the Merger. The accounting rules applicable to the contingent consideration require that DaVita determine the fair value of the contingent consideration on a quarterly basis. To the extent that the fair value in any quarter exceeds the prior quarter s determination, DaVita will be required to record the increase in fair value as an expense in its financial statements. Any such expense will reduce DaVita s net income in the quarter in which it is recognized. These requirements will also limit DaVita s ability to predict its earnings in the quarters in which it must assess the fair value of the contingent consideration, and have not been included in any of DaVita s existing earnings guidance.

The Merger is subject to the receipt of approvals, waivers or consents from regulatory authorities and third parties that may impose conditions that could have an adverse effect on DaVita, and DaVita may terminate the Merger Agreement if holders of more than 5% of the outstanding HCP common units validly exercise dissenters rights.

Before the Merger can be completed, various approvals, waivers or consents must be obtained from regulatory authorities. These authorities may impose conditions on the completion of the Merger or require changes to the terms of the Merger. Although DaVita and HCP do not currently expect that any such conditions or changes will be imposed, there can be no assurance that they will not be, and such conditions or changes could have the effect of delaying completion and closing of the Merger or imposing additional costs on or limiting the revenues of DaVita following the Merger. See HCP s Business Government Regulations beginning on page S-184. In addition, HCP must obtain the consent of third parties to assign certain contracts, including contracts with health plans. In addition, DaVita may terminate the Merger Agreement if, at the time of termination, holders of more than 5% of the outstanding HCP common units have validly exercised their dissenters rights (and not withdrawn such exercise or otherwise become ineligible to effect such exercise) in respect of the transactions.

HCP operates in a different line of business from DaVita s historical business, and the Merger is significantly larger than any other acquisition DaVita has made to date. DaVita may face challenges managing HCP as a new business and may not realize anticipated benefits.

The Merger is the largest acquisition DaVita has attempted to date and will result in DaVita being significantly engaged in a new line of business. Upon entering into a new line of business, DaVita may not have the expertise, experience, and resources to pursue all of its businesses at once, and it may be unable to successfully operate the businesses. The administration of the businesses will require implementation of appropriate operations, management, and financial reporting systems and controls. DaVita may experience difficulties in effectively implementing these and other systems. The management of HCP will require the focused attention of DaVita s management team, including a significant commitment of its time and resources. The need for management to focus on these matters could have a material and adverse impact on DaVita s revenues and operating results. If the HCP operations are less profitable than DaVita currently anticipates or if DaVita does not have the experience, the appropriate expertise, or the resources to pursue all businesses in the combined company, the results of operations and financial condition may be materially and adversely affected.

Table of Contents

HCP will become a subsidiary of DaVita following the Merger. If HCP s liabilities are greater than expected, or if there are unknown HCP obligations, DaVita s business could be materially and adversely affected.

As a result of the Merger, HCP will become a subsidiary of DaVita and HCP s liabilities, including contingent liabilities, will be consolidated with DaVita s. DaVita may learn additional information about HCP s business that adversely affects DaVita, such as unknown liabilities, issues relating to internal controls over financial reporting or issues that could affect DaVita s ability to comply with other applicable laws, including healthcare laws and regulations. As a result, DaVita cannot assure you that the Merger will be successful or will not, in fact, harm its business. Among other things, if HCP s liabilities are greater than expected, or if there are obligations of HCP of which DaVita is not aware at the time of completion of the Merger, DaVita s business could be materially and adversely affected.

DaVita has limited indemnification rights in connection with matters affecting HCP. HCP may also have other unknown liabilities which DaVita will be responsible for after the Merger. If DaVita is responsible for liabilities not covered by indemnification rights or substantially in excess of amounts covered through any indemnification rights, DaVita could suffer severe consequences that would substantially reduce its revenues, earnings and cash flows.

If we fail to successfully integrate HCP into our internal control over financial reporting or if the current internal control of HCP over financial reporting were found to be ineffective, the integrity of DaVita s and/or HCP s financial reporting could be compromised which could result in a material adverse effect on our reported financial results.

As a private company, HCP has not been subject to the requirements of the Securities Exchange Act of 1934, as amended, with respect to internal control over financial reporting, and for a period of time after the consummation of the Merger our management evaluation and auditor attestation regarding the effectiveness of our internal control over financial reporting will be permitted to exclude the operations of HCP. The integration of HCP into our internal control over financial reporting will require significant time and resources from our management and other personnel and will increase our compliance costs. If we fail to successfully integrate these operations into our internal control over financial reporting, our internal control over financial reporting may not be effective. Failure to achieve and maintain an effective internal control environment could have a material adverse effect on our ability to accurately report our financial results and the market s perception of our business and our stock price. In addition, if HCP s internal control over financial reporting were found to be ineffective, the integrity of HCP s past financial reporting could be adversely impacted.

Risks Relating to Investment in the Notes

The notes will be unsecured.

Except as described under Description of Notes Escrow of proceeds; release conditions, the notes will not be secured by any of our or our subsidiaries assets. The indenture governing the notes permits us and our subsidiaries to incur secured debt, including pursuant to our existing and future senior secured credit facilities and other forms of secured debt. As a result, the notes and the guarantees will be effectively subordinated to all of our and the guarantors existing and future secured obligations to the extent of the value of the assets securing such obligations. As of June 30, 2012, after giving pro forma effect to the Financings and the Merger as if they had occurred on that date, DaVita and the guarantors would have had total secured debt of approximately $5,650 million and approximately $284 million of additional secured debt available to be borrowed under our amended senior secured credit facilities (after giving effect to outstanding letters of credit of approximately $66 million), and the notes and the guarantees would have been structurally subordinated to $510 million of liabilities, including $64 million of indebtedness and the rest being primarily trade payables, of non-guarantor subsidiaries.

If we or the subsidiary guarantors were to become insolvent or otherwise fail to make payment on the notes or the guarantees, except as described under Description of Notes Escrow of proceeds; release conditions,

Table of Contents

holders of any of our and the subsidiary guarantors secured obligations would be paid first out of the proceeds of the assets securing such obligations before the holders of the notes would receive any payments from such proceeds. You may therefore not be fully repaid, or repaid at all, if we or the subsidiary guarantors become insolvent or otherwise fail to make payment on the notes.

The indentures governing the notes offered hereby, our outstanding 6 3/8% Senior Notes due 2018, or our 2018 Notes, and our outstanding 6 5/8% Senior Notes due 2020, or our 2020 Notes, and the agreement governing the existing senior secured credit facilities contain, and we expect that the agreement governing the amended senior secured credit facilities will contain, various covenants which limit our management s discretion in the operation of our business.

The indentures governing the notes offered hereby, the 2018 Notes and the 2020 Notes restrict, among other things, our ability and the ability of our restricted subsidiaries to:

- incur additional indebtedness and issue certain preferred stock;
- make certain distributions, investments and other restricted payments;
- sell certain assets;
- agree to restrictions on the ability of restricted subsidiaries to make payments to us;
- create liens;
- merge, consolidate or sell substantially all of our assets; and
- enter into certain transactions with affiliates.

In addition, the agreement governing our existing senior secured credit facilities requires us to comply with, and we expect that the agreement governing our amended senior secured credit facilities will require us to comply with, certain financial ratios and negative covenants. Our ability to comply with the ratios and covenants may be affected by events beyond our control.

Any failure to comply with the restrictions of the indenture governing the notes offered hereby, the 2018 Notes or the 2020 Notes, or of the existing or amended senior secured credit facilities or any other subsequent financing agreements, may result in an event of default under those agreements. Such a default will generally allow the creditors under the applicable agreement to declare the debt outstanding thereunder to be due and payable immediately, and such default and acceleration may cause other debt to become immediately due and payable as a result of cross-acceleration or cross-default provisions in such other indebtedness. In addition, lenders may have the right in these circumstances to terminate any commitments they have to provide further borrowings. Our assets and cash flow may not be sufficient to fully repay borrowings under our outstanding debt agreements if accelerated upon an event of default.

Federal and state statutes may allow courts, under specific circumstances, to void the guarantees and require noteholders to return payments received from guarantors.

Under federal bankruptcy law and comparable provisions of state fraudulent transfer laws, a guarantee could be deemed a fraudulent transfer if the guarantor received less than a reasonably equivalent value in exchange for giving the guarantee and

was insolvent on the date that it gave the guarantee or became insolvent as a result of giving the guarantee, or

was engaged in business or a transaction, or was about to engage in business or a transaction, for which property remaining with the guarantor was an unreasonably small capital, or

intended to incur, or believed that it would incur, debts that would be beyond the guarantor s ability to pay as those debts matured.

Table of Contents

A court would likely find that a guarantor did not receive reasonably equivalent value or fair consideration for its guarantee if the guarantor did not substantially benefit directly or indirectly from the issuance of the guarantees. A guarantee could also be deemed a fraudulent transfer if it was given with actual intent to hinder, delay or defraud any entity to which the guarantor was or became, on or after the date the guarantee was given, indebted.

The measures of insolvency for purposes of the foregoing laws will vary depending upon the law applied in any proceeding with respect to the foregoing. Generally, however, a guarantor would be considered insolvent if:

- the sum of its debts, including contingent liabilities, is greater than all its assets, at a fair valuation, or
- the present fair saleable value of its assets is less than the amount that would be required to pay its probable liability on its existing debts, including contingent liabilities, as they become absolute and mature, or
- it could not pay its debts as they become due.

We cannot predict:

- what standard a court would apply in order to determine whether a guarantor was insolvent as of the date it issued the guarantee or whether, regardless of the method of valuation, a court would determine that the guarantor was insolvent on that date; or
- whether a court would determine that the payments under the guarantee constituted fraudulent transfers or conveyances on other grounds.

The indenture governing the notes offered hereby will contain a savings clause intended to limit each subsidiary guarantor s liability under its guarantee to the maximum amount that will result in the obligations of such subsidiary guarantor under its guarantee of the notes not constituting a fraudulent conveyance or fraudulent transfer under applicable law. However, as was demonstrated in a recent bankruptcy case originating in the State of Florida which was affirmed by the Eleventh Circuit Court of Appeals on other grounds, this provision may not be effective to protect the subsidiary guarantees from being voided under fraudulent conveyance or fraudulent transfer laws. Accordingly, there can be no assurance that this provision will be upheld as intended.

If a guarantee is deemed to be a fraudulent transfer, it could be voided altogether, or it could be subordinated to all other debts of the guarantor. In such case, any payment by the guarantor pursuant to its guarantee could be required to be returned to the guarantor or to a fund for the benefit of the creditors of the guarantor. If a guarantee is voided or held unenforceable for any other reason, holders of the notes offered hereby would cease to have a claim against the subsidiary guarantor based on the guarantee and would be creditors only of the Company and any guarantor whose guarantee was not similarly voided or otherwise held unenforceable.

We may not have sufficient funds to purchase notes upon a change of control.

If there is a change of control (as defined in the indenture governing the notes) and we have not previously exercised our right to redeem all of the outstanding notes as described under Description of Notes Optional redemption or Description of Notes Special mandatory redemption, each holder of notes may require us to purchase all or a portion of its notes at a purchase price equal to 101% of the principal amount thereof, plus accrued interest to the date of purchase. Certain agreements governing our existing and future indebtedness (including the agreements governing our existing and anticipated amended senior credit facilities) restrict or may restrict our ability to purchase the notes upon a change of control. As a result, in order to purchase notes following a change of control, we may be required to seek the consent of holders of our other indebtedness to purchase the notes or to refinance our outstanding indebtedness, which we might not be able to do, and even if we were able to refinance our other indebtedness, any financing might be on terms unfavorable to us. Under those circumstances, if we do not obtain the consent of the holders of our other indebtedness or refinance our other indebtedness, we will or may be prohibited from purchasing notes.

Table of Contents

We cannot assure you that we will have the financial ability to purchase outstanding notes upon the occurrence of a change of control. This risk is increased by the fact that the indentures governing the 2018 Notes and the 2020 Notes contain change of control provisions requiring us to offer to repurchase all of the outstanding 2018 Notes and the 2020 Notes upon the occurrence of change of control events substantially similar to those that would require us to offer to repurchase the notes offered hereby. The amount required to be escrowed by the Company as described below under Description of Notes Escrow of proceeds; release conditions is less than the amount required to pay for all of the outstanding notes upon the occurrence of a change of control.

In addition, our existing senior secured credit facilities provide, and we expect that our amended senior secured credit facilities will provide, that the occurrence of certain kinds of change of control events will constitute a default under our senior secured credit facilities. Any future agreements to which we become a party may contain similar restrictions and provisions. In the event a change of control under the indenture governing the notes offered hereby occurs at a time when we are prohibited from purchasing notes pursuant to such agreements and we do not obtain a consent or repay the borrowings, we will remain prohibited from purchasing notes. Our failure to purchase tendered notes would constitute an event of default under the indenture which may, in turn, constitute a default under our other debt agreements. See Description of Notes Change of control and Events of default. Likewise, any failure or inability to repurchase the 2018 Notes or the 2020 Notes upon the occurrence of change of control events specified in the indentures governing those notes could have similar consequences.

Courts interpreting change of control provisions under New York law (which will be the governing law of the indenture governing the notes) have not provided clear and consistent meanings of such change of control provisions, leading to subjective judicial interpretation. In addition, a court case in Delaware has questioned whether a change of control provision contained in an indenture could be unenforceable on public policy grounds. No assurances can be given that another court would enforce the change of control provisions in the indenture governing the notes as written for the benefit of the holders of the notes, or as to how these change of control provisions would be impacted were we to become a debtor in a bankruptcy case.

Furthermore, the change of control provisions of the notes may not provide holders of the notes protection in the event of in the event of highly leveraged transactions, reorganizations, restructurings, mergers, or similar transactions involving us that may adversely affect holders of notes. In particular, such a transaction may not give rise to a change of control, in which case we would not be required to make an offer to purchase the notes as required by the indenture governing the notes.

In addition, under the indenture governing the notes offered hereby, a change of control will occur when a majority of the members of our board of directors are not continuing directors (as defined in the indenture). In a decision in connection with a proxy contest, the Court of Chancery of Delaware held that the occurrence of a change of control under a similar indenture provision may nevertheless be avoided if the existing directors were to approve the slate of new director nominees (who would constitute a majority of the new board of directors) as continuing directors solely for purposes of avoiding the triggering of such change of control clause, provided the incumbent directors give their approval in the good faith exercise of their fiduciary duties. Therefore, in certain circumstances involving a significant change in the composition of our board of directors, including in connection with a proxy contest where our board of directors does not endorse a dissident slate of directors but approves them as continuing directors, holders of the notes may not be entitled to require us to make an offer to purchase the notes as required by the indenture governing the notes.

Moreover, a change of control will occur under the indenture governing the notes when there is a sale, lease, transfer, conveyance or other disposition (other than by way of merger or consolidation) of all or substantially all of the assets of DaVita and its restricted subsidiaries (as defined in the indenture), taken as a whole. Although there is a limited body of case law interpreting the phrase substantially all, there is no precise established definition of the phrase under applicable law. Accordingly, in certain circumstances there may be uncertainty as to whether a particular transaction would involve a disposition of substantially all of the

Table of Contents

property of DaVita and its restricted subsidiaries. As a result, it may be unclear whether a change of control has occurred under the indenture governing the notes and whether a holder of notes offered hereby may require us to make an offer to repurchase the notes under those circumstances.

Investors may find it difficult to trade the notes.

The notes are a new issue of securities and there is currently no public market for the notes. We do not intend to apply for a listing of the notes on any securities exchange or quotation system. Although the underwriters have informed us that they intend to make a market in the notes, they are under no obligation to do so and may discontinue any market making activities at any time without notice. Any such market making will be subject to the limitations imposed by the Securities Act of 1933, as amended and the Securities Exchange Act of 1934, as amended.

We also cannot assure you that you will be able to sell your notes at a particular time or that the prices that you receive when you sell will be favorable. We also cannot assure you as to whether a trading market for the notes will develop or as to the liquidity of any trading market for the notes which may develop. Future trading prices of the notes will depend on many factors, including:

- our operating performance, prospects and financial condition or the operating performance, prospects and financial condition of companies in our industry generally;
- prevailing interest rates and other economic conditions;
- the interest of securities dealers in making a market for the notes; and
- the market for similar securities.

It is possible that the market for the notes will be subject to disruptions. Any disruptions may have a negative effect on the holders of the notes, regardless of our prospects and financial performance.

Changes in credit ratings issued by nationally recognized statistical rating organizations could adversely affect our cost of financing and the market price of the notes.

Credit rating agencies rate our debt securities on factors that include our operating results, actions that we take, their view of the general outlook for our industry and their view of the general outlook for the economy. Actions taken by the rating agencies can include maintaining, upgrading, or downgrading the current rating or placing us on a watch list for possible future downgrading. Downgrading the credit rating of our debt securities or placing us on a watch list for possible future downgrading would likely increase our cost of financing, limit our access to the capital markets and have an adverse effect on the market price of the notes.

Not all of our subsidiaries or other entities included in our consolidated financial statements guarantee our obligations under the notes, and the assets of the non-guarantor subsidiaries and other entities may not be available to make payments on the notes.

Certain of our domestic subsidiaries will not be guarantors of the notes. In addition, while we currently do not have significant foreign operations, the notes will not be guaranteed by any of our existing or future foreign subsidiaries. Payments on the notes are only required to be made by the subsidiary guarantors and us. As a result, no payments are required to be made from the assets of subsidiaries that do not guarantee the notes. As of June 30, 2012, after giving pro forma effect to the Financings and the Merger as if they had occurred as of that date, our non-guarantor subsidiaries would have had aggregate total indebtedness and other liabilities including trade debt of approximately $510 million on their respective balance sheets and would have represented approximately 16.0% of our total assets as of June 30, 2012.

In the event of a bankruptcy, liquidation or reorganization of any of the non-guarantor subsidiaries, holders of their indebtedness and other obligations, including their trade creditors, will be entitled to payment of their

claims from the assets of those subsidiaries before any assets are made available for distribution to us. As a result, the notes are structurally subordinated to all the liabilities of the non-guarantor subsidiaries. The indenture governing the notes offered hereby will permit, our existing senior secured credit facilities permit, and our amended senior secured credit facilities are expected to permit the incurrence of certain additional indebtedness by our non-guarantor subsidiaries in the future.

HCP provides services to certain affiliated physician groups that are not owned by HCP, will not constitute Subsidiaries (as defined in the indenture governing the notes) and will not guarantee the notes, even though the accounts of these groups are consolidated with the financial statements of HCP and would be consolidated with the financial statements of the Company following the Merger. Pursuant to management agreements between HCP and these affiliated physician groups, a substantial portion of the aggregate net revenues of these groups is payable to subsidiaries of HCP and will be payable to entities that will be guarantors of the notes as compensation for management and administrative services under management services agreements. See HCP s Business Government Regulations Corporate Practice of Medicine and Fee Splitting. As of June 30, 2012, after giving pro forma effect to the Financing and the Merger as if they had occurred on that date, our consolidated balance sheet would have included third party liabilities of these affiliated physician groups, in the amount of approximately $305 million and assets of these affiliated physician groups in the amount of approximately $510 million after elimination of intercompany receivables (or approximately 3% of our consolidated total assets at that date). The pro forma consolidated net operating revenues and Adjusted EBITDA of DaVita for the twelve months ended June 30, 2012, giving effect to the Financing and the Merger as if they had occurred on July 1, 2011, would have been $9,929 million and $2,167 million, respectively. The pro forma consolidated net operating revenues and Adjusted EBITDA of DaVita, excluding HCP s affiliated physician groups and DaVita s existing non-guarantor Subsidiaries, for the twelve months ended June 30, 2012, giving effect to the Financing and the Merger as if they had occurred on July 1, 2011, would have been $6,623 million and $1,744 million, respectively. Substantially all of the difference between pro forma consolidated Adjusted EBITDA of $2,167 million and the pro forma consolidated Adjusted EBITDA excluding HCP s affiliated physician groups and DaVita s existing non-guarantor subsidiaries of $1,744 million for the twelve months ended June 30, 2012 is attributable to the exclusion of the existing non-guarantor subsidiaries of DaVita. The consolidated net operating revenues and Adjusted EBITDA of HCP for the twelve months ended June 30, 2012 were $2,564 million and $561 million, respectively. Excluding HCP s affiliated physician groups, but inclusive of the management fees earned by HCP from the affiliated physician groups of $725 million, the net operating revenue and Adjusted EBITDA of HCP for the twelve months ended June 30, 2012 would have been $1,731 million and $557 million, respectively. Excluding the management fees earned by HCP from the affiliated physician groups, HCP net operating revenue for the twelve months ended June 30, 2012 would have been $1,006 million.

If the conditions to our Merger with HCP and certain other conditions are not satisfied on or prior to the Escrow End Date, or in certain other circumstances, we will be required to redeem all of the notes. If this occurs, you may not obtain your expected return on the notes.

Upon consummation of the offering of the notes, we will deposit the net proceeds (after deducting the underwriting discount from this offering), together with additional amounts needed to redeem the notes into escrow at the special mandatory redemption price as described in Description of Notes Escrow of proceeds; release conditions. If the conditions to our Merger with HCP and certain other conditions are not satisfied on or prior to the Escrow End Date, or if we notify the escrow agent that we will not pursue consummation of the Merger, the amounts deposited in escrow will be applied to redeem all of the notes offered hereby at a special mandatory redemption price equal to 100% of the issue price of the notes, plus accrued and unpaid interest from the date of initial issuance, or the most recent date to which interest has been paid or duly provided for, as the case may be, to but excluding the special mandatory redemption date. See Description of Notes Special mandatory redemption. There can be assurance that the conditions to our Merger with HCP or these other conditions, many of which are beyond our control, will be satisfied. Likewise, the Merger Agreement may be terminated under various circumstances specified therein or may be terminated or amended voluntarily by agreement of us and HCP. If we are not able to satisfy the conditions to the Merger and these other conditions prior to the Escrow End Date, or we give the escrow agent the notice described above prior to that date, the

Table of Contents

amounts deposited in escrow will be applied to effect this special mandatory redemption. Following such redemption, you may not be able to reinvest the proceeds from the redemption in an investment that yields a return comparable to the return on the notes. Additionally, you may suffer a loss on your investment if you purchased the notes at a price greater than the special optional redemption price. As a result, you may not obtain your expected return on the notes or you may suffer a loss on your investment in the notes.

We will not be required to redeem the notes if, between the date of this prospectus supplement and the consummation of the Merger with HCP, we or HCP experiences adverse changes in our respective business or financial condition.

Your decision to invest in the notes is made at the time of this offering of the notes. You will have no rights under the special mandatory redemption provisions as long as the conditions to the Merger with HCP and certain other conditions are satisfied or waived and none of the other events that would require us to effect a special optional redemption as described in the preceding risk factor occurs, in each case on or prior to the Escrow End Date. Likewise, we will not be required to redeem the notes, nor will you have any right to require us to repurchase your notes, if, between the closing of the notes offering and the closing of the Merger, we or HCP experience adverse changes in our respective businesses, results of operations, financial condition or prospects, or if the terms of the Merger change.

If a bankruptcy or reorganization case is commenced, bankruptcy laws may prevent the release of the escrowed funds.

If we or any of our subsidiaries commences a bankruptcy or reorganization case, or one is commenced against us or any of our subsidiaries, while amounts remain in the escrow account described under Description of Notes Escrow of proceeds; release conditions, applicable bankruptcy laws may prevent the escrow agent from releasing, the escrowed funds. or applying those funds to effect a special mandatory redemption of the notes or otherwise applying those funds for the benefit of the holders of the notes. The court adjudicating that case might find that such escrow account is the property of the bankruptcy estate. Although the amounts in the escrow account will be pledged as collateral for payment, if required, of the special mandatory redemption price, the automatic stay provisions of the federal bankruptcy laws generally prohibit secured creditors from foreclosing upon or disposing of a debtors property without bankruptcy court approval. As a result, holders of the notes may not be able to have the escrow funds applied at the time or in the manner contemplated by the indenture and could suffer a loss as a result.

Our substantial indebtedness could adversely affect our financial health and prevent us from fulfilling our obligations under the notes.

As of June 30, 2012, after giving pro forma effect to the Financings and the Merger as if each of the Financings and the Merger had occurred on that date, we would have had approximately $8,308 million in outstanding debt excluding the debt discounts associated with our term loans on our consolidated balance sheet and approximately $284 million of available unused borrowing capacity under the revolving portion of our amended senior secured credit facilities (after giving effect to outstanding letters of credit of approximately $66 million) and for the twelve months then ended our debt expense, calculated on a pro forma basis as if the Financings and the Merger had occurred as of the first day of such twelve month period, would have been approximately $430 million. Our substantial indebtedness could have important consequences to you. For example, it could:

- make it more difficult for us to satisfy our obligations with respect to the notes,
- increase our vulnerability to general adverse economic and industry conditions,
- require us to dedicate a substantial portion of our cash flow from operations to payments on our indebtedness, thereby reducing the availability of our cash flow to fund working capital, capital expenditures, acquisitions and investments and other general corporate purposes,

expose us to interest rate fluctuations because the interest on the debt under our amended senior secured credit facilities may be at variable rates,

limit our flexibility in planning for, or reacting to, changes in our business and the markets in which we operate,

place us at a competitive disadvantage compared to our competitors that have less debt, and

limit our ability to borrow additional funds.

In addition, we may incur substantial additional indebtedness in the future. The terms of the indentures governing the notes, the 2008 Notes or the 2010 Notes, the existing senior secured credit facilities and the amended senior secured credit facilities will allow us to incur substantial additional debt. If new debt is added to current debt levels, the related risks described above could intensify. If additional debt financing is not available when required or is not available on acceptable terms, we may be unable to grow our business, take advantage of business opportunities, respond to competitive pressures or refinance maturing debt, any of which could have a material adverse effect on our operating results and financial condition.

We will require a significant amount of cash to service our indebtedness. Our ability to generate cash depends on many factors beyond our control.

Our ability to make interest and principal payments on our indebtedness, including the notes, and to fund planned capital expenditures and expansion efforts, including any strategic acquisitions we may make in the future, will depend on our ability to generate cash. This, to a certain extent, is subject to general economic, financial, competitive, regulatory and other factors that are beyond our control.

We cannot assure you that our business will generate sufficient cash flow from operations in the future, that our currently anticipated growth in revenue and cash flow will be realized on schedule or that future borrowings will be available to us in an amount sufficient to enable us to service our indebtedness, including the notes, to refinance our indebtedness when it matures or to fund other liquidity needs. We may need to refinance all or a portion of our indebtedness, including the notes, on or before maturity. Our existing senior secured credit facilities are secured and our amended senior secured credit facilities will be secured by substantially all of our and the subsidiary guarantors assets. In particular, our existing senior secured credit facilities are secured by first priority pledges of 100% of the equity interests owned by us in our direct and indirect domestic subsidiaries and 65% of the equity interests of our direct foreign subsidiaries and the amended or any successor credit facility is likely to be secured on a similar basis. As such, our ability to refinance the notes or seek additional financing could be limited by the fact that these assets have been pledged to secure borrowings under our credit facilities. We cannot assure you that we will be able to service or refinance our indebtedness on commercially reasonable terms or at all.

Table of Contents

THE MERGER

Rationale for the Merger

DaVita believes that the Merger with HCP can open a large new market for DaVita the integrated healthcare services market that HCP serves offering considerable growth opportunities beyond domestic dialysis. The combination offers the potential to create an industry leading company that may be well positioned to capitalize on anticipated trends in U.S. healthcare, including growth in managed healthcare services, especially to the Medicare-eligible population.

As a significant participant in healthcare delivery with a proven track record, HCP is a recognized leader in its field and should allow DaVita to significantly expand the range of services it provides with only limited additional operational resources required. HCP s industry leadership provides it substantial credibility with governmental entities, physician groups, large hospital systems and payors across the U.S.

There are many similarities in the values and cultures of DaVita and HCP, including a strong common culture of putting the patient first. In the case of HCP, this is demonstrated by its commitment to and the success of its integrated care model, which has had high quality clinical outcomes and has been able to effectively manage its costs under capitated arrangements. DaVita believes that HCP s business model is in the right place to capitalize on long-term trends in healthcare in the U.S. the need to more effectively manage the cost of providing healthcare services, especially to the Medicare-eligible population, while continuing to deliver high quality care. In addition, DaVita believes that HCP s experience may be able to help DaVita achieve attractive reimbursement for globally capitated kidney care.

Merger Agreement

On May 20, 2012, we entered into a Merger Agreement providing for our acquisition of HCP pursuant to the Merger of a newly formed wholly owned subsidiary of DaVita into HCP. Under the Merger Agreement, HCP will be the surviving entity in the Merger and will become a wholly owned subsidiary of DaVita. Following the Merger, DaVita will be renamed DaVita HealthCare Partners Inc.

If the Merger is completed, the total merger consideration to be paid to the holders of HCP common units and vested and unvested options to purchase HCP common units is an aggregate of $3.6 billion in cash and approximately 9.4 million shares of DaVita common stock, subject to certain adjustments.

In addition to the merger consideration payable at the closing of the Merger and amounts that may be released over time from the escrow accounts as further described below in Merger Agreement Escrows , HCP members and holders of HCP options may receive up to $275.0 million of additional cash consideration in the form of two separate earn-out payments of $137.5 million in cash that are based on the financial performance of HCP and the achievement of certain financial targets for fiscal years 2012 and 2013.

The completion of the Merger is subject to various customary conditions, including, among others, (i) obtaining the approval of HCP s members, (ii) subject to certain materiality exceptions, the accuracy of the representations and warranties made by DaVita and HCP, respectively, and compliance by DaVita and HCP with their respective obligations under the Merger Agreement, and (iii) declaration of the effectiveness by the Securities and Exchange Commission of the registration statement filed by DaVita regarding the shares of DaVita common stock to be issued in the Merger.

The Merger must be approved by a vote of the majority of the HCP members. The board of managers of HCP made a recommendation to the HCP members to approve the principal terms of the Merger and the Merger Agreement and the holders of approximately 74% of the outstanding HCP common units has entered into a voting agreement with DaVita pursuant to which it has agreed to vote in favor of the principal terms of the Merger and the Merger Agreement. Accordingly, pursuant to such voting agreement the HCP member approval is assured.

Table of Contents

The Merger Agreement contains certain termination rights for each of DaVita and HCP and provides that DaVita is required to pay HCP a $125.0 million termination fee in the event that the Merger Agreement is terminated under certain circumstances. Specifically, in the event that DaVita cannot obtain the financing required for the Merger, each party to the Merger generally has the right to terminate the Merger Agreement and HCP may be entitled to the termination fee.

The Merger Agreement provides that at the closing the DaVita board of directors will be increased in size by one member, and Dr. Robert Margolis, Chairman and Chief Executive Officer of HCP, will be appointed to fill the newly created directorship as Co-Chairman . In addition, for a minimum period of four consecutive annual meetings of stockholders of DaVita, Dr. Margolis will hold the office of Co-Chairman until the expiration of his term of office or until his successor is duly elected and qualified, subject to his earlier death, resignation, disqualification, or removal in accordance with DaVita s bylaws and/or applicable law.

Merger Agreement Escrows

Approximately $575 million of the closing merger consideration will be withheld from payment and contributed to escrow accounts that support a potential working capital adjustment, certain indemnification obligations, certain contingent payments, and certain costs and expenses that may be incurred by the HCP member representative designated in the Merger Agreement. Beginning on the second anniversary of the closing, funds in escrow, to the extent not previously released or reserved for certain indemnity claims, will be released on various dates, with the final release to occur on or about October 15, 2017.

Employment Agreements

Concurrently with the execution of the Merger Agreement, each of Dr. Margolis, Mr. Mazdyasni, Dr. Chin, Dr. Thomas Paulsen, Executive Medical Director, California of HCP, Zan Calhoun, Chief Operating Officer of HCP, and Lorie Glisson, Chief Executive Officer JSA Healthcare, entered into an employment agreement with HCP and DaVita that will become effective upon the consummation of the Merger.

Financing of the Merger

We expect to finance the cash portion of the Merger consideration through a combination of available cash, the net proceeds of the notes offered hereby, and additional borrowings under our senior secured credit facilities, which senior secured credit agreement is expected to be amended to permit or facilitate, among other things, the additional borrowings under the senior secured credit facilities, the Merger and this note offering. There is no financing condition to the Merger; however, DaVita must use its reasonable best efforts to arrange and obtain the financing required to consummate the Merger.

We currently intend to enter into an amendment to our senior secured credit facilities to provide for additional borrowings in an aggregate principal amount of $3,000 million, comprised of:

- a new five year Term Loan A-3 facility in an aggregate principal amount of $1,350 million, and
- a new seven year Term Loan B-2 facility in an aggregate principal amount of $1,650 million.

The proceeds from these additional borrowings, together with available cash, will be used to finance a portion of the cash portion of the Merger consideration, to repay approximately $198 million of our Term Loan A-2 outstanding under our existing senior secured credit agreement, to repay the net amount of HCP indebtedness as a result of the Merger, and pay related fees and expenses.

We intend to borrow all $3,000 million of the term loans and issue $1,000 million of the notes offered hereby. Based upon the amount of available cash, and the proceeds of the notes and secured debt expected to be available to the Company, after giving pro forma effect to the Financing and the Merger as if they had occurred on June 30, 2012, we do not anticipate borrowing any amounts under our revolving credit facility.

Table of Contents

The terms and conditions of the amended senior secured credit facilities have not been finalized and are subject to change. We may not finalize the terms until prior to the consummation of the Merger, but after the issuance of the notes offered hereby.

We expect that our amended senior secured credit facilities will be guaranteed by a substantial portion of our direct or indirect wholly owned domestic subsidiaries and will be secured by substantially all of our and our subsidiary guarantors assets. In particular, these facilities will be secured by first priority pledges of 100% of the equity interests owned by us and the subsidiary guarantors in our direct domestic subsidiaries and 65% of the equity interests of our and the subsidiary guarantors direct foreign subsidiaries, if any.

We expect that our amended senior credit facilities will contain limits and restrictions on certain of our business activities. In addition, we expect that the amended senior secured credit facilities will require compliance on a quarterly basis with certain financial covenants.

As a result of the borrowings that we will incur to finance the Merger, the aggregate amount of our indebtedness and annual debt expense will increase substantially following the Merger. See Risk Factors, Capitalization and Unaudited Pro Forma Condensed Consolidated Financial Information.

Table of Contents

USE OF PROCEEDS

We estimate the net proceeds from this offering, after deducting the underwriting discount and other estimated expenses payable by us, will be approximately $983.0 million. The net proceeds, after deducting the underwriting discount, will be deposited into an escrow account upon the closing of this offering. Funds held in escrow will be released upon the consummation of the Merger and satisfaction of certain other conditions and we intend to use the escrowed proceeds from this offering, together with proceeds from our anticipated amended senior secured credit facilities and cash on hand, to finance the aggregate cash consideration of the Merger and pay related fees and expenses. The following table illustrates the sources and uses of funds from the Financing.

Sources of Funds (in millions)	
Amended senior secured credit facilities[1]	$ 3,000
Notes offered hereby	1,000
Equity consideration[2]	907
Cash from balance sheet	67
Total sources	$ 4,974

Uses of Funds (in millions)	
Cash portion of purchase price[3]	$ 3,592
Equity portion of purchase price[2]	907
Repayment of Term Loan A-2	198
Repayment of HCP s existing debt[4]	187
Estimated fees and expenses	90
Total uses	$ 4,974

(1) Assumes that such amounts are obtained through the issuance of additional term loans under the amended senior secured credit facilities. The terms of the amended senior secured credit facilities have not yet been finalized and are subject to change.

(2) Based upon the issuance of 9,380,312 shares of Davita Inc. common stock valued at the closing market price on August 10, 2012 as reported by the NYSE.

(3) The cash portion of the purchase price for HCP consists of $3.66 billion in cash less an estimated negative working capital adjustment of $68 million.

(4) Represents HCP s debt to be repaid at the closing of the Merger (based upon HCP s existing debt net of available cash, in each case as of June 30, 2012).

If the Merger is not consummated on or prior to the Escrow End Date, or if we notify the escrow agent that we will not pursue consummation of the Merger, the amount deposited in escrow will be applied to redeem all of the notes offered hereby at a special mandatory redemption price equal to 100% of the issue price of the notes, plus accrued and unpaid interest from the date of initial issuance, or the most recent date to which interest has been paid or duly provided for, as the case may be, to but excluding the special mandatory redemption date. If the conditions to the Merger are satisfied on or before the Escrow End Date, the amounts deposited in escrow will be released to us and applied to finance a portion of the cash consideration for the merger. See Use of Proceeds and Description of Notes Special mandatory redemption. Funds held in the escrow until released from escrow will be invested in be invested in short-term, investment-grade, interest bearing securities.

Table of Contents

CAPITALIZATION

The following table sets forth our capitalization as of June 30, 2012:

on an actual basis,

on an as adjusted basis to give effect to the Financings, as if they had occurred on that date, and

on a further adjusted basis to give effect to the Merger as if it had occurred on that date.

You should read the following table in conjunction with the financial statements incorporated by reference in this prospectus supplement and the related notes thereto and the section of the prospectus supplement entitled Use of Proceeds.

	As of June 30, 2012		
	Actual	As Adjusted	As Further Adjusted
	(Unaudited, dollars in millions)		
Cash and cash equivalents	$ 273	$ (67)	$ 206[5]
Senior debt:			
Senior secured credit facilities:			
Revolving credit facility[1]			
Term loans			
Existing Term Loan A and Term Loan B	2,649		2,649
Term Loan A-2	198	(198)	
New Term Loans[2]		3,000	3,000
Other	36		36
Total secured debt	$ 2,883		$ 5,685
Unsecured debt:			
Existing notes	1,550		1,550
New notes offered hereby		1,000	1,000
Other	72		72
Total unsecured debt	$ 1,622		$ 2,622
Total debt[3]	$ 4,505		$ 8,307
Net debt[4]	4,281		8,167
Total DaVita Inc. shareholders equity	2,379	896	3,275
Total capitalization	$ 7,157		$ 11,788

(1) As of June 30, 2012, after giving pro forma effect to the Financings and the Merger as if they had occurred on that date, DaVita and the guarantors would have had approximately $284 million available for future borrowings under the revolving credit facility (after giving effect to letters of credit of approximately $66 million).

(2) Excludes upfront fees payable to lenders, if any.

(3) Total debt refers to total funded debt outstanding and excludes the unamortized balance of debt discounts associated with our Term Loans.

(4) Net debt is total debt including our outstanding letters of credit (approximately $49 million on an actual basis and approximately $66 million on an as adjusted basis to give effect to the Financings and the Merger) less cash and cash equivalents.

(5) As adjusted balance excludes the effect of expenses.

Table of Contents

UNAUDITED PRO FORMA CONDENSED CONSOLIDATED FINANCIAL INFORMATION

The following table presents unaudited pro forma condensed consolidated financial information about the financial condition and results of operations of DaVita after giving effect to the Merger. The unaudited pro forma condensed consolidated income statement data for the six months ended June 30, 2012 and the year ended December 31, 2011 give effect to the Merger as if the Merger had taken place on January 1, 2011. The unaudited pro forma condensed consolidated balance sheet data gives effect to the Merger as if it had taken place on June 30, 2012.

The following unaudited pro forma condensed consolidated financial information has been prepared by applying the purchase method of accounting with DaVita treated as the acquirer and does not give effect to any potential cost savings or other operating efficiencies that could result from the Merger. In addition, DaVita s fair value of consideration paid to HCP unitholders will be allocated to the assets acquired and liabilities assumed based upon their estimated fair values as of the date of the Merger. The allocation is dependent upon certain valuations and other studies that have not progressed to the state where there is sufficient information to make a definitive allocation. Accordingly, the purchase price allocation pro forma adjustments are preliminary and have been made solely for the purpose of providing unaudited pro forma condensed consolidated financial information in this prospectus supplement. The actual number of shares of DaVita common stock issued in respect of each unit of HCP in the Merger will be established shortly before completion of the Merger.

You should read the information set forth below in conjunction with each of DaVita s and HCP s consolidated financial statements and the related notes, Management s Discussion and Analysis of Financial Condition and Results of Operations, DaVita Selected Historical Financial and Other Data, HCP Selected Historical Financial and Other Data and Unaudited Pro Forma Condensed Consolidated Financial Information. The unaudited pro forma condensed consolidated financial information set forth below has been presented for informational purposes only and is not necessarily indicative of what the consolidated financial condition or results of operations actually would have been had the Merger been completed as of the dates indicated. In addition, the unaudited pro forma condensed consolidated financial information presented below does not purport to project the consolidated financial condition or operating results for any future period.

Table of Contents

Unaudited pro forma condensed consolidated statement of income

Year ended December 31, 2011

	Historical DaVita	Historical HCP	Pro forma adjustment[i] Merger and related financing	Pro forma consolidated
	(dollars in millions, except per share data)			
Net dialysis patient service revenues, less provision for uncollectable accounts of $190	$ 6,273	$		$ 6,273
Integrated care revenue		2,375		2,375
Other revenues[1]	519	47		566
Net operating revenues	6,792	2,422		9,214
Operating expenses and charges:				
Patient care costs	4,681	1,721		6,402
General and administrative	691	207	(2)[a]	896
Depreciation and amortization	267	31	143[a]	425
			(16)[a]	
Provision for uncollectible accounts	7			7
Equity investment income	(9)	(25)		(34)
Goodwill impairment charge	24			24
Total operating expenses and charges	5,661	1,934		7,720
Operating income	1,131	488		1,494
Debt expense	(241)	(16)	(169)[b]	(434)
			(12)[b]	
			17[b]	
			(13)[b]	
Other income	3	8		11
Income from continuing operations before income taxes	893	480		1,071
Income tax expense	316	71	3[c]	390
Income from continuing operations	577	409		681
Discontinued operations:				
Income from operations of discontinued operations, net of tax	1			1
Loss on disposal of discontinued operations, net of tax	(5)			(5)
Net income	573	409		677
Less: Net income attributable to noncontrolling interests	(95)			(95)
Net income attributable to DaVita Inc.	$ 478	$ 409		$ 582
Earnings per share:				
Basic income from continuing operations per share attributable to DaVita Inc.	$ 5.09			$ 5.63
Basic net income per share attributable to DaVita Inc.	$ 5.05			$ 5.59
Diluted income from continuing operations per share attributable to DaVita Inc.	$ 4.99			$ 5.53

Diluted net income per share attributable to DaVita Inc.	$ 4.96		$ 5.49
Weighted average shares for earnings per share:				
Basic	94,658,027	9,380,312	104,038,339
Diluted	96,532,110	9,380,312	105,912,422
Amounts attributable to DaVita Inc.:				
Income from continuing operations	$ 482		$ 586
Discontinued operations	(4)		(4)
Net income	$ 478		$ 582

(1) Other revenues for DaVita include revenues from our ancillary services and strategic initiatives and fees for providing management and administrative services and the other revenues for HCP include revenues primarily from consulting services and fees from providing management and administrative services.

Table of Contents

Notes to unaudited pro forma condensed consolidated statement of income

Year ended December 31, 2011

(a) Reflects net amortization expense associated with the customer relationships, non-compete agreements and other intangible assets. The customer relationships are being amortized over seventeen years, the non-compete agreements are being amortized over three and seven years and the other intangible assets are being amortized over five to ten years, as set forth in the table below:

	Amount	Life	Amortization
		(dollars in millions)	
Customer relationships	$ 940	17	$ 55
Non-compete agreements	$ 220	3-7	33
Other intangibles	$ 478	5-10	55
			$ 143

Historical HCP amortization expense of $16 million will be replaced with the estimated $143 million of amortization expense as a result of recording the acquisition at fair value.

Transaction costs of $2 million that were recognized during the year ended December 31, 2011 have been reversed since they represent non-recurring charges directly related to the transaction.

(b) Reflects adjustments to interest expense to reflect: (i) increase in annual interest expense of $169 million associated with borrowings under the amended senior secured credit facilities and the incurrence of the additional senior indebtedness, (ii) the amortization of deferred financing costs and debt discount associated with the Financings of approximately $12 million, (iii) reduced interest expense associated with the repayment of HCP s outstanding debt of approximately $14 million, and (iv) the amortization of previously recognized deferred financings costs and interest expense with respect to DaVita s previously outstanding Term Loan A-2 of $3 million. Pro forma debt expense assumes a weighted average effective interest rate of 4.48% including the impact of our anticipated new swap agreements for the year ending December 31, 2011. Pro forma debt expense assumes the interest rates on the financings that we expect to obtain at the time of closing, actual interest rates may vary. An increase or decrease of 0.125% in the interest rate applicable to the additional $3,802 million of indebtedness at closing of the Merger would result in an approximate change of approximately $5 million in debt expense annually (assuming that (A) DaVita will enter into swap agreements with respect to the additional borrowings under the amended senior secured credit facilities with a notional amount of $1,350 million and associated debt expense of $13 million and (B) the prevailing LIBOR rate on the closing date of the Merger will be less than the assumed interest rate floor of 1.00% associated with the portion of the additional borrowings under the amended senior secured credit facilities that will not be subject to the swap agreements referred to in clause (A)).

(c) Reflects the adjustment to the income tax expense amount of $3 million based on the overall pro forma pre-tax income at 40.0% after considering noncontrolling interests.

(i) The unaudited pro forma condensed consolidated statement of income for the year ended December 31, 2011 gives effect to the acquisition of HCP and related borrowings as if each had occurred on January 1, 2011.

Table of Contents

Unaudited pro forma condensed consolidated statement of income

six months ended June 30, 2012

	Historical DaVita	Historical HCP	Pro forma adjustment[i] Merger and related financing	Pro forma consolidated
		(dollars in millions, except per share data)		
Dialysis patient service operating revenue, less provision for uncollectable accounts of $107	$ 3,465	$		$ 3,465
Integrated care revenue		1,294		1,294
Other revenues[1]	332	28		360
Net operating revenues	3,797	1,322		5,119
Operating expenses and charges:				
Patient care costs	2,575	940		3,515
General and administrative	422	110	(19)[a]	513
Depreciation and amortization	154	16	72[a]	234
			(8)[a]	
Provision for uncollectible accounts	4			4
Equity investment income	(5)	(12)		(17)
Legal proceeding contingency accrual and related expenses	78			78
Total operating expenses	3,228	1,054		4,327
Operating income	569	268		792
Debt expense	(122)	(6)	(83)[b]	(212)
			(6)[b]	
			11[b]	
			(6)[b]	
Other income, net	2	4		5
Income before income taxes	449	266		585
Income tax expense	164	33	23[c]	220
Net income	285	233		365
Less: Net income attributable to noncontrolling interests	(49)			(49)
Net income	$ 236	$ 233		$ 316
Earnings per share:				
Basic	$ 2.51			$ 3.06
Diluted	$ 2.46			$ 3.01
Weighted average shares for earnings per share:				
Basic	93,970,295		9,380,312	103,350,607

Diluted	95,865,605	9,380,312	105,245,917

(1) Other revenues for DaVita include revenues from our ancillary services and strategic initiatives and fees for providing management and administrative services and the other revenues for HCP include revenues primarily from consulting services and fees from providing management and administrative services.

Table of Contents

Notes to unaudited pro forma condensed consolidated statement of income

six months ended June 30, 2012

(a) Reflects net amortization expense associated with the customer relationships, non-compete agreements and other intangible assets. The customer relationships are being amortized over seventeen years, the non-compete agreements are being amortized over seven and three years and the other intangible assets are being amortized over five to ten years, as set forth in the table below:

	Amount	Life	Amortization
		(dollars in millions)	
Customer relationships	$ 940	17	$ 28
Non-compete agreements	$ 220	3-7	16
Other intangibles	$ 478	5-10	28
			$ 72

Historical HCP amortization of $8 million will be replaced with the estimated $72 million of amortization expense as a result of recording the acquisition at fair value.

Transaction costs of $19 million that were recognized during the first six months of 2012 have been revered since they represent non-recurring charges directly related to the transaction.

(b) Reflects adjustments to interest expense to reflect: (i) increase in annual interest expense of $83 million associated with borrowings under the amended senior secured credit facilities and the incurrence of the additional senior indebtedness, (ii) the amortization of deferred financing costs and debt discount associated with the Financings of approximately $6 million, (iii) reduced interest expense associated with the repayment of HCP s outstanding debt of approximately $6 million, and (iv) the amortization of previously recognized deferred financings costs and interest expense with respect to DaVita s previously outstanding Term Loan A-2 of $5 million. Pro forma debt expense assumes a weighted average effective interest rate of 4.49% including the impact of our anticipated new swap agreements for the six months ended June 30, 2012. Pro forma debt expense assumes the interest rates on the financings that we expect to obtain at the time of closing, actual interest rates may vary. An increase or decrease of 0.125% in the interest rate applicable to the additional $3,802 million of indebtedness at closing of the Merger would result in an approximate change of approximately $2 million in debt expense for the six month period (assuming that (A) DaVita will enter into swap agreements with respect to the additional borrowings under the amended senior secured credit facilities with a notional amount of $1,350 million and associated debt expense of $6 million and (B) the prevailing LIBOR rate on the closing date of the Merger will be less than the assumed interest rate floor of 1.00% associated with the portion of the additional borrowings under the amended senior secured credit facilities that will not be subject to the swap agreements referred to in clause (A)).

(c) Reflects the adjustment to the income tax expense amount of $23 million based on the overall impact of the pro forma pre-tax income at 41.0% after considering noncontrolling interests.

(i) The unaudited pro forma condensed consolidated statement of income for the six months ended June 30, 2012 gives effect to the acquisition of HCP and related borrowings as if each had occurred on January 1, 2011.

Table of Contents

DAVITA INC. AND HEALTHCARE PARTNERS HOLDINGS, LLC

UNAUDITED PRO FORMA CONDENSED CONSOLIDATED

FINANCIAL STATEMENTS

Unaudited pro forma condensed consolidated balance sheet

As of June 30, 2012

	Historical DaVita	Historical HealthCare Partners	Pro forma adjustments[i] DaVita and HealthCare Partners Merger[a]	Related Borrowings	Pro forma Consolidated
			(dollars in millions)		
Assets					
Cash and cash equivalents	$ 273	$ 355	$ (3,592)	$ 3,712[b]	$ 206
				(542)[f]	
Short-term investments	9	180			189
Accounts receivable, net	1,250	172			1,422
Inventories	78				78
Other receivables	211				211
Other current assets	46	106			152
Income tax receivable	12			1[e]	19
				4[d]	
				2[f]	
Deferred income taxes	300	7	(7)		300
Total current assets	2,179	820			2,577
Property and equipment, net	1,586	79			1,665
Amortizable intangibles, net	162	158	1,638	52[d]	1,850
			(158)	(2)[e]	
Notes receivable, net		8			8
Equity investments	28		4		32
Long-term investments	12				12
Other long-term assets	30	62	(4)	(5)[f]	83
Goodwill	5,258	288	3,361		8,716
			158		
			(288)		
			(68)		
			7		
	$ 9,255	$ 1,415			$ 14,943
Liabilities and shareholders equity					
Accounts payable	$ 299	$ 222			$ 521
Other liabilities	395		$ 144		539
Accrued compensation and benefits	436				436
Medical claims and related payables		228			228
Current portion of long-term debt	106	30		(2)[b]	188
				84[c]	
				(30)[f]	

Total current liabilities	1,236	480			1,912
Long-term debt	4,393	512		(196)[b]	8,086
				4,000[c]	
				(84)[c]	
				(27)[d]	
				(512)[f]	
Other long-term liabilities	147	107	116		370
Alliance and product supply agreement, net	17				17
Deferred income taxes	431	68	200		631
			(68)		
Total liabilities	6,224	1,167			11,016

Table of Contents

	Historical DaVita	Historical HealthCare Partners	Pro forma adjustments[i] DaVita and HealthCare Partners Merger[a]	Related Borrowings	Pro forma Consolidated
	(dollars in millions, except per share data)				
Noncontrolling interests subject to put provisions	523				523
Shareholders equity:					
Preferred stock ($0.001 par value; 5,000,000 shares authorized; none issued)					
Common stock ($0.001 par value; 450,000,000 shares authorized; 134,862,283 shares issued; 94,486,725 and 103,867,037 shares outstanding historically and on a pro forma basis, respectively)					
Additional paid-in capital	565		536		1,101
Retained earnings	3,431			(1)[e]	3,420
				(7)[d]	
				(3)[f]	
Treasury stock, at cost (40,375,558 shares historically and 30,995,246 on a pro forma basis)	(1,598)		371		(1,227)
Accumulated other comprehensive loss	(19)				(19)
Total DaVita Inc. shareholders equity	2,379				3,275
Members equity		248	(248)		
Noncontrolling interests not subject to put provisions	129				129
Total equity	2,508	248			3,404
Total liabilities plus shareholders equity	$ 9,255	$ 1,415			$ 14,943

Table of Contents

Notes to unaudited pro forma condensed consolidated balance sheet

(a) The purchase of HCP for approximately $4,749 million comprised of $3,592 million in cash (which includes the effect of an estimated negative working capital adjustment of $68 million), a $275 million contingent earn-out consideration with a preliminary estimated fair value of $250 million and $907 million from the issuance of 9,380,312 shares of DaVita common stock valued at the closing market price as reported by the NYSE as of August 10, 2012. The purchase price is subject to a final working capital true-up adjustment at closing (as described under the Merger Agreement).

	(dollars in millions)
Customer relationships	$ 940
Practice management tools	250
Non-compete agreements	220
Trade names	220
Provider network	8
Net tangible liabilities	(198)
Deferred income taxes	(200)
Other closing liabilities	(10)
Goodwill	3,519
	$ 4,749

Goodwill is also being adjusted for the elimination of HCP s historical amounts for goodwill and deferred taxes in the amount of $288 million and $61 million, respectively.

Assuming the Company s stock price were to either decrease or increase by 15% as compared to the price on August 10, 2012, then the overall purchase price would be adjusted by approximately $136 million and would result in a corresponding adjustment to goodwill.

Of the total contingent earn-out consideration, $134 million is expected to be short-term and the balance of $116 million is considered to be long-term.

The $275 million total contingent earn-out consideration as described above can be earned in two tranches. The first tranche consists of $137.5 million if the EBITDA for HCP for 2012 is equal or greater than $550 million and the second tranche consists of $137.5 million if the earn-out EBITDA for HCP for 2013 is equal or greater than $600 million. We have estimated the preliminary fair value of the contingent earn-out consideration to be $250 million as of the expected closing date. The contingent earn-out consideration will subsequently be remeasured to fair value at each reporting date until the contingency is resolved with changes in the liability due to the re-measurement recorded in earnings. Therefore, if HCP achieves both of these earn-out EBITDA targets, we would be required to record a charge to earnings in the amount of $25 million, primarily in 2013, representing the difference between the preliminary fair value of the contingent earn-out consideration of $250 million as compared to the total potential pay-out of $275 million.

Conversely, if the fair value of the contingent earn-out consideration were to decrease below the preliminary fair value amount of $250 million, we would then record a gain to earnings.

For purposes of this pro forma presentation, we estimate that the amounts for tangible assets and liabilities reflected on HCP s consolidated balance sheet approximate the fair values of such assets and liabilities, and accordingly, such amounts have not been adjusted in the accompanying pro forma financial information. Our projections and underlying assumptions concerning the initial purchase price allocations and fair values of HCP s identifiable assets, liabilities and contingent earn-out consideration represent our current best estimates and are based upon the information available to us at this time. However, these estimates are preliminary and subject to change based upon completion of final valuation analyses. Additionally, the final purchase price is subject to a working capital true-up adjustment. Accordingly, the final amounts will differ from the amounts shown above.

This includes the reclassification of equity investments of $4 million for consistent presentation.

Table of Contents

(b) Net proceeds of cash as a result of the Financings related to the acquisition of HCP as follows: net proceeds from borrowings under the amended senior credit facilities of $3,000 million, plus the net proceeds of $1,000 million from the incurrence of additional senior financing reduced by an estimated $90 million of fees and the pay-off of Term Loan A-2 for $198 million.

(c) The borrowing under the amended senior secured credit facilities and from the incurrence of the additional senior financing is set forth in the table below:

	(dollars in millions)
Senior secured credit facilities	
Term Loan A-3	$ 1,350
Term Loan B-2	1,650
Total new Term Loans	3,000
Additional Senior Financing	1,000
Total borrowings	$ 4,000

Of the $4,000 million of total borrowings, $84 million is expected to be short-term and $3,916 million is expected to be long-term.

(d) Fees and expenses totaling $90 million are expected to be paid from the proceeds of the borrowings and as described above and are as follows:

	(dollars in millions)
Deferred financing costs	$ 52
Debt discount	27
Transaction costs (expensed)	11
	$ 90

We estimate that all of the deferred financing costs of $52 million associated with the amended senior secured credit facilities and the incurrence of additional senior financing will be capitalized and that no existing deferred financing costs associated with the existing senior secured credit facilities, except for the Term Loan A-2, will be written off. However, these amounts are subject to change depending upon the final calculations that will determine the actual amount of deferred financing costs that will be capitalized or expensed.

(e) Write-off of the existing deferred financing costs associated with the extinguishment of the Term Loan A-2 of $2 million.

(f) In conjunction with the Merger, it is anticipated that all of HCP s outstanding debt totaling $542 million will be paid-off at close and the related deferred financing costs of $5 million will be written-off.

(i) The unaudited pro forma condensed consolidated balance sheet as of June 30, 2012 gives effect to the acquisition of HCP and related borrowings as if each had occurred on June 30, 2012.

Table of Contents

DAVITA SELECTED HISTORICAL FINANCIAL AND OTHER DATA

The following selected consolidated financial data should be read in conjunction with DaVita s financial statements for the years ended December 31, 2009, 2010 and 2011 and unaudited financial information for the six months ended June 30, 2012 and 2011, and related notes thereto incorporated by reference in this prospectus supplement. The consolidated statement of operations data and balance sheet data presented below are derived from DaVita s consolidated financial statements included or incorporated by reference in this prospectus supplement. Effective January 1, 2012, DaVita adopted FASB s ASU No 2011-07 Health Care Entities Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts. Upon adoption of this standard, DaVita was required to change the presentation of its provision for uncollectible accounts related to patient service revenue as a deduction from patient service operating revenues. These consolidated financial results have been revised for all prior periods presented to reflect the retrospective application of adopting these new presentation and disclosures requirement for the provision for uncollectible accounts.

	Year ended December 31,					Six months ended June 30,	
	2007	2008	2009	2010	2011	2011	2012
			(audited)			(unaudited)	
	(dollars in millions)						
Statement of operations data:							
Net dialysis patient service revenues, less provision for uncollectible accounts	$ 4,970	$ 5,247	$ 5,601	$ 5,877	$ 6,273	$ 2,992	$ 3,465
Other revenue	154	264	343	395	519	232	332
Net operating revenues	5,124	5,511	5,944	6,272	6,792	3,224	3,797
Operating expenses and charges:							
Patient care costs	3,584	3,915	4,242	4,467	4,681	2,277	2,575
General and administrative	491	508	531	579	691	315	422
Depreciation and amortization	193	216	228	234	267	126	154
Provision for uncollectible accounts	3	4	5	4	7	3	4
Valuation gain on the Product Supply Agreement[1]	(55)						
Goodwill impairment charge[1]					24	24	
Legal proceeding contingency accrual and related expenses[2]							78
Equity investment income	(1)	(1)	(2)	(9)	(9)	(4)	(5)
Total operating expenses and charges	4,215	4,642	5,004	5,275	5,661	2,742	3,228
Operating income	909	869	940	997	1,131	482	569
Debt expense[3]	(257)	(225)	(186)	(182)	(241)	(118)	(122)
Refinancing and debt redemption charges[4]				(74)			
Other income[5]	22	13	4	3	3	1	2
Income from continuing operations before income taxes	674	657	758	744	893	365	449

Income tax expense	245	236	278	260	316	130	164
Income from continuing operations	429	421	480	484	577	235	285
Discontinued operations[6]					(4)	1	
Net income	429	421	480	484	573	236	285
Less: Net income attributable to noncontrolling interests	(47)	(47)	(57)	(78)	(95)	(41)	(49)
Net income attributable to DaVita Inc.	$ 382	$ 374	$ 423	$ 406	$ 478	$ 195	$ 236
Balance sheet data (as end of period):							
Cash and cash equivalents	447	411	539	860	394	730	273
Working capital	890	965	1,256	1,699	1,128	1,478	943
Total assets	6,944	7,286	7,558	8,114	8,892	8,193	9,255
Total debt	3,707	3,695	3,632	4,309	4,505	4,286	4,498
Total shareholder s equity[7]	1,504	1,768	2,135	1,978	2,141	1,881	2,379
Operating data:							
Maintenance capital expenditures	114	105	114	159	224	88	122
Centers	1,359	1,449	1,530	1,612	1,820	1,669	1,903
Patients	107,000	112,000	118,000	125,000	143,000	131,000	150,000
U.S. Dialysis treatments	15,296,000	16,192,000	16,985,000	17,964,000	19,599,000	9,364,000	10,766,000

Table of Contents

(1) Operating expenses and charges in 2011 include $24 million of a non-cash goodwill impairment charge related to our infusion therapy business and $55 million in 2007 of valuation gains on the alliance and product supply agreement with Gambro Renal Products, Inc. Operating expenses and charges in 2007 also include $7 million of gains from insurance settlements related to Hurricane Katrina and a fire that destroyed one center.

(2) Represents a legal proceeding contingency accrual and related expenses that resulted from an agreement we reached in principle to settle the Woodard Private Civil Suit. See DaVita s Business Legal Proceedings beginning on page S-169.

(3) Debt expense in 2007 includes the write-off of approximately $4 million of deferred financing costs associated with our principal prepayments on our term loans.

(4) In 2010, we incurred $74 million of refinancing and debt redemption charges in conjunction with the extinguishment of our previously existing senior secured credit facilities and the redemption of $200 million of our previously outstanding 6 $^{5}/_{8}$% senior notes.

(5) Other income, net, includes $6 million of gains in 2007 from the sale of investment securities.

(6) During 2011, we divested a total of 28 outpatient dialysis centers in conjunction with a consent order issued by the Federal Trade Commission on September 30, 2011 in order for us to complete the acquisition of DSI. In addition, we also completed the sale of two additional centers that were previously pending state regulatory approval in conjunction with the acquisition of DSI on October 31, 2011. The operating results of the historical DaVita divested centers are reflected as discontinued operations in our consolidated financial statements for all periods presented. In addition, the operating results for the DSI divested centers are reflected as discontinued operation in our consolidated financial statements beginning September 1, 2011.

(7) Share repurchases consisted of 3,794,686 shares of DaVita common stock for $323 million in 2011, 8,918,760 shares of DaVita common stock for $618 million in 2010, 2,902,619 shares of DaVita common stock for $153 million in 2009, 4,788,881 shares of DaVita common stock for $233 million in 2008, 111,300 shares of DaVita common stock for $6 million in 2007 and 3,710,086 shares of DaVita common stock for $316 million in the first six months of 2011. Shares issued in connection with stock awards amounted to 1,260,259 in 2011, 1,771,384 in 2010, 2,104,304 in 2009, 1,314,074 in 2008, and 2,480,899 in 2007.

Table of Contents

HCP SELECTED HISTORICAL FINANCIAL AND OTHER DATA

The following selected combined and consolidated financial data should be read in conjunction with HCP s financial statements for the years ended December 31, 2009, 2010 and 2011, and unaudited financial information for the six months ended June 30, 2012 and 2011, and related notes thereto included in this prospectus and the discussion under Management s Discussion and Analysis of Financial Condition and Results of Operations included in this prospectus. The combined statement of operations and balance sheet data presented below, are derived from the combined and consolidated financial statements of HCP.

	Year ended December 31,					Six months ended June 30,	
	2007	2008	2009	2010	2011	2011	2012
			(audited)			(unaudited)	
	(dollars in millions, except operating data)						
Statement of operations data:							
Medical revenues	$ 1,187	$ 1,557	$ 1,731	$ 2,049	$ 2,375	$ 1,158	$ 1,294
Other operating revenues	42	46	46	40	47	22	28
Total operating revenues	1,229	1,603	1,777	2,089	2,422	1,180	1,322
Operating expenses and charges:							
Medical expenses	605	814	930	1,034	1,165	569	620
Hospital expenses	122	191	212	222	248	121	155
Clinic support and other operating costs	175	197	226	263	308	148	165
General and administrative expenses	120	142	136	178	207	101	110
Depreciation and amortization	19	24	26	29	31	16	16
Total operating expenses	1,041	1,368	1,530	1,726	1,959	955	1,066
Equity earnings of unconsolidated joint ventures	12	11	12	15	25	9	12
Operating income	200	246	259	378	488	234	268
Interest income	6	6	6	6	7	3	4
Interest expense	(20)	(14)	(6)	(5)	(16)	(9)	(6)
Investment impairment		(5)					
Gain on sale of investments			2		1	1	
Total other income (expense)	(14)	(13)	2	1	(8)	(5)	(2)
Income before income taxes	186	233	261	379	480	229	266
Provision for income taxes	9	30	41	49	71	37	33
Net income	$ 177	$ 203	$ 220	$ 330	$ 409	$ 192	$ 233
Balance sheet data (end of period):							
Cash and cash equivalents	154	214	358	361	395	183	355
Working capital.	28	72	179	360	304	192	341
Total assets.	590	748	911	1,286	1,366	1,188	1,415
Total debt	260	223	220	218	556	571	542
Member s equity.	84	225	340	566	188	29	248
Other financial data:							
Capital expenditures	12	28	12	21	23	11	10
Net cash provided by operating activities	218	233	286	343	509	181	184
Operating data:							

Managed care members	469,700	586,500	589,900	658,000	667,700	659,200	669,400
Medical clinic locations	82	90	99	129	152	138	157
Full time physicians	461	496	570	715	794	734	818
IPA Primary care physicians	875	1,178	1,268	1,291	1,458	1,414	1,454

Table of Contents

MANAGEMENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

DaVita

Forward-looking statements

This Management s Discussion and Analysis of Financial Condition and Results of Operations contains forward-looking statements within the meaning of the federal securities laws. All statements that do not concern historical facts are forward-looking statements and include, among other things, statements about our expectations, beliefs, intentions and/or strategies for the future. These forward-looking statements include statements regarding our future operations, financial condition and prospects, expectations for treatment growth rates, revenue per treatment, expense growth, levels of the provision for uncollectible accounts receivable, operating income, cash flow, operating cash flow, estimated tax rates, capital expenditures, the development of new centers and center acquisitions, government and commercial payment rates, revenue estimating risk and the impact of our related level of indebtedness on our financial performance, including earnings per share and the anticipated timing of the closing of the HCP transaction. These statements involve substantial known and unknown risks and uncertainties that could cause our actual results to differ materially from those described in the forward-looking statements, including, but not limited to, risks resulting from uncertainties associated with governmental regulations, general economic and other market conditions, competition, accounting estimates, the variability of our cash flows, the concentration of profits generated from commercial payor plans, continued downward pressure on average realized payment rates from commercial payors, which may result in the loss of revenue or patients, a reduction in the number of patients under higher-paying commercial plans, a reduction in government payment rates under the Medicare ESRD program or other government-based programs, the impact of health care reform legislation that was enacted in the U.S. in March 2010, changes in pharmaceutical or anemia management practice patterns, payment policies, or pharmaceutical pricing, our ability to maintain contracts with physician medical directors, legal compliance risks, including our continued compliance with complex government regulations, current or potential investigations by various governmental entities and related government or private-party proceedings, the impact of our agreement in principle to settle all allegations relating to claims arising out of previously disclosed litigation filed in 2002 in the U.S. District Court in the Eastern District of Texas to resolve the federal program claims regarding EPO relating to historical EPO practices dating back to 1997, continued increased competition from large and medium-sized dialysis providers that compete directly with us, the emergence of new models of care introduced by the government or private sector, such as accountable care organizations, independent practice association and integrated delivery systems, and changing affiliation models for physicians, such as employment by hospitals, that may further erode our patient base and reimbursement rates, our ability to complete any acquisitions, mergers or dispositions that we might be considering or announce, including the HCP transaction, or integrate and successfully operate any business we may acquire, expansion of our operations and services to markets outside the U.S., or to businesses outside of dialysis and the other risk factors set forth in our Annual Report on Form 10-K for the fiscal year ended December 31, 2011 and Part II, Item 1A. of our Quarterly Report on Form 10-Q for the quarterly period ended June 30, 2012 each as filed with the Securities and Exchange Commission. We base our forward-looking statements on information currently available to us, and we undertake no obligation to update or revise any forward-looking statements, whether as a result of changes in underlying factors, new information, future events or otherwise.

The following should be read in conjunction with our consolidated financial statements and Item 1. Business of our Annual Report Form 10-K for the fiscal year ended December 31, 2011.

Overview

We are a leading provider of kidney dialysis services, primarily in the U.S., through a network of approximately 1,809 outpatient dialysis centers and approximately 900 hospitals, located in the U.S. throughout 43 states and District of Columbia, serving a total of approximately 142,000 patients. We estimate that we have approximately a 32% market share in the U.S. based upon the number of patients that we serve. In 2011, our overall network of dialysis centers increased by 208 centers primarily as a result of acquisitions and from

Table of Contents

opening new centers. In September 2011 we acquired DSI, a medium sized dialysis provider, for approximately $723 million in net cash plus the assumption of certain liabilities. DSI contributed a net 83 dialysis centers, after which we agreed to divest a total of 30 dialysis centers in order to complete the acquisition of DSI. In addition, the overall number of patients that we serve in the U.S. increased by approximately 13% as compared to 2010.

In addition, as of December 31, 2011, we provided dialysis and administrative services to a total of 11 outpatient dialysis centers located in three countries outside of the U.S. Our international dialysis operations are currently in a start-up phase in which we primarily commenced operations during the fourth quarter of 2011. The total operating revenues generated from our international operations were not material during 2011 and are included as a component of our ancillary services and strategic initiatives. Therefore, all references in this document to dialysis and related lab services continue to refer only to our U.S. dialysis and related lab services business for the year ended December 31, 2011.

Our national scale and size, among other things, allows us to provide industry-leading quality care with superior clinical outcomes that attracts patients and referring physicians, as well as qualified medical directors, provides our patient base with convenient locations and access to a full range of services and provides us the ability to effectively control certain costs while maintaining strong compliance programs.

Our stated mission is to be the provider, partner and employer of choice. We believe our attention to these three stakeholders our patients, our business partners, and our teammates represents the major driver of our long-term performance, although we are subject to the impact of external factors such as government policy and physician practice patterns. Accordingly, two principal non-financial metrics we track are quality clinical outcomes and teammate turnover. We have developed our own composite index for measuring improvements in our clinical outcomes, which we refer to as the DaVita Quality Index, or DQI. Our clinical outcomes as measured by DQI have improved over each of the past three years which we believe directly decreases patient mortalities. Although it is difficult to reliably measure clinical performance across our industry, we believe our clinical outcomes compare favorably with other dialysis providers in the U.S. and generally exceed the dialysis outcome quality indicators of the National Kidney Foundation. In addition, over the past several years our teammate turnover has remained relatively constant, which we believe was a major contributor to our continued clinical performance improvements and also a major driver of our ability to maintain or improve clinical hours per treatment. We will continue to focus on these stakeholders and our clinical outcomes as we believe these are fundamental long-term value drivers.

Our overall financial performance was strong for 2011 and was characterized by strong treatment volume growth, primarily from acquisitions and non-acquired growth rates and by decreased operating costs from a decline in the utilization of physician-prescribed pharmaceuticals due to continued evolution of clinical practices and physicians responding to the new FDA label for EPO.

Our major financial operating performance indicators in 2011 as compared to 2010 were as follows: