Original

10-092

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: Springfield South		
Street Address: 2930 South 6th Street		
City and Zip Code: Springfield 62703		
County: Sangamon	Health Service Area 3	Health Planning Area:

Applicant /Co-Applicant Identification
[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name: DaVita, Inc.
Address: 601 Hawaii Street, El Segundo, CA 90245
Name of Registered Agent: Illinois Corporation Service Company
Name of Chief Executive Officer: Kent J. Thiry
CEO Address: 601 Hawaii Street, El Segundo, CA 90245
Telephone Number: (310) 792-2600 Ext. 2100

Type of Ownership of Applicant/Co-Applicant

☐	Non-profit Corporation	☐	Partnership		
☒	For-profit Corporation	☐	Governmental		
☐	Limited Liability Company	☐	Sole Proprietorship	☐	Other

- Corporations and limited liability companies must provide an **Illinois certificate of good standing.**
- Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.

APPEND DOCUMENTATION AS ATTACHMENT-1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Primary Contact
[Person to receive all correspondence or inquiries during the review period]

Name: Kara Friedman
Title: Attorney
Company Name: Polsinelli Shughart PC
Address: 161 North Clark Street, Suite 4200
Telephone Number: 312-873-3639
E-mail Address: kfriedman@polsinelli.com
Fax Number: 312-873-2939

Additional Contact
[Person who is also authorized to discuss the application for permit]

Name: Cindy Emley
Title: Regional Operations Director
Company Name: DaVita, Inc.
Address: 2930 South Montvale Dr. Suite A, Springfield, IL 62704
Telephone Number: (217) 547-1229
E-mail Address: Cindy.Emley@davita.com
Fax Number: (866)620-0543

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: Springfield South
Street Address: 2930 South 6th Street
City and Zip Code: Springfield 62703
County: Sangamon Health Service Area 3 Health Planning Area:

Applicant /Co-Applicant Identification

[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name: Total Renal Care, Inc.
Address: 601 Hawaii Street, El Segundo, CA 90245
Name of Registered Agent: Illinois Corporation Service Company
Name of Chief Executive Officer: Kent J. Thiry
CEO Address: 601 Hawaii Street, El Segundo, CA 90245
Telephone Number: (310) 792-2600 Ext. 2100

Type of Ownership of Applicant/Co-Applicant

- ☐ Non-profit Corporation
- ☒ For-profit Corporation
- ☐ Limited Liability Company
- ☐ Partnership
- ☐ Governmental
- ☐ Sole Proprietorship
- ☐ Other

- Corporations and limited liability companies must provide an **Illinois certificate of good standing.**
- Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.

APPEND DOCUMENTATION AS ATTACHMENT-1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Primary Contact

[Person to receive all correspondence or inquiries during the review period]

Name: Kara Friedman
Title: Attorney
Company Name: Polsinelli Shughart PC
Address: 161 North Clark Street, Suite 4200
Telephone Number: 312-873-3639
E-mail Address: kfriedman@polsinelli.com
Fax Number: 312-873-2939

Additional Contact

[Person who is also authorized to discuss the application for permit]

Name: Cindy Emley
Title: Regional Operations Director
Company Name: DaVita, Inc.
Address: 2930 South Montvale Dr. Suite A, Springfield, IL 62704
Telephone Number: (217) 547-1229
E-mail Address: Cindy.Emley@davita.com
Fax Number: (866)620-0543

Post Permit Contact

[Person to receive all correspondence subsequent to permit issuance-**THIS PERSON MUST BE EMPLOYED BY THE LICENSED HEALTH CARE FACILITY AS DEFINED AT 20 ILCS 3960**

Name: Cindy Emley
Title: Regional Operations Director
Company Name: DaVita, Inc.
Address: 2930 South Montvale Dr. Suite A, Springfield, IL 62704
Telephone Number: (217) 547-1229
E-mail Address: Cindy.Emley@davita.com
Fax Number: (866)620-0543

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: 2636 South Sixth Street LLC % William Furlong III, Springfield, IL 62703
Address of Site Owner: C/o C. Robbins Realtor, 2144 S. Macarthur Blvd., Springfield, IL 62704
Street Address or Legal Description of Site: 2930 South 6th Street, Springfield, IL 62703 **Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statement, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease or a lease.**
APPEND DOCUMENTATION AS ATTACHMENT-2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

[Provide this information for each applicable facility, and insert after this page.]

Exact Legal Name: Total Renal Care, Inc. d/b/a Springfield South
Address: 601 Hawaii Street, El Segundo, CA 90245

☐ Non-profit Corporation ☐ Partnership
☒ For-profit Corporation ☐ Governmental
☐ Limited Liability Company ☐ Sole Proprietorship ☐ Other

- Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.
- Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.
- **Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.**

APPEND DOCUMENTATION AS ATTACHMENT-3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Organizational Relationships

Provide (for each co-applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in Part 1130.140). If the related person or entity is participating in the development or funding of the project, describe the interest and the amount and type of any financial contribution.

APPEND DOCUMENTATION AS ATTACHMENT-4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Flood Plain Requirements

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2005-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at **www.FEMA.gov** or **www.illinoisfloodmaps.org**. **This map must be in a readable format**. In addition please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2005-5 **(http://www.hfsrb.illinois.gov)**.

APPEND DOCUMENTATION AS ATTACHMENT -5, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

Provide documentation regarding compliance with the requirements of the Historic Resources Preservation Act.

APPEND DOCUMENTATION AS ATTACHMENT-6, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

DESCRIPTION OF PROJECT

1. Project Classification

[Check those applicable - refer to Part 1110.40 and Part 1120.20(b)]

Part 1110 Classification:	Part 1120 Applicability or Classification: [Check one only.]
☐ Substantive	☐ Part 1120 Not Applicable
☒ Non-substantive	☐ Category A Project
	☒ Category B Project
	☐ DHS or DVA Project

2. Narrative Description

Provide in the space below, a brief narrative description of the project. Explain **WHAT** is to be done in **State Board defined terms**, **NOT WHY** it is being done. If the project site does NOT have a street address, include a legal description of the site. Include the rationale regarding the project's classification as substantive or non-substantive.

DaVita, Inc. and Total Renal Care, Inc. (the "Applicants") request authority from the Illinois Health Facilities and Services Review Board ("HFSRB") to establish a twelve station end stage renal disease ("ESRD") facility to be located at 2930 South 6th Street, Springfield, IL 62703. The proposed dialysis facility will include a total of 6,100 gross square feet.

The Project is considered substantive because it involves the establishment of a health care facility.

Project Costs and Sources of Funds

Complete the following table listing all costs (refer to Part 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to Part 1130.140) of the component must be included in the estimated project cost. If the project contains non-reviewable components that are not related to the provision of health care, complete the second column of the table below. Note, the use and sources of funds must equal.

Project Costs and Sources of Funds			
USE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Preplanning Costs	0		0
Site Survey and Soil Investigation	0		0
Site Preparation	0		0
Off Site Work	0		0
New Construction Contracts	0		0
Modernization Contracts	761,000		761,000
Contingencies	76,100		76,100
Architectural/Engineering Fees	61,000		61,000
Consulting and Other Fees	48,000		48,000
Movable or Other Equipment (not in construction contracts)	471,161		471,161
Bond Issuance Expense (project related)	0		0
Net Interest Expense During Construction (project related)	0		0
Fair Market Value of Leased Space or Equipment	778,570		778,570
Other Costs To Be Capitalized	0		0
Acquisition of Building or Other Property (excluding land)	0		0
TOTAL USES OF FUNDS	**$2,195,831**		**$2,195,831**
SOURCE OF FUNDS	**TOTAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities	1,417,261		1,417,261
Pledges	0		0
Gifts and Bequests	0		0
Bond Issues (project related)	0		0
Mortgages	0		0
Leases (fair market value)	778,570		778,570
Governmental Appropriations	0		0
Grants	0		0
Other Funds and Sources	0		0
TOTAL SOURCES OF FUNDS	**$2,195,831**		**$2,195,831**

NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT-7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Related Project Costs

Provide the following information, as applicable, with respect to any land related to the project that will be or has been acquired during the last two calendar years:

Land acquisition is related to project ☐ Yes ☒ No
Purchase Price: $_____
Fair Market Value: $_____

The project involves the establishment of a new facility or a new category of service
☒ Yes ☐ No

If yes, provide the dollar amount of all **non-capitalized** operating start-up costs (including operating deficits) through the first full fiscal year when the project achieves or exceeds the target utilization specified in Part 1100.

Estimated start-up costs and operating deficit cost is $ 1,789,999.

Project Status and Completion Schedules

Indicate the stage of the project's architectural drawings:

☐ None or not applicable ☒ Preliminary
☐ Schematics ☐ Final Working

Anticipated project completion date (refer to Part 1130.140): December 31, 2012

Indicate the following with respect to project expenditures or to obligation (refer to Part 1130.140):

☐ Purchase orders, leases or contracts pertaining to the project have been executed.
☐ Project obligation is contingent upon permit issuance. Provide a copy of the contingent "certification of obligation" document, highlighting any language related to CON Contingencies
☒ Project obligation will occur after permit issuance.

APPEND DOCUMENTATION AS ATTACHMENT-8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

State Agency Submittals

Are the following submittals up to date as applicable:

☐ Cancer Registry – NOT APPLICABLE
☐ APORS – NOT APPLICABLE
☒ All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
☒ All reports regarding outstanding permits

Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.

Cost Space Requirements

Provide in the following format, the department/area **DGSF** or the building/area **BGSF** and cost. The type of gross square footage either **DGSF** or **BGSF** must be identified. The sum of the department costs **MUST** equal the total estimated project costs. Indicate if any space is being reallocated for a different purpose. Include outside wall measurements plus the department's or area's portion of the surrounding circulation space. **Explain the use of any vacated space.**

		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Dept. / Area	**Cost**	**Existing**	**Proposed**	**New Const.**	**Modernized**	**As Is**	**Vacated Space**
REVIEWABLE							
Medical Surgical							
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical							
NON REVIEWABLE							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
TOTAL							

APPEND DOCUMENTATION AS ATTACHMENT-9, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Facility Bed Capacity and Utilization NOT APPLICABLE

Complete the following chart, as applicable. Complete a separate chart for each facility that is a part of the project and insert following this page. Provide the existing bed capacity and utilization data for the latest **Calendar Year for which the data are available. Include observation days in the patient day totals for each bed service.** Any bed capacity discrepancy from the Inventory will result in the application being deemed **incomplete**.

FACILITY NAME:		**CITY:**			
REPORTING PERIOD DATES:		**From:**		**to:**	
Category of Service	**Authorized Beds**	**Admissions**	**Patient Days**	**Bed Changes**	**Proposed Beds**
Medical/Surgical					
Obstetrics					
Pediatrics					
Intensive Care					
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
General Long Term Care					
Specialized Long Term Care					
Long Term Acute Care					
Other ((identify)					
TOTALS:					

CERTIFICATION

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) are:

- in the case of a corporation, any two of its officers or members of its Board of Directors;
- in the case of a limited liability company, any two of its managers or members (or the sole manger or member when two or more managers or members do not exist);
- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

This Application for Permit is filed on the behalf of DaVita, Inc.* **in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the permit application fee required for this application is sent herewith or will be paid upon request.**

SIGNATURE

Kent Thiry

PRINTED NAME

Chief Executive Officer

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 21st day of December, 2010

Signature of Notary

Seal

LEIGH ANN ROCHA NOTARY PUBLIC STATE OF COLORADO My Commission Expires 04/07/2013

SIGNATURE

Dennis Lee Kogod

PRINTED NAME

Chief Operating Officer

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 17th day of December, 2010

Signature of Notary

Seal

LEIGH ANN ROCHA NOTARY PUBLIC STATE OF COLORADO My Commission Expires 04/07/2013

*Insert EXACT legal name of the applicant

CERTIFICATION

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) are:

- in the case of a corporation, any two of its officers or members of its Board of Directors;
- in the case of a limited liability company, any two of its managers or members (or the sole manger or member when two or more managers or members do not exist);
- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

**This Application for Permit is filed on the behalf of Total Renal Care, Inc.*
in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the permit application fee required for this application is sent herewith or will be paid upon request.**

SIGNATURE

Kent Thiry
PRINTED NAME

Chief Executive Officer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 21st day of December 2010

Signature of Notary

Seal

LEIGH-ANN ROCHA NOTARY PUBLIC STATE OF COLORADO My Commission Expires 04/07/2013

SIGNATURE

Dennis Lee Kogod
PRINTED NAME

Chief Operating Officer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 17th day of December 2010

Signature of Notary

Seal

LEIGH-ANN ROCHA NOTARY PUBLIC STATE OF COLORADO My Commission Expires 04/07/2013

*Insert EXACT legal name of the applicant

SECTION III – BACKGROUND, PURPOSE OF THE PROJECT, AND ALTERNATIVES - INFORMATION REQUIREMENTS

This Section is applicable to all projects except those that are solely for discontinuation with no project costs.

Criterion 1110.230 – Background, Purpose of the Project, and Alternatives

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.
2. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application.
3. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to: official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**
4. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest the information has been previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

APPEND DOCUMENTATION AS ATTACHMENT-11, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 11.

PURPOSE OF PROJECT

1. Document that the project will provide health services that improve the health care or well-being of the market area population to be served.
2. Define the planning area or market area, or other, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed, as applicable and appropriate for the project. [See 1110.230(b) for examples of documentation.]
4. Cite the sources of the information provided as documentation.
5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.
6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals **as appropriate**.

For projects involving modernization, describe the conditions being upgraded if any. For facility projects, include statements of age and condition and regulatory citations if any. For equipment being replaced, include repair and maintenance records.

NOTE: Information regarding the "Purpose of the Project" will be included in the State Agency Report.

APPEND DOCUMENTATION AS ATTACHMENT-12, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-6) MUST BE IDENTIFIED IN ATTACHMENT 12.

ALTERNATIVES

1) Identify **ALL** of the alternatives to the proposed project:

Alternative options **must** include:

A) Proposing a project of greater or lesser scope and cost;

B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes;

C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and

D) Provide the reasons why the chosen alternative was selected.

2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of total costs, patient access, quality and financial benefits in both the short term (within one to three years after project completion) and long term. This may vary by project or situation. **FOR EVERY ALTERNATIVE IDENTIFIED THE TOTAL PROJECT COST AND THE REASONS WHY THE ALTERNATIVE WAS REJECTED MUST BE PROVIDED.**

3) The applicant shall provide empirical evidence, including quantified outcome data that verifies improved quality of care, as available.

APPEND DOCUMENTATION AS ATTACHMENT-13, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION IV - PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE

Criterion 1110.234 - Project Scope, Utilization, and Unfinished/Shell Space

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

1. Document that the amount of physical space proposed for the proposed project is necessary and not excessive. **This must be a narrative.**

2. If the gross square footage exceeds the BGSF/DGSF standards in Appendix B, justify the discrepancy by documenting one of the following::

   a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies;

   b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that results in a size exceeding the standards of Appendix B;

   c. The project involves the conversion of existing space that results in excess square footage.

Provide a narrative for any discrepancies from the State Standard. A table must be provided in the following format with Attachment 14.

SIZE OF PROJECT				
DEPARTMENT/SERVICE	PROPOSED BGSF/DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?

APPEND DOCUMENTATION AS ATTACHMENT-14, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

PROJECT SERVICES UTILIZATION:

This criterion is applicable only to projects or portions of projects that involve services, functions or equipment for which HFSRB has established utilization standards or occupancy targets in 77 Ill. Adm. Code 1100.

Document that in the second year of operation, the annual utilization of the service or equipment shall meet or exceed the utilization standards specified in 1110.Appendix B. **A narrative of the rationale that supports the projections must be provided.**

A table must be provided in the following format with Attachment 15.

UTILIZATION					
	DEPT./ SERVICE	HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.	PROJECTED UTILIZATION	STATE STANDARD	MET STANDARD?
YEAR 1					
YEAR 2					

APPEND DOCUMENTATION AS ATTACHMENT-15, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

UNFINISHED OR SHELL SPACE:

Provide the following information:

1. Total gross square footage of the proposed shell space;
2. The anticipated use of the shell space, specifying the proposed GSF tot be allocated to each department, area or function;
3. Evidence that the shell space is being constructed due to
   a. Requirements of governmental or certification agencies; or
   b. Experienced increases in the historical occupancy or utilization of those areas proposed to occupy the shell space.
4. Provide:
   a. Historical utilization for the area for the latest five-year period for which data are available; and
   b. Based upon the average annual percentage increase for that period, projections of future utilization of the area through the anticipated date when the shell space will be placed into operation.

APPEND DOCUMENTATION AS ATTACHMENT-16, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

ASSURANCES:

Submit the following:

1. Verification that the applicant will submit to HFSRB a CON application to develop and utilize the shell space, regardless of the capital thresholds in effect at the time or the categories of service involved.
2. The estimated date by which the subsequent CON application (to develop and utilize the subject shell space) will be submitted; and
3. The anticipated date when the shell space will be completed and placed into operation.

APPEND DOCUMENTATION AS ATTACHMENT-17, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

G. Criterion 1110.1430 - In-Center Hemodialysis

1. Applicants proposing to establish, expand and/or modernize In-Center Hemodialysis must submit the following information:

2. Indicate station capacity changes by Service: Indicate # of stations changed by action(s):

Category of Service	# Existing Stations	# Proposed Stations
☒ **In-Center Hemodialysis**	**0**	**12**

3. READ the applicable review criteria outlined below and **submit the required documentation for the criteria:**

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.1430(b)(1) - Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X		
1110.1430(b)(2) - Planning Area Need - Service to Planning Area Residents	X	X	
1110.1430(b)(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.1430(b)(4) - Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.1430(b)(5) - Planning Area Need - Service Accessibility	X		
1110.1430(c)(1) - Unnecessary Duplication of Services	X		
1110.1430(c)(2) - Maldistribution	X		
1110.1430(c)(3) - Impact of Project on Other Area Providers	X		
1110.1430(d)(1) - Deteriorated Facilities			X
1110.1430(d)(2) - Documentation			X
1110.1430(d)(3) - Documentation Related to Cited Problems			X
1110.1430(e) - Staffing Availability	X	X	
1110.1430(f) - Support Services	X	X	X
1110.1430(g) - Minimum Number of Stations	X		
1110.1430(h) - Continuity of Care	X		
1110.1430(j) - Assurances	X	X	X

APPEND DOCUMENTATION AS ATTACHMENT-26, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

4. Projects for relocation of a facility from one location in a planning area to another in the same planning area must address the requirements listed in subsection (a)(1) for the "Establishment of Services or Facilities", as well as the requirements in Section 1110.130 - "Discontinuation" and subsection 1110.1430(i) - "Relocation of Facilities".

The following Sections DO NOT need to be addressed by the applicants or co-applicants responsible for funding or guaranteeing the funding of the project if the applicant has a bond rating of A- or better from Fitch's or Standard and Poor's rating agencies, or A3 or better from Moody's (the rating shall be affirmed within the latest 18 month period prior to the submittal of the application):

- **Section 1120.120 Availability of Funds – Review Criteria**
- **Section 1120.130 Financial Viability – Review Criteria**
- **Section 1120.140 Economic Feasibility – Review Criteria, subsection (a)**

VIII. - 1120.120 - Availability of Funds

The applicant shall document that financial resources shall be available and be equal to or exceed the estimated total project cost plus any related project costs by providing evidence of sufficient financial resources from the following sources, as applicable: **Indicate the dollar amount to be provided from the following sources:**

$1,417,261	a)	Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: 1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and 2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;
_____	b)	Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
_____	c)	Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;
$778,570	d)	Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including: 1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated; 2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate; 3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.; 4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment; 5) For any option to lease, a copy of the option, including all terms and conditions.
_____	e)	Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent;
_____	f)	Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt;
_____	g)	All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
$2,195,831		**TOTAL FUNDS AVAILABLE**

APPEND DOCUMENTATION AS ATTACHMENT-39, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

IX. 1120.130 - Financial Viability

All the applicants and co-applicants shall be identified, specifying their roles in the project funding or guaranteeing the funding (sole responsibility or shared) and percentage of participation in that funding.

Financial Viability Waiver

The applicant is not required to submit financial viability ratios if:

1. **All of the projects capital expenditures are completely funded through internal sources**
2. **The applicant's current debt financing or projected debt financing is insured or anticipated to be insured by MBIA (Municipal Bond Insurance Association Inc.) or equivalent**
3. **The applicant provides a third party surety bond or performance bond letter of credit from an A rated guarantor.**

See Section 1120.130 Financial Waiver for information to be provided

APPEND DOCUMENTATION AS ATTACHMENT-40, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

The applicant or co-applicant that is responsible for funding or guaranteeing funding of the project shall provide viability ratios for the latest three years for which **audited financial statements are available and for the first full fiscal year at target utilization, but no more than two years following project completion.** When the applicant's facility does not have facility specific financial statements and the facility is a member of a health care system that has combined or consolidated financial statements, the system's viability ratios shall be provided. If the health care system includes one or more hospitals, the system's viability ratios shall be evaluated for conformance with the applicable hospital standards.

Provide Data for Projects Classified as:	**Category A or Category B (last three years)**			**Category B (Projected)**
Enter Historical and/or Projected Years:				
Current Ratio				
Net Margin Percentage				
Percent Debt to Total Capitalization				
Projected Debt Service Coverage				
Days Cash on Hand				
Cushion Ratio				

Provide the methodology and worksheets utilized in determining the ratios detailing the calculation and applicable line item amounts from the financial statements. Complete a separate table for each co-applicant and provide worksheets for each.

2. Variance

Applicants not in compliance with any of the viability ratios shall document that another organization, public or private, shall assume the legal responsibility to meet the debt obligations should the applicant default.

APPEND DOCUMENTATION AS ATTACHMENT 41, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

X. 1120.140 - Economic Feasibility

This section is applicable to all projects subject to Part 1120.

A. Reasonableness of Financing Arrangements

The applicant shall document the reasonableness of financing arrangements by submitting a notarized statement signed by an authorized representative that attests to one of the following:

1) That the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation; or

2) That the total estimated project costs and related costs will be funded in total or in part by borrowing because:

A) A portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or

B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

B. Conditions of Debt Financing

This criterion is applicable only to projects that involve debt financing. The applicant shall document that the conditions of debt financing are reasonable by submitting a notarized statement signed by an authorized representative that attests to the following, as applicable:

1) That the selected form of debt financing for the project will be at the lowest net cost available;

2) That the selected form of debt financing will not be at the lowest net cost available, but is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term (years), financing costs and other factors;

3) That the project involves (in total or in part) the leasing of equipment or facilities and that the expenses incurred with leasing a facility or equipment are less costly than constructing a new facility or purchasing new equipment.

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

1. Identify each department or area impacted by the proposed project and provide a cost and square footage allocation for new construction and/or modernization using the following format (insert after this page).

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE

Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Cost/Square Foot Mod.	Gross Sq. Ft. New	Gross Sq. Ft. Circ.*	Gross Sq. Ft. Mod.	Gross Sq. Ft. Circ.*	Const. $ (A x C)	Mod. $ (B x E)	
Contingency									
TOTALS									

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

The applicant shall provide the projected direct annual operating costs (in current dollars per equivalent patient day or unit of service) for the first full fiscal year at target utilization but no more than two years following project completion. Direct cost means the fully allocated costs of salaries, benefits and supplies for the service.

E. Total Effect of the Project on Capital Costs

The applicant shall provide the total projected annual capital costs (in current dollars per equivalent patient day) for the first full fiscal year at target utilization but no more than two years following project completion.

APPEND DOCUMENTATION AS ATTACHMENT 42, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

XI. Safety Net Impact Statement

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for ALL SUBSTANTIVE AND DISCONTINUATION PROJECTS:

1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.

2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.

3. How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

Safety Net Impact Statements shall also include all of the following:

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.

2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.

3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

A table in the following format must be provided as part of Attachment 43.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**Year**	**Year**	**Year**
Inpatient			
Outpatient			
Total			
Charity (cost in dollars)			
Inpatient			
Outpatient			
Total			
MEDICAID			
Medicaid (# of patients)	**Year**	**Year**	**Year**
Inpatient			
Outpatient			
Total			

Medicaid (revenue)			
Inpatient			
Outpatient			
Total			

APPEND DOCUMENTATION AS ATTACHMENT-43, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

XII. Charity Care Information

Charity Care information MUST be furnished for ALL projects.

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three audited fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.

2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.

3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

Charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer. (20 ILCS 3960/3) Charity Care must be provided at cost.

A table in the following format must be provided for all facilities as part of Attachment 44.

CHARITY CARE			
	Year	Year	Year
Net Patient Revenue			
Amount of Charity Care (charges)			
Cost of Charity Care			

APPEND DOCUMENTATION AS ATTACHMENT-44, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Section I, Identification, General Information, and Certification
Applicants

Certificates of Good Standing for Davita, Inc. and Total Renal Care, Inc. are attached at Attachment – 1. As the ultimate parent of the proposed operator, Total Renal Care, Inc., DaVita, Inc. is named as an applicant for this CON application. DaVita, Inc. does not do business in the State of Illinois. A Certificate of Good Standing for DaVita, Inc. from the state of its incorporation, Delaware is attached.

Attachment – 1

Delaware

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "DAVITA INC." IS DULY INCORPORATED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL CORPORATE EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE THIRTIETH DAY OF NOVEMBER, A.D. 2010.

AND I DO HEREBY FURTHER CERTIFY THAT THE SAID "DAVITA INC." WAS INCORPORATED ON THE FOURTH DAY OF APRIL, A.D. 1994.

AND I DO HEREBY FURTHER CERTIFY THAT THE FRANCHISE TAXES HAVE BEEN PAID TO DATE.

AND I DO HEREBY FURTHER CERTIFY THAT THE ANNUAL REPORTS HAVE BEEN FILED TO DATE.

Jeffrey W. Bullock, Secretary of State

2391269 8300

101133217

AUTHENTICATION: 8386715

DATE: 11-30-10

You may verify this certificate online at corp.delaware.gov/authver.shtml

Attachment – 1A

File Number 5823-002-2

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

TOTAL RENAL CARE, INC., INCORPORATED IN CALIFORNIA AND LICENSED TO TRANSACT BUSINESS IN THIS STATE ON MARCH 10, 1995, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE BUSINESS CORPORATION ACT OF THIS STATE RELATING TO THE PAYMENT OF FRANCHISE TAXES, AND AS OF THIS DATE, IS A FOREIGN CORPORATION IN GOOD STANDING AND AUTHORIZED TO TRANSACT BUSINESS IN THE STATE OF ILLINOIS.

SEAL OF THE STATE OF ILLINOIS
AUG. 26TH 1818

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 18TH *day of* OCTOBER *A.D.* 2010 .

Jesse White

SECRETARY OF STATE

Authentication #: 1029100457
Verify at www.cyberdriveillinois.com

Attachment – 1B

Section I, Identification, General Information, and Certification
Site Ownership

The letter of intent between Total Renal Care, Inc. and 2636 South Sixth Street, LLC to lease the property located at 2930 South 6th Street, Springfield, Illinois 62703 is attached at Attachment – 2.

Attachment – 2

Charles Robbins REALTOR

Residential Office
2144 S. MacArthur Boulevard
Springfield, IL 62704
Telephone (217) 525-2117
Fax # (217) 525-2275

Commercial Development Office
2144 S. MacArthur Boulevard
Springfield, IL 62704
Telephone (217) 525-7765
Fax # (217) 525-0545

www.charlesrobbins.com E-mail: rex@charlesrobbins.com

November 24, 2010

RE: Letter of Intent: 2930 S. 6th Street, Springfield, Illinois 62703

Dear Mr. Furling:

USI Real Estate Brokerage Services Inc. and Charles Robbins Realtor have been authorized by DaVita Inc. to provide this letter of Intent to lease the above mentioned property under the terms and conditions below

LOCATION: 2930 South Sixth Street, Springfield, Illinois 62703

TENANT: "Total Renal Care, Inc. or related entity to be named".

LANDLORD: **2636 South Sixth Street LLC % William Furling III, Springfield, IL 62703**

INITIAL SPACE REQUIREMENTS: Approximately 6100 contiguous usable square feet. No load factor added

PRIMARY TERM: 10 years

POSSESSION AND COMMENCEMENT: Tenant shall take possession of the premises upon the later of completion of Landlords required work (if any) or mutual lease execution. In any event, the rent and term shall commence the earlier of seven (7) months from possession or until:

a. Leasehold Improvements within the Premises have been completed in accordance with the final construction documents (except for nominal punch list items); and

b. A Certificate of Occupancy for the Premises has been obtained from the City of Springfield, IL; and

c. Tenant has obtained all necessary licenses and permits.

FAILURE TO DELIVER PREMISES: If Landlord has not delivered the premises to Tenant with all base building items substantially completed by ninety (90) days from lease execution, Tenant may elect to terminate the lease by written notice to Landlord. Landlord shall deliver premises to Tenant 90 days after the latter of issuance of Certification of Need date or TIF approval date unless Tenant elects to forfeit TIF reimbursement.

LEASE FORM: The Tenant shall provide its standard lease form

USE:

The use is for a Dialysis Clinic, related medical, office and distribution of pharmaceuticals. Please verify that the use and parking are permitted within the building's zoning.

BASE BUILDING:

The following items must be delivered by the Landlord to the premises as part of the base building:

- A 2" dedicated water meter and line
- A 4" sewer line to a municipal sewer system
- Minimum 400 to 800 , 120/208 volt 3 phase, 4 wire electrical service
- Gas service, at a minimum, will be rated to have 6" of water column pressure and supply 800,000-BTU's
- HVAC rooftop Units/Systems and all associated cost with unit

Please refer to the attached Exhibit B regarding additional base building improvements and site development requirements.

TENANT IMPROVEMENTS:

Please describe whether Leasehold Improvements will be provided on a "Turnkey" or "Allowance" basis and the amount included within the Base Rent schedule. Furthermore, state if Landlord is willing to amortize additional improvements into the rent over the lease term. Landlord will with the cooperation of Tenant submit eligible improvement to City of Springfield for reimbursement from TIF funds. Reimbursement can be up to 1/3 of eligible expenses. Landlord will reimburse Tenant for its build out expense to the extent that TIF funds are paid to Landlord.

OPTION TO RENEW:

Tenant desires three (3) five (5) year options to renew the lease. Option Rent shall be the lesser of 95% of fair market value, or, the rent during the prior term escalated by the increase in the CPI-U over the prior term, capped at two percent (2%) annually with prior written notice due six (6) months.

RIGHT OF FIRST REFUSAL ON ADJACENT SPACE:

Tenant shall have the right of first offer on any adjacent space that may become available during the initial term of the lease and any extension thereof.

RENTAL RATE:

10 years $13 per foot per year with 2% per year escalation..

HOLDING OVER:

In the event Tenant remains in possession of the Premises after the expiration of the term of this Lease, then Tenant shall be obligated to pay rent at 125% the then current rate.

PARKING:

Tenant requires five (5) designated spaces for its use.

CONCESSIONS:

TIF reimbursement as outlined above

COMMON AREA EXPENSES AND REAL ESTATE TAXES:

Real Estate Taxes 2010 were $2.77 /sqft/yr Insurance costs for 2010 were $0.40 /sqft/yr CAM costs for 2010 were $1.42/sqft/yr to include utilities (water and exterior lighting), landscape, snow removal, maintenance, utilities, security ect.

SIGNAGE:	Tenant shall have the right to install building signage at the Premises, subject to Landlord's consent, which consent shall not be unreasonably withheld, and subject to compliance by Tenant with all applicable laws and regulations. Landlord, at Landlord's expense will furnish Tenant with space for Tenant's designated names on the building directory board in the lobby of the building and will put Tenant's name on any other directory board which may be part of the building or complex.
BUILDING HOURS:	Tenant requires building hours of 24 hours a day, 7 days a week.
SUBLEASE/ASSIGNMENT:	Tenant will have the right at any time to sublease or assign its interest in this Lease to any majority owned subsidiaries or related entities of DaVita Inc. without the consent of the Landlord.
GOVERNMENTAL COMPLIANCE:	Landlord shall represent and warrant to Tenant that Landlord, at Landlord's sole expense, will cause Tenant's Premises, the Building and parking facilities to be in full compliance with any governmental laws, ordinances, regulations or orders relating to, but not limited to, compliance with the Americans with Disabilities Act (ADA), and environmental conditions relating to the existence of asbestos and/or other hazardous materials, or soil and ground water conditions, and shall indemnify and hold Tenant harmless from any claims, liabilities and cost arising from environmental conditions not caused by Tenant(s).
ROOF RIGHTS:	If the building does not have cable television service, then Tenant will need the right to place a satellite dish on the roof at no additional fee.
RADIUS RESTRICTION:	Landlord shall not lease space to another Dialysis clinic or similar facility at the property or at any of the other properties Landlord controls within five (5) miles of the subject property.
EARLY TERMINATION OPTION:	No Early Termination Option
SECURITY DEPOSIT:	The client, by company policy, does not provide security deposits.
CORPORATE GUARANTEE:	A corporate guarantee from DaVita Inc. will be required
CONTINGENCIES	Tenant will need to apply for a Certificate of Need for the final location. If Tenant does not get the Certificate of Need by April 30, 2011, the Lease will be null and void. If they do get the Certificate of Need, then they will go forward with the lease based on satisfying the other contingencies that are in their standard Lease Document. Tenant CON Obligation. Landlord and Tenant understand and agree that the establishment of any chronic outpatient dialysis facility in the State of Illinois is subject to the requirements of the Illinois Health Facilities Planning Act, 20 ILCS 3960/1 et seq. and, thus, the Tenant cannot establish a dialysis facility on the Premises or execute a binding real estate lease in connection therewith unless Tenant obtains a Certificate of Need (CON) permit from the Illinois Health Facilities Planning Board (the "Planning Board"). Tenant agrees to proceed using

its commercially reasonable best efforts to submit an application for a CON permit and to prosecute said application to obtain the CON permit from the Planning Board. Based on the length of the Planning Board review process, Tenant does not expect to receive a CON permit prior to April 30, 2011. In light of the foregoing facts, the parties agree that they shall promptly proceed with due diligence to negotiate the terms of a definitive lease agreement and execute such agreement prior to approval of the CON permit provided, however, the lease shall not be binding on either party prior to the approval of the CON permit and the lease agreement shall contain a contingency clause indicating that the lease agreement is not effective pending CON approval. Assuming CON permit approval is granted, the effective date of the lease agreement shall be the first day of the calendar month following CON permit approval. In the event that the Planning Board does not award Tenant a CON permit to establish a dialysis center on the Premises by April 30, 2011 neither party shall have any further obligation to the other party with regard to the negotiations, lease or Premises contemplated by this Letter of Intent.

BROKERAGE FEE: Landlord agrees that it recognizes USI Real Estate Brokerage Services Inc. and Charles Robbins Realtor as the client's sole representatives and a brokerage fee of five percent (5%) of the gross rent due over the term shall be paid to USI, or its designated local affiliate, per separate commission agreement. The client shall retain the right to offset rent for failure to pay the Real Estate Commission.

Please submit your response to this Request for Proposal via e-mail and hard copy no later than Monday November 15, 2010 to:

Ronald D. Lasley
Charles Robbins Realtor
2344 S. Macarthur Blvd.
Springfield, Illinois 62704

It should be understood that this Letter of Intent is subject to the terms of Exhibit A attached hereto.

Agreed to and accepted this 24th Day of November 2010

By: _____

2636 South Sixth Street LLC % William Furling III,
Springfield, IL 62703

("Landlord")

Agreed to and accepted this 24th Day of November 2010

By: Cindy Epley, Reg Operations Director

On behalf of Total Renal Care, Inc a wholly owned subsidiary of DaVita, Inc. ("Tenant")

Thank you for your time and cooperation in this matter.

Very truly yours,

Ronald D. Ladley

Cc: USI Real Estate Brokerage Services

EXHIBIT A

NON-BINDING NOTICE

NOTICE: THE PROVISONS CONTAINED IN THIS LETTER OF INTENT ARE AN EXPRESSION OF THE PARTIES' INTEREST ONLY. SAID PROVISIONS TAKEN TOGETHER OR SEPERATELY ARE NEITHER AN OFFER WHICH BY AN "ACCEPTANCE" CAN BECOME A CONTRACT, NOR A CONTRACT. BY ISSUING THIS LETTER OF INTENT, NEITHER TENANT NOR LANDLORD (OR USI) SHALL BE BOUND TO ENTER INTO ANY (GOOD FAITH OR OTHERWISE) NEGOTIATIONS OF ANY KIND WHATSOEVER. TENANT RESERVES THE RIGHT TO NEGOTIATE WITH OTHER PARTIES. NEITHER TENANT, LANDLORD OR USI INTENDS ON THE PROVISIONS CONTAINED IN THIS LETTER OF INTENT TO BE BINDING IN ANY MANNER, AS THE ANALYSIS FOR AN ACCEPTABLE TRANSACTION WILL INVOLVE ADDITIONAL MATTERS NOT ADDRESSED IN THIS LETTER, INCLUDING, WITHOUT LIMITATION, THE TERMS OF ANY COMPETING PROJECTS, OVERALL ECONOMIC AND LIABILITY PROVISIONS CONTAINED IN ANY LEASE DOCUMENT AND INTERNAL APPROVAL PROCESSES AND PROCEDURES. THE PARTIES UNDERSTAND AND AGREE THAT A CONTRACT WITH RESPECT TO THE PROVISIONS IN THIS LETTER OF INTENT WILL NOT EXIST UNLESS AND UNTIL THE PARTIES HAVE EXECUTED A FORMAL, WRITTEN LEASE AGREEMENT APPROVED IN WRITING BY THEIR RESPECTIVE COUNSEL. USI IS ACTING SOLELY IN THE CAPACITY OF SOLICITING, PROVIDING AND RECEIVING INFORMATION AND PROPOSALS AND NEGOTIATING THE SAME ON BEHALF OF OUR CLIENTS. UNDER NO CIRCUMSTANCES WHATSOEVER DOES USI HAVE ANY AUTHORITY TO BIND OUR CLIENTS TO ANY ITEM, TERM OR COMBINATION OF TERMS CONTAINED HEREIN. THIS LETTER OF INTENT IS SUBMITTED SUBJECT TO ERRORS, OMISSIONS, CHANGE OF PRICE, RENTAL OR OTHER TERMS; ANY SPECIAL CONDITIONS IMPOSED BY OUR CLIENTS; AND WITHDRAWAL WITHOUT NOTICE. WE RESERVE THE RIGHT TO CONTINUE SIMULTANEOUS NEGOTIATIONS WITH OTHER PARTIES ON BEHALF OF OUR CLIENT. NO PARTY SHALL HAVE ANY LEGAL RIGHTS OR OBLIGATIONS WITH RESPECT TO ANY OTHER PARTY, AND NO PARTY SHOULD TAKE ANY ACTION OR FAIL TO TAKE ANY ACTION IN DETRIMENTAL RELIANCE ON THIS OR ANY OTHER DOCUMENT OR COMMUNICATION UNTIL AND UNLESS A DEFINITIVE WRITTEN LEASE AGREEMENT IS PREPARED AND SIGNED BY TENANT AND LANDLORD.

Exhibit B

FOR EXISTING BUILDING]
[SUBJECT TO MODIFICATION BASED ON INPUT FROM LESSEE'S PROJECT MANAGER WITH RESPECT TO EACH CENTER PROJECT]

SCHEDULE A - TO WORK LETTER

MINIMUM BASE BUILDING IMPROVEMENT REQUIREMENTS

(Note: Sections with an Asterisk (*) have specific requirements for 1.1.2 in California and other select States – see end of document for changes to that section)

At a minimum, the Lessor shall provide the following Base Building Improvements to meet Lessee's requirements for an Existing Base Building Improvements at Lessor's sole cost.

All MBBI work completed by the Lessor will need to be coordinated and approved by the Lessee and there Consultants prior to any work being completed, including shop drawings and submittals reviews

1.0 - Building Codes & Design *

All Minimum Base Building Improvements (MBBI) are to be performed in accordance with all local, state, and federal building codes including any related amendments, fire and life safety codes, ADA regulations, State Department of Public Health, and other applicable and codes as it pertains to Dialysis. All Lessor's work will have Governmental Authorities Having Jurisdiction ("GAHJ") approved architectural and engineering (Mechanical, Plumbing, Electrical, Structural, Civil, Environmental) plans and specifications prepared by a licensed architect and engineer.

Lessee shall have full control over the selection of the General Contractor for the tenant improvement work.

2.0 - Zoning & Permitting

Building and premises must be zoned to perform services as a dialysis clinic. Lessor to provide all Zoning information related to the base building. Any new Zoning changes/variances necessary for use of the premises as a dialysis clinic shall be the responsibility of the Lessee with the assistance of the Lessor to secure Zoning change/variance. Permitting of the interior construction of the space will be by the Lessee.

3.0 - Common Areas

Lessee will have access and use of all common areas i.e. Lobbies Hallways, Corridors, Restrooms, Stairwells, Utility Rooms, Roof Access, Emergency Access Points and Elevators. All common areas must be code and ADA compliant (Life Safety, ADA, etc.) per current federal, state and local code requirements.

4.0 - Demolition

Lessor will be responsible for demolition of all interior partitions, doors and frames, plumbing, electrical, mechanical systems (other than what is designated for reuse by Lessee) and finishes of the existing building from slab to roof deck to create a "Vanilla box" condition. Space shall be broom clean and ready for interior improvements specific to the buildout of a dialysis facility. Building to be free and clear of any components, asbestos or material that is in violation of any EPA standards of acceptance and local hazardous material jurisdiction standards.

5.0 - Foundation and Floor *

Existing Foundations and Slab on Grade in Lessee space must be free of cracks and settlement issues. Any cracks and settlement issues evident at any time prior commencement of tenant improvement work shall be subject to inspection by a Licensed Structural Engineer stating that such cracks and / or settlement issues are within limits of the structural integrity and performance anticipated for this concrete and reinforcement design for the term of the lease. Lessor to confirm that the site does not contain expansive soils and to confirm the depth of the water table. Existing concrete slabs shall contain control joints and structural reinforcement

All repairs will be done by Lessor at his cost and be done prior to Lessee acceptance of space for construction. Any issues with slab during Lessee construction will be brought up to Lessor attention and cost associated with slab issue to repair will be paid by Lessor.

Any slab replacement will be of the same thickness of the adjacent slab (or a minimum of 5") with a minimum concrete strength of 3,000-psi with wire or fiber mesh, and/or rebar reinforcement over vapor barrier and granular fill. Infill slab/trenches will be pinned to existing slab at 24" O.C. with # 4bars or greater x 16" long or as designed per higher standards by Lessee's structural engineer depending on soils and existing slab condition

Existing Concrete floor shall not have more than 3-lbs of moisture per 1000sf/24 hours is emitted per completed calcium chloride testing results. Means and methods to achieve this level will be sole responsibility of the Lessor.

6.0 - Structural *

Existing exterior walls, lintels, floor and roof framing shall remain as-is and be free of defects. Should any defects be found repairs will be made by Lessor at his cost. Any repairs will meet with current codes and approved by a Structural Engineer and Lessee.

Lessor shall supply Lessee (if available) structural engineering drawings of space

7.0 – Existing Exterior Walls

All exterior walls shall be in good shape and properly maintained. Any damaged drywall and or insulation will be replaced by Lessor prior to Lessee taking possession.

It will be the Lessor's responsibility for all cost to bring exterior walls up to code before Lessee takes possession.

7.0 - Demising walls

New or Existing demising walls shall be a 1 or 2hr fire rated wall depending on local codes, state and or regulatory requirements (NFPA 101 – 2000) whichever is more stringent. If it does not meet this, Lessor will bring demising wall up to meet the ratings/UL requirements. Walls to be fire caulked in accordance with UL standards at floor and roof deck. Demising walls will have sound attenuation batts from floor to underside of deck.

At Lessee's option and as agreed upon by Lessor, any new demising wall interior drywall to lessee's space shall not be installed until after Lessee's improvements are complete in the wall.

8.0 - Roof Covering *

The roof shall be properly sloped for drainage and flashed for proper water shed. The roof, roof drains and downspouts shall be properly maintained to guard against roof leaks and can properly drain. Lessor will provide Lessee the information on the Roof and Contractor holding warranty. Lessor to provide minimum of R30 roof insulation at roof deck. If the R30 value is not meet, Lessor to increase R-Value by having installed additional insulation to meet GAHJ requirements to the underside of the roof structure/deck.

Any new penetrations made during buildout will be at the Lessee's cost. Lessor shall grant Lessee that right to conceal or remove existing skylights as deemed appropriate by Lessee and their Consultants.

9.0 - Canopy *

Lessor shall allow Lessee to design and construct a canopy structure for patient drop off and if allowed local code.

10.0 – Waterproofing and Weatherproofing

Lessor shall provide complete water tight building shell inclusive but not limited to. Flashing and/or sealant around windows, doors, parapet walls, Mechanical / Plumbing / Electrical penetrations. Lessor shall properly seal the building's exterior walls, footings, slabs as required in high moisture conditions such as (including but not limited to) finish floor sub-grade, raised planters, and high water table. Lessor shall be responsible for replacing any damaged items and repairing any deficiencies exposed during / after construction of tenant improvement.

11.0 - Windows

Any single pane window systems must be replaced by Lessor with code compliant Energy efficient thermal pane windows with thermally broken aluminum frames. Broken, missing and/or damaged glass or frames will be replaced by Lessor. Lessor shall allow Lessee, at Lessee's discretion, to tint the existing windows (per manufactures recommendations) per Lessee's tenant improvement design.

12.0 - Thermal Insulation

Lessor to replace any missing and/or damaged wall or ceiling insulation with R-13, 19 or R30 insulation.

13.0 - Exterior Doors

American Disabilities Act (ADA), Local Codes and State Department of Health requirements for egress. If not Lessor at his cost will need to bring them up to code, this will include installing push paddles and/or panic hardware or any other hardware for egress. Any missing weather stripping, damage to doors or frames will be repaired or replaced by Lessor.

Lessor will provide, if not already present, a front entrance and rear door to space. Should one not be present at each of the locations Lessor, to have them installed per the following criteria:

- Front/ Patient Entry Doors: Provide Storefront with insulated glass doors and Aluminum framing to be 42" width including push paddle/panic bar hardware, continuous hinge and lock mechanism. Door to be prepped to accept power assist opener and push button keypad lock provided by Lessee.

- Service Doors: Provide 72" wide double door (Alternates for approval by Lessee's Project Manager to include: 60" Roll up door, or a 48" wide single door or double door with 36" and 24" doors) with 20 gauge insulated hollow metal (double doors), Flush bolts, T astragal, Heavy Duty Aluminum threshold, continuous hinge each leaf, prepped for panic bar hardware (as required by code) painted with rust inhibiting paint and prepped to receive a push button keypad lock provided by Lessee. Door to have a 10" square vision panel cut out with insulated glass installed if requested by Lessee.

Any doors that are designated to be provided modified or prepared by Lessor, Lessor shall provide to Lessee, prior to door fabrication, submittals containing specification information, hardware and shop drawings for review and acceptance by Lessee and Lessee's architect.

14.0 - Utilities

All utilities to be provided at designated utility entrance points into the building at locations approved by the Lessee at a common location for access. Lessor is responsible for all tap/connection and impact fees for all new utilities required for a dialysis facility. All Utilities to be coordinated with Lessee's Architect.

15.0 - Plumbing *

Lessor to provide a segregated/d dedicated 2" water line, if not already present (and not tied-in to any other lessees spaces, fire suppression systems, or irrigation systems) with a shut off valve, 2 (two) 2" backflow preventors in

parallel (with drain under BFP's), and 2" meter (1 1/2" meter under special circumstances which must be approved by Lessee) to provide a continuous minimum 50 psi (maximum of 80psi), with a minimum flow rate of 30 gallons per minute to Lessee space. Lessor to provide Lessee with the most recent water flow and pressure test results (gallons per minute and psi) for approval. Lessor shall perform water flow and pressure test prior to lease execution. Lessor shall stub the dedicated water line into the Lessee space to a location on Lessee plans. Lessor to provide and pay for all tap fees related to new sanitary sewer and water services in accordance with local building and regulatory agencies. Lessor may elect to dedicate the existing 2" line and 2" meter (1-1/2" meter if approved by Lessee), if existing, to Lessee for Lessee's exclusive and dedicated use. Lessor shall then be responsible to install a new water line and water meter(s) for use by adjacent tenants) as needed to meet adjacent tenant water requirements and water demands. Lessor shall be responsible for all fees and costs associated with the line, tap, meter and impact fees related to this work.

All existing hose bibs will be in proper working condition prior to Lessees possession of space.

Existing Sanitary sewer line will need to be a four-inch (4") minimum line to Lessee space and have an invert level of 42" minimum or a sanitary line('s) that will adequately support the drainage requirements leaving the space. Lift station/sewage ejectors will not be permitted. The sanitary sewer line feeding the demised space will need to be video scoped for integrity with a copy available for Lessee and his architect to review. Sewer line to receive a power rod with high pressure cleaning to insure flow integrity from facility inlet to city main.

If the Sanitary line is not a 4" line, Lessor will have installed a new line to a location per Lessee plans to support the drainage requirements (with a minimum invert level of 42") and to meet local code. All cost associated with line, tap and impact fees will be Lessor responsibility.

Sanitary sampling manhole if required by local municipality on new line.

16.0 - Fire Suppression and Alarm System

Existing Fire Sprinkler Systems and fire alarm control panel shall be maintained by Lessor. Lessor to provide pertinent information on systems for Lessee Engineers for design. Lessor to provide current vendor for system and monitoring company.

If a Sprinkler System is not present and is required by Lessee usage based on NFPA 101, 2000, Lessor to provide cost, to be included in lease rate, for the design and installation of a complete turnkey sprinkler system (less drops and heads in lessee space) that meets all local building and life safety codes for the entire building. This system will be on a dedicated water line independent of Lessee's water line requirements, including municipal approved shop drawings, service drops and sprinkler heads at heights per Lessee's reflective ceiling plan, flow control switches wired and tested, alarms including wiring and an electrically/telephonically controlled fire alarm control panel connected to a monitoring systems for emergency dispatch.

Existing Fire Alarm system shall be maintained and in good working order by Lessor prior to Lessee acceptance of space. Lessor to provide pertinent information on systems for Lessee's design. Lessor to provide current vendor for system and monitoring company. If FA Panel is unable to accommodate Lessee requirements Lessor to upgrade panel at Lessor's cost.

Fire Suppression and Alarm system equipment shall be equipped for double detection activation per GAHJ.

17.0 – Electrical;

Service size to be determined by Lessee's engineer dependant on facility size and gas availability (400amp to 800amp service) 120/208 volt, 3 phase, 4 wire. Existing service to be a combined single service for Lessee space. Lessee will not accept multiple services to obtain the necessary amperage. Should this not be available Lessor to upgrade to meet the following criteria:

Provide new service (preferably underground) with a dedicated meter via a new CT cabinet. Service size to be determined by Lessee's engineer dependant on facility size and gas availability (400amp to 800amp service) 120/208 volt, 3 phase, 4 wire to a load center in the Lessee's utility room (location to be per Code and to a location per Lessee plans) for Lessee's exclusive use in powering equipment, appliances, lighting, heating, cooling and miscellaneous use. Transformer coordination with utility company, transformer pad, and underground conduit sized for service, circuit termination cabinet, grounding rod, main panel with breaker, conduit and wire inclusive of excavation, trenching and restoration. Lessee's Engineer shall have the final approval on the electrical service size and location. If 480V power is supplied, Lessor to provide step down transformer to Lessee requirements above.

If combined service meter cannot be provided then Lessor shall provide written verification from Power Utility supplier stating multiple meters are allowed for use by the facility for the duration of the lease term

Lessor will allow Lessee to have installed, at Lessee cost, Transfer Switch for temporary generator hook-up, or permanent generator.

18.0 - Gas Service

Existing Natural gas service at a minimum to have a 6" water column pressure and be able to supply 800,000 BTU's. Natural gas line shall be individually metered and sized per demand.

19.0 - Mechanical /Heating Ventilation Air Conditioning

Lessor to provide a detailed report from a HVAC company on all existing HVAC units i.e. age, CFM's, cooling capacity, service records etc for review by Lessee. HVAC Units, components and equipment that Lessee intends to reuse shall be left in place "as is" by Lessor. Lessor shall allow Lessee, at Lessee's discretion to remove, relocate, replace or modify existing unit(s) as needed to meet HVAC code requirements and design layout requirements.

If determined by Lessee that the units need to be replaced and or additional units are needed, Lessor will be responsible for the cost of the replacement/additional HVAC units. Lessee will complete the all work with the replacement/additional HVAC Units. Units replaced or added will meet the design requirements as stated below.

The criteria is as follows: Equipment to be Carrier or Trane. Equipment will be new and come with a full warranty on parts (minimum of 5yrs) including labor. Supply air shall be provided to the Premises sufficient for cooling at the rate of 325 square feet per ton to meet Lessee's demands for dialysis facility. Ductwork shall be extended 5' into the space for supply and return air. System to be a ducted return air design. All ductwork to externally lined except for the drops from the units. Work to include, but not limited to, the purchase of the units, installation, roof framing, mechanical curbs, flashings, gas & electrical hook-up, thermostats and start-up. Anticipate minimum up to five (5) zones with programmable thermostat. Lessee's engineer shall have the final approval on the sizes, tonnages, zoning, location and number of HVAC units based on design criteria and local and state codes.

20.0 - Telephone

If in a multi tenant building Lessor to provide a 1" conduit from Building Demark location to phone room location in Lessee space.

21.0 – Cable or Satellite TV

Lessor to have Cable TV extend to Lessee space if available. Lessor will also allow for a satellite dish on the roof regardless if cable is present or not at Lessee's costs. Lessor will need to grant right of access to cable company for new service.

22.0 - Handicap Accessibility

Full compliance with ADA and all local jurisdictions' handicap requirements. Lessor shall comply with all ADA regulations affecting the Building and entrance to Lessee space including, but not limited to, the elevator, exterior and interior doors, concrete curb cuts, ramps and walk approaches to / from the parking lot, parking lot striping for

four (4) dedicated handicap stalls for a unit up to 20 station clinic and six (6) HC stalls for units over 20 stations inclusive of pavement markings and stall signs with current local provisions for handicap parking stalls, delivery areas and walkways.

Lessor shall provide pavement marking: curb ramp and accessible path of travel for a dedicated delivery access in the rear of the building. The delivery access shall link the path from the driveway paving to the designated Lessee delivery door and also link to the accessible path of travel.

23.0 - Generator

Lessor to allow a generator to be installed onsite if required by code or Lessee chooses to provide one.

24.0 – Existing Site Lighting

Lessor to provide adequate lighting per code and to illuminate all parking, pathways, for new and existing building access points. Parking lot lighting to be on a timer (and be programmed per Lessee business hours of operation) or photocell. Parking lot lighting shall be connected to and powered by Lessor house panel and equipped. If new lighting is provided it will need to be code compliant with an 90 minute battery back up at all access points.

25.0– Exterior Building Lighting

Lessor to provide adequate lighting per code and to illuminate the building main and service entrance/exits with related sidewalks. Lighting shall be connected to and powered by Lessor house panel and equipped with a code compliant 90 minute battery back up at all access points.

26.0 – Parking Lot

Provide adequate amount of ADA curb cuts, handicap and standard parking stalls in accordance with dialysis use and overall building uses. Stalls to receive striping, lot to receive traffic directional arrows and concrete parking bumpers. Bumpers to be anchored in place onto the asphalt per stall layout.

27.0 – Refuse Enclosure *

If an area is not designated, lessor to provide Refuse area for Lessee dumpsters. Lessor to provide a minimum 6" thick reinforced concrete pad approx 100 to 150SF based and an 8' x 12' apron way to accommodate dumpster and vehicle weight. Enclosure to be provided as required by local codes

28.0 - Signage

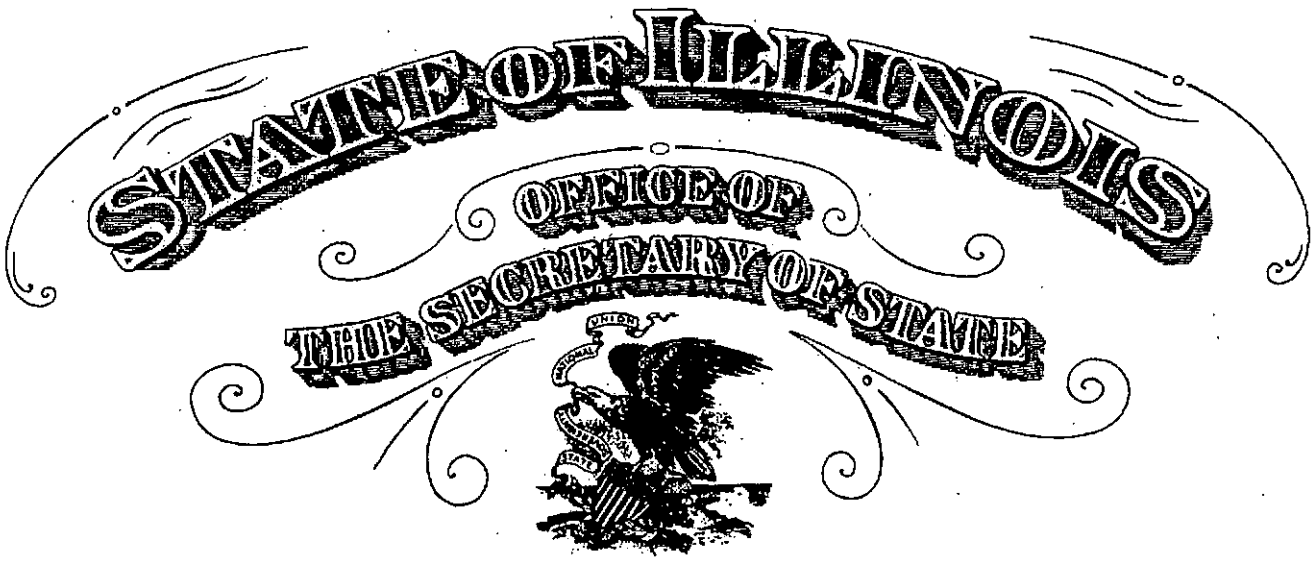
Lessor to allow for an illuminated façade mounted sign and rights to add signage to existing Pylon/monument sign. Final sign layout to be approved by Lessee and the City.

Section I, Identification, General Information, and Certification
Operating Identity/Licensee

The Illinois Certificate of Good Standing for Total Renal Care, Inc. is attached at Attachment – 3.

Attachment – 3

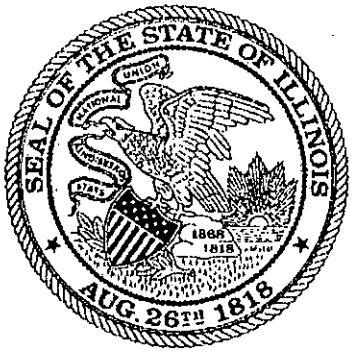
File Number 5823-002-2



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

TOTAL RENAL CARE, INC., INCORPORATED IN CALIFORNIA AND LICENSED TO TRANSACT BUSINESS IN THIS STATE ON MARCH 10, 1995, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE BUSINESS CORPORATION ACT OF THIS STATE RELATING TO THE PAYMENT OF FRANCHISE TAXES, AND AS OF THIS DATE, IS A FOREIGN CORPORATION IN GOOD STANDING AND AUTHORIZED TO TRANSACT BUSINESS IN THE STATE OF ILLINOIS.



In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 18TH *day of* OCTOBER *A.D.* 2010 .

Jesse White

SECRETARY OF STATE

Authentication #: 1029100457
Verify at www.cyberdriveillinois.com

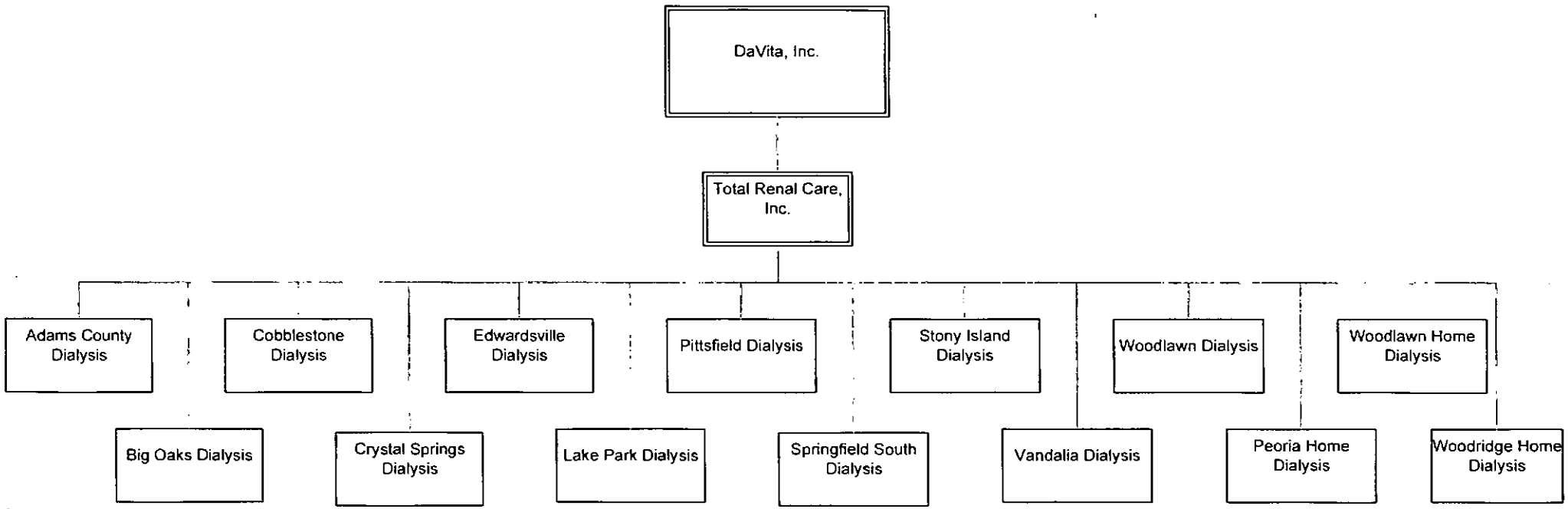
Attachment – 3

Section I, Identification, General Information, and Certification
Organizational Relationships

The organizational charts for Davita, Inc. and Total Renal Care, Inc. are attached at Attachment – 4A.

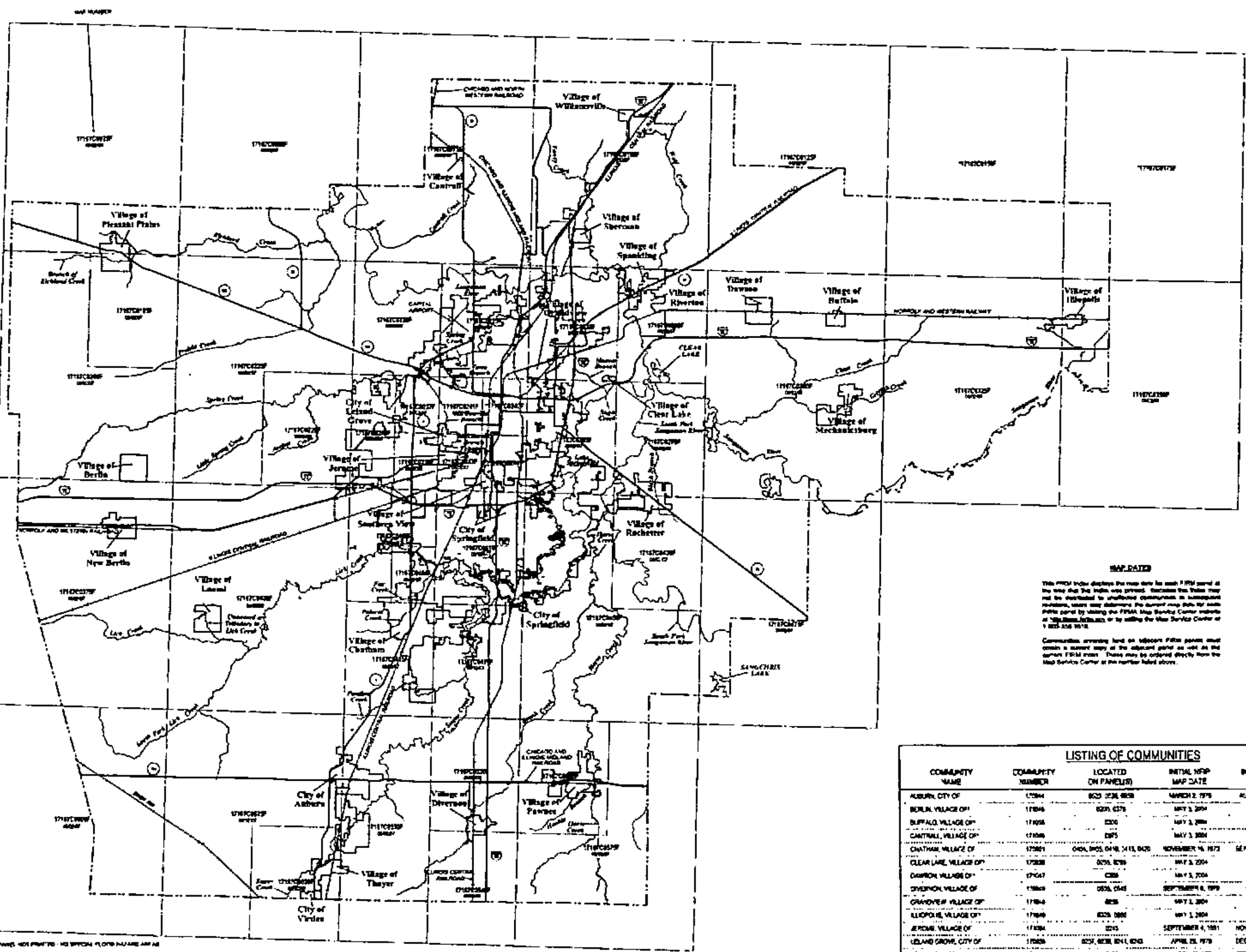
Organizational Structure

DaVita, Inc. & Total Renal Care, Inc.



Section I, Identification, General Information, and Certification
Flood Plain Requirements

The proposed facility site complies with the requirements of Illinois Executive Order #2005-5. The proposed facility is located at 2930 South 6th Street, Springfield, Illinois 62703. As shown on the attached FEMA Flood Insurance Rate Map, Map Index, this area is located on panel 17167C0243F. This is a non-printed panel with no special flood hazard area identified.



MAP DATES

MAP REPOSITORIES

AUBURN, CITY OF:

CHATHAM, VILLAGE OF:

DIVERNON, VILLAGE OF:

JEROME, VILLAGE OF

LELAND GROVE, CITY OF

LOAMI, VILLAGE OF:

MECHANICSBURG, VILLAGE OF

PAWNEE, VILLAGE OF:

PLEASANT PLAINS, VILLAGE OF

RIVERTON, VILLAGE OF

ROCHESTER, VILLAGE OF

SANGAMON COUNTY (UNINCORPORATED AREAS)

SHERMAN, VILLAGE OF:

SPAULDING, VILLAGE OF:

SPRINGFIELD, CITY OF

THAYER, VILLAGE OF

WILLIAMSVILLE, VILLAGE OF

NOTE TO USER

LISTING OF COMMUNITIES

COMMUNITY NAME	COMMUNITY NUMBER	LOCATED ON PANEL(S)	INITIAL NFIP MAP DATE	INITIAL FIRM DATE	MOST RECENT* FIRM PANEL DATE
AUBURN, CITY OF	[illegible]	[illegible]	MARCH 2, 1979	AUGUST 15, 1979	AUGUST 2, 2007
BERLIN, VILLAGE OF†	[illegible]	[illegible]	MAY 3, 2004	MAY 3, 2004	AUGUST 2, 2007
BUFFALO, VILLAGE OF†	[illegible]	[illegible]	MAY 3, 2004	MAY 3, 2004	AUGUST 2, 2007
CANTRALL, VILLAGE OF†	[illegible]	[illegible]	MAY 3, 2004	MAY 3, 2004	AUGUST 2, 2007
CHATHAM, VILLAGE OF	[illegible]	[illegible]	NOVEMBER 16, 1973	SEPTEMBER 2, 1981	AUGUST 2, 2007
CLEAR LAKE, VILLAGE OF†	[illegible]	[illegible]	MAY 3, 2004	MAY 3, 2004	AUGUST 2, 2007
DAWSON, VILLAGE OF†	[illegible]	[illegible]	MAY 3, 2004	MAY 3, 2004	AUGUST 2, 2007
DIVERNON, VILLAGE OF	[illegible]	[illegible]	SEPTEMBER [illegible], 1979	MAY 15, 1984	AUGUST 2, 2007
GRANDVIEW, VILLAGE OF†	[illegible]	[illegible]	MAY 3, 2004	MAY 3, 2004	AUGUST 2, 2007
ILLIOPOLIS, VILLAGE OF†	[illegible]	[illegible]	MAY 3, 2004	MAY 3, 2004	AUGUST 2, 2007
JEROME, VILLAGE OF	[illegible]	[illegible]	SEPTEMBER 4, 1981	NOVEMBER 15, 1983	AUGUST 2, 2007
LELAND GROVE, CITY OF	[illegible]	[illegible]	APRIL 28, 1978	DECEMBER 15, 1983	AUGUST 2, 2007
LOAMI, VILLAGE OF	[illegible]	[illegible]	MARCH 29, 1974	SEPTEMBER [illegible], 1985	AUGUST 2, 2007
MECHANICSBURG, VILLAGE OF	[illegible]	[illegible]	JANUARY 26, 1979	MAY 3, 2004	AUGUST 2, 2007
NEW BERLIN, VILLAGE OF†	[illegible]	[illegible]	MAY 3, 2004	MAY 3, 2004	AUGUST 2, 2007
PAWNEE, VILLAGE OF	[illegible]	[illegible]	MAY 17, 1974	MAY 3, 1982	AUGUST 2, 2007
PLEASANT PLAINS, VILLAGE OF	[illegible]	[illegible]	MARCH 22, 1974	SEPTEMBER 2, 1981	AUGUST 2, 2007
RIVERTON, VILLAGE OF	[illegible]	[illegible]	NOVEMBER 16, 1973	DECEMBER 1, 1981	AUGUST 2, 2007
ROCHESTER, VILLAGE OF	[illegible]	[illegible]	MARCH 21, 1973	JUNE 15, 1982	AUGUST 2, 2007
SANGAMON COUNTY (UNINCORPORATED AREAS)	[illegible]	ALL	MAY [illegible], 1978	JANUARY [illegible], 1983	AUGUST 2, 2007
SHERMAN, VILLAGE OF	[illegible]	[illegible]	JANUARY [illegible], 1979	NOVEMBER [illegible], 1983	AUGUST 2, 2007
SOUTHERN VIEW, VILLAGE OF†	[illegible]	[illegible]	MAY 3, 2004	MAY 3, 2004	AUGUST 2, 2007
SPAULDING, VILLAGE OF	[illegible]	[illegible]	MAY 3, 2004	MAY 3, 2004	AUGUST 2, 2007
SPRINGFIELD, CITY OF	[illegible]	[illegible]	JUNE 7, 1974	FEBRUARY 1, 1982	AUGUST 2, 2007
THAYER, VILLAGE OF	[illegible]	[illegible]	MARCH 29, 1974	MAY 3, 1982	AUGUST 2, 2007
VIRDEN, CITY OF†	[illegible]	[illegible]	MAY 3, 2004	MAY 3, 2004	AUGUST 2, 2007
WILLIAMSVILLE, VILLAGE OF	[illegible]	[illegible]	MAY 3, 2004	MAY 3, 2004	AUGUST 2, 2007

†NO SPECIAL FLOOD HAZARD AREAS IDENTIFIED
‡PANEL NOT PRINTED - NO SPECIAL FLOOD HAZARD AREAS
*INCLUDES MOST RECENT MAP INDEX

NFIP NATIONAL FLOOD INSURANCE PROGRAM

MAP INDEX

FIRM

FLOOD INSURANCE RATE MAP

SANGAMON COUNTY, ILLINOIS

AND INCORPORATED AREAS

(SEE LISTING OF COMMUNITIES TABLE)

MAP INDEX

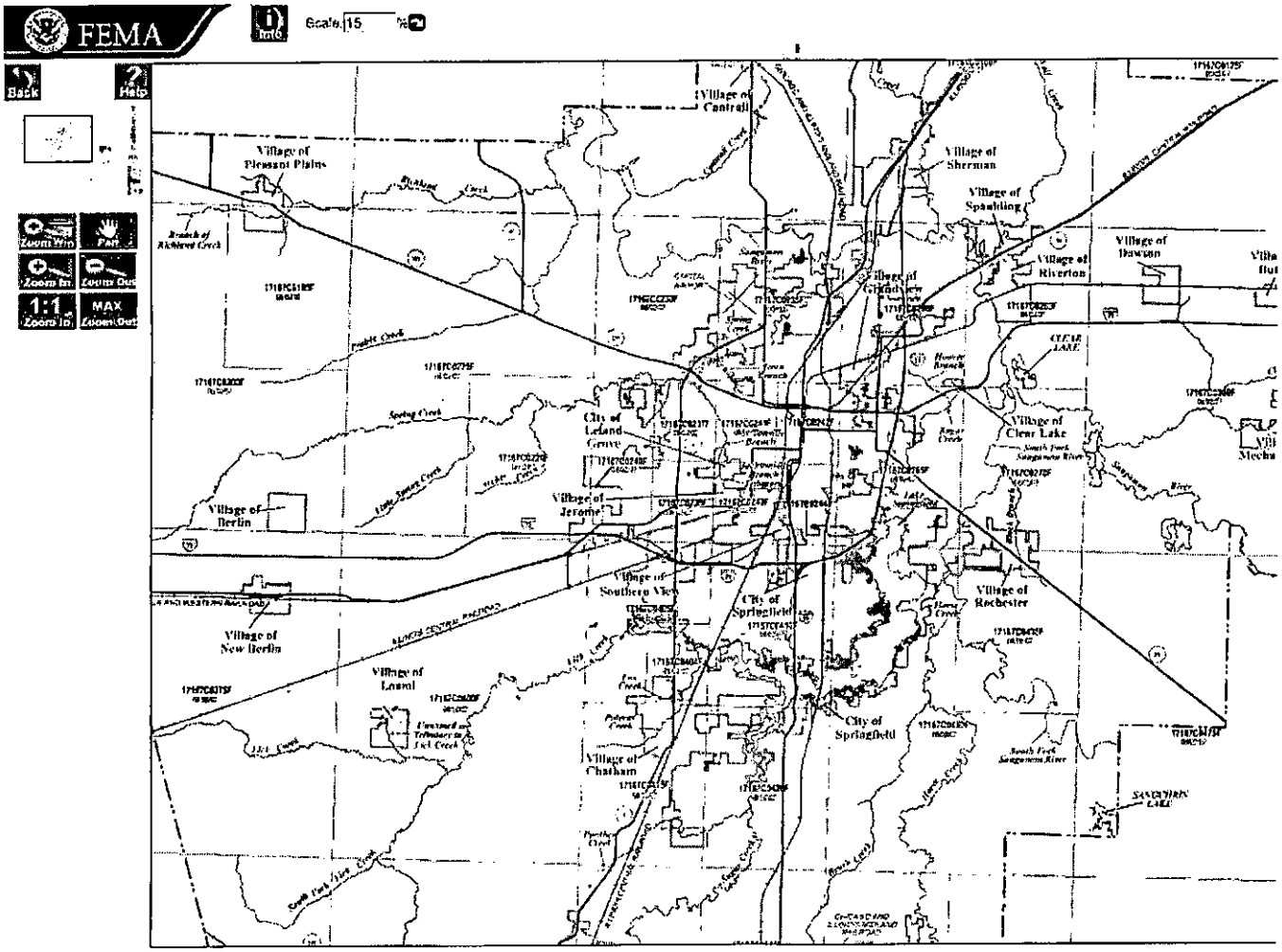
PANELS PRINTED: 25, 50, 75, 100, 125, 185, 200, 220, 225, 230, 235, 237, 239, 240, 241, 243, 255, 260, 265, 270, 300, 325, 330, 375, 400, 404, 425, 413, 415, 420, 436, 450, 475, 500, 520, 525, 535, 545, 550, 565, 575

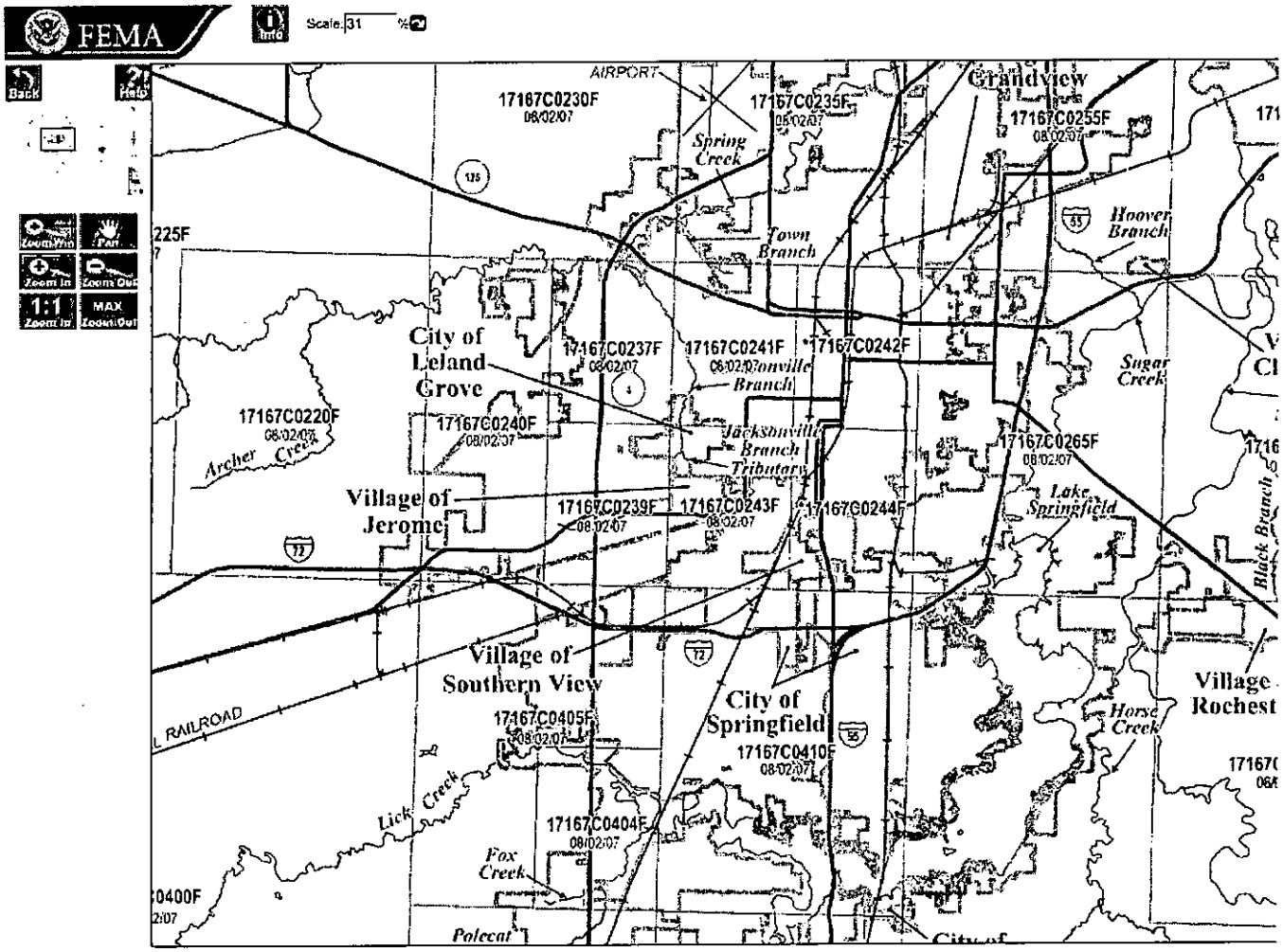
MAP NUMBER 17167CIND0B

MAP REVISED AUGUST 2, 2007

Federal Emergency Management Agency

Attachment – 5


FEMA
Scale 15
Back
Help
Village of Pleasant Plains
Village of Centralia
Village of Sherman
Village of Spaulding
Village of Dawson
Village of Riverton
City of Leland Grove
Village of Jerome
Village of Clear Lake
Village of Berlin
Village of Southern View
City of Springfield
Village of Rochester
Village of New Berlin
Village of Loami
Village of Chatham
City of Springfield


FEMA
Scale: 31 %
Back
Help
Zoom In
Zoom Out
1:1
MAX
AIRPORT
17167C0230F
08/02/07
17167C0235F
08/02/07
Spring Creek
Grandview
17167C0255F
08/02/07
Hoover Branch
Town Branch
City of Leland Grove
17167C0237F
08/02/07
17167C0241F
08/02/07
17167C0242F
Donville Branch
Sugar Creek
17167C0220F
08/02/07
Archer Creek
17167C0240F
08/02/07
Jacksonville Branch Tributary
17167C0265F
08/02/07
Village of Jerome
17167C0239F
08/02/07
17167C0243F
08/02/07
17167C0244F
Lake Springfield
Black Branch
Village of Southern View
City of Springfield
17167C0405F
08/02/07
17167C0410F
08/02/07
Horse Creek
Village Rochest
L RAILROAD
Lick Creek
17167C0404F
08/02/07
Fox Creek
Polecat

FEMA Info Scale: 19 %

Back Help

Zoom In Pan Zoom In Zoom Out 1:1 Zoom In MAX Zoom Out

community

LISTING OF COMMUNITIES

COMMUNITY NAME	COMMUNITY NUMBER	LOCATED ON PANEL(S)	INITIAL NFIP MAP DATE	INITIAL FIRM DATE	MOST RECENT FIRM PANEL DATE
AUBURN, CITY OF	170044	0520, 0525, 0540	MARCH 2, 1979	AUGUST 19, 1985	AUGUST 2, 2007
BERLIN, VILLAGE OF	171045	0200, 0375	MAY 3, 2004	MAY 3, 2004	AUGUST 2, 2007
BUFFALO, VILLAGE OF	171054	0300	MAY 3, 2004	MAY 3, 2004	AUGUST 2, 2007
CANTRALL, VILLAGE OF	171046	0075	MAY 3, 2004	MAY 3, 2004	AUGUST 2, 2007
CHATHAM, VILLAGE OF	173801	0404, 0405, 0410, 0415, 0470	NOVEMBER 15, 1972	SEPTEMBER 2, 1981	AUGUST 2, 2007
CLEAR LAKE, VILLAGE OF	173839	0255 0265	MAY 3, 2004	MAY 3, 2004	AUGUST 2, 2007
DAWSON, VILLAGE OF	171047	0520	MAY 3, 2004	MAY 3, 2004	AUGUST 2, 2007
DIVERNON, VILLAGE OF	170948	0535, 0545	SEPTEMBER 8, 1978	MAY 15, 1984	AUGUST 2, 2007
GRANDVIEW, VILLAGE OF	171048	0255	MAY 3, 2004	MAY 3, 2004	AUGUST 2, 2007
ILLIOPOLIS, VILLAGE OF	171049	0325, 0350	MAY 3, 2004	MAY 3, 2004	AUGUST 2, 2007
JEROME, VILLAGE OF	171004	0743	SEPTEMBER 4, 1981	NOVEMBER 16, 1983	AUGUST 2, 2007
LELAND GROVE, CITY OF	173505	0237, 0330, 0741, 0243	APRIL 26, 1978	DECEMBER 26, 1982	AUGUST 2, 2007
LOAMI, VILLAGE OF	173705	0400	MARCH 29, 1974	SEPTEMBER 4, 1985	AUGUST 2, 2007
MECHANICSBURG, VILLAGE OF	170960	0300	JANUARY 26, 1979	MAY 3, 2004	AUGUST 2, 2007
NEW BERLIN, VILLAGE OF	171002	0375	MAY 3, 2004	MAY 3, 2004	AUGUST 2, 2007
PAWNEE, VILLAGE OF	173802	0385	MAY 17, 1974	MAY 3, 1982	AUGUST 2, 2007
PLEASANT PLAINS, VILLAGE OF	170708	0025, 0185	MARCH 22, 1974	SEPTEMBER 2, 1981	AUGUST 2, 2007
RIVERTON, VILLAGE OF	170973	0250	NOVEMBER 19, 1973	DECEMBER 1, 1981	AUGUST 2, 2007
ROCHESTER, VILLAGE OF	170049	0255, 0270, 0435, 0450	MARCH 21, 1975	JUNE 15, 1982	AUGUST 2, 2007
SANGAMON COUNTY (UNINCORPORATED AREAS)	170912	ALL	MAY 5, 1978	JANUARY 6, 1983	AUGUST 2, 2007
SHERMAN, VILLAGE OF	170999	0075 0100, 0235, 0256	JANUARY 12, 1979	NOVEMBER 15, 1983	AUGUST 2, 2007
SOUTHERN VIEW, VILLAGE OF	171051	0243, 0244	MAY 3, 2004	MAY 3, 2004	AUGUST 2, 2007
SPAULDING, VILLAGE OF	171050	0255 0260	MAY 3, 2004	MAY 3, 2004	AUGUST 2, 2007
SPRINGFIELD, CITY OF	170504	0220, 0230, 0235 0237, 0239, 0241, 0241, 0242, 0243, 0244, 0253 0255, 0430, 0404, 0405 0410 0420, 0490	JUNE 7, 1974	FEBRUARY 2, 1982	AUGUST 2, 2007
THAYER, VILLAGE OF	170804	0520, 0550	MARCH 22 1974	MAY 3, 1982	AUGUST 2, 2007
VIRDEN, CITY OF	170435	0520	MAY 3, 2004	MAY 3, 2004	AUGUST 2, 2007
WILLIAMSVILLE, VILLAGE OF	171031	0100	MAY 3, 2004	MAY 3, 2004	AUGUST 2, 2007

*NO SPECIAL FLOOD HAZARD AREAS IDENTIFIED
†PANEL NOT PRINTED – NO SPECIAL FLOOD HAZARD AREAS
‡INCLUDES MOST RECENT MAP INDEX

NFIP NATIONAL FLOOD INSURANCE PROGRAM

MU

FIRM
FLOOD INSU
SANGAM
ILLINOIS
AND INCOR
(SEE LISTING OF

MAP I
PANELS PRI
100, 125, 185, 2
235, 237, 239, 2
260, 265, 270, 3
400, 404, 405, 4
450, 475, 500, 5
550, 555, 575

Federal Emerg

Section I, Identification, General Information, and Certification
Historic Resources Preservation Act Requirements

The Historic Resources Preservation Act determination from the Illinois Historic Preservation Agency is attached at Attachment – 6.

Attachment – 6

Illinois Historic
Preservation Agency

FAX (217) 782-8161

1 Old State Capitol Plaza • Springfield, Illinois 62701-1512 • www.illinois-history.gov

Sangamon County
Springfield
CON - Rehabilitation of Establish a 12-Station Dialysis Facility
2930 S. 6th St.
IHPA Log #013112410

December 10, 2010

Anne Cooper
Polsinelli Shughart
161 N. Clark St,. Suite 4200
Chicago, IL 60601

Dear Ms. Cooper:

This letter is to inform you that we have reviewed the information provided concerning the referenced project.

Our review of the records indicates that no historic, architectural or archaeological sites exist within the project area.

Please retain this letter in your files as evidence of compliance with Section 4 of the Illinois State Agency Historic Resources Preservation Act (20 ILCS 3420/1 et. seq.). This clearance remains in effect for two years from date of issuance. It does not pertain to any discovery during construction, nor is it a clearance for purposes of the Illinois Human Skeletal Remains Protection Act (20 ILCS 3440).

If you have any further questions, please contact me at 217/785-5027.

Sincerely,

Anne E. Haaker

Anne E. Haaker
Deputy State Historic
Preservation Officer

Attachment – 6

Section I, Identification, General Information, and Certification
Project Costs and Sources of Funds

Table 1120.110			
Project Cost	**Clinical**	**Non-Clinical**	**Total**
Modernization Contracts	$761,000		$761,000
Contingencies	$76,100		$76,100
Architectural/Engineering Fees	$61,000		$61,000
Consulting & Other Fees	$48,000		$48,000
Moveable or Other Equipment			
Communications	$60,310		$60,310
Water Treatment	$110,880		$110,880
Bio-Medical Equipment	$8,885		$8,885
Clinical Equipment	$203,073		$203,073
Clinical Furniture/Fixtures	$18,414		$18,414
Lounge Furniture/Fixtures	$2,815		$2,815
Storage Fixtures/Equipment	6,859		6,859
Business Office Fixtures	$25,925		$25,925
General Furniture/Fixtures	$22,500		$22,500
Signage	$11,500		$11,500
Total Moveable and Other Equipment	$471,161		$471,161
Fair Market Value of Leased Space or Equipment	$778,570		$778,570
Total Project Costs	**$2,195,831**		**$2,195,831**

Section I, Identification, General Information, and Certification
Cost Space Requirements

Cost Space Table							
		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Dept. / Area	Cost	Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
CLINICAL							
ESRD	$2,195,831	6,100	0	0	6,100	0	0
Total Clinical	**$2,195,831**	**6,100**	**0**	**0**	**6,100**	**0**	**0**
NON CLINICAL							
Total Non-clinical	**$0**	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL	**$2,195,831**	**6,100**	**0**	**0**	**6,100**	**0**	**0**

Attachment – 9

Section III, Project Purpose, Background and Alternatives – Information Requirements
Criterion 1110.230, Project Purpose, Background and Alternatives

Background of the Applicant

Davita, Inc. and Total Renal Care, Inc. (the "Applicants") are fit, willing and able, and have the qualifications, background and character to adequately provide a proper standard of health care services for the community. DaVita is a leading provider of dialysis services in the United States. The name DaVita is an adaptation of an Italian phrase meaning, "giving life." DaVita's core values embrace service excellence, integrity, team, accountability, continuous improvement and fulfillment.

Service Excellence

Serving others — the reason for existing. DaVita continually seeks to understand the needs of those who depend on it (patients, doctors, and fellow team members) and then to exceed their expectations.

Integrity

DaVita says what it believes, and does what it says. DaVita is trusted because it is trustworthy. In its personnel, team, and organizational values, DaVita strives for alignment in what it says and does.

Team

One for All, and All for One! DaVita works together, sharing a common purpose, a common culture and common goals. DaVita genuinely cares for and supports, not only those to whom it provides care, but those with whom it works shoulder-to-shoulder. DaVita works to pursue achieving its Mission.

Continuous Improvement

DaVita never stands still; it is never satisfied. Individually, and as teams, DaVita constantly looks at what it does, and asks, "How can we do this better?" Then, it uses a systematic approach to take action.

Accountability

DaVita never says, "It's not our fault," or "It's not our job." It takes responsibility for meeting its commitments — the personal ones as well as those of the entire organization. DaVita takes ownership of the results.

Fulfillment

DaVita makes a difference. DaVita feels rewarded — personally and as a team — because what it does in its jobs is consistent with its goals and dreams. DaVita believes "You must be the change you wish to see in the world." (Mahatma Gandhi). And, when you *are* the change, that's fulfilling!

DaVita has taken on many initiatives to improve the lives of patients suffering from chronic kidney disease ("CKD") and end stage renal disease ("ESRD"). These programs include the EMPOWER, IMPACT, CathAway, and transplant assistance programs. Information on the EMPOWER, IMPACT and CathAway programs are attached at Attachment – 11A.

There are over 26 million patients with CKD and that number is expected to rise. Current data reveals a disturbing trend:

- The prevalence of CKD stages 1 to 4 has increased from 10% to 13.1% between 1988 and 2004[1]
- Increasing prevalence of diabetes and hypertension, the two major causes of CKD

Additionally, approximately 65% of CKD Medicare patients (patients 67 and older) have never been evaluated by a nephrologist.[2] Timely CKD care, however, is imperative because adverse outcomes of CKD can often be prevented or delayed through early detection and treatment. Several studies have shown that early detection, intervention and care of CKD may result in improved patient outcomes:

- Reduced GFR is an independent risk factor for morbidity and mortality,
- A reduction in the rate of decline in kidney function upon nephrologists referrals has been associated with prolonged survival of CKD patients,
- Late referral to a nephrologists has been correlated with lower survival during the first 90 days of dialysis, and
- Timely referral of CKD patients to a multidisciplinary nephrology team may improve outcomes and reduce cost.

A care plan for patients with CKD includes strategies to slow the loss of kidney function, manage comorbidities, and prevent or treat cardiovascular disease and other complications of CKD, as well as ease the transition to kidney replacement therapy. Through the EMPOWER program, DaVita offers educational services to CKD patients that can help patients reduce, delay, and prevent adverse outcomes of untreated CKD. The EMPOWER program encourages CKD patients to take control of their health and make informed decisions about their dialysis care.

The IMPACT program seeks to reduce patient mortality rates during the first 90-days of dialysis through patient intake, education and management, and reporting. In fact, since piloting in October 2007, the program has not only shown to reduce mortality rates by 8 percent but has also resulted in improved patient outcomes.

The CathAway program seeks to reduce the number of patients with central venous catheters ("CVC") through arteriovenous fistula ("AV fistula") placement. AV fistulas have superior patency, lower complication rates, improved adequacy, lower cost to the healthcare system, and decreased risk of patient mortality compared to CVCs. In July 2003, the Centers for Medicare and Medicaid Services, the End Stage Renal Disease Networks and key providers jointly recommended adoption of a National Vascular Access Improvement Initiative ("NVAII') to increase the appropriate use of AV fistulas for hemodialysis. The CathAway program is designed to comply with NAVII through patient education outlining the benefits for AV fistula placement and support through vessel mapping, fistula surgery and maturation, first cannulation and catheter removal.

DaVita's transplant referral and tracking program ensures every dialysis patient is informed of transplant as a modality option and promotes access to transplantation for every patient who is interested and eligible for transplant. The social worker or designee obtains transplant center guidelines and criteria for selection of appropriate candidates and assists transplant candidates with factors that may affect their eligibility, such as severe obesity, adherence to prescribed medicine or therapy, and social/emotional/ financial factors related to post-transplant functioning.

In an effort to better serve all kidney patients, DaVita believes in requiring that all providers measure outcomes in the same way and report them in a timely and accurate basis or be subject to penalty. There are four key measures that are the most common indicators of quality care for dialysis providers - dialysis adequacy, fistula use rate, nutrition and bone and mineral metabolism. Adherence to these standard measures has been directly linked to 15-20% fewer hospitalizations. On each of these measures, DaVita

---

[1] US Renal Data System, USRDS 2007 Annual Data Report: Atlas of Chronic Kidney Disease and End-Stage Renal Disease in the United States, Bethesda, MD: National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases; 2007.

[2] Id.

has demonstrated superior clinical outcomes, which directly translated into 7% reduction in hospitalizations among DaVita patients, the monetary result of which is $210M to $230M in hospitalization savings to the health care system and the American taxpayer.

No adverse action has been taken against any of the applicants, or against any Illinois health care facilities owned or operated by the Applicants, directly or indirectly, within three years preceding the filing of this application.

1. Health care facilities owned or operated by the Applicants:

   A list of health care facilities owned or operated by DaVita, Inc. was provided in the application for permit for Project No. 10-068 filed with the HFSRB on September 24, 2010. See Proj. No. 10-068 App. pgs. 66 – 116. A certification that no change in the health care facilities owned or operated by DaVita, Inc. is attached at Attachment – 11B.

   A list of healthcare facilities owned or operated by Total Renal Care, Inc. is provided below:

Facility	Location
Vandalia Dialysis	Vandalia
Big Oaks Dialysis	Niles
Adams County Dialysis	Quincy
Edwardsville Dialysis	Edwardsville
Pittsfield Dialysis	Pittsfield
Stony Island Dialysis	Chicago
Lake Park Dialysis	Chicago
Woodlawn Dialysis	Chicago
Crystal Springs Dialysis	Crystal Lake
Cobblestone Dialysis	Elgin

   Dialysis facilities are not subject to State Licensure and Joint Commission accreditation.

2. Certification that no adverse action has been taken against any of the Applicants, or against any health care facilities owned or operated by the Applicants, directly or indirectly, within three years preceding the filing of this application is attached at Attachment – 11C.

3. An authorization permitting the Illinois Health Facilities and Services Review Board ("HFSRB") and the Illinois Department of Public Health ("IDPH") access to any documents necessary to verify information submitted, including, but not limited to: official records of IDPH or other State agencies; and the records of nationally recognized accreditation organizations is attached at Attachment – 11C.

4. DaVita, Inc. submitted an application for permit for Project No. 10-068 with the HFSRB on September 24, 2010. A certification that no changes regarding the information regarding health care facilities owned or operated by DaVita, Inc. previously provided in that application is attached at Attachment 11-B.

OCMO
Relentless pursuit of quality

Office of the Chief
Medical Officer (OCMO)
Allen R. Nissenson, MD
Chief Medical Officer
Meredith Mathews, MD
Robert Provenzano, MD
John Robertson, MD
David B. Van Wyck, MD

601 Hawaii Street, El Segundo, CA 90245 | 1-800-313-4872 | www.davita.com/physicians

April 30, 2009

Dear Physicians:

As your partner, DaVita® and OCMO are committed to helping you achieve unprecedented clinical outcomes with your patients. As part of OCMO's Relentless Pursuit of Quality™, DaVita will be launching our top two clinical initiatives; IMPACT and CathAway™, at our annual 2009 Nationwide Meeting. Your facility administrators will be orienting you on both programs upon their return from the meeting in early May.

IMPACT: The goal of IMPACT is to reduce incident patient mortality. IMPACT stands for Incident Management of Patients Actions Centered on Treatment. The program focuses on three components: patient intake, education and management and reporting. IMPACT has been piloting since October 2007 and has demonstrated a reduction in mortality. The study recently presented at the National Kidney Foundation's Spring Clinical Meeting in Nashville, TN. In addition to lower mortality rates, patient outcomes improved - confirming this vulnerable patient population is healthier under DaVita's relentless pursuit of quality care.

CathAway: Higher catheter use is associated with increased infection, morbidity, mortality and hospitalizations [1] [2]. The 7-step Cathaway Program supports reducing the number of patients with central venous catheters (CVCs). The program begins with patient education outlining the benefits of fistula placement. The remaining steps support the patient through vessel mapping, fistula surgery and maturation, first cannulation and catheter removal. For general information about the CathAway program, see the November 2008 issue of QUEST, DaVita's Nephrology Journal.

Here is how you can support both initiatives in your facilities:

- **Assess incident patients regularly in their first 90 days**: Discuss patients individually and regularly. Use the IMPACT scorecard to prompt these discussions.
- **Adopt "Facility Specific Orders"**: Create new facility specific orders using the form that will be provided to you.
- **Minimize the "catheter-removal" cycle time**: Review each of your catheter patients with your facility teammates and identify obstacles causing delays in catheter removal. Work with the team and patients to develop action plans for catheter removal.
- **Plan fistula and graft placements**: Start AV placement plans early by scheduling vessel mapping and surgery evaluation appointments for Stage 4 CKD patients. Schedule fistula placement surgery for those patients where ESRD is imminent in the next 3-6 months.

Launch Kits:

In May, Launch Kits containing materials and tools to support both initiatives will be arriving at your facilities. IMPACT kits will include a physician introduction to the program, step by step implementation plan and a full set of educational resources. FAs and Vascular Access Leaders will begin training on a new tool to help identify root-causes for catheter removal delays.

Your support of these efforts is crucial. As always, I welcome your feedback, questions and ideas. Together with you, our physician partners, we will drive catheter use to all-time lows and help give our incident patients the quality and length of life they deserve.

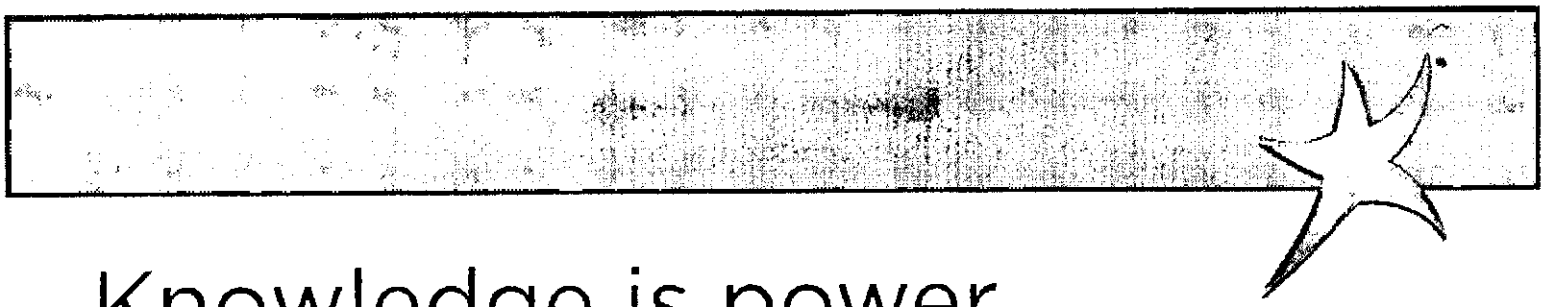
Sincerely,

Allen R. Nissenson, MD, FACP
Chief Medical Officer, DaVita

(1) Dialysis Outcomes and Practice Patterns Study (DOPPS): 2 yrs/7 Countries / 10,000 pts.
(2) Pastan et al: Vascular access and increased risk of death among hemodialysis patients.

OCMO

DaVita.



Knowledge is power.

EMPOWER® is an educational program by DaVita®. The program includes a series of free community based classes for patients with chronic kidney disease (CKD). These classes encourage you to take control of your kidney disease and prepare for dialysis by making healthy choices about your kidney care

Taking Control Of Kidney Disease

Learn how to slow the progression of kidney disease.

- Kidney disease and related conditions
- Behavior modification
- Dietary guidelines
- Common medications
- Insurance choices
- Ways to cope with CKD
- Questions to ask your health care team

Making Healthy Choices

Learn how to prepare for dialysis.

- Kidney disease and related conditions
- Behavior modification
- Dietary guidelines
- Common medications
- Treatments that allow you to stay active and continue to work
- Insurance choices
- Ways to cope with CKD
- Questions to ask your health care team

Treatment Choices

An in-depth look at all of your treatment choices.

- Kidney disease and related conditions
- Treatments that allow you to stay active and continue to work
- Insurance choices
- Ways to cope with CKD
- Questions to ask your health care team

To register for a class, call 1-888-MyKidney (695-4363).

EMPOWER®
1-888-MyKidney (695-4363) | DaVita.com/EMPOWER

DaVita®

IMPACT stands for Incident Management of Patients, Actions Centered on Treatment. It's a comprehensive patient management program designed to focus on incident patients throughout their first three months of dialysis. The first days of dialysis are particularly challenging for patients, families and health care teams.

These patients require more education and closer management than patients who have been receiving dialysis for a longer period because of their compromised conditions and high mortality risk. IMPACT is focused on easing the process for patients transitioning to dialysis.

The desired goal of this program are to provide comprehensive patient education, target key monitoring points in the first 90 days for better adherence to treatment, improved outcomes and reduced mortality.

Achieve "Top Two" status in 2010.

What's the significance of achieving Top Two status?

Reducing both incident patient mortality and the number of catheter patients are DaVita's top two clinical goals for 2010. Medical Directors, FAs and RODs who achieve both program goals in 2010 will achieve Top Two status for the year.

These initiatives are tied to strong clinical outcomes and improved quality of life. Reaching the Top Two goals means a high level of care for your patients, and special recognition and honors.

To reach your 2010 IMPACT Goal:
Achieve a graduate grade of 75% or better by December 31 for September new admits

To reach your 2010 CathAway Goal:
Achieve Day-90 catheter percentage of 18% or lower by December 31


TEAM IMPACT
FIRST
90
DAYS
INCIDENT MANAGEMENT OF PATIENTS ACTIONS CENTERED ON TREATMENT

DaVita®

OCMO
Relentless pursuit of quality

Dear Physician Partners:

IMPACT™ is an initiative focused on reducing incident patient mortality. The program provides a comprehensive onboarding process for incident patients, with program materials centered on four key clinical indicators—access, albumin, anemia, and adequacy.

Medical Directors: How can you support IMPACT in your facilities?

- Customize the new Standard Admission Order template into facility-specific orders. Drive use of the standard order with your attending physicians
- Review your facility IMPACT scorecard at your monthly QIFMM meeting
- Talk about IMPACT regularly with your attending physicians

Attending Physicians: How can you support IMPACT in your facilities?

- Use the IMPACT scorecard to assess incident patients
- Educate teammates about the risk incident patients face and how IMPACT can help

How was IMPACT developed? What are the initial results?
From October 2007 to April 2009, IMPACT was piloted in DaVita® centers. Early results, presented at the National Kidney Foundation's Spring Clinical Meeting in Nashville, TN this April, showed an 8% reduction in annualized mortality. In addition to lower mortality, IMPACT patients showed improvements in fistula placement rates and serum albumin levels. The results are so impressive that we are implementing this program throughout the Village.

Your support of this effort is crucial.
If you have not seen the IMPACT order template and scorecard by the end of June, or if you have additional questions about the program, email impact@davita.com. Together we can give our incident patients the quality and length of life they deserve.

Sincerely,

Dennis Kogod
Cheif Operating Officer

Allen R. Nissenson, MD, FACP
Chief Medical Officer

DaVita. Corporate Office : 601 Hawaii Street, El Segundo, CA 90245 1-800-313-4872 DaVita.com/physicians

DaVita.

FOR IMMEDIATE RELEASE

DaVita's IMPACT Program Reduces Mortality for New Dialysis Patients

Study Shows New Patient Care Model Significantly Improves Patient Outcomes

El Segundo, Calif., (March, 29, 2009) – DaVita Inc., a leading provider of kidney care services for those diagnosed with chronic kidney disease (CKD), today released the findings of a study revealing DaVita's IMPACT™ (Incident Management of Patients, Actions Centered on Treatment) pilot program can significantly reduce mortality rates for new dialysis patients. The study presented at the National Kidney Foundation's Spring Clinical Meeting in Nashville, TN details how the IMPACT patient care model educates and manages dialysis patients within the first 90 days of treatment, when they are most unstable and are at highest risk. In addition to lower mortality rates, patient outcomes improved - confirming the health of this vulnerable patient population is better supported under DaVita's *Relentless Pursuit of Quality*™ care.

The pilot program was implemented with 606 patients completing the IMPACT program over a 12 month period in 44 DaVita centers around the nation. IMPACT focuses on patient education and important clinical outcomes - such as the measurement of adequate dialysis, access placement, anemia, and albumin levels - monitoring the patient's overall health in the first 90 days on dialysis. Data reflects a reduction in annualized mortality rates by eight percent for IMPACT patients compared with non-IMPACT patients in the DaVita network. Given that DaVita has roughly 28,000 new patients starting dialysis every year, this reduction affects a significant number of lives.

In addition, a higher number of IMPACT patients versus non-IMPACT patients had an arteriovenous fistula (AVF) in place. Research show that fistulas - the surgical connection of an artery to a vein - last longer and are associated with lower rates of infection, hospitalization and death compared to all other access choices.

Allen R. Nissenson, MD, Chief Medical Officer at DaVita says, "The IMPACT program is about quality patient care starting in the first 90 days and extending beyond. Improved outcomes in new dialysis patients translates to better long term results and healthier patients overall."

Researchers applaud the IMPACT program's inclusion of all patients starting dialysis, regardless of their cognitive ability or health status. Enrolling all patients at this early stage in their treatment allows them to better understand their disease and care needs while healthcare providers work to improve their outcomes. Through this program, DaVita mandates reporting on this particular population to better track and manage patients through their incident period.

Dennis Kogod, Chief Operating Officer of DaVita says, "We are thrilled by the promising results IMPACT has had on our new dialysis patients. DaVita continues to be the leader in the kidney care community, and we look forward to rolling out this program to all facilities later this year, to improve the health of all new dialysis patients."

Poster Presentation
NKF Spring Clinical Meeting
Nashville, TN
March 26-28, 2009

Incident Management of Hemodialysis Patients: Managing the First 90 Days

John Robertson[1], Pooja Goel[1], Grace Chen[1], Ronald Levine[1], Debbie Benner[1], and Amy Burdan[1]
[1]DaVita Inc., El Segundo, CA, USA

IMPACT (Incident Management of Patients, Actions Centered on Treatment) is a program to reduce mortality and morbidity in new patients during the first 3 months of dialysis, when these patients are most vulnerable. IMPACT was designed to standardize the onboarding process of incident patients from their 0 to 90-day period. We report on an observational (non-randomized), un-blinded study of 606 incident patients evaluated over 12 months (Oct77-Oct08) at 44 US DaVita facilities.

The study focused on 4 key predictive indicators associated with lower mortality and morbidity —anemia, albumin, adequacy and access (4As). IMPACT consisted of:

(1) Structured New Patient Intake Process with a standardized admission order, referral fax, and an intake checklist;
(2) 90-day Patient Education Program with an education manual and tracking checklist;
(3) Tools for 90-day Patient Management Pathway including QOL; and
(4) Data Monitoring Reports.

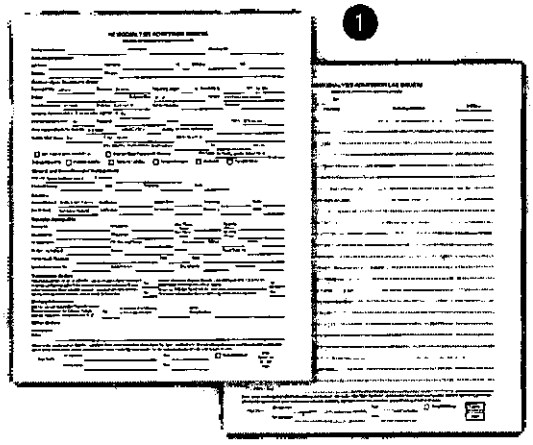
Data as of July, 2008 is reported. Patients in the IMPACT group were 60.6 3 15.1 years old (mean3SD), 42.8% Caucasian, 61% male with 25% having a fistula. Results showed a reduction in 90-day mortality almost 2 percentage points lower (6.14% vs. 7.98%; $p<0.10$) among IMPACT versus nonIMPACT patients. Changes among the 4As showed higher albumin levels from 3.5 to 3.6 g/dL (note that some IMPACT patients were on protein supplementation during this period) and patients achieving fistula access during their first 90-days was 25% vs. 21.4%, IMPACT and nonIMPACT, respectively ($p\leq0.05$). However, only 20.6% of IMPACT patients achieved Hct targets ($33\leq3xHb\leq36$) vs. 23.4% for controls ($p<0.10$); some IMPACT patients may still have >36-level Hcts. Mean calculated Kt/V was 1.54 for IMPACT patients vs. 1.58 for nonIMPACT patients ($p\leq0.05$).

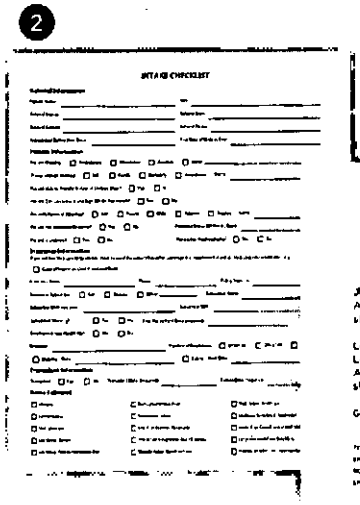
IMPACT is a first step toward a comprehensive approach to reduce mortality of incident patients. We believe this focus may help us to better manage CKD as a continuum of care. Long-term mortality measures will help determine if this process really impacts patients in the intended way, resulting in longer lives and better outcomes.

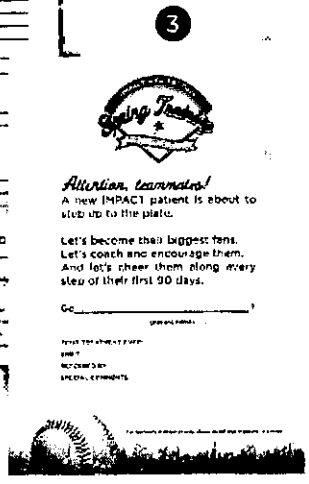
IMPACT Tools

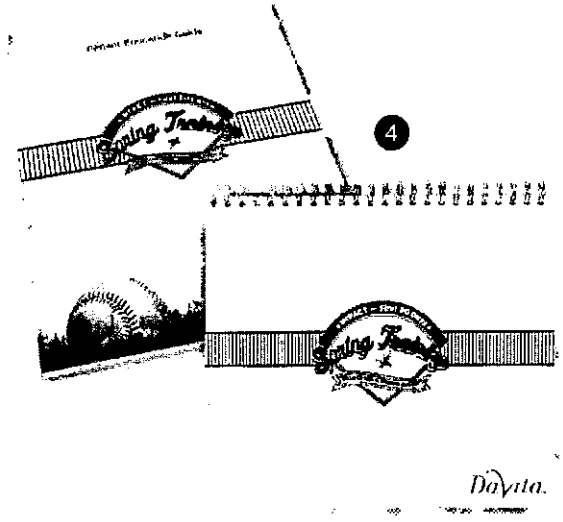
Here's how the IMPACT program will help the team record data, educate patients and monitor their progress in your facilities.

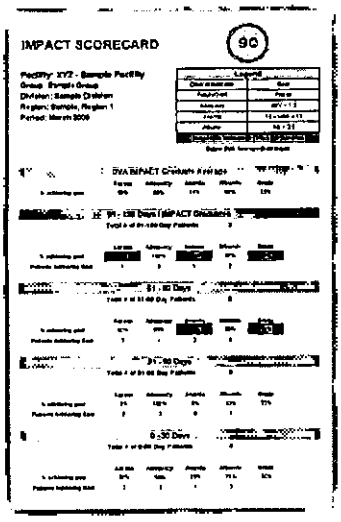
1. Standard Order Template, a two-page form with drop-down menus that can be customized into a center-specific template
2. Intake Checklist to gather registration and clinical data prior to admission
3. Patient Announcement to alert teammates about new incident patients
4. Patient Education Book and Flip Chart to teach patients about dialysis
5. Tracking Checklist for the team to monitor progress over the first 90 days
6. IMPACT Scorecard to track monthly center summary and patient level detail for four clinical indictors: access, albumin, adequacy, anemia

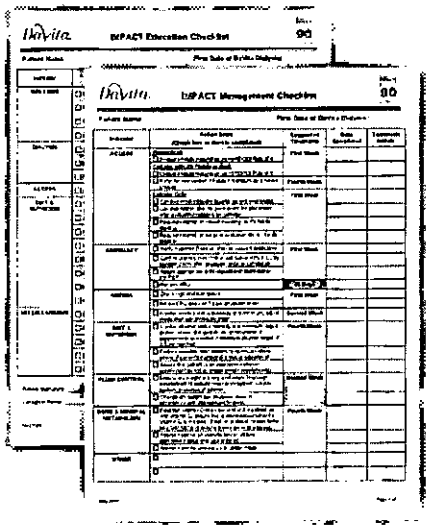












DaVita.

Casa Nueva
1551 Wewatta Street
Denver, CO 80202-6173
Tel: 303-405-2100
www.davita.com

December 17, 2010

Dale Galassie
Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Chairman Galassie:

I hereby certify under penalty of perjury as provided in § 1-109 of the Illinois Code of Civil Procedure, 735 ILCS 5/1-109 that the information regarding all health care facilities owned or operated by DaVita, Inc. was included in the application for permit for Project No. 10-068 filed with the Health Facilities and Services Review Board on September 24, 2010. No changes have occurred to the information that was previously provided.

Sincerely,

Kent J. Thiry
Chief Executive Officer
DaVita, Inc.

Subscribed and sworn to me
This 17th day of December, 2010

Tara L. Motley
Notary Public

"OFFICIAL SEAL"
Tara L Motley
Notary Public, State of Illinois
My Commission Expires 6/11/2013

DaVita.

Casa Nueva
1551 Wewatta Street
Denver, CO 80202-6173
Tel: 303-405-2100
www.davita.com

December 17, 2010

Dale Galassie
Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Chairman Galassie:

I hereby certify under penalty of perjury as provided in § 1-109 of the Illinois Code of Civil Procedure, 735 ILCS 5/1-109 that no adverse action has been taken against any facility owned or operated by DaVita, Inc. or Total Renal Care, Inc. during the three years prior to filing this application.

Additionally, pursuant to 77 Ill. Admin. Code § 1110.230(a)(3)(C), I hereby authorize the Health Facilities and Services Review Board ("HFSRB") and the Illinois Department of Public Health ("IDPH") access to any documents necessary to verify information submitted as part of this application for permit. I further authorize HFSRB and IDPH to obtain any additional information or documents from other government agencies which HFSRB or IDPH deem pertinent to process this application for permit.

Sincerely,

Kent J. Thiry
Chief Executive Officer
DaVita, Inc.
Total Renal Care, Inc.

Subscribed and sworn to me
This 17th day of December, 2010

Tara L. Motley
Notary Public

"OFFICIAL SEAL"
Tara L. Motley
Notary Public, State of Illinois
My Commission Expires 3/11/2013

Attachment – 11C

Section III, Project Purpose, Background and Alternatives – Information Requirements
Criterion 1110.230(b), Project Purpose, Background and Alternatives

Purpose of the Project

1. The purpose of the project is to maintain access to life sustaining dialysis to residents of Springfield and nearby communities. As shown in Table 1110.230(b) below, there are currently four dialysis facilities within 30 minutes normal travel time from the proposed dialysis facility. These facilities serve a county of almost 200,000. (The 2009 U.S. Census Bureau estimate is 195,716.)

Table 1110.230(b)
Average Utilization – Facilities within 30 Minutes of Proposed Facility

Facility	Address	Miles	Travel Time	Stations as of 09-30-2010	Patients as of 09/30/2010	9/30/2010 Utilization
Memorial Medical Center	800 North Rutledge Street	3.76 mi	11 min	6	6	16.67%
Lincolnland Dialysis Center	1112 Centre West Drive	5.28 mi	9 min	14	61	72.62%
DaVita - Springfield Central	932 North Rutledge Street	3.87 mi	11 min	21	98	77.78%
DaVita - Montvale	2930 Montvale Drive, Suite A	2.99 mi	6 min	17	74	72.55%
Total				**58**	**239**	**68.68%**
Total (excluding Memorial)				**52**	**233**	**74.68%**

Average utilization of the facilities within 30 minutes travel time of the proposed facility is 68.68%. While average utilization is below the HFSRB utilization standard of 80%, this is primarily due to underutilization at Memorial Medical Center ("Memorial"). As set forth in the letter from Memorial attached at Attachment 12-A, Memorial serves special needs patients, e.g., larger patients who cannot be accommodated in recliner chairs and patients with behavioral problems. In 1998, Memorial divested its other dialysis stations, maintaining only six stations to accommodate the limited number of special needs patients that cannot be treated in freestanding dialysis facilities. Memorial does not solicit or make its services available to the general ESRD population. Excluding Memorial, average utilization of the remaining three facilities is 74.68%. Assuming target utilization of 80%, the remaining facilities only have capacity for 18 additional ESRD patients.

Importantly, utilization at each of the existing facilities has increased over the past two years, averaging 4% per year. With the current obesity epidemic in America and an increase in the elderly population (individuals 65 and older), this growth in demand for dialysis services is expected to increase in the coming years. Assuming historical growth rates remain unchanged, these facilities should reach the HFSRB 80% utilization rate, within the next 12 to 15 months while the planned facility is under construction.

Moreover, Central Illinois Kidney and Dialysis Associates, S.C. is currently treating 28 Stage 5 chronic kidney disease ("CKD") patients and 175 Stage 4 CKD patients whose condition is advancing to end-stage renal disease and who will likely require dialysis within the next 12 to 18 months. See Attachment – 12B. Conservatively, the Applicants assumed a 20% attrition rate for Stage 5 patients and a 40% attrition rate for Stage 4 CKD patients. That is, because of CKD patient death, transplant or relocation, only 80% of Stage 5 CKD patients and 60% of Stage 4 CKC patients are expected to initiate dialysis. That means approximately 127 of the current Stage 4 and Stage 5 CKD patients will require dialysis within the next 12 to 18 months. While some of these patients will be referred to existing facilities within the market area, sufficient capacity within the market area does not exist to accommodate the projected ESRD patient referrals from Central Illinois Kidney and Dialysis Associates. By December 31, 2012, the proposed project completion date, all of the existing facilities will likely be operating at 80% utilization. As shown in the table on the following page, operating at full (100%) capacity, these facilities can only accommodate 55 of the 127 projected patients. As a

result 72 patients would need to travel outside the market area to receive dialysis treatment. Further, operation of a facility at maximum capacity creates a number of barriers to optimal care and should be avoided. For example, some patients, especially obese patients and patients with fluid overload require a longer than normal prescription for dialysis which can cause the subsequent patient shift to be disrupted if a patient is slotted immediately behind. When a facility is fully loaded at all shifts, closing times are delayed substantially creating staffing and transportation issues. At the Springfield Montvale facility where nocturnal dialysis is provided, the facility needs to be available for 8 hours from the third shift to the first shift the next day and overcapacity problems can interfere with the nocturnal program.

Facility	Stations as of 09-30-2010	Projected Patients 12/31/2012	Projected Utilization 12/31/2012	Excess Capacity (100% Utilization)
Lincolnland Dialysis Center	14	70	83.33%	14
DaVita - Springfield Central	21	103	81.75%	23
DaVita - Montvale	17	84	82.35%	18
Total	**52**	**257**	**82.37%**	**55**

Without additional dialysis stations in the market area, these ESRD patients will be forced to travel outside of the market area three times per week to receive life sustaining dialysis treatment. Many ESRD patients are reliant upon family members, public transportation, non-emergency transportation, or nursing homes to transport them to and from medical appointments. Requiring ESRD patients to travel outside the market area would be an extreme hardship for both the patients and their caregivers. Given the expense and time of the additional travel, patients may frequently miss treatments or forego dialysis altogether. This would result in ESRD patients suffering renal failure and death. Accordingly, a 12-station dialysis facility is necessary to maintain access to dialysis services.

Importantly, 58 ESRD patients are necessary for a 12-station dialysis facility to achieve target utilization. Treating only the 72 patients that could not be accommodated by the existing facilities (operating at 100% capacity), the proposed facility would already operate at 100% capacity, which is above the HFSRB standard. Accordingly, the proposed dialysis facility is necessary to maintain adequate access to dialysis services for residents of Springfield.

2. A map of the market area for the proposed facility is attached at Attachment – 12C. The market area encompasses a 20 mile radius around the proposed facility. The boundaries of the market area of are as follows:

   - North approximately 30 minutes normal travel time to Fancy Prairie
   - Northeast approximately 30 minutes normal travel time to Mount Pulaski
   - East approximately 30 minutes normal travel time to Mount Auburn
   - Southeast approximately 30 minutes normal travel time to Taylorville
   - South approximately 30 minutes normal travel time to Waggoner
   - Southwest approximately 30 minutes normal travel time to Waverly
   - West approximately 30 minutes normal travel time to Jacksonville
   - Northwest approximately 30 minutes normal travel time to Pleasant Plains

3. The purpose of the project is to maintain access to life sustaining dialysis to residents of Springfield and surrounding areas. As discussed more fully above, there are only three dialysis facilities within 30 minutes normal travel time of the proposed facility that are available to the general ESRD patient population, and these facilities are rapidly approaching the HFSRB utilization standard. In fact, the average annual growth rate of these existing facilities is approximately 4%. Assuming no changes in the growth rate, these facilities will reach the 80% utilization standard no later than December 31,

2012, the proposed project completion date. Accordingly, there will be no capacity within the market area to accommodate additional growth after December 31, 2012.

Moreover, Central Illinois Kidney and Dialysis Associates, S.C. is currently treating 28 Stage 5 CKD patients and 175 Stage 4 CKD patients. Based upon historical attrition rates, approximately 127 of these patients are expected to require in-center hemodialysis within the next 12 to 18 months; however, and as discussed above, the existing facilities will reach target utilization within the next 12 to 15 months. Assuming all three facilities are operating at 100% capacity, i.e., three shifts per day, six days per week, collectively, they can only accommodate 55 of the 127 projected ESRD patient referrals. Accordingly, there is insufficient capacity in the market area to accommodate the increasing need for dialysis services.

4. The proposed project will improve access to dialysis services by adding 12-stations to the market. As discussed more fully above, there are only three facilities within 30 minutes normal travel time of the proposed facility. These facilities are rapidly approaching target utilization and cannot accommodate future growth. Adding a 12-station dialysis facility will allow existing facilities to operate at their optimum capacity (80%) while accommodating future growth.

   In March 2008, DaVita began offering nocturnal dialysis at its Montvale facility. The program operates three nights per week, Sunday, Tuesday and Thursday. Montvale is usually at or near capacity for its nocturnal shift. As the program grows in popularity, the Applicants anticipate that they can expand the nocturnal dialysis offering to the Springfield South facility.

   Nocturnal dialysis has been found to be a more desirable alternative to conventional dialysis based upon dose, duration and frequency. Studies have found that due to the longer treatment times (nocturnal dialysis treatments generally last from 8 to 10 hours compared to 4-5 hours for conventional dialysis), there is better removal of wastes, electrolytes and minerals. It is gentler on the patient as blood flow and dialysate flow rates are typically lower. Moreover, patients on nocturnal dialysis generally have stronger clinical values, lower drug usage, improved nutrition, QOL increase, lower mortality rates and lower hospitalizations than patients on conventional dialysis. Information regarding the nocturnal dialysis program is attached at Attachment – 12D.

   Importantly, nocturnal dialysis improves the quality of life of the patients who choose this treatment option. It is a viable alternative for working patients, patients with child care needs, and patients who want more flexibility in their lives and do not want to schedule their lives around dialysis treatments. It takes advantage of rather unproductive time during nightly sleep. Patients generally arrive for treatment in the evening and are encouraged to sleep, "lights out" occurs around 11 p.m. Treatments last between 8 and 10 hours and are usually finished at or around 5 a.m.

5. The Applicants anticipate the proposed facility will have quality outcomes comparable to the Springfield Central and Montvale facilities. KtV > 1.2 data for the most recent twelve months for the Springfield Central and Montvale facilities is provided below:

Indicators/Monitors (HD)				
	4th Qtr 2009	1st Qtr 2010	2nd Qtr 2010	3rd Qtr 2010
Springfield Central	97.1%	97.1%	95.5%	96.8%
Montvale	93.5%	94.3%	96.8%	98.2%

Additionally, In an effort to better serve all kidney patients, DaVita believes in requiring that all providers measure outcomes in the same way and report them in a timely and accurate basis or be subject to penalty. There are four key measures that are the most common indicators of quality care for dialysis providers - dialysis adequacy, fistula use rate, nutrition and bone and mineral metabolism. Adherence to these standard measures has been directly linked to 15-20% fewer hospitalizations. On each of these measures, DaVita has demonstrated superior clinical outcomes, which directly

translated into 7% reduction in hospitalizations among DaVita patients, the monetary result of which is $210M to $230M in hospitalization savings to the health care system and the American taxpayer.

Memorial MEDICAL CENTER
701 North First Street • Springfield, Illinois 62781-0001
memorialmedical.com • **Phone (217) 788-3000**
A Memorial Health System Affiliate

December 7, 2010

Dale Galassie
Chairman
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: Letter of Support for DaVita Springfield South

Dear Chairman Galassie:

I am writing to you on behalf of Memorial Medical Center ("Memorial") in support of the proposed establishment of a 12-station dialysis facility to be located at 2930 South 6th Street, Springfield, Illinois, to be known as DaVita – Springfield South. Utilization of existing dialysis facilities in Springfield is rapidly approaching 80%. Given current utilization trends, within the next two years, there will not be sufficient capacity among existing facilities to accommodate the growth in demand for dialysis services.

Memorial currently operates a 6-station dialysis facility located on its hospital campus. In 1998, we significantly downsized our dialysis program to accommodate primarily special needs patients. Predominantly, we treat oversized patients who cannot be accommodated in recliner chairs, patients with behavioral issues who cannot be adequately treated in a freestanding dialysis facility, and patients admitted for a medical or surgical procedure who require outpatient dialysis prior to discharge.

With regard to the proposed establishment of the proposed dialysis facility, we believe a 12-station facility will accommodate future demand for dialysis services while at the same time allowing existing facilities to operate at their optimal capacity. Additionally, a 12-station facility is consistent with industry norms and should provide for adequate patient through-put, optimal staffing, and better access for patients.

DaVita is a leading provider of dialysis services in the United States. It has taken on many initiatives to improve the lives of patients suffering from chronic kidney disease ("CKD") and ESRD. One example is its EMPOWER program. DaVita launched the EMPOWER program workshops in 2008. The workshops are free community-based educational seminars that encourage CKD patients to take control of their health and make informed decisions about their dialysis care. Led by a team of DaVita nurses, renal dietitians, and social workers, EMPOWER uses a multidisciplinary approach to educate patients with CKD about their disease, ways to

delay progression, and different treatment options. Workshops also focus on preparing patients for life on dialysis or with a kidney transplant. DaVita recognizes the unique and vital role that it plays in enhancing care for renal patients throughout the country. Memorial is grateful that the residents of Springfield have the benefit of a provider like DaVita in the community. Accordingly, we fully support the proposed establishment of DaVita – Springfield South.

Thank you for your consideration.

Sincerely,

Kevin R. England
Vice President
Business Development

KRE/bdk

CENTRAL ILLINOIS KIDNEY AND DIALYSIS ASSOCIATES, S.C.

932 N. Rutledge, Springfield, IL 62702

Pradeep Mehta, M.D. Lawrence J. Smith, M.D. Ashraf Tamizuddin, M.D.
Allen S. Krall, M.D. X. Gary Chen, M.D., Ph.D.

Satellite Outpatient Clinics
Litchfield, Decatur, Jacksonville, Effingham, Mattoon, Taylorville

Appointments/Nurses (217) 788-3875 Business Office (217) 544-5100

December 13, 2010

Dale Galassie
Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Chairman Galassie:

I am a nephrologist in practice with Central Illinois Kidney and Dialysis Associates, S.C. ("CIKD"). I am writing on behalf of CIKD in support of the proposed establishment of a 12-station dialysis facility to be located at 2930 South 6th Street, Springfield, Illinois (the "Proposed Facility"). There are three dialysis facilities accessible to the general end-stage renal disease ("ESRD") patient population in Springfield. All three of these facilities are rapidly approaching the Health Facilities and Services Review Board 80% utilization standard. Based upon current utilization trends, within the next two years, there will be insufficient capacity in the Springfield market area to accommodate the growing demand for dialysis services. A new dialysis facility is needed to ensure the residents of Springfield maintain access to life sustaining dialysis.

CIKD is currently treating 175 Stage 4 and 28 Stage 5 pre-ESRD patients that reside in the Springfield area. Utilizing a 40% attrition rate for Stage 4 and 20% attrition rate for Stage 5 pre-ESRD patients, we project 127 of these current pre-ESRD patients will initiate dialysis within the next 12 to 24 months. We anticipate referring at least 58 of these patients to the Proposed Facility. The total number of pre-ESRD patients by initial and zip code is attached hereto. No patients will be transferred from other providers to the Proposed Facility.

These patient referrals have not been used to support another pending or approved certificate of need application. The information in this letter is true and correct to the best of my knowledge.

I support the proposed establishment of Springfield South Dialysis.

OFFICIAL SEAL
STEPHANIE SKINNER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:03/10/12

Sincerely,

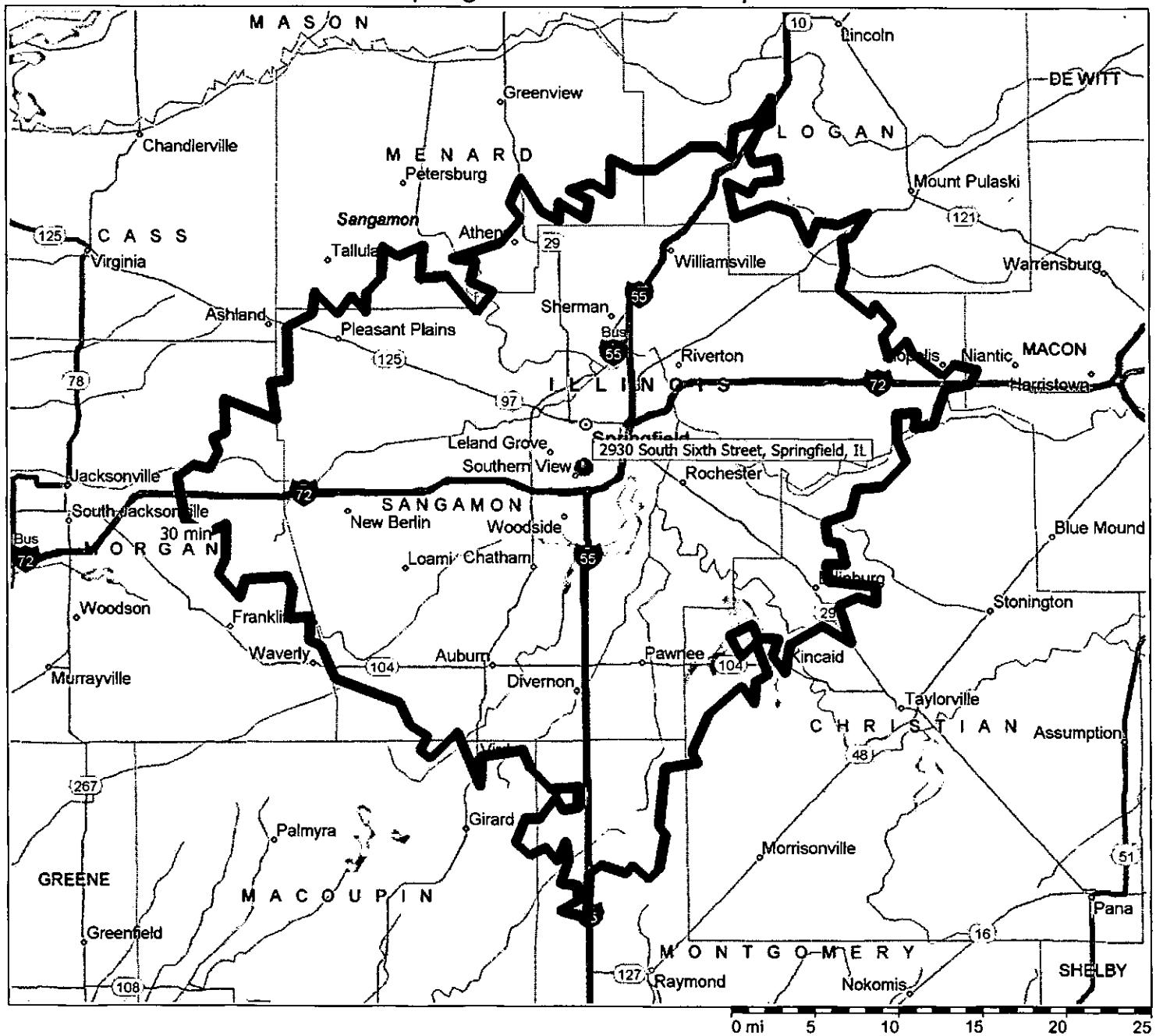
P. Mehta M.D

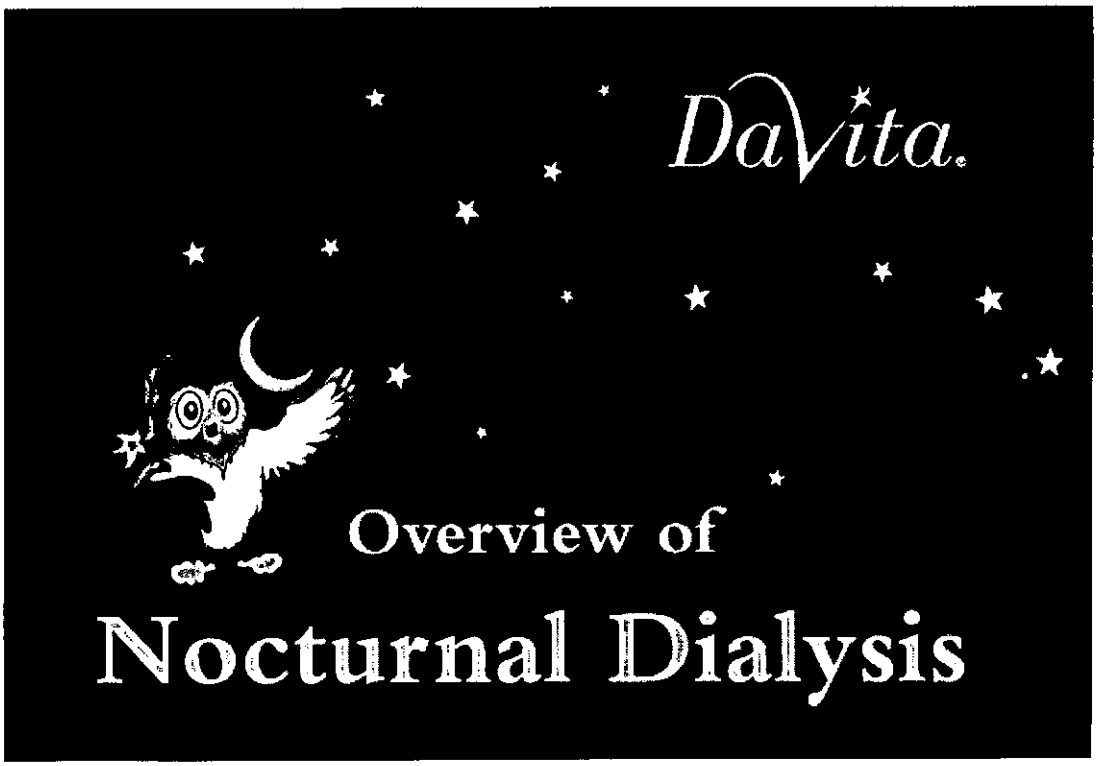
Pradeep Mehta, M.D.
Central Illinois Kidney and Dialysis Associates, S.C.
932 North Rutledge Avenue
Springfield, Illinois 62702

Subscribed and sworn to me
This 13th day of December, 2010

Notary Public

Springfield South GSA Map





Dr. Francisco is a DaVita Nephrologist in Wichita, Kansas currently prescribing nocturnal dialysis for some of her patients.

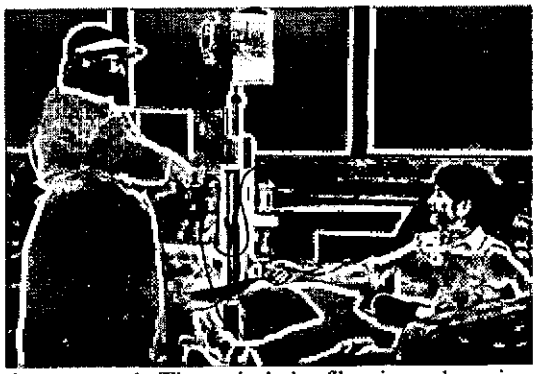
Written by Dr. Linda Francisco

Conventional hemodialysis shortfalls

It is well known that the mortality rate of patients undergoing maintenance hemodialysis remains unacceptably high. An extremely high morbidity and a relatively low quality of life has also been observed in the chronic hemodialysis patient. The institution of more intensive dialysis regimens appears to improve morbidity and, possibly, mortality among this patient population, although studies are still badly needed for the evaluation of mortality improvement. Compared to conventional regimens, hemodialysis associated with longer duration and/or higher frequency correlates with enhanced outcomes as defined by improved laboratory and decreased usage of erythropoiten, with improved Kt/V values. With this in mind, nocturnal hemodialysis was introduced as a more desirable alternative to conventional dialysis. It was thought that nocturnal dialysis could provide superior dialysis based on dose, duration, and frequency. It also takes advantage of the rather unproductive time during the nightly sleep.

About nocturnal hemodialysis treatment

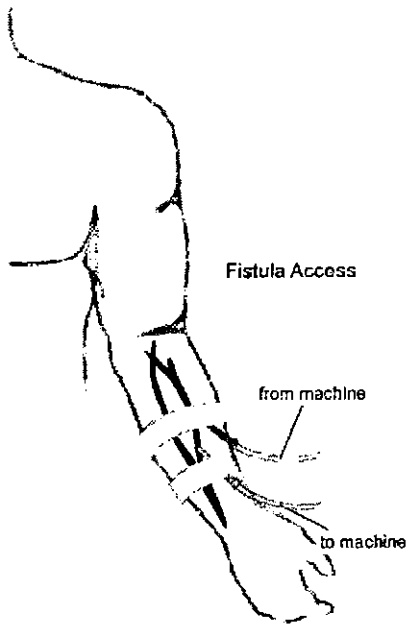
Nocturnal hemodialysis can be either done at home or in center. Nocturnal hemodialysis at home is generally performed 5-7 nights per week during sleep for a variable amount of time, based upon the length of sleep usually desired. This can be from 6-12 hours. In-center hemodialysis is generally performed 3 nights per week for 8-10 hours depending on the center availability. In either home or in-center nocturnal hemodialysis, the dialysate composition is a sodium bath of 140 mEq/L, a potassium bath of 2 mEq/L, a bicarbonate bath of 28-35 mEq/L, with a calcium concentration of 2.5-4.0 mEq/L. A higher dialysate calcium is prescribed for patients with high ultrafiltration volumes. The blood flow rate is generally 200300 cc/min, depending on clearances, and the dialysate flow rate is anywhere from 100 cc/min to 800 cc/min. The in-center nocturnal hemodialysis would tend to favor the higher end of blood and dialysate flows since the actual time per week on dialysis is less than on home nocturnal hemodialysis, i.e. 3 days versus 5



days per week. The typical ultrafiltration volume is 1-2 liters, with a range of 1-7 liters per dialysis treatment. Any dialyzer membrane can be used, including smaller surface area dialyzers, but most centers use high-flux dialyzers. In addition, nocturnal hemodialysis can be performed with any hemodialysis machine and existing machines can be modified for the requirements of the longer dialysis treatment. Dialyzer reuse can be used and the usual technique of reuse is applied. Anticoagulation is also used and it accounts for approximately 1,000 U of heparin per hour of dialysis.

Nocturnal dialysis vascular access

Vascular access for nocturnal dialysis is the same as it is for any hemodialysis. Central venous catheters are used, although these are considered less popular, especially with the fistula-first initiative. Preferably, arteriovenous fistulas are used. Arteriovenous grafts have also been successful in nocturnal dialysis.



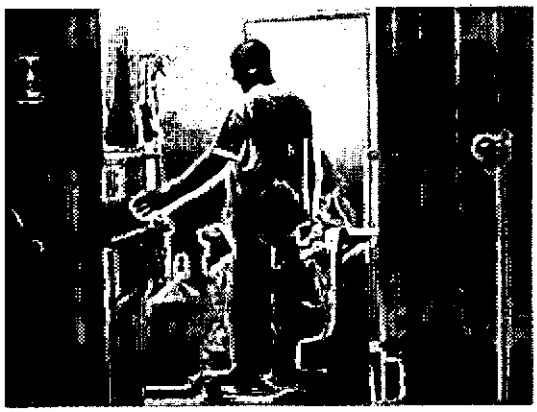
In-center vs. at-home nocturnal dialysis

As mentioned above, nocturnal hemodialysis can be performed at home or in the dialysis facility. If home hemodialysis is done at night, remote monitoring has been done via regular telephone lines or the Internet.
Live monitoring provides the following benefits:

- ★ It helps prevent blood from clotting in an idle extracorporeal system.
- ★ It provides reassurance to the patient.
- ★ It ensures compliance.
- ★ It aids in the collection of data.

If performed in the dialysis facility, nursing personnel provide the same benefits.

In addition to the monitoring performed above, there are other safety measures that can be employed with in-center or home nocturnal hemodialysis, such as inexpensive moisture sensors that are placed strategically on the floor to detect dialysate and/or blood leaks. Their use should be considered an obligatory safety measure.



Which patients should consider home nocturnal dialysis?

Patient groups that can be preferentially targeted for recruitment for home nocturnal hemodialysis include patients who are followed in a chronic kidney disease clinic prior to development of end stage kidney disease. This prevents the state of dependence frequently encountered in an in-center unit. Training can be instituted very early and patients can recognize the benefits of self-care settings. Another group that can be targeted includes patients who are ineligible for kidney transplantation, in that nocturnal dialysis can be viewed as the modality of independence closest to

kidney transplantation. Another group to be considered for home or in-center nocturnal hemodialysis includes those with significant morbidities such as cardiac disease, diabetes mellitus, severe hypertension, dialysis-related symptoms and/or large interdialytic weight gain. Patients who fail chronic ambulatory peritoneal dialysis, yet want to maintain some degree of independence, should also be considered for home nocturnal hemodialysis. The final group that is very frequently benefited by nocturnal hemodialysis, whether, in-center or home, include large-sized patients and patients not adequately dialyzed because of poor blood flow in their access.

Quality-of-life improvements from nocturnal hemodialysis

Nocturnal hemodialysis is usually associated with marked benefits including improved solute clearance and quality of life. Patients will declare their improvement of quality of life almost uniformly. There is also noted to be much better blood pressure control and a reduction of medication requirements for control of hypertension. Urea and phosphorus clearances have been increased with nocturnal hemodialysis. Better hemoglobin values with less erythropoiten usage have also been reported. Some have suggested an enhanced survival, however, this requires further analysis. At present, there are no published randomized trials of nocturnal hemodialysis. As a result, some investigators feel that studies comparing nocturnal hemodialysis to conventional hemodialysis should be performed to better understand the benefits of nocturnal hemodialysis.

In summary, nocturnal hemodialysis done at home or in-center offers another modality of care for the patient with end-stage renal disease and should be available to patients. Further studies are required to evaluate the benefits and indications for its usage.

Nocturnal Hemodialysis

A five-minute Homeroom Lesson

noc·tur·nal (nŏk-tûr′nəl)
adj.
1. Of, relating to, or occurring in the night: *nocturnal stillness.*
2. *Botany* Having flowers that open during the night.
3. *Zoology* Most active at night: *nocturnal animals* (Free Dictionary, 2007)

More and more DaVita centers are now offering nocturnal dialysis. To learn about this treatment option, consider reviewing the following questions in one of your Homeroom Meetings.

What is nocturnal hemodialysis? What would a typical <u>in-center</u> treatment look like?

- Patients arrive at the center in the evening and dialyze during the night.
- To improve comfort, patients are asked to bring their own pillows, blankets, and toothbrushes.
- To encourage sleep, "lights out" occurs around 11pm.
- The treatment is usually over at about 5am.
- While physician orders may vary, treatments frequently include eight (8) hours of dialysis three(3) times a week.

What <u>advantages</u> are there to this longer dialysis treatment?

- Longer treatment time → Better removal of *wastes* → Less urea in the blood → *better appetite, less anemia (lower EPO dosages), less neuropathy, less fatigue...*
- Longer treatment time → Better removal of *electrolytes & minerals* → Fewer potassium and phosphorus restrictions (less need for phosphate-binders).
- Longer treatment time → *Less fluid removed per hour (lower UF rates)* → *Decreased risk of hypotension ("crashing") or cramping, less "recovery time" post treatment (less likely to feel washed out)* → Decreased need for antihypertensive medications (blood pressure medications).
- Longer treatment time → a gentler dialysis (blood flow and dialysate flow rates are typically lower – like a "delicate wash cycle").
- *Higher survival rates.* According to a study by Charra (2005), the death rate per 1000 patient years was 52.4 deaths in the group with longer dialysis treatment (8 hours, 3/week) vs. 99 deaths, almost twice as high, in the group with more traditional style dialysis. The researchers believed better survival was in part due to a lower pre-dialysis mean arterial pressure (MAP) that was present in the longer treatment group.

"Aiming for optimal, rather than just adequate dialysis." Charra, 2005

What are the <u>numbers</u>? Where is this option available?

- *As of July 1, 2007* DaVita's <u>in-center</u> nocturnal program included 180 patients in 20 dialysis centers. *By the end of this year*, DaVita's goal is to increase these numbers to 500 patients in 70 centers.
- Nocturnal hemodialysis can also occur at home. Currently DaVita has seven nocturnal home programs and 24 patients.
- Programs will soon be located throughout the country. Ask your FA or your regional director for the centers located closest to you.
- For more information, go to http://villageweb.davita.com/index.shtml?act=dept1&DepartmentID=228 .

Homeroom Lesson
July 2007

Thanks for your interest in learning!
the Clinical Education Team
donna.swartzendruber@davita.com

Nocturnal Clinical Findings

August 2010

DaVita.
IN-CENTER
NOCTURNAL.

Key Questions

DRAFT

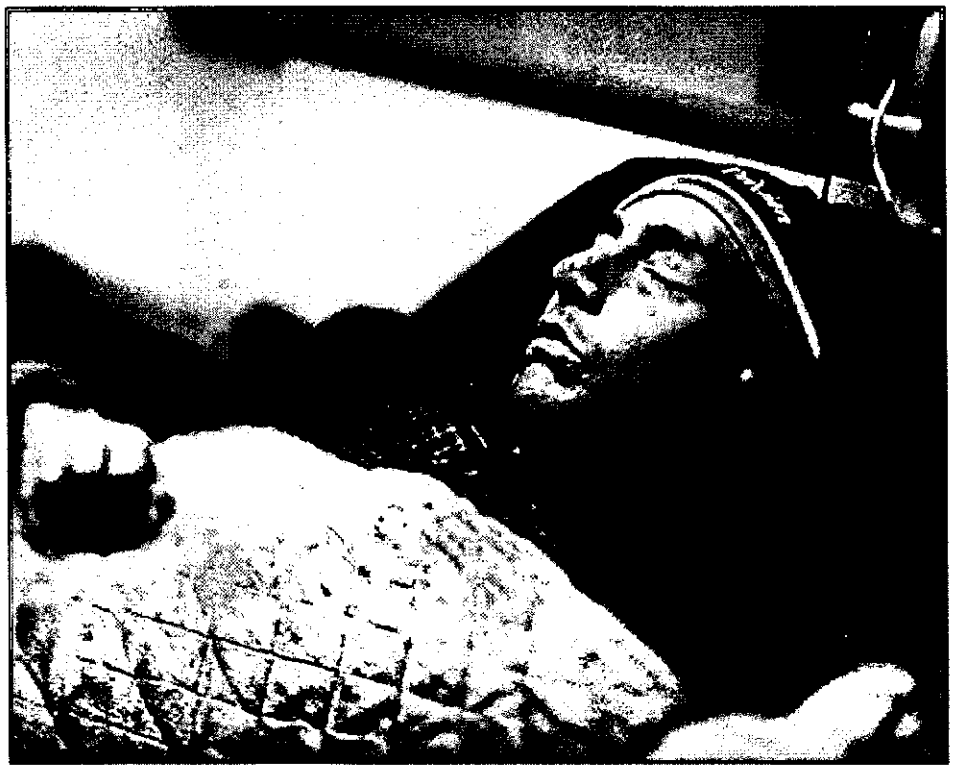
1. What clinical studies have been published regarding extended nighttime tx v. traditional day-shift hemo?

2. How does DVA Nocturnal compare clinically to traditional day-shift hemo?

78

In-Center Nocturnal Tx

DRAFT



- Nighttime dialysis
- 6-8 hr Tx duration
- 3x / wk
- Slower blood & dialysate flow rates
- Gentler on patient

External Clinical Studies

DRAFT

- Multiple studies depict benefits of extended nighttime dialysis v. traditional day-shift hemo
- Txs per week stay the same, only differences are:
  - Time on therapy
  - Slower flow rates
  - When tx is administered
- Upside – before-and-after results using patients as their own control group
- Downside – studies limited by small sample sets

External Study Highlights

DRAFT

Lead Doc & Study Location	Clinical/Social Benefits
Bugeja, Canada	• Binders & BP meds decrease • QOL, sleep, cramps, energy and appetite showed significant improvement on Nocturnal
Troidle, USA	• Serum phosphorus & B2M levels decrease dramatically during extended Noc tx
Cravedi, Italy	• Significant positive results with BP and reduction in BP meds • Reductions in phosphorus levels
Koch, The Netherlands	• Significant increases in sleep quality, melatonin surge, REM sleep and energy
Charra, France	• 35 years of lower mortality and hospitalization rates • Increased cardiovascular health

External Study Summation

DRAFT

- External studies show positive results across clinical and social measures
  - Stronger clinical values
  - Lower drug usage
  - Deeper sleep
  - Improved nutrition
  - QOL increases
  - Lower mortality rates
  - Lower hospitalizations

82

Nocturnal Patient Opportunities

DRAFT

- Clinical opportunities
  - Interdialytic hypotension
  - Chronic fluid overload
  - Refractory hypertension
  - Refractory inadequate dialysis
  - Malnutrition
  - Phosphorus control
- Social needs
  - Working patients
  - Child care needs
  - Personal opportunities (hobbies, family, travel, etc.)

83

Key Questions Revisited

DRAFT

1. What clinical studies have been published regarding extended nighttime tx v. traditional day-shift hemo?

2. How does DVA Nocturnal compare clinically to traditional day-shift hemo?

DVA Nocturnal Progression

DRAFT

- One of the largest Nocturnal pt populations in US
- Grown to more than 1,000 pts across 90+ programs
- Began piloting Noc therapy in 2004 – six years of experience with nighttime tx administration
- Patients report substantial positive changes in lives after transition to Noc (clinical and social benefits)
- **Growing pt demand for therapy**
- **Growing doc support for therapy**

85

DRAFT

2007-09 Outcomes (Noc v. ICHD)

Noc produces stronger clinical results in most major indicators v. ICHD

Metrics	FY07	FY08	FY09	Before & After Comparison
Pt Growth YOY	+300%	+100%	+30%	
Kt/V	+	+	+	+
Albumin	+	+	+	+
Hematocrits	+	+	+	+
Phosphorus	+	+	+	+
Calcium	-	-	-	-
Ca x Phos Product	+	+	+	+
iPTH	-	-	-	-
CVC Mix	+	+	+	+

+	**Better than ICHD**	-	**Slightly lower than ICHD, not clinically significant – assessing causes**

DVA Clinical Studies

DRAFT

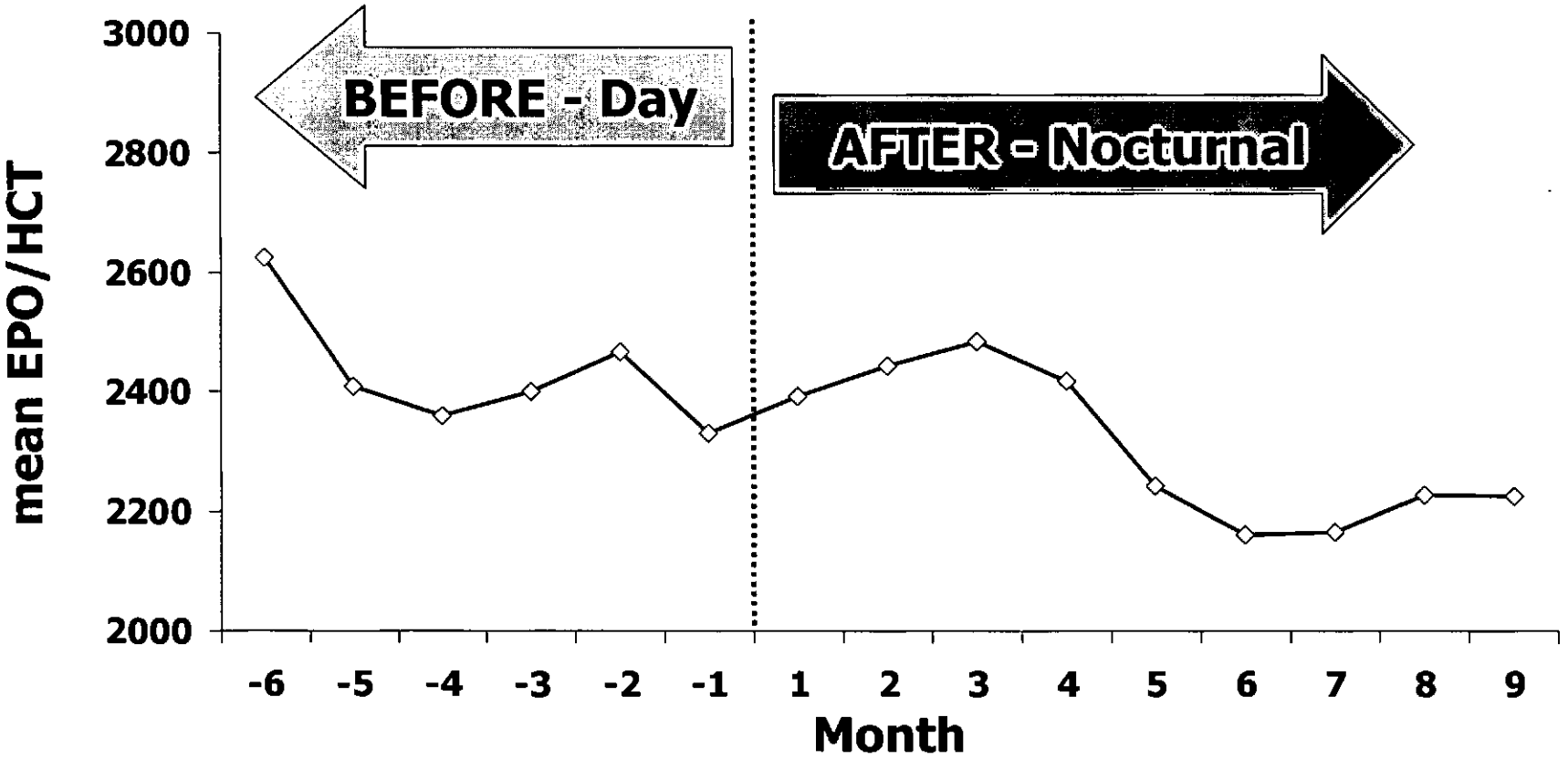
- Efforts to corroborate smaller external studies with larger DVA pt study population
- Before-and-after (day-shift hemo v. NOC)
  - Six months pre-NOC on day-shift hemo
  - Nine months post-conversion to NOC
  - Largest observational pt study to date (400+ qualifying pts)
- Early results promising – published four studies over last six months, continuing research
  - Lowered serum Phosphorus levels
  - Improved Hb sensitivity (anemia management)
  - Decreases in EPO and Venofer consumption
  - Positive affect on protein levels and BMM (single time pt study)
  - Reductions in BP meds

67

DVA Anemia Management Study

DRAFT

- NOC pts more sensitive to EPO than ICHD (presented by Dr. Francisco at ASN'09)



DRAFT

DVA & External Study Takeaways

Observed Results	Clinical/Economic Benefits
Albumin & Phosphorus Improvements	Improved mortality rates
Stronger Kt/v & Hematocrits results	Reductions in admissions, ALOS & ER visits
Greater pt sensitivity to EPO/Iron & BP/Phosphorus redux	Lower IV & oral meds usage

In total, Nocturnal provides better results for pts

Section III, Project Purpose, Background and Alternatives – Information Requirements
Criterion 1110.230(c), Project Purpose, Background and Alternatives

Alternatives

The Applicants explored several options prior to determining to establish a 12-station dialysis facility. The options considered are as follows:

a. Do nothing;

b. Utilize existing facilities;

c. Establish a new facility.

After exploring these options, which are discussed in more detail below, the Applicants determined to establish a 12-station facility. A review of each of the options considered and the reasons they were rejected follows.

Do Nothing

Currently, there are four dialysis facilities within 30 minutes normal travel time of the proposed facility. Based upon the latest inventory from the HFSRB, there is currently an excess of one dialysis station in HSA 3. This figure is misleading and does not reflect the need for additional dialysis capacity in Springfield. First, the inventory calculation does not take into account the current use rate for HSA 3 and it includes Memorial Medical Center, which as discussed in greater detail in Criterion 1110.230(b), only serves special needs patients and does not solicit or offer its services to the general ESRD patient population. As shown below in the revised inventory calculation for HSA 3, updating the HSA 3 Use Rate to reflect the most recent population and dialysis patient statistics results in a need for 16 additional stations in HSA 3.

	Revised Need Calculation (07/01/2009 Utilization)
State Institutional Dialysis Patients[1]	14,086
State Population[2]	12,910,409
State Use Rate	1.091
Minimum Institutional Dialysis Use Rate	0.655
HSA 3 Institutional Dialysis Patients[1,3]	508
HSA 3 Population[2]	574,061
HSA 3 Use Rate	0.885
HSA 3 2015 Population Projection[4]	622,212
2015 Estimated Dialysis Patients	551
Patients Adjusted for Increase	732
Projected Treatments - 2015	114,241
Stations Needed - 2015	153
Approved Existing Stations[3]	137
Additional Stations Needed	16

[1] 06/30/200Renal Disease Network Utilization

[2] U.S. Census Bureau Population Estimates 2000 - 2009
[3]Excludes Memorial Medical Center
[4] Illinois Department of Commerce and Economic Opportunity, Population Projections by County

Additionally, utilization at the remaining facilities in the Springfield market area is quickly approaching the HFSRB 80% standard utilization rate. In fact, the average utilization has increased 4% annually at these facilities in the last three years. With the current obesity epidemic in America and aging population, this growth is not expected to decrease but rather increase in the coming years. Based upon the U.S. Census Bureau 5-Year Estimates for 2005 – 2009, 13.7% of the residents of Sangamon County are 65 years or older, compared to the State average of 12.1%.[3] Conservatively assuming historical growth rates remain unchanged, these facilities are expected to reach 80% utilization by the date the proposed facility is operational.

In addition to the historical growth rate, Central Illinois Kidney and Dialysis Associates, S.C. is currently treating 28 Stage 5 CKD patients and 175 Stage 4 CKD patients. Based upon historical attrition rates, approximately 127 of these patients are expected to require dialysis within the next 12 to 18 months. As shown in the table below, assuming utilization at the existing facilities remains unchanged, sufficient capacity does not exist in the Springfield market area to accommodate all 127 patients.

Facility	Stations as of 09-30-2010	Projected Patients 12/31/2012	Projected Utilization 12/31/2012	Excess Capacity (100% Utilization)
Lincolnland Dialysis Center	14	70	83.33%	14
DaVita - Springfield Central	21	103	81.75%	23
DaVita - Montvale	17	84	82.35%	18
Total	**52**	**257**	**82.37%**	**55**

While this alternative would result in no cost to the Applicants, it would not provide for sufficient access to life sustaining dialysis services to the residents of Springfield. Accordingly, this alternative was rejected.

Utilize Existing Facilities

As discussed above, the existing facilities in the Springfield market are rapidly approaching the HFSRB's standard utilization rate of 80%. Additionally, Central Illinois Kidney and Dialysis Associates, S.C. is currently treating 28 Stage 5 CKD patients and 175 Stage 4 CKD patients. Based upon historical attrition rates, approximately 127 of these patients are expected to require in-center hemodialysis within the next 12 to 18 months. For the existing facilities to accommodate all 127 projected ESRD patients, at least two, and most likely all of three facilities would be required to operate four shifts per day, six days per week.

Operating four shifts per day is not a feasible alternative for many reasons. When a fourth shift is operated, the dialysis facility is operated nearly around the clock with staff opening the facility around 5:00 a.m. and closing it around midnight. Not only is staffing a fourth shift difficult for clinic personnel, it is also suboptimal for the patients themselves who are chronically ill and usually elderly. Patients,

[3] U.S. CENSUS BUREAU, AMERICAN FACTFINDER, 2005-2009 AMERICAN COMMUNITY SURVEY 5-YEAR ESTIMATES, DATA PROFILE HIGHLIGHTS *available at* http://factfinder.census.gov/servlet/ACSSAFFFacts?_event=&geo_id=05000US17167&_geoContext=01000US%7C04000US17%7C05000US17167&_street=&_county=sangamon&_cityTown=sangamon&_state=04000US17&_zip=&_lang=en&_sse=on&ActiveGeoDiv=&_useEV=&pctxt=fph&pgsl=050&_submenuId=factsheet_1&ds_name=null&_ci_nbr=null&qr_name=null&reg=null%3Anull&_keyword=&_industry= (last visited Dec. 28, 2010).

many of whom rely on assistive devices such as canes and walkers, are faced with additional safety hazards when arriving and departing the facility in the dark. Some of these hazards cannot be avoided in the winter but patients feel much more secure when coming and going in the daylight. Adding a fourth shift would increase operating costs by adding additional staffing costs and utilities cost. The costs would be somewhat higher than the operating costs of adding stations.

Additionally, none of the existing facilities can accommodate a nocturnal dialysis program. Currently, only the Montvale dialysis facility offers nocturnal dialysis. As set forth in Criterion 110.230(b), DaVita initiated a nocturnal dialysis program at its Montvale facility in March 2008. The Montvale program operates three nights per week and can accommodate up to 17 patients. Expansion of the current nocturnal program is not feasible. Because the facility is operating 24 hours on those days when nocturnal dialysis offered, it is difficult to clean and maintain the equipment and facility on those days. Accordingly, expanding the Montvale nocturnal dialysis program to six nights is not feasible.

The existing facilities in the market area cannot accommodate increasing future need for dialysis services without adding a fourth shift. While this would result in no project costs to the Applicants, it would result in suboptimal care for ESRD patients. Accordingly, this alternative was rejected.

Establish a New Facility

Based upon current utilization of the existing facilities and the projected number of CKD patients that will require in-center hemodialysis within the next 12-18 months, the only feasible option is to add dialysis stations to the market area by establishing a 12-station dialysis facility. This alternative will ensure residents of Springfield have continued access to life sustaining dialysis treatment. The cost of this alternative is $2,195,831.

Table 1110.230(c)
Alternatives to Proposed Project
Cost Benefit Analysis

Alternative	Community Need	Access	Cost	Status
Do Nothing	Not Met	Decreased	$0	Reject
Utilize Existing Facilities	Not Met	Decreased	$0	Reject
Establish New Facility	Met	Maintained	$2,195,831	Accept

Section IV, Project Scope, Utilization, and Unfinished/Shell Space
Criterion 1110.234(a), Size of the Project

The Applicants propose to establish a 12-station dialysis facility. Pursuant to Section 1110, Appendix B of the HFSRB's rules, the State standard is 360-520 gross square feet per dialysis station for a total of 4,320 – 6,240 gross square feet for twelve dialysis stations. The total gross square footage of the proposed dialysis facility is 6,100 gross square feet. Accordingly, the proposed facility meets the State standard.

SIZE OF PROJECT				
DEPARTMENT/SERVICE	PROPOSED BGSF/DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?
ESRD	6,100	4,320 – 6,240	0	Meets State Standard

Attachment – 14

Section IV, Project Scope, Utilization, and Unfinished/Shell Space
Criterion 1110.234(b), Project Services Utilization

By the second year of operation, annual utilization at the proposed dialysis facility shall exceed HFSRB's utilization standard of 80%. Pursuant to Section 1100.1430 of the HFSRB's rules, facilities providing in-center hemodialysis should operate their dialysis stations at or above an annual utilization rate of 80%, assuming three patient shifts per day per dialysis station, operating six days per week. Currently, there are 28 Stage 5 CKD patients and 175 Stage 4 CKD patients who will likely require dialysis within the next 12 to 18 months. Assuming 80% of the Stage 5 and 60% of the Stage 4 CKD patients receive in-center hemodialysis treatment within the first year after project completion, the proposed facility will be operating at 80.55% capacity, or 58 patients.

Table 1110.234(b) Utilization

	Dept./ Service	Historical Utilization (Treatments)	Projected Utilization	State Standard	Met Standard?
Year 1	ESRD	N/A	9,048	8,986	Yes
Year 2	ESRD	N/A	9,048	8,986	Yes

Section IV, Project Scope, Utilization, and Unfinished/Shell Space
Criterion 1110.234(c), Unfinished or Shell Space

This project will not include unfinished space designed to meet an anticipated future demand for service. Accordingly, this criterion is not applicable.

Section IV, Project Scope, Utilization, and Unfinished/Shell Space
Criterion 1110.234(d), Assurances

This project will not include unfinished space designed to meet an anticipated future demand for service. Accordingly, this criterion is not applicable.

Section VII, Service Specific Review Criteria
In-Center Hemodialysis
Criterion 1110.1430(b), Planning Area Need

1. Planning Area Need

   a. This criterion requires the applicant to document that the number of stations to be established for in-center hemodialysis conforms to the projected station deficit calculated by the HFSRB. Based upon the latest inventory data, there is currently an excess of one station in HSA 3. This excess is due to an outdated area use rate and underutilization at Memorial Medical Center. As shown in the updated need calculation below, there is a need for 16 dialysis stations in HSA 3. The applicants propose to establish a 12-station dialysis facility. Accordingly, there is need for the proposed facility.

	Revised Need Calculation (07/01/2009 Utilization)
State Institutional Dialysis Patients[1]	14,086
State Population[2]	12,910,409
State Use Rate	1.091
Minimum Institutional Dialysis Use Rate	0.655
HSA 3 Institutional Dialysis Patients[1,3]	508
HSA 3 Population[2]	574,061
HSA 3 Use Rate	0.885
HSA 3 2015 Population Projection[4]	622,212
2015 Estimated Dialysis Patients	551
Patients Adjusted for Increase	732
Projected Treatments - 2015	114,241
Stations Needed - 2015	153
Approved Existing Stations[3]	137
Additional Stations Needed	16

[1] 06/30/200Renal Disease Network Utilization
[2] U.S. Census Bureau Population Estimates 2000 - 2009
[3]Excludes Memorial Medical Center
[4] Illinois Department of Commerce and Economic Opportunity, Population Projections by County

   b. As shown in the revised need calculation above, there is currently a need for 16 dialysis stations in HSA 3. The applicants propose to establish a 12-station dialysis facility. Accordingly, the number of stations proposed does not exceed the projected deficit.

2. Service to Planning Area Residents

As set forth throughout this application, there are currently three dialysis facilities within thirty minutes normal travel time of the proposed facility available to treat the general ESRD patient population. These facilities are experiencing significant growth and will no longer be able to accommodate additional ESRD patients in the near future. The applicants propose to establish a

12-station dialysis facility to help minimize overutilization at the existing facilities and accommodate the projected ESRD patient referrals. Importantly, to accommodate the growing demand for dialysis services, the proposed facility will be built to accommodate 16 dialysis stations with minimal additional cost.

As shown in Table 1110.1430(b)(2), Central Illinois Kidney and Dialysis Associates, S.C. is currently treating 28 Stage 5 CKD and 175 Stage 4 CKD patients. Based upon historical attrition rates approximately 127 Stage 4 and Stage 5 CKD patients will receive in-center hemodialysis treatment. All projected patients live within the geographic service area of the proposed facility.

Table 1110.1430(b)(2)
CKD Patients by Zip Code

Zip Code	Stage 5	Stage 4	Grand Total
62701	0	4	4
62702	7	51	58
62703	9	42	51
62704	5	49	54
62707	4	9	13
62711	2	16	18
62712	1	4	5
Grand Total	**28**	**175**	**203**

3. Service Demand

Attached at Attachment – 26A are physician referral letters from Central Illinois Kidney and Dialysis Associates, S.C. and a schedule of pre-ESRD patients by zip code. A summary of projected referrals is provided in Table 1110.1430(b)(3) below.

Table 1110.1430(b)(3)
Projected Patient Referrals by Zip Code

Zip Code	Patient Referrals
62701	4
62702	58
62703	51
62704	54
62707	13
62711	18
62712	5
Grand Total	**203**

4. Service Accessibility

There are currently three dialysis facilities within thirty minutes normal travel time of the proposed facility available to treat the general ESRD patient population. As shown in Table 1110.1430(b)(5) on the following page, these facilities are experiencing significant growth and will no longer be able to accommodate additional ESRD patients by December 31, 2012, the proposed facility's project completion date. Accordingly, additional dialysis stations are necessary to ensure life sustaining dialysis services remain accessible to ESRD patients in the Springfield market area.

Table 1110.1430(b)(5) Projected Utilization of Existing Facilities 03/31/2012							
Facility	Stations as of 09-30-2010	Patients 01/01/2008	Patients 09/30/2010	Historical Annual Growth Rate	Projected Patients 12/31/2012	Projected Utilization 12/31/2012	Excess Capacity (100% Utilization)
Lincolnland Dialysis Center	14	55	61	6.23%	70	83.33%	14
DaVita - Springfield Central	21	94	98	2.43%	103	81.75%	23
DaVita - Montvale	17	67	74	5.97%	84	82.35%	18
Total	**52**	**216**	**233**	**4.50%**	**257**	**82.37%**	**55**

Section VII, Service Specific Review Criteria
In-Center Hemodialysis
Criterion 1110.1430(c), Unnecessary Duplication/Maldistribution

1. Unnecessary Duplication

a. The proposed dialysis facility will be located at 2930 South Sixth Street, Springfield, Illinois. A map of the Springfield South Dialysis Center market area is attached at Attachment – 26B. A list of all zip codes located, in total or in part, within 30 minutes normal travel time of the site of the proposed dialysis facility as well as 2000 census figures for each zip code is provided in Table 1110.1430(c)(1)(A) below. Please note a significant number of zip codes for the City of Springfield were added by the U.S. Postal Service after the 2000 Census accordingly, population data for these new zip codes is not available.

Table 1110.1430(c)(1)(A)
Population of Zip Codes within 30 Minutes of Proposed Facility

Zip Code	City	Population
62703	Springfield	31,211
62704	Springfield	41,264
62701	Springfield	1,122
62705	Springfield	N/A
62706	Springfield	N/A
62708	Springfield	N/A
62715	Springfield	N/A
62716	Springfield	N/A
62719	Springfield	N/A
62721	Springfield	N/A
62722	Springfield	N/A
62726	Springfield	N/A
62736	Springfield	N/A
62739	Springfield	N/A
62746	Springfield	N/A
62756	Springfield	N/A
62757	Springfield	N/A
62761	Springfield	N/A
62762	Springfield	N/A
62763	Springfield	N/A
62764	Springfield	N/A
62765	Springfield	N/A
62766	Springfield	N/A
62767	Springfield	N/A
62769	Springfield	N/A
62776	Springfield	N/A
62777	Springfield	N/A
62786	Springfield	N/A
62791	Springfield	N/A
62794	Springfield	N/A
62796	Springfield	N/A
62712	Springfield	N/A
62711	Springfield	N/A
62702	Springfield	39,437
62563	Rochester	4,868
62707	Springfield	27,197

Table 1110.1430(c)(1)(A) Population of Zip Codes within 30 Minutes of Proposed Facility		
Zip Code	**City**	**Population**
62536	Glenarm	942
62629	Chatham	9,543
62561	Riverton	4,750
62520	Dawson	1,451
62684	Sherman	3,739
62625	Cantrall	853
62670	New Berlin	2,725
62558	Pawnee	3,564
62530	Divernon	1,561
62545	Mechanicsburg	948
62615	Auburn	5,424
62677	Pleasant Plains	2,501
62515	Buffalo	1,010
62661	Loami	1,294
62693	Williamsville	1,712
62570	Tovey	516
62531	Edinburg	1,955
62613	Athens	3,428
62517	Bulpitt	225
62689	Thayer	538
62540	Kincaid	1,392
62690	Virden	4,157
62519	Cornland	85
62662	Lowder	N/A
62688	Tallula	944
62692	Waverly	2,107
Total		**202,463**

Source: U.S. Census Bureau, Census 2000, Zip Code Fact Sheet *available at* http://factfinder.census.gov/servlet/SAFFPopulation?_event=Search&_name=&_state=04000US17&_county=&_cityTown=&_zip=&_sse=on&_lang=en&pctxt=fph (last visited Nov. 22, 2010).

b. A list of existing and approved dialysis facilities located within 30 minutes normal travel time of the proposed dialysis facility is provided in Table 1110.1430(c)(1)(C) below. A map of the all existing and approved dialysis facilities is attached at Attachment – 26B.

Table 1110.1430(c)(1)(C) Existing Facilities within 30 Minutes for Proposed Facility						
Facility	**Address**	**City**	**Zip Code**	**Distance**	**Time**	**Adjusted Time**
DaVita - Montvale	2930 Montvale Drive, Suite A	Springfield	62704	2.99 mi	6 min	6.9 min
DaVita – Springfield Central	932 North Rutledge Street	Springfield	62703	3.87 mi	11 min	12.65 min
Lincolnland Dialysis Center	1112 Centre West Drive	Springfield	62703	5.28 mi	9 min	10.35 min
Memorial Medical Center	800 North Rutledge Street	Springfield	62702	3.76 mi	11 min	12.65 min

2. Maldistribution of Services

The proposed dialysis facility will not result in a maldistribution of services. A maldistribution exists when an identified area has an excess supply of facilities, stations, and services characterized by such factors as, but not limited to: (1) ratio of stations to population exceeds one and one-half times the State Average; (2) historical utilization for existing facilities and services is below the State Board's utilization standard; or (3) insufficient population to provide the volume or caseload necessary to utilize the services proposed by the project at or above utilization standards. As discussed more fully below, the ratio of stations to population in the geographic service area is 95.5% of the State average, the average utilization of dialysis facilities within the geographic service area is above the State Board's 80% utilization standard, and sufficient population exists to achieve target utilization. Accordingly, the proposed dialysis facility will not result in a maldistribution of services.

a. Ratio of Stations to Population

As shown in Table 1110.1430(c)(2)(A), the ratio of stations to population is 95.5% of the State Average.

Table 1110.1430(c)(2)(A)
Ratio of Stations to Population

	Population	Dialysis Stations	Stations to Population
Geographic Service Area	202,463	58	1:3,491
State	12,829,014	3,511	1:3,653

b. Historic Utilization of Existing Facilities

Table 1110.1430(c)(2)(B) below provides the average utilization of existing dialysis facilities in the market area. While the average utilization of the existing facilities in the market area is below the HFSRB target utilization rate of 80%, this is primarily due to the underutilization at Memorial Medical Center. As discussed more fully in Criterion 1110.230(b), Memorial serves special needs ESRD patients who cannot be adequately treated in traditional in-center hemodialysis facilities. As set forth in the letter from Memorial attached at Attachment – 26C, Memorial does not solicit or make its services available to the general ESRD patient population. Excluding Memorial, average utilization of the existing facilities is approaching the HFSRB target utilization rate. In fact, assuming an 80% target utilization, the remaining facilities only have capacity for 18 additional ESRD patients.

Table 1110.1430(c)(2)(B)
Utilization of Existing Dialysis Facilities

Facility	Stations	Patients	Utilization
DaVita - Montvale	17	74	72.55%
DaVita – Springfield Central	21	98	77.78%
Lincolnland Dialysis Center	14	61	62.62%
Memorial Medical Center	6	6	16.67%
Total Utilization - Existing Facilities	**58**	**239**	**68.68%**
Total Utilization (excluding Memorial)	**52**	**233**	**74.68%**

c. Sufficient Population to Achieve Target Utilization

The Applicants propose to establish a 12-station dialysis facility. To achieve the State Board's 80% utilization standard within the first two years after project completion, the Applicants would need 58 patient referrals. Central Illinois Kidney and Dialysis Associates,

S.C. is currently treating 28 Stage 5 CKD patients and 175 Stage 4 CKD patients who will likely require dialysis within the next 12 to 18 months. Assuming attrition rates of 20% for Stage 5 CKD patients and 40% for Stage 4 CKD patients, approximately 127 of the current Stage 4 and Stage 5 CKD patients will initiate dialysis within the next 12 to 18 months. As set forth throughout this application, the existing dialysis facilities do not have sufficient capacity to accommodate all of the projected patient referrals. Accordingly, there is sufficient population to achieve target occupancy.

3. Impact to Other Providers

a. The proposed dialysis facility will not have an adverse impact on existing facilities in the proposed geographic service area. All of the identified patients are current Stage 4 and Stage 5 CKD patients of Central Illinois Kidney and Dialysis Associates, S.C. and will not be transferred from existing facilities. Moreover, as discussed in greater detail in Criterion 1110.1430(b) no existing or approved facility has the capacity to accommodate these Stage 4 and Stage 5 CKD patients.

b. The proposed dialysis facility will not lower the utilization of other area providers that are operating below the occupancy standards.

Section VII, Service Specific Review Criteria
In-Center Hemodialysis
Criterion 1110.1430(e), Staffing

1. The proposed facility will be staffed in accordance with all State and Medicare staffing requirements.

   a. Medical Director: Pradeep Kumar Mehta, M.D. will serve as the Medical Director for the proposed facility. Dr. Mehta currently serves as the Medical Director for DaVita's Springfield Central and Lincoln facilities. A copy of Dr. Mehta's curriculum vitae is attached at Attachment – 26D.

   b. Other Clinical Staff: Initial staffing for the proposed facility will be as follows:

      Administrator
      Registered Nurse
      Patient Care Technician (1.5 FTE)
      Biomedical Technician (0.2 FTE)
      Social Worker (licensed MSW) (0.5 FTE)
      Registered Dietitian (0.5 FTE)
      Administrative Assistant

      As patient volume increases, nursing and patient care technician staffing will increase accordingly to maintain a ratio of at least one direct patient care provider for every 4 ESRD patients. At least one registered nurse will be on duty while the facility is in operation.

2. All staff will be training under the direction of the proposed facility's Governing Body, utilizing DaVita's comprehensive training program. DaVita's training program meets all State and Medicare requirements. The training program includes introduction to the dialysis machine, components of the hemodialysis system, infection control, anticoagulation, patient assessment/data collection, vascular access, kidney failure, documentation, complications of dialysis, laboratory draws, and miscellaneous testing devices used. In addition, it includes in-depth theory on the structure and function of the kidneys; including, homeostasis, renal failure, ARF/CRF, uremia, osteodystrophy and anemia, principles of dialysis; components of hemodialysis system; water treatment; dialyzer reprocessing; hemodialysis treatment; fluid management; nutrition; laboratory; adequacy; pharmacology; patient education, and service excellence. A summary of the training program is attached at Attachment – 26E

3. The proposed facility will maintain an open medical staff.

Section VII, Service Specific Review Criteria
In-Center Hemodialysis
Criterion 1110.1430(f), Support Services

Attached at Attachment – 26F is a letter from Kent J. Thiry, Chief Executive Officer, DaVita, Inc. and Total Renal Care, Inc., attesting that Springfield South will participate in a dialysis data system, will make support services available to patients, and will provide training for self-care dialysis, self-care instruction, home and home-assisted dialysis, and home training.

Section VII, Service Specific Review Criteria
In-Center Hemodialysis
Criterion 1110.1430(g), Minimum Number of Stations

The proposed dialysis facility will be located in the Springfield, Illinois metropolitan statistical area ("MSA"). A dialysis facility located within an MSA must have a minimum of eight dialysis stations. The Applicants propose to establish a 12-station dialysis facility. Accordingly, this criterion is met.

Section VII, Service Specific Review Criteria
In-Center Hemodialysis
Criterion 1110.1430(h), Continuity of Care

A copy of the backup agreement with Memorial Medical Center is attached at Attachment – 26G.

Section VII, Service Specific Review Criteria
In-Center Hemodialysis
Criterion 1110.1430(j), Assurances

Attached at Attachment – 26H is a letter from Kent J. Thiry, Chief Executive Officer of DaVita, Inc. and Total Renal Care, Inc. certifying that Springfield South will achieve target utilization by the second year of operation

CENTRAL ILLINOIS KIDNEY AND DIALYSIS ASSOCIATES, S.C.

932 N. Rutledge, Springfield, IL 62702

Pradeep Mehta, M.D. Lawrence J. Smith, M.D. Ashraf Tamizuddin, M.D.
Allen S. Krall, M.D. X. Gary Chen, M.D., Ph.D.

Satellite Outpatient Clinics
Litchfield, Decatur, Jacksonville, Effingham, Mattoon, Taylorville

Appointments/Nurses (217) 788-3875 Business Office (217) 544-5100

December 13, 2010

Dale Galassie
Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Chairman Galassie:

I am a nephrologist in practice with Central Illinois Kidney and Dialysis Associates, S.C. ("CIKD"). I am writing on behalf of CIKD in support of the proposed establishment of a 12-station dialysis facility to be located at 2930 South 6th Street, Springfield, Illinois (the "Proposed Facility"). There are three dialysis facilities accessible to the general end-stage renal disease ("ESRD") patient population in Springfield. All three of these facilities are rapidly approaching the Health Facilities and Services Review Board 80% utilization standard. Based upon current utilization trends, within the next two years, there will be insufficient capacity in the Springfield market area to accommodate the growing demand for dialysis services. A new dialysis facility is needed to ensure the residents of Springfield maintain access to life sustaining dialysis.

CIKD is currently treating 175 Stage 4 and 28 Stage 5 pre-ESRD patients that reside in the Springfield area. Utilizing a 40% attrition rate for Stage 4 and 20% attrition rate for Stage 5 pre-ESRD patients, we project 127 of these current pre-ESRD patients will initiate dialysis within the next 12 to 24 months. We anticipate referring at least 58 of these patients to the Proposed Facility. The total number of pre-ESRD patients by initial and zip code is attached hereto. No patients will be transferred from other providers to the Proposed Facility.

These patient referrals have not been used to support another pending or approved certificate of need application. The information in this letter is true and correct to the best of my knowledge.

I support the proposed establishment of Springfield South Dialysis.

Sincerely,

P. Mehta M.D

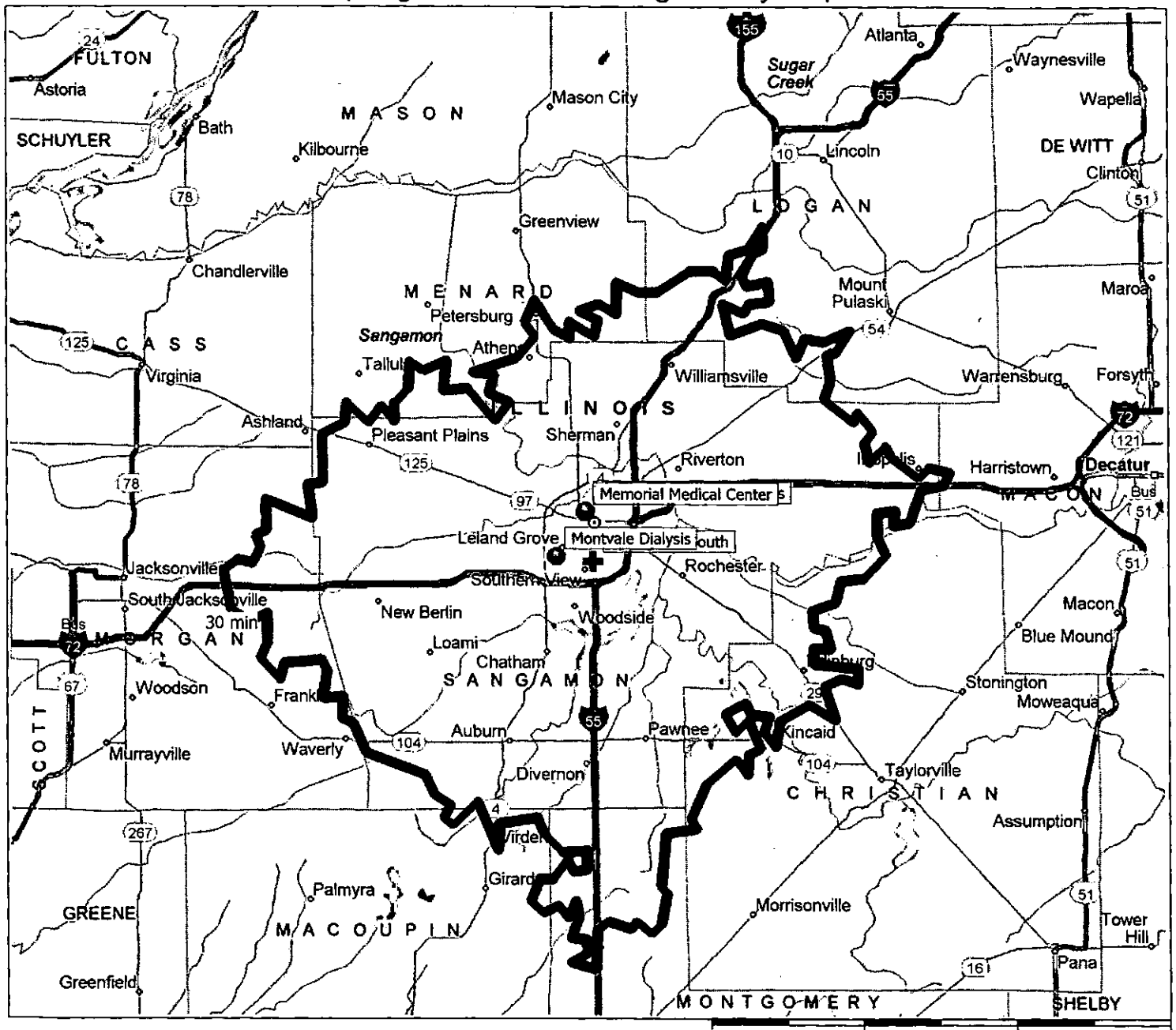
Pradeep Mehta, M.D.
Central Illinois Kidney and Dialysis Associates, S.C.
932 North Rutledge Avenue
Springfield, Illinois 62702

OFFICIAL SEAL
STEPHANIE SKINNER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:03/10/12

Subscribed and sworn to me
This 13th day of December, 2010

Notary Public

Springfield South Existing Facility Map



Memorial MEDICAL CENTER
701 North First Street • Springfield, Illinois 62781-0001
memorialmedical.com • Phone (217) 788-3000
A Memorial Health System Affiliate

December 7, 2010

Dale Galassie
Chairman
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: Letter of Support for DaVita Springfield South

Dear Chairman Galassie:

I am writing to you on behalf of Memorial Medical Center ("Memorial") in support of the proposed establishment of a 12-station dialysis facility to be located at 2930 South 6th Street, Springfield, Illinois, to be known as DaVita – Springfield South. Utilization of existing dialysis facilities in Springfield is rapidly approaching 80%. Given current utilization trends, within the next two years, there will not be sufficient capacity among existing facilities to accommodate the growth in demand for dialysis services.

Memorial currently operates a 6-station dialysis facility located on its hospital campus. In 1998, we significantly downsized our dialysis program to accommodate primarily special needs patients. Predominantly, we treat oversized patients who cannot be accommodated in recliner chairs, patients with behavioral issues who cannot be adequately treated in a freestanding dialysis facility, and patients admitted for a medical or surgical procedure who require outpatient dialysis prior to discharge.

With regard to the proposed establishment of the proposed dialysis facility, we believe a 12-station facility will accommodate future demand for dialysis services while at the same time allowing existing facilities to operate at their optimal capacity. Additionally, a 12-station facility is consistent with industry norms and should provide for adequate patient through-put, optimal staffing, and better access for patients.

DaVita is a leading provider of dialysis services in the United States. It has taken on many initiatives to improve the lives of patients suffering from chronic kidney disease ("CKD") and ESRD. One example is its EMPOWER program. DaVita launched the EMPOWER program workshops in 2008. The workshops are free community-based educational seminars that encourage CKD patients to take control of their health and make informed decisions about their dialysis care. Led by a team of DaVita nurses, renal dietitians, and social workers, EMPOWER uses a multidisciplinary approach to educate patients with CKD about their disease, ways to

delay progression, and different treatment options. Workshops also focus on preparing patients for life on dialysis or with a kidney transplant. DaVita recognizes the unique and vital role that it plays in enhancing care for renal patients throughout the country. Memorial is grateful that the residents of Springfield have the benefit of a provider like DaVita in the community. Accordingly, we fully support the proposed establishment of DaVita – Springfield South.

Thank you for your consideration.

Sincerely,

Kevin R. England
Vice President
Business Development

KRE/bdk

CURRICULUM VITAE

PRADEEP KUMAR MEHTA, M.D.

DATE OF BIRTH: September 25, 1945

Address:

3108 Falcon Point (Home)
Springfield, Illinois 62707
(217) 546-9091

932 North Rutledge (Work)
Springfield, Illinois 62702
(217) 544-5100

CITIZENSHIP: U.S.A.

EDUCATION:

Medical School — Grant Medical College
Amristsar, India
1962 - 1967 M.B.B.S.

Specialty Training - Post Graduate Medical Institute
Chandigarh, India
Internal Medicine
January 1968 - December 1970

U.S. Training - Resident in Internal Medicine
Cook County Hospital
Chicago, Illinois
July 1973 - June 1975

Nephrology Fellowship
University of Illinois
Abraham Lincoln School of Medicine
Chicago, Illinois
June 1975 - June 1977

PROFESSIONAL APPOINTMENTS:

Registrar in Medicine
Post Graduate Medical Institute
Chandigarh, India
1971 - 1973

PROFESSIONAL APPOINTMENTS (continued):

Associate in Medicine
Abraham Lincoln School of Medicine
University of Illinois
Chicago, IL
1975 - 1977

Associate Professor of Medicine, Nephrology
Abraham Lincoln School of Medicine
University of Illinois
Chicago, Illinois
1977 - 1979

Attending in Nephrology
Westside Veterans Administration Hospital
Chicago, Illinois
1977 - 1979

Director, Hypertension Service
University of Illinois Hospital
Chicago, Illinois
1977 – 1979

Attending Nephrologist
Memorial Medical Center
Springfield, Illinois
1979 – July 1983

Clinical Assistant Professor
Southern Illinois University School of Medicine
Springfield, Illinois
1979 – February 1997

Clinical Associate Professor
Southern Illinois University School of Medicine
Springfield, Illinois
February 1997 – Present

Medical Director
Gambro Healthcare
Springfield, Illinois
1998 - 2005

Medical Director
DaVita Dialysis
Springfield, Illinois
Lincoln, Illinois
2005- Present

Partner
Central Illinois Kidney and Dialysis Assoc., SC
Springfield, Illinois
July 1983 – Present

PROFESSIONAL SOCIETIES MEMBERSHIP:

American Society of Nephrology
Indian Society of Nephrology
International Society of Nephrology

LICENSURE:

Illinois 1974

CERTIFICATION:

Board Certified, Internal Medicine
June 1976

Board Certified, Nephrology
June 1978

BIBLIOGRAPHY

Paper

1. Mehta, P.K. and Wahi, P.L.: A Study of Ventilatory Pulmonary Function Tests in Young Smokers and Non-Smokers. A Thesis. Submitted to the Post Graduate Medical Institute, Chandigarh, India 1971.

2. Mehta, P. K.; Mamdani, B.H.; Shansky, R. M.; Mahurkar, S.D. and Dunea, G.: SevereHypertension: Treatment With Minoxidil. JAMA 233:249, 1975

3. Mamdani, B.H.; Mehta, P. K.; Mahurkar, S.D.; Sassoon, H. and Dunea, G.: High Dose Bolus Urography: A Superior Technique in Advanced Renal Failure. JAMA 234:1054, 1975

4. Walter, R.; Smith, C.W.; Mehta, P.K.; Boonjarern, S.; Arruda, JAL and Kurtzman, N.A.: Conformational Considerations of Vasopressin as a Guide to the Development of Biological Probes and Therapeutic Agents. Chapter in Disturbances in Body Fluid Osmolality (Andreoli, Grantham and Rector, eds.); American Physiological Society, Bethesda, Maryland, 1977, pp 1-36.

5. Boonjarern, S.; Mehta, P. K.; Laski, M.E.; Earnest, W.T. and Kurtzman, N.A.: Effect of Furosemide on the Renal Handling of Glucose in the Rat. Amer J. Physiol 1:F438, 1977.

6. Arruda, JAL; Nascimento, L.: Mehta, P. K.; Rademacher, D.R.; Sehy, J.T.; Westenfelder, C. and Kurtzman, N.A.: The Critical Importance of Urinary Concentrating Ability in the Generation of Urinary Carbon Dioxide Tension. J Clin Inves 60:922, 1977.

7. Arruda, JAL; Sabatini, S.; Mehta, P.K.; Sodhi, B. and Baranowski, R.L.: Functional Characterization of Drug-Induced Experimental Papillary Necrosis. Kidney Internat 15:264, 1979

8. Mehta, P.K.; Arruda, JAL; Kurtzman, N.A.; Smith, C.W. and Walter, N.W.: Effect of Neurohypophyseal Peptides on Electrolyte Excretion. Min Elect Metab 3:10, 1980.

9. Mehta, P.K.; Arruda, JAL; Sodhi, B. and Kurtzman, N.A.: Interaction of Amiloride and Lithium Chloride on Distal Acidification. J. Lab Clin Med 93: 983, 1979.

10. Arruda, JAL; Roseman, M.K.; Sehy, J.T.; Mehta, P.K. and Kurtzman, N.A.:In vivo and In Vitro Studies of Urinary Acidification. Min Electrolyte Metab 3:123-135, 1980.

Bibliography - Papers (cont.)

11. Wong, L.; Nation, R.L.; Chiou, W.L.; Mehta, P.K.: Plasma Concentrations of Propranolol and 4-Hydroxypropranolol During Chronic Oral Propranolol Therapy. Br J Clin Pharmacol 1979, August:8 (2) 163-7.

12. Sabatini, S.; Mehta, P.K.; Hayes, S.; Kurtzman, N.A. and Arruda, JAL: Drug-Induced Papillary Necrosis: Electrolyte Excretion and Nephro-Heterogeneity. Ame J Physiology, 1981, July, 241 (1): F 14-22.

Abstracts and Presentations

1. Mehta, P.K.; Mamdani, B.H.; Shansky, R.M.; Manhurkar, S.D. and Dunea, G.: Treatment of Severe Hypertension with Minoxidil. Clinc Res 22:626A, 1974.

2. Mamdani, B.H.; Mehta, P.K.; Sassoon, H.; Mahurkar, S.D. and Dunea, G.: High-Dose Bolus Nephrotomography in Chronic Renal Failure. Proc Amer Soc Nephr 7:58, 1974.

3. Mehta, P.K.; Mamdani, B.H.; Mahurkar, S.D.; Sassoon, H. and Dunea, G.: Radiological Studies in Acute Renal Failure. Proc Kidney Found Clin Dialysis Transplant Forum, November, 1974.

4. Mehta, P.K.; Mamdani, B.H.; Shansky, R.M.; Huang, C.: Mahurkar, S.D. and Dunea, G.: A Double-Bind Study of Minoxidil and Hydralazine Proc Internet Soc Nephr, 819, 1975. Presented to Internet Soc Neph at Florence, Italy, June, 1975.

5. Boonjaren, S.; Mehta, P.K.; Laski, M.E.; Earnest, W.R. and Kurtzman, N.A.: Failure to Demonstrate the Glucosuric Effect of Furosemide in the Rat. Clin Res 24: 394A, 1976.

6. Mehta, P.K.; Smith, C.; Boonjarern, S.; Arruda, JAL;, Walter, R. and Kurtzman N.A.: Renal Effects of Analogues of Vasopressin and Oxytocin. Clin Res 24:555A, 1976.

7. Mehta, P.K.; Smith, C: Boonjarern, S.; Arruda, JAL; Walter, R. and Kurtzman, N.A.: Renal Effects of Analogues of Vasopressin and Oxytocin. Proc 9th Amer Soc Nephro 9:107A, 1976.

8. Arruda, JAL; Mehta, P.K.; Nascimento, L. and Kurtzman, N.A.: Urine HCO3 Concentration: A Critical Determinant of Urine pCO2. Clin Res 25:425A, 1977.

9. Arruda, JAL: Mehta, P.K.; Nascimento, L. and Kurtzman, N.A.: Urine pCO2 May Not Assess Distal Acidification (DA) in Highly Alkaline Urine. Clin Res 25:425A, 1977.

Bibliography - Abstracts and Presentations (continued):

10. Arruda, JAL: Roseman, M.K.; Sehy, J.T.; Mehta, P.K. and Kurtzman, N.A.: On the Mechanism of Formation of Urine (U) pCO2: Effect of Carbonic Anhydrase (CA) and Tris (T) on Urine-Blood (U-B) pCO2 Gradient. Clin Res 25:627A, 1977.

11. Mehta, P.K,; Sodhi, B.; Arruda, JAL and Kurtzman, N.A.: Functional Studies in Experimental Medullary Necrosis (MN). Clin Res 25:595A, 1977.

12. Arruda, JAL; Mehta, P.K.; Sodhi, B. and Kurtzman, N.A.: Interaction of Amiloride (A) and LiCL Administration on Distal H+ Secretion (S). Clin Res 25:592A, 1977.

13. Sabatini, S.; Mehta, P.K.; Baranowski, R.L.: Westenfelder, C, : Arruda, JAL and Kurtzman, N.S.: Role of Medullary Collecting Ducts (MCD) in Electrolyte Transport as Assessed by a Model of Medullary Necrosis. Clin Res 26:475A, 1978.

14. Sabatini, S.; Mehta, P.K., Julka, N.K.; Westenfelder, C. and Arruda, JAL: Experimental Papillary Necrosis: Functional, Enzymatic and Morphologic Studies. Clin Res 26:692A, 1978.

15. Sabatini, S.; Mehta, P.K.; Julka, N.K.; Westenfelder, C. and Arruda, JAL; Experimental Papillary Necrosis: Functional, Enzymatic and Morphologic Studies. Proc Amer Soc Neph 11:97A, 1978.

16. Sabatini, S.; Mehta, P.K.; Chang, E.S.; Hsieh, J.; Kurtzman, N.A. and Arruda, JAL: The Effects of Early Papillary Necrosis on Deep Nephron Glomerular Filtration. Clin Res 27:669A, 1979.

17 Mehta, P.K.; Mitra, S.; Kienstra, R.A.; Maher, C.C., Jr.; Bilinsky, R.T.: Glycosylated Hemoglobin Measurements in Diabetic and Non-Diabetic Chronic Renal Failure. Clin Rest 28:750, 1980.

18. Mitra, S; Maher, C.D. Jr.; Mehta, P.K.; Kienstra, R.A. and Eagleton, L.: Sleep Apnea in Dialysis Patients with Diabetes. Amer Soc of Neph, 1982.

19. Mitra, S.; Maher, C.C., Jr.; Mehta, P.K. and Kienstra, R.A.: Comparative Study of Home Hemodialysis (HHD) and CAPD in ESRD Patients. IXth International Congress of Nephrology, 1984.

PROGRAM DESCRIPTION

Introduction to Program

The Hemodialysis Education and Training Program is grounded in DaVita's Core Values. These core values include a commitment to providing *service excellence*, promoting *integrity*, practicing a *team* approach, systematically striving for *continuous improvement*, practicing *accountability*, and experiencing *fulfillment* and *fun*.

The Hemodialysis Education and Training Program is designed to provide the new teammate with the necessary theoretical background and clinical skills necessary to function as a competent hemodialysis patient care provider.

DaVita hires both non-experienced and experienced teammates.
A **non-experienced teammate** is defined as:

- A newly hired patient care teammate without prior dialysis experience.
- A rehired patient care teammate who left prior to completing the initial training.

An **experienced teammate** is defined as:

- A newly hired patient care teammate with prior dialysis experience as evidenced by successful completion of a competency exam.
- A rehired patient care teammate who left and can show proof of completing their initial training.

The curriculum of the Hemodialysis Education and Training Program is modeled after the American Nephrology Nurses Association Core Curriculum for Nephrology Nursing and the Board of Nephrology Examiners Nursing and Technology guidelines.

The program incorporates the policies, procedures, and guidelines of DaVita Inc.

The new teammate will be provided with a "StarTracker". The "StarTracker" is a tool that will help guide the training process while tracking progress. The facility administrator and preceptor will review the Star Tracker to plan and organize the training and professional development of the new teammate. The Star Tracker will guide the new teammate through the initial phase of training and then through the remainder of their first year with DaVita, thus increasing their knowledge of all aspects of dialysis. It is designed to be used in conjunction with the "My Learning Plan Workbooks."

Program Description

- The education program for the newly hired patient care provider teammate **without prior dialysis experience** is composed of at least (1) 120 hours didactic instruction and (2) 280 hours clinical practicum, unless otherwise specified by individual state regulations.

  The **didactic phase** consists of instruction including but not limited to lectures, readings, self-study materials, on-line learning activities, specifically designed hemodialysis

workbooks for the teammate, demonstrations and observations. This education may be coordinated by the Clinical Services Specialist (CSS), the administrator, or the preceptor. This training includes introduction to the dialysis machine, components of the hemodialysis system, dialysis delivery system, principles of hemodialysis, infection control, anticoagulation, patient assessment/data collection, vascular access, kidney failure, documentation, complications of dialysis, laboratory draws, and miscellaneous testing devices used, introduction to DaVita Policies and Procedures, and introduction to the Amgen Core Curriculum.

The **didactic phase** also includes classroom training with the Clinical Services Specialist, which covers more in-depth theory on structure and functions of the kidneys. This includes homeostasis, renal failure ARF/CRF, uremia, osteodystrophy and anemia, principles of dialysis, components of the hemodialysis system, water treatment, dialyzer reprocessing, hemodialysis treatment (which includes machine troubleshooting and patient complications), documentation, complication case studies, heparinization and anticoagulation, vascular access (which includes vascular access workshop), patient assessment (including workshop), fluid management with calculation workshop, nutrition, laboratory, adequacy, pharmacology, patient teaching/adult learning, service excellence (which includes professionalism, ethics and communications).

A final comprehensive examination score of ≥ 80% must be obtained to successfully complete this portion of the didactic phase. If a score of less than 80% is attained, the teammate will receive additional appropriate remediation and a second exam will be given.

Also included in the **didactic phase** is additional classroom training covering Health and Safety Training, DaVita Virtual Training Program (which includes 21 hours of computer training classes), One For All orientation training, HIPAA training, LMS mandatory water classes, emergency procedures specific to facility, location of disaster supplies, and orientation to the unit.

Included in the **didactic phase** for nurses is additional classroom training. The didactic phase includes:

- The role of the dialysis nurse in the facility
- Pharmacology for nurses
- Outcomes management
- Patient assessment for the dialysis nurse.

The **clinical practicum phase** consists of supervised clinical instruction provided by the facility preceptor, a registered nurse, or the clinical services specialist (CSS). During this phase the teammate will demonstrate a progression of skills required to perform the hemodialysis procedures in a safe and effective manner. A *Procedural Skills Inventory Checklist* will be completed to the satisfaction of the preceptor and the administrator.

The clinical hemodialysis workbooks will also be utilized for this training and must be completed to the satisfaction of the preceptor and the administrator.

Those teammates who will be responsible for the Water Treatment System within the facility are required to complete the Mandatory LMS Educational Water courses and the corresponding skills checklists.

Both the didactic phase and/or the clinical practicum phase of a specific skill set will be successfully completed prior to the new teammate receiving an independent assignment for that specific skill set. The new teammate is expected to attend all training sessions and complete all assignments and workbooks.

- The education program for the newly hired patient care provider teammate **with previous dialysis experience** is individually tailored based on the identified learning needs. The initial orientation to the *Health Prevention and Safety Training* will be successfully completed prior to the new teammate working/receiving training in the clinical area. The *Procedural Skills Inventory Checklist* including verification of review of applicable policies and procedures will be completed by the preceptor, a registered nurse, and/or the clinical services specialist (CSS) and the new teammate upon demonstration of an acceptable skill-level. The new teammate will also utilize the hemodialysis training workbook and progress at their own pace. This workbook should be completed within a timely manner as to also demonstrate acceptable skill-level.

  The *Initial Competency Exam* will be completed; a score of ≥ 80% or higher is required prior to the new teammate receiving an independent patient-care assignment. If the new teammate receives a score of less than 80%, this teammate will receive theory instruction pertaining to the area of deficiency and a second competency exam will then be given. If the new teammate receives a score of less than 80% on the second exam, this teammate will be evaluated by the administrator, preceptor, and educator to determine if completion of formal training is appropriate.

Following completion of the training, a *Verification of Competency* form will be completed (see forms TR1-06-05, TR1-06-06). In addition to the above, further training and/or certification will be incorporated as applicable by state law.

The goal of the program is for the trainee to successfully meet all training requirements. Failure to meet this goal is cause for dismissal from the training program and subsequent termination by the facility.

Process of Program Evaluation

The Hemodialysis Education Program utilizes various evaluation tools to verify program effectiveness and completeness. Key evaluation tools include the, DaVita Prep Class Evaluation (TR1-06-08), the New Teammate Satisfaction Survey on the LMS and random surveys of facility administrators to determine satisfaction of the training program. To assure continuous

DaVita.

Casa Nueva
1551 Wewatta Street
Denver, CO 80202-6173
Tel: 303-405-2100
www.davita.com

December 17, 2010

Dale Galassie
Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: Certification of Support Services

Dear Chairman Galassie:

I hereby certify under penalty of perjury as provided in § 1-109 of the Illinois Code of Civil Procedure, 735 ILCS 5/1-109 and pursuant to 77 Ill. Admin. Code § 1110.1430(f) that Springfield South Dialysis:

- Participates in a dialysis data system;
- Provides support services consisting of clinical laboratory service, blood bank, nutrition, rehabilitation, psychiatric services, and social services are available; and
- Provides training for self-care dialysis, self-care instruction, home and home-assisted dialysis, and home training.

Sincerely,

Kent J. Thiry
Chief Executive Officer
DaVita, Inc.
Total Renal Care, Inc.

Subscribed and sworn to me
This 17th day of December, 2010

Tara L. Motley
Notary Public

"OFFICIAL SEAL"
Tara L Motley
Notary Public, State of Illinois
My Commission Expires 6/11/2013

FOR MEDICAL CENTER USE ONLY:
Clinic #: 3320

BACKUP DIALYSIS SERVICES AGREEMENT

This **BACKUP DIALYSIS SERVICES AGREEMENT** ("Agreement") is made the 23rd day of August, 2009 by and between Memorial Medical Center, an affiliate of Memorial Health System, an Illinois not for profit corporation which is licensed as a "hospital" under the Hospital Licensing Act (hereinafter "Medical Center") and DVA Renal Healthcare, Inc. ("Company").

RECITALS

WHEREAS, Company owns and operates an outpatient hemodialysis treatment center known as Springfield Central Dialysis which is located at 932 N RUTLEDGE ST SPRINGFIELD, IL 62702-3721 ("Facility") that is experienced and qualified to administer dialysis services and clinically manage patients with ESRD on an out-patient basis; and

WHEREAS, the parties hereto desire to enter into this Agreement governing the provision of backup dialysis services to Medical Center's patients in the case of emergency or disaster, as required by 42 C.F.R §405.2140(d); and

WHEREAS, the parties hereto desire to enter into this Agreement in order to specify the procedure for ensuring the transfer of patients between the Facility and Medical Center in the event of an emergency or disaster; and

WHEREAS, the parties wish to facilitate the continuity of care and transfer of patients between the Facility and Medical Center in the event of an emergency or disaster.

NOW THEREFORE, in consideration of the premises herein contained and for other good and valuable consideration, the receipt and legal sufficiency of which are hereby acknowledged, the parties agree as follows:

1. **FACILITY OBLIGATIONS.**

In accordance with the policies and procedures as hereinafter provided, and upon request by Medical Center in the case of an emergency (including but not limited to fire, natural disaster, act of war or terrorism, or functional failure in equipment), Facility agrees as follows:

(a) Facility shall have, and have maintained, a hemodialysis facility (including all necessary supplies and equipment), and shall provide access to such facility for Medical Center's patients in the event of an emergency; and

(b) Facility agrees to exercise its best efforts to ensure the prompt admission of patients as necessary, provided that all usual, reasonable conditions of admission are met. In doing so, Facility agrees to accept and treat patients in emergency situations requiring transfer of a patient from Medical Center to Facility. All transfers between the facilities shall be

made in accordance with applicable federal and state laws and regulations, the standards of The Joint Commission and any other applicable accrediting bodies, and reasonable policies and procedures of the facilities. Facility and its staff shall cooperate with Medical Center's staff to ensure the provision of safe and adequate care to Medical Center's patients who are transferred to Facility to receive dialysis services in the case of an emergency.

2. **MEDICAL CENTER'S OBLIGATIONS.**

In conjunction with transfer of patients to Facility for backup dialysis services, Medical Center agrees:

(a) That it shall, if possible, transfer medical records to Facility;

(b) That Medical Center's staff shall accompany Medical Center patient(s) to Facility, to ensure that care is rendered safely and that patient(s) remain under care of Medical Center; and

(c) That Medical Center's staff shall cooperate with Facility in provision of care to patients, including assisting Facility staff in the provision of dialysis services; and

(d) That Medical Center shall accept Facility's scheduling for patient dialysis services (including after hours scheduling), as consistent with patient care needs.

3. **BILLING, PAYMENT AND FEES.**

Facility shall be responsible for billing the appropriate payer for the services it provides hereunder. To the extent Medical Center supplies are used in the provision of services hereunder, Facility shall reimburse Medical Center for such supplies at the usual and customary rate, unless other such rates are mutually agreed upon and set forth in an exhibit attached hereto. No compensation shall be exchanged by and between the parties for services provided under this Agreement.

4. **HIPAA.**

Facility and Medical Center agree to comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Facility and Medical Center acknowledge and agree that from time to time, HIPAA may require modification to this Agreement for compliance purposes. Facility and Medical Center further acknowledge and agree to comply with requests by the other party hereto related to HIPAA.

5. **STATUS AS INDEPENDENT CONTRACTORS.**

(a) None of the provisions of this Agreement are intended to create, nor shall be deemed or construed to create, any relationship between the parties hereto other than that of

independent entities contracting with each other hereunder solely for the purpose of effecting the provisions of this Agreement. Neither this Agreement nor the fulfillment of any of the obligations of Facility or Medical Center hereunder shall be deemed to create any partnership, joint venture, legal association, or other operating relationship between the parties other than as independent contractors.

(b) The Governing Bodies of each of the Facility and Medical Center shall have exclusive control of the policies, management, assets, and affairs of their respective facilities.

(c) Nothing in this Agreement shall be construed as limiting the right of either to affiliate or contract with any other party or facility on either a limited or general basis while this Agreement is in effect. Neither party shall use the name of the other in any promotional or advertising material unless review and approval of the intended use shall be obtained from the party, whose name is to be used, and their legal counsel.

6. DISPUTE RESOLUTION.

(a) Informal Resolution. Should any dispute between the parties arise under this Agreement, written notice of such dispute shall be delivered from one party to the other party and thereafter, the parties, through appropriate representatives, shall first meet and attempt to resolve the dispute in face-to-face negotiations. This meeting shall occur within thirty (30) days of the date on which the written notice of such dispute is received by the other party.

(b) Resolution Through Mediation. If no resolution is reached through informal resolution, pursuant to Section 6(a) above, the parties shall, within forty five (45) days of the first meeting referred to in Section 6(a) above, attempt to settle the dispute by formal mediation. If the parties cannot otherwise agree upon a mediator and the place of the mediation within such forty-five (45) day period, the American Arbitration Association ("AAA") in the state of Illinois shall administer the mediation. Such mediation shall occur no later than ninety (90) days after the dispute arises. All findings of fact and results of such mediation shall be in written form prepared by such mediator and provided to each party to such mediation. In the event that the parties are unable to resolve the dispute through formal mediation pursuant to this section, the parties shall be entitled to seek any and all available legal remedies.

7. TERM AND TERMINATION.

(a) This Agreement shall be effective for an initial period of one (1) year, commencing on the last date of execution below and shall continue in effect for no more than four (4) years after such initial term, provided that either party may terminate by giving at least sixty (60) days written notice to the other party of its intention to terminate this Agreement. Termination shall be effective at the expiration of such sixty (60) day notice period.

(b) Notwithstanding the foregoing, if either party shall have its license to operate its facility revoked by the state where such facility is located or become ineligible as a provider of service under Medicare or Medicaid laws, this Agreement shall automatically terminate on the date such revocation or ineligibility becomes effective.

8. **INDEMNIFICATION.**

(a) Medical Center Indemnity. Facility hereby agrees to defend, indemnify and hold harmless Medical Center and its affiliates, officers, directors, employees, and agents for, from and against any claim, loss, liability, cost and expense (including, without limitation, costs of investigation and reasonable attorney's fees), directly or indirectly relating to, resulting from or arising out of any action or failure to act arising out of this Agreement by Facility and its staff regardless of whether or not it is caused in part by Medical Center or its officers, directors, agents, representatives, employees, successors and assigns. This indemnification provision shall not be effective as to any loss attributable exclusively to the negligence or willful act or omission of Medical Center.

(b) Facility Indemnity. Medical Center hereby agrees to defend, indemnify and hold harmless Facility and its shareholders, affiliates, officers, directors, employees, and agents for, from and against any claim, loss, liability, cost and expense (including, without limitation, costs of investigation and reasonable attorney's fees), directly or indirectly relating to, resulting from or arising out of any action or failure to act arising out of this Agreement by Medical Center and its staff regardless of whether or not it is caused in part by Facility or its officers, directors, agents, representatives, employees, successors and assigns. This indemnification provision shall not be effective as to any loss attributable exclusively to the negligence or willful act or omission of Facility.

(c) Survival. The indemnification obligations set forth in this section shall continue in full force and effect notwithstanding the expiration or termination of this Agreement with respect to any such expenses, costs, damages, claims and liabilities which arise out of or are attributable to the performance of this Agreement prior to its expiration or termination.

9. **AMENDMENT AND SEVERABILITY.**

This Agreement may be modified or amended from time to time by mutual written agreement of the parties, signed by authorized representatives thereof, and any such modification or amendment shall be attached to and become part of this Agreement. No oral agreement or modification shall be binding unless reduced to writing and signed by both parties. The provisions of this Agreement are severable. The invalidity or unenforceability of any term or provisions hereto in any jurisdiction shall in no way affect the validity or enforceability of any other terms or provisions in that jurisdiction, or of this entire Agreement in any other jurisdiction.

10. **COMPLIANCE RELATED MATTERS.**

(a) Facility and Medical Center agree and certify that this Agreement is not intended to generate referrals for services or supplies for which payment maybe made in whole or in part under any federal health care program. Facility and Medical Center will comply with statutes, rules, and regulations as promulgated by federal and state regulatory agencies or legislative authorities having jurisdiction over the parties.

(b) Company has advised Medical Center that Company is subject to a Corporate Integrity Agreement with the Office of the Inspector General of the Federal Department of Health and Human Services (the "CIA"), and company has informed Medical Center that such CIA imposes various reporting and operational compliance related obligations on Company. Medical Center agrees to exert a reasonable effort to cooperate with Company, at Company's request to enable Company to comply with the requirements of such CIA, as such requirements may apply to Medical Center under this Agreement.

(c) Medical Center certifies that it will abide by the terms of the Anti-Kickback Statute in all matters involving Facility.

11. **NOTICES.**

All notices, requests, and other communications to any party hereto shall be in writing and shall be addressed to the receiving party's address set forth below or to any other address as a party may designate by notice hereunder, and shall either be (a) delivered by hand, (b) sent by recognized overnight courier, or (c) by certified mail, return receipt requested, postage prepaid.

If to Facility:	Springfield Central Dialysis 932 North Rutledge Springfield, IL 62702-3721 Attention: Facility Administrator
With a copy to:	DVA Renal Healthcare, Inc. 2611 N. Halsted St. Chicago, IL 60614 Attn: Group General Counsel
If to Medical Center:	Memorial Medical Center 701 North 1st Street Springfield, IL 62781 Attn: Kevin England

All notices, requests, and other communication hereunder shall be deemed effective (a) if by hand, at the time of the delivery thereof to the receiving party at the address of such party set forth above, (b) if sent by overnight courier, on the next business day following the day such

notice is delivered to the courier service, or (c) if sent by certified mail, five (5) business days following the day such mailing is made.

12. MISCELLANEOUS.

(a) Entire Agreement. This Agreement constitutes the entire agreement between the parties with respect to the subject matter hereof and supersedes any and all other agreements, either oral or written, between the parties (including, without limitation, any prior agreement between Facility and Medical Center or any of its subsidiaries or affiliates) with respect to the subject matter hereof.

(b) Counterparts. This Agreement may be executed simultaneously in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

(c) Headings. The headings appearing in this Agreement are for convenience and reference only, and are not intended to, and shall not, define or limit the scope of the provisions to which they relate.

(d) Assignment. This Agreement shall not be assigned in whole or in part by either party hereto without the express written consent of the other party, except that Facility may assign this Agreement to one of its affiliates or subsidiaries without the consent of Medical Center.

(e) Non-Discrimination. All services provided by the parties hereunder shall be in compliance with all federal and state laws prohibiting discrimination on the basis of race, color religion, sex national origin, handicap, or veteran status.

13. APPROVAL BY DAVITA INC. ("DAVITA") AS TO FORM. The parties acknowledge and agree that this Agreement shall take effect and be legally binding upon the parties only upon full execution hereof by the parties and upon approval by DaVita Inc. as to the form hereof.

14. NO REQUIRED REFERRALS. This Agreement is to be strictly interpreted and construed so as to comply with all of the provisions of and the referral restrictions which are contained within the federal statutes and laws which are commonly referred to as the Medicare Fraud and Abuse or the Anti-Kickback Statute and the Ethics in Patient Referrals Act, or the "Stark Laws," and all of the rules and regulations promulgated pursuant to, and all of the cases or opinions interpreting, such statutes and laws, as well as any other state statutes or laws which may be applicable to such arrangements. As a consequence, Company is not obligated or required by the provisions of this Agreement to refer any patients to Medical Center, or any affiliate of Medical Center, to obtain or receive any medical diagnosis, care or treatment from Medical Center, or to purchase any health care related services or products from Medical Center. Neither Medical Center nor Company is entering into this Agreement with an expectation that such patient referrals will occur or develop between Company and Medical Center as a

consequence of this Agreement. Any patient referrals which develop between the parties will be based solely on the medical judgment and discretion of a patient's physician while acting in the best interests of the patient.

IN WITNESS WHEREOF, the undersigned have executed this Agreement as of the day, month and year first above written.

Medical Center

Memorial Medical Center, an
Affiliate of Memorial Health System

By: _____

Name: _____

Title: VICE PRESIDENT - OPERATIONS

Date: 11/23/09

Facility

DVA Renal Healthcare, Inc.

By: _____

Name: Conway Emley

Title: Regional Operations Director

Date: 9-30-2009

APPROVED AS TO FORM ONLY:
DAVITA INC.

By: _____

Name: Steven E. Lieb

Title: Group General Counsel

DaVita.

Casa Nueva
1551 Wewatta Street
Denver, CO 80202-6173
Tel: 303-405-2100
www.davita.com

December 17, 2010

Dale Galassie
Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: In-Center Hemodialysis Assurances

Dear Chairman Galassie:

Pursuant to 77 Ill. Admin. Code § 1110.1430(j), I hereby certify the following:

- By the second year after project completion, Springfield South Dialysis will achieve and maintain 80% target utilization as specified in 77 Ill. Admin. Code; and
- Hemodialysis outcome measures will be achieved and maintained as follows:
  - ≥ 85% of hemodialysis patient population achieves urea reduction ratio (URR) ≥ 65% and
  - ≥ 85% of hemodialysis patient population achieves Kt/V Daugirdas II .1.2

Sincerely,

Kent. J. Thiry
Chief Executive Officer
DaVita, Inc.
Total Renal Care, Inc.

Subscribed and sworn to me
This 17th day of December, 2010

Tara L. Motley
Notary Public

"OFFICIAL SEAL"
Tara L Motley
Notary Public, State of Illinois
My Commission Expires 6/11/2013

Section VIII, Financial Feasibility
Criterion 1120.120 Availability of Funds

The project will be funded with $1,417,261 in cash and securities from DaVita, Inc. and a lease with 2636 South Sixth Street LLC. A copy of DaVita's 2009 10-K Statement, evidencing sufficient funds to finance the project as well as a letter of intent to lease the facility are attached at Attachments – 39A and 39B.

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-K

For the Fiscal Year Ended

December 31, 2009

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

Commission File Number: 1-14106

DAVITA INC.

601 Hawaii Street
El Segundo, California 90245
Telephone number (310) 536-2400

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

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

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

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

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

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

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

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

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

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

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

As of June 30, 2009, the number of shares of the Registrant's common stock outstanding was approximately 104.0 million shares and the aggregate market value of the common stock outstanding held by non-affiliates based upon the closing price of these shares on the New York Stock Exchange was approximately $5.1 billion.

As of January 29, 2010, the number of shares of the Registrant's common stock outstanding was approximately 103.2 million shares and the aggregate market value of the common stock outstanding held by non-affiliates based upon the closing price of these shares on the New York Stock Exchange was approximately $6.2 billion.

Documents incorporated by reference

Portions of the Registrant's proxy statement for its 2010 annual meeting of stockholders are incorporated by reference in Part III of this Form 10-K.

Attachment – 39A

PART I

Item 1. Business

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

Overview

DaVita is a leading provider of dialysis services in the United States for patients suffering from chronic kidney failure, also known as end stage renal disease, or ESRD. As of December 31, 2009, we operated or provided administrative services to 1,530 outpatient dialysis centers located in 43 states and the District of Columbia, serving approximately 118,000 patients. We also provide acute inpatient dialysis services in approximately 720 hospitals and related laboratory services. Our dialysis and related lab services business accounts for approximately 95% of our consolidated net operating revenues. Other ancillary services and strategic initiatives currently account for approximately 5% of our consolidated net operating revenues and relate primarily to our core business of providing renal care services.

The dialysis industry

The loss of kidney function is normally irreversible. ESRD is the stage of advanced kidney impairment that requires continued dialysis treatments or a kidney transplant to sustain life. Dialysis is the removal of toxins, fluids and salt from the blood of ESRD patients by artificial means. Patients suffering from ESRD generally require dialysis at least three times per week for the rest of their lives.

Since 1972, the federal government has provided universal payment coverage for dialysis treatments under the Medicare ESRD program regardless of age or financial circumstances. Under this system, Congress establishes Medicare rates for dialysis treatments, related supplies, lab tests and medications. Approximately 88% of our total patients are under government-based programs, with approximately 80% of our patients under Medicare and Medicare-assigned plans.

ESRD patient base

There are more than 358,000 ESRD dialysis patients in the United States according to the latest information published by the United States Renal Data System. The recent historical compound annual growth rate in the number of ESRD dialysis patients has been approximately 3%-4%. 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.

Treatment options for ESRD

Treatment options for ESRD are dialysis and kidney transplantation.

Dialysis Options

- *Hemodialysis*

Hemodialysis, the most common form of ESRD treatment, is usually performed in outpatient dialysis centers. It may also be done while a patient is at home or while hospitalized. The hemodialysis machine uses an artificial kidney, called a dialyzer, to remove toxins, fluids and salt from the patient's blood. The dialysis process

occurs across a semi-permeable membrane that divides the dialyzer into two distinct chambers. While blood is circulated through one chamber, a pre-mixed fluid is circulated through the other chamber. The toxins, salt and excess fluids from the blood cross the membrane into the fluid, allowing cleansed blood to return into the patient's body. Each hemodialysis treatment that occurs in the outpatient dialysis centers typically lasts approximately three and one-half hours and is usually performed three times per week.

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

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

- *Peritoneal dialysis*

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

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

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

- *Transplantation*

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

Services we provide

Dialysis and Related Lab Services

Outpatient dialysis services

As of December 31, 2009, we operated or provided administrative services to 1,530 outpatient dialysis centers in the United States that are designed specifically for outpatient hemodialysis. In 2009, we added a net total of 81 outpatient dialysis centers primarily as a result of acquisitions and the opening of new centers, net of center closures and divestitures. This represented a total increase of approximately 6% to our overall network of outpatient dialysis centers.

As required by law, we contract with a nephrologist or a group of affiliated nephrologists to provide medical director services at each of our centers. In addition, other nephrologists may apply for practice privileges to treat

their patients at our centers. Each center has an administrator, typically a registered nurse, who supervises the day-to-day operations of the center and its staff. The staff of each center typically consists of registered nurses, licensed practical or vocational nurses, patient care technicians, a social worker, a registered dietician, biomedical technician support and other administrative and support personnel.

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

Under Medicare regulations, we cannot promote, develop or maintain any kind of contractual relationship with our patients which would directly or indirectly obligate a patient to use or continue to use our dialysis services, or which would give us any preferential rights other than those related to collecting payments for our services. Our total patient turnover averages approximately 30% per year. However, in 2009 the overall number of patients that we treated increased by approximately 6%, primarily from continued growth within the industry, lower mortality rates and the opening of new centers and acquisitions.

Hospital inpatient dialysis services

We provide hospital inpatient hemodialysis services, excluding physician services, to patients in approximately 720 hospitals. We render these services for a contracted per-treatment fee that is individually negotiated with each hospital. When a hospital requests our services, we typically administer the dialysis treatment at the patient's bedside or in a dedicated treatment room in the hospital, as needed. Hospital inpatient hemodialysis services are required for patients as discussed above. In 2009, hospital inpatient hemodialysis services accounted for approximately 5% of our total dialysis treatments.

ESRD laboratory services

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

Management services

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

Ancillary services and strategic initiatives

Ancillary services and strategic initiatives, which currently account for approximately 5% of our total consolidated net operating revenues, consist of the following:

- *Pharmacy services.* DaVita Rx is a pharmacy that provides oral medications to DaVita's patients with ESRD. The main objectives of the pharmacy are to improve clinical outcomes by facilitating increased patient compliance and to provide our patients a convenient way to fill their prescription needs. Revenues are recognized as prescriptions are filled and shipped to patients.

- *Infusion therapy services.* HomeChoice Partners provides personalized infusion therapy services to patients typically in their own homes as a cost-effective alternative to inpatient hospitalization. Intravenous and nutritional support therapies are typically managed by registered and/or board-certified professionals including pharmacists, nurses and dieticians in collaboration with the patient's physician in support of the patient's ongoing healthcare needs. Revenues are recognized in the period when infusion therapy services are provided.

- *Disease management services.* VillageHealth provides advanced care management services to health plans and government agencies for employees/members diagnosed with Chronic Kidney Disease (CKD) or ESRD. Through a combination of clinical coordination, medical claims analysis and information technology, we endeavor to assist our customers and patients in obtaining superior renal health care and improved clinical outcomes, as well as helping to reduce overall medical costs. Revenues are typically based upon an established contract fee and are recognized as earned over the contract period and can include additional fees for cost savings recognized by certain customers. VillageHealth also provided full service health care plans for ESRD patients during 2009 and 2008. As of December 31, 2009, VillageHealth discontinued providing full service health care plans for ESRD patients.

- *Vascular access services.* Lifeline provides management and administrative services to physician-owned vascular access clinics that provide surgical and interventional radiology services for dialysis patients. Lifeline also is the majority-owner of one vascular access clinic. Management fees generated from providing management and administrative services are recognized as earned typically based on a percentage of revenues or cash collections generated by the clinics. Revenues associated with the vascular access clinic that is majority-owned are recognized in the period when physician services are provided.

- *ESRD clinical research programs.* DaVita Clinical Research conducts research trials principally with dialysis patients and provides administrative support for research conducted by DaVita-affiliated nephrology practices. Revenues are based upon an established fee per study, as determined by contract with drug companies and other sponsors and are recognized as earned according to the contract terms.

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

Quality care

We believe our reputation for providing quality care is a key factor in attracting patients and physicians and in securing contracts with healthcare plans. We engage in organized and systematic efforts through our quality management programs to monitor and improve the quality of services we deliver. These efforts include the development and implementation of patient care policies and procedures, clinical education and training programs, education and mentoring related to our clinical guidelines and protocols and audits of the quality of services rendered at each of our centers.

We employ over 160 clinical service specialists. The primary focus of this group is assuring and facilitating processes that aim to achieve superior clinical outcomes at our facilities. Our physician leadership in the Office of the Chief Medical Officer (OCMO) includes five senior nephrologists, led by our Chief Medical Officer, with a variety of academic, clinical practice, and clinical research backgrounds. Our Physician Council is an advisory body to senior management, composed of seven physicians with extensive experience in clinical practice in addition to the members of OCMO and five Group Medical Directors. The Physician Council and Group Medical Directors represent both private and academic centers. The Physician Council provides strategic input regarding the outcomes of current clinical programs and on new programs that should be considered for development.

Sources of revenue—concentrations and risks

Our dialysis and related lab services business revenues represent 95% of our total consolidated net operating revenues with the balance of our revenues from ancillary services and strategic initiatives. Dialysis and related lab services revenues are derived from providing dialysis treatments, the administration of pharmaceuticals, related laboratory services and management fees generated from providing management and administrative services to certain outpatient dialysis centers.

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

The following table summarizes our dialysis and related lab services revenues by source for the year ended December 31, 2009:

	Revenue percentages
Medicare and Medicare-assigned plans	57%
Medicaid and Medicaid-assigned plans	6%
Other government-based programs	2%
Total government-based programs	65%
Commercial (including hospital inpatient dialysis services)	35%
Total dialysis and related lab services revenues	100%

The following table summarizes our dialysis and related lab services revenues by modality for the year ended December 31, 2009:

	Revenue percentages
Outpatient hemodialysis centers	84%
Peritoneal dialysis and home-based hemodialysis	11%
Hospital inpatient hemodialysis	5%
Total dialysis and related lab services revenues	100%

Medicare revenue

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

ESRD patients receiving dialysis services become eligible for primary Medicare coverage at various times, depending on their age or disability status, as well as whether they are covered by an employer group health plan.

Generally, for a patient not covered by an employer group health plan, Medicare becomes the primary payor either immediately or after a three-month waiting period. For a patient covered by an employer group health plan, Medicare generally becomes the primary payor after 33 months, which includes a three month waiting period, or earlier if the patient's employer group health plan coverage terminates. When Medicare becomes the primary payor, the payment rate we receive for that patient shifts from the commercial insurance plan rate to the Medicare payment rate.

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

The Medicare composite payment rates set by Congress for dialysis treatments that were in effect for 2009 were between $150 and $167 per treatment, with an average rate of $159 per treatment. Medicare payment rates for dialysis services, historically, have not been routinely increased to compensate for the impact of inflation, which negatively impacts our margins as patient care costs continue to rise. In July 2008, the Medicare Improvements for Patients and Providers Act for 2008, or MIPPA, was passed by Congress. The legislation provided for an increase in the composite rate of 1% which went into effect on January 1, 2009 and an additional 1% which went into effect on January 1, 2010. MIPPA also introduced a new payment system for dialysis services which in part provides for a new single bundled payment rate which, as currently proposed, would be adjusted annually for inflation based upon a market basket index, less 1% of such index, beginning in 2012.

The new payment system for dialysis services under MIPPA begins in January 2011 and provides that ESRD payments will be made under a bundled payment rate which will provide for a fixed rate for all goods and services provided during the dialysis treatment. On September 15, 2009, the Centers for Medicare and Medicaid Services, or CMS, released the proposed rule regarding the new bundled payment rate system. The initial 2011 bundled rate is required to be set based on a 2% reduction in the payment rate that providers would have received under the historical fee for service payment methodology and based on the lowest average industry pharmaceutical utilization from 2007 to 2009. Among other things, the proposed rule requires dialysis facilities to provide certain oral medications but does not provide funding sufficient to cover our costs for those medications. In addition, all laboratory tests ordered by nephrologists would be included in the bundle, whether or not the laboratory tests are related to the ESRD treatment, without funding sufficient to cover our costs for those tests. The proposed rule also includes an expanded list of case-mix adjustors, many of which may be difficult or impossible for dialysis clinics to track, consequently reducing the payment rate for ESRD treatments. The proposed rule also introduced a transition adjustment that would reduce payments to providers by 3%. The combined effect of the adjustments provided in the proposed rule would result in a bundled rate that represents a significantly greater than 2% reduction in the payment rate that we would have received for our services prior to bundling. Also, beginning in 2012, the proposed rule provides that 2% of payments due to providers will be set aside subject to provider satisfaction of certain quality standards. A failure to achieve the required quality standards will result in the forfeiture of the 2% reserve. Dialysis providers have the option to move fully to the bundled payment system in 2011 or to phase in the payment system over three years. If the new bundled payment rate system is implemented as proposed, it could have a material adverse effect on our revenues, earnings and cash flows.

We participate in two Medicare demonstration programs through a contract with CMS. One program is an ESRD demonstration program that started in January 2006. It was originally contracted for a four year term and the term was extended by one year in 2009 until December 2010. The revenue is capitated for all medical services required by enrollees in the program. We are at risk for all medical costs of the program in excess of the capitation payments. The other program is a CKD/ESRD demonstration program which started in November 2008 and will continue for three years. We are paid a management fee for program enrollees relating to CKD and ESRD disease states. Management fee revenues are subject to retraction if medical cost savings targets are not met.

Medicaid revenue

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

Commercial revenues

Before Medicare becomes the primary payor, a patient's commercial insurance plan, if any, is responsible for payment of the dialysis services provided. Although commercial payment rates vary significantly, average commercial payment rates are generally significantly higher than Medicare rates. The payments we receive from commercial payors generate nearly all of our profits. Payment methods from commercial payors include a single lump-sum per treatment, referred to as bundled rates and separate payments for treatments and pharmaceuticals, if used as part of the treatment, referred to as fee for service rates. Commercial payment rates are typically the result of negotiations between us and insurers or third-party administrators, but also include non-contracted or out-of-network payment rates as well. Our out-of-network payment rates are on average higher than in-network payment rates. We are continuously in the process of negotiating agreements with our commercial payors and if our negotiations result in overall commercial rate reductions in excess of our commercial rate increases, our revenues and operating results could be negatively impacted. In addition, if there are sustained or increased job losses in the United States as a result of current economic conditions, or depending upon changes to the healthcare regulatory system, we could experience a decrease in the number of patients under commercial plans.

Approximately 35% of our dialysis and related lab services revenues and 12% of our patients were associated with commercial payors for the year ended December 31, 2009. Less than 1% of our dialysis and related lab services payments are due directly from patients. No single commercial payor accounted for more than 5% of total dialysis and related lab services revenues for the year ended December 31, 2009.

Revenue from EPO and other pharmaceuticals

Approximately 30% of our total dialysis and related lab services revenues for the year ended December 31, 2009 are associated with the administration of physician-prescribed pharmaceuticals that improve clinical outcomes when included with the dialysis treatment. These pharmaceuticals include EPO, vitamin D analogs and iron supplements.

EPO is an erythropoiesis stimulating agent, or ESA, genetically engineered form of a naturally occurring protein that stimulates the production of red blood cells. EPO is used in connection with all forms of dialysis to treat anemia, a medical complication most ESRD patients experience. The administration of EPO, which is currently separately billable under the Medicare payment program until January 1, 2011, at which time it will be included as part of the new bundled payment rate, accounted for approximately 20% of our dialysis and related lab services revenues for the year ended December 31, 2009. Changes in the levels of physician-prescribed EPO and commercial and government payment rates related to EPO can significantly influence our revenues and operating income.

Furthermore, EPO is produced by a single manufacturer, Amgen, which can unilaterally increase its price for EPO at any time during the term of our agreement with them. Any interruption of supply or product cost increases could adversely affect our operations. In 2009, we experienced an increase in the cost of EPO of approximately 2%. Our agreement with Amgen also provides for specific rebates based on a combination of factors, including process improvement and data submission.

In the past there has been significant government scrutiny regarding anemia management practices for ESRD patients in the United States, initially prompted by risks identified in certain patient populations that utilize EPO and similar pharmaceuticals. Following congressional hearings, the FDA required warning labels for EPO and Aranesp®, an ESA also produced by Amgen, and CMS changed EPO reimbursement amounts and payment coverage policies which impacted the prescribing habits of our physicians and which has in the past and may in the future result in lower pharmaceutical intensities. The FDA held additional hearings to revisit these label changes as they apply to ESRD and has indicated that they will convene in 2010 to further review ESA labeling. In addition, HHS and CMS have given notice that a meeting of the Medicare Evidence Development & Coverage Advisory Committee, or MedCAC, will be convened on March 24, 2010 to review policies around the administration of ESAs, including, among other things, an evaluation of the efficacy of certain hemoglobin targets in CKD patients. These meetings could result in further restrictions on the utilization and reimbursement for ESAs which could result in decreased EPO utilization. Practice guidelines may continue to change as anemia management practices are scrutinized. Even though we believe our anemia management practices have been compliant with existing laws and regulations, we may be subject to further inquiries from a variety of government bodies as these payment policies and practicing guidelines evolve.

Physician relationships

An ESRD patient generally seeks treatment at an outpatient dialysis center near his or her home and at which his or her treating nephrologist has practice privileges. Our relationships with local nephrologists and our ability to meet their needs and the needs of their patients are key factors in the success of our outpatient dialysis centers. Over 3,400 nephrologists currently refer patients to our dialysis centers. As is typical in the dialysis industry, one or a few physicians, including the dialysis center's medical director, usually account for all or a significant portion of a dialysis center's patient referral base. Our medical directors provide a substantial portion of our patient referrals. If a significant number of physicians were to cease referring patients to our dialysis centers, our business could be adversely affected.

Participation in the Medicare ESRD program requires that dialysis services at an outpatient dialysis center be under the general supervision of a medical director who is a licensed physician. We have engaged physicians or groups of physicians to serve as medical directors for each of our dialysis centers. At some dialysis centers, we also separately contract with one or more physicians to serve as assistant or associate medical directors or to direct specific programs, such as home dialysis training programs. We have contracts with approximately 1,300 individual physicians and physician groups to provide medical director services.

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

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

Government regulation

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

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

- Loss or suspension of federal certifications;
- Loss or suspension of licenses under the laws of any state or governmental authority from which we generate substantial revenues;
- Exclusion from government healthcare programs including Medicare and Medicaid;
- Significant reductions or lack of inflation-adjusted increases in payment rates or reduction of coverage for dialysis and ancillary services and related pharmaceuticals;
- Fines, damages and monetary penalties for anti-kickback law violations, Stark Law violations, submission of false claims, civil or criminal liability based on violations of law or other failures to meet regulatory requirements;
- Claims for monetary damages from patients who believe their protected health information has been used or disclosed in violation of federal and state patient privacy laws;
- Government mandated practice changes that significantly increase operating expenses; or
- Refunds of payments received from government payors and government health care program beneficiaries because of any failures to meet applicable requirements.

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

Licensure and Certification

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

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

CMS continues to study the regulations applicable to Medicare certification to provide dialysis services. On April 15, 2008, CMS issued new regulations for Medicare certified ESRD facilities to provide dialysis services, referred to as Conditions for Coverage. The Conditions for Coverage were effective October 14, 2008, with some

provisions having a phased in implementation date of February 1, 2009. The new regulations are patient, quality and outcomes focused. Among other things, they establish performance expectations for facilities and staff, eliminate certain procedural requirements, and promote continuous quality improvement and patient safety measures. We have established an interdisciplinary work group to facilitate implementation of the Conditions of Coverage and have developed comprehensive auditing processes to monitor ongoing compliance. We continue to assess the impact these changes will have on our operating results.

Federal anti-kickback statute

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

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

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

The Department of Health and Human Services regulations create exceptions or "safe harbors" for some business transactions and arrangements. Transactions and arrangements structured within these safe harbors are deemed to not violate the anti-kickback statute. A business transaction or arrangement must satisfy every element of a safe harbor to be protected by that safe harbor. Transactions and arrangements that do not satisfy all elements of a relevant safe harbor do not necessarily violate the statute, but can be subject to greater scrutiny by enforcement agencies.

Our medical directors refer patients to our centers and these arrangements, by which we pay them for their medical director services, must be in compliance with the federal anti-kickback statute. Among the available safe harbors is one for personal services furnished for fair market value. However, most of our agreements with our medical directors do not satisfy all seven of the requirements of the personal services safe harbor. We believe that because of the nature of our medical directors' duties, it is impossible to satisfy the anti-kickback safe-harbor requirement that if the services provided under the agreement are on a part-time basis, as they are with our medical directors, the agreement must specify the schedule of intervals of service, their precise length and the exact charge for such intervals. Accordingly, while we believe that our agreements with our medical directors satisfy as many of the elements of this safe harbor as we believe is reasonably possible, our arrangements do not qualify for safe harbor protection. We also note that there is little guidance available as to what constitutes fair market value for medical director services. We believe, however, that our agreements do not violate the federal anti-kickback statute; however, since the arrangements do not satisfy all of the requirements for safe harbor protection, these arrangements could be challenged.

We own a controlling interest in numerous dialysis related joint ventures, which represented approximately 16% of our dialysis and related lab services revenues. In addition, we also own equity investments in several other dialysis related joint ventures. Our relationships with physicians and other referral sources relating to these joint ventures are required to comply with the anti-kickback statute. Although there is a safe harbor for certain

investment interests in "small entities," it is not clear if any of our joint ventures satisfies all of the requirements for protection by this safe harbor. Under current law, physician joint ventures are not prohibited but instead require a case-by-case evaluation under the anti-kickback statute. We have structured our joint ventures to satisfy as many safe harbor requirements as we believe are reasonably possible and we believe that these investments are offered on a fair market value basis and provide returns to the physician investors only in proportion to their actual investment in the venture. We believe that our agreements do not violate the federal anti-kickback statute; however, since the arrangements do not satisfy all of the requirements for safe harbor protection, these arrangements could be challenged.

We lease space for approximately 470 of our centers from entities in which physicians hold ownership interests and we sublease space to referring physicians at approximately 170 of our dialysis centers. These arrangements must be in compliance with the anti-kickback statute. We believe that we meet the elements of the safe harbor for space rentals in all material respects.

Some medical directors and other referring physicians may own our common stock. We believe that these interests materially satisfy the requirements of the safe harbor for investments in large publicly traded companies for the anti-kickback statute.

Because we are purchasing and selling items and services in the operation of our centers that may be paid for, in whole or in part, by Medicare or a state healthcare program and because we acquire certain items and services at a discount, we must structure these arrangements in compliance with the federal anti-kickback statute. Subject to certain requirements and limitations, discounts representing reductions in the amounts we are charged for items or services based on arm's-length transactions can qualify for safe harbor protection if we fully and accurately report the discounts in the applicable Medicare cost reports. While some of the safe harbor criteria are subject to interpretation, we believe that our vendor contracts with discount provisions are in compliance with the anti-kickback statute.

Stark Law

Another federal law, known as the "Stark Law", prohibits a physician who has a financial relationship, or who has an immediate family member who has a financial relationship, with entities providing designated health services, or DHS, from referring Medicare patients to such entities for the furnishing of such services, unless an exception applies. Stark Law DHS include home health services, outpatient prescription drugs, inpatient and outpatient hospital services and clinical laboratory services. The Stark Law also prohibits the DHS entity receiving a prohibited referral from filing a claim or billing for the services arising out of the prohibited referral. The prohibition applies regardless of the reasons for the financial relationship and the referral; unlike the federal anti-kickback statute, intent to induce referrals is not required. Sanctions for violation of the Stark Law include denial of payment for claims for services provided in violation of the prohibition, refunds of amounts collected in violation, a civil penalty of up to $15,000 for each service arising out of the prohibited referral, exclusion from the federal healthcare programs, including Medicare and Medicaid and a civil penalty of up to $100,000 against parties that enter into a scheme to circumvent the Stark Law prohibition. Stark Law violations also can form the basis for False Claims Act liability. The types of financial arrangements between a physician and a DHS entity that trigger the self-referral prohibitions of the Stark Law are broad and include direct and indirect ownership and investment interests and compensation arrangements.

CMS has adopted implementing regulations under the Stark Law collectively, Stark Regulations. CMS has not yet adopted implementing regulations regarding application of the Stark Law to Medicaid, but has indicated that it anticipates issuing additional regulations regarding the application of the Stark Law to Medicaid referrals.

The definition of DHS under the Stark Law excludes services paid under a composite rate, even if some of the components bundled in the composite rate are DHS. Since most services furnished to Medicare beneficiaries provided in our dialysis centers are reimbursed through a composite rate, the services performed in our facilities generally are not DHS, and the Stark Law referral prohibition does not apply to those services. The definition of

DHS also excludes inpatient dialysis performed in hospitals that are not certified to provide ESRD services. Consequently, our arrangements with such hospitals for the provision of dialysis services to hospital inpatients do not trigger the Stark Law referral prohibition.

In addition, although prescription drugs are DHS, there is an exception in the Stark Regulations for EPO and other specifically enumerated dialysis drugs when furnished in or by an ESRD facility, in compliance with the anti-kickback statute and applicable billing requirements. The exception is available only for drugs included on a list of CPT/HCPCS codes published by CMS, and in the case of home dialysis, the exception applies only to EPO, Aranesp® and equivalent drugs dispensed by the facility for use at home. While we believe that most drugs furnished by our dialysis centers are covered by the exception, dialysis centers may administer drugs that are not on the list of CPT/HCPCS codes and therefore do not meet this exception. In order for a physician who has a financial relationship with a dialysis center to order one of these drugs from the center and for the center to obtain Medicare reimbursement, another exception must apply.

We have entered into several types of financial relationships with referring physicians, including compensation arrangements. We believe that the compensation arrangements under our medical director agreements satisfy the personal services compensation arrangement exception to the Stark Law. While we believe that compensation under our medical director agreements, which is the result of arm's length negotiations, results in fair market value payments for medical director services, an enforcement agency could nevertheless challenge the level of compensation that we pay our medical directors. If the arrangement does not meet a Stark Law exception, we could in the future be required to change our practices, face civil penalties, pay substantial fines, return certain payments received from Medicare and beneficiaries or otherwise experience a material adverse effect as a result of a challenge to payments made pursuant to referrals from these physicians under the Stark Law.

Some of our dialysis centers are leased from entities in which referring physicians hold interests and we sublease space to referring physicians at some of our dialysis centers. The Stark Law provides an exception for lease arrangements if specific requirements are met. We believe that our leases and subleases with referring physicians satisfy the requirements for this exception.

Some medical directors and other referring physicians may own our common stock. We believe that these interests satisfy the Stark Law exception for investments in large publicly traded companies.

Some of our referring physicians also own equity interests in entities that operate our dialysis centers. None of the Stark Law exceptions applicable to physician ownership interests in entities to which they make DHS referrals applies to the kinds of ownership arrangements that referring physicians hold in several of our subsidiaries that operate dialysis centers. Accordingly, these dialysis centers cannot bill Medicare for DHS referrals from physician owners. If the dialysis centers bill for DHS referred by physician owners, the dialysis center would be subject to the Stark Law penalties described above.

While we believe that most of our operations do not implicate the Stark Law, and that to the extent that our dialysis centers furnish DHS, they either meet an exception or do not bill for services that do not meet a Stark Law exception, if CMS determined that we have submitted claims in violation to the Stark Law, we would be subject to the penalties described above. In addition, it might be necessary to restructure existing compensation agreements with our medical directors and to repurchase or to request the sale of ownership interests in subsidiaries and partnerships held by referring physicians or, alternatively, to refuse to accept referrals for DHS from these physicians. Any such penalties and restructuring could have a material adverse effect on our operations.

If any of our business transactions or arrangements, including those described above, were found to violate the federal anti-kickback statute of Stark Law, we could face criminal, civil or administrative sanctions, including possible exclusion from participation in Medicare, Medicaid and other state and federal healthcare programs. Any findings that we have violated these laws could have a material adverse impact on our earnings.

Fraud and abuse under state law

Many states in which we operate dialysis centers have statutes prohibiting physicians from holding financial interests in various types of medical facilities to which they refer patients. Some of these statutes could be interpreted as prohibiting physicians who hold shares of our publicly traded stock from referring patients to our dialysis centers if the centers use our laboratory subsidiary to perform laboratory services for their patients. Some states also have laws similar to the federal anti-kickback statute that may affect our ability to receive referrals from physicians with whom we have financial relationships, such as our medical directors. Some state anti-kickback statutes also include civil and criminal penalties. Some of these statutes include exemptions applicable to our medical directors and other physician relationships or for financial interests limited to shares of publicly traded stock. Some, however, include no explicit exemption for medical director services or other services for which we contract with and compensate referring physicians or for joint ownership interests of the type held by some of our referring physicians or for financial interests limited to shares of publicly traded stock. If these statutes are interpreted to apply to referring physicians with whom we contract for medical director and similar services, to referring physicians with whom we hold joint ownership interests or to physicians who hold interests in DaVita limited solely to publicly traded stock, we may be required to terminate or restructure some or all of our relationships with or refuse referrals from these referring physicians and could be subject to civil and administrative sanctions, refund requirements and exclusions from government healthcare programs, including Medicare and Medicaid. Such events could negatively affect the decision of referring physicians to refer patients to our centers.

The False Claims Act

The federal False Claims Act, or FCA, is a means of policing false bills or false requests for payment in the healthcare delivery system. In part, the FCA authorizes the imposition of up to three times the government's damages and civil penalties on any person who:

- Knowingly presents or causes to be presented to the federal government, a false or fraudulent claim for payment or approval;
- Knowingly makes, uses or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the federal government;
- Conspires to defraud the federal government by getting a false or fraudulent claim allowed or paid; or
- Knowingly makes, uses or causes to be made or used, a false record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the federal government.

In addition, recent 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 accelerate 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.

The penalties for a violation of the FCA range from $5,500 to $11,000 for each false claim plus three times the amount of damages caused by each such claim. The federal government has used the FCA to prosecute a wide variety of alleged false claims and fraud allegedly perpetrated against Medicare and state healthcare programs, including coding errors, billing for services not rendered, the submission of false cost reports, billing for services at a higher payment rate than appropriate, billing under a comprehensive code as well as under one or more component codes included in the comprehensive code and billing for care that is not considered medically necessary. Although still subject to dispute, several courts have also determined that a violation of the federal anti-kickback statute can form the basis for liability under the FCA, and filing claims or failing to refund amounts collected in violation of the Stark Law can form the basis for liability under the FCA. In addition to the

provisions of the FCA, which provide for civil enforcement, the federal government can use several criminal statutes to prosecute persons who are alleged to have submitted false or fraudulent claims for payment to the federal government.

The Health Insurance Portability and Accountability Act of 1996

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 (HITECH Act) (collectively referred to as HIPAA), requires us to provide certain protections to patients and their health information (Protected Health Information, or PHI). HIPAA requires us to afford patients certain rights regarding their PHI, and to limit uses and disclosure of their PHI existing in any media form (electronic and hardcopy). HIPAA also requires us to implement administrative, physical, and technical safeguards with respect to electronic PHI. We believe our HIPAA Privacy and Security Program sufficiently addresses HIPAA requirements.

Other regulations

Our operations are subject to various state hazardous waste and non-hazardous medical waste disposal laws. These laws do not classify as hazardous most of the waste produced from dialysis services. Occupational Safety and Health Administration regulations require employers to provide workers who are occupationally subject to blood or other potentially infectious materials with prescribed protections. These regulatory requirements apply to all healthcare facilities, including dialysis centers, and require employers to make a determination as to which employees may be exposed to blood or other potentially infectious materials and to have in effect a written exposure control plan. In addition, employers are required to provide or employ hepatitis B vaccinations, personal protective equipment and other safety devices, infection control training, post-exposure evaluation and follow-up, waste disposal techniques and procedures and work practice controls. Employers are also required to comply with various record-keeping requirements. We believe that we are in material compliance with these laws and regulations.

A few states have certificate of need programs regulating the establishment or expansion of healthcare facilities, including dialysis centers. We believe that we are in material compliance with all applicable state certificate of need laws.

Corporate compliance program

We have implemented a company-wide corporate compliance program as part of our commitment to comply with all applicable laws and regulations and to maintain the high standards of conduct we expect from all of our teammates. We continuously review this program and enhance it as necessary. The primary purposes of the program include:

- Increasing, through training and education, the awareness of our teammates and affiliated professionals of the necessity of complying with all applicable laws and regulations in an increasingly complicated regulatory environment;
- Auditing and monitoring the activities of our dialysis centers, laboratories and billing offices on a regular basis to identify potential instances of noncompliance in a timely manner; and
- Ensuring that we take steps to resolve instances of noncompliance or to address areas of potential noncompliance as promptly as we become aware of them.

When evaluating the effectiveness of our corporate compliance program, we take into consideration a number of factors, including favorable results under various government inquiries and adherence to industry standards.

We have a code of conduct that each of our teammates and affiliated professionals must follow and we have a confidential toll-free hotline (888-458-5848) for teammates and patients to report potential instances of noncompliance. Our Chief Compliance Officer administers the compliance program. The Chief Compliance Officer reports directly to our Chief Executive Officer, our Chief Operating Officer and to the Compliance Committee of our Board of Directors.

Corporate Integrity Agreement

On December 1, 2004, Gambro Healthcare, Inc, which we acquired in October 2005, entered into a settlement agreement with the Department of Justice and other agencies of the United States government relating to the Department of Justice's investigation of Gambro Healthcare's Medicare and Medicaid billing practices and its relationships with physicians and pharmaceutical manufacturers. In connection with the settlement agreement, Gambro Healthcare, without admitting liability, entered into a five-year corporate integrity agreement with the Office of the Inspector General, U.S. Department of Health and Human Services, or OIG. The centers we acquired from Gambro Healthcare were subject to the corporate integrity agreement. The corporate integrity agreement expired by its own terms on November 30, 2009. We submitted our final annual report to the OIG on January 14, 2010. On February 16, 2010, we were informed by the OIG that it has reviewed our final annual report and determined that DVA Renal Healthcare (formerly Gambro Healthcare) complied with the terms of the corporate integrity agreement during the final reporting period and that the Fifth Annual Report is complete. The five year term of the corporate integrity agreement has now concluded and DVA Renal Healthcare is no longer subject to its terms.

Insurance

We maintain insurance for property and general liability, professional liability, directors' and officers' liability, workers compensation and other coverage in amounts and on terms deemed adequate by management based on our claims experience and expectations for future claims. Future claims could, however, exceed our applicable insurance coverage. Physicians practicing at our dialysis centers are required to maintain their own malpractice insurance and our medical directors are required to maintain coverage for their individual private medical practices. Our liability policies cover our medical directors for the performance of their duties as medical directors.

Capacity and location of our centers

We are able to increase our capacity by extending hours at our existing centers, expanding our existing centers, relocating our centers, developing new centers and by acquiring centers. The development of a typical outpatient center by us generally requires approximately $2.0 million for leasehold improvements, equipment and first-year working capital. Based on our experience, a new center typically opens within a year after the property lease is signed, normally achieves operating profitability in the second year after certification and normally reaches maturity within three to five years. Acquiring an existing center requires a substantially greater initial investment, but profitability and cash flow are generally initially more predictable. To a limited extent, we enter into agreements to provide management and administrative services to dialysis centers in which we either own an equity investment, or are wholly-owned by third parties in return for management fees, which are typically based on a percentage of revenues or cash collections of the managed operations.

The table below shows the growth of our Company by number of dialysis centers.

	2009	2008	2007	2006	2005
Number of centers at beginning of year	1,449	1,359	1,300	1,233	658
Acquired centers	19	20	16	26	609(1)
Developed centers	78	86	64	55	46
Net change in centers with management and administrative services agreements*	8(4)	1	(15)(3)	—	4(1)
Divested and closed centers	(8)	(9)	(4)	(5)(2)	(72)(1)
Merged into existing center**	(16)	(8)	(2)	(9)	(12)
Number of centers at end of year	1,530	1,449	1,359	1,300	1,233

(1) 566 centers were added, including 11 centers under management and administrative services agreements, as a result of the DVA Renal Healthcare acquisition and 74 centers were divested in connection with this acquisition, including three centers under management and administrative services agreements.

(2) Three centers were divested in connection with the acquisition of DVA Renal Healthcare.

(3) In November 2007, one of our management and administration service agreements was terminated, in which we provided management and administrative services to 20 dialysis centers.

(4) During 2009, we made equity investments in 6 centers and we entered into 2 additional management and administrative service agreements.

* Represents dialysis centers in which we either own an equity investment, or are wholly-owned by third parties.

** Represents dialysis centers that were closed and the majority of patients were retained and transferred to other existing dialysis centers.

As of December 31, 2009, we operated or provided administrative services to 1,530 outpatient dialysis centers, of which 1,498 are consolidated in our financial statements. Of the remaining 32 dialysis centers, we own an equity investment in 15 centers and provide management and administrative services to 17 dialysis centers that are wholly-owned by third parties. The locations of the 1,498 dialysis centers consolidated in our financial statements at December 31, 2009 were as follows:

State	Centers	State	Centers	State	Centers
California	185	New York	33	Nebraska	13
Florida	130	Indiana	32	Wisconsin	13
Texas	121	Oklahoma	30	Massachusetts	12
Georgia	97	Colorado	28	Arkansas	9
Ohio	66	Kentucky	26	District of Columbia	9
Pennsylvania	62	Louisiana	25	Idaho	8
North Carolina	57	Arizona	23	Utah	4
Virginia	55	New Jersey	23	Mississippi	3
Michigan	52	South Carolina	22	New Mexico	3
Maryland	49	Washington	20	South Dakota	3
Illinois	48	Connecticut	19	West Virginia	3
Minnesota	38	Kansas	18	Delaware	2
Alabama	37	Nevada	16	North Dakota	2
Tennessee	36	Iowa	15	New Hampshire	1
Missouri	35	Oregon	15		

Competition

The dialysis industry is highly competitive, particularly in terms of acquiring existing dialysis centers. We continue to face increased competition in the dialysis industry from large and medium-sized providers which compete directly with us for the acquisition of dialysis businesses, relationships with physicians to act as medical directors and for individual patients. Acquisitions and patient retention are an important part of our growth strategy and our business could be adversely affected if we are not able to continue to make acquisitions on reasonable terms or if we face significant patient attrition to our competitors. Competition for qualified physicians to act as medical directors and for inpatient dialysis services agreements with hospitals is also intense. Occasionally, we have also experienced competition from former medical directors or referring physicians who have opened their own dialysis centers. In addition, we experience competitive pressures in connection with negotiating contracts with commercial healthcare payors.

The two largest dialysis companies, Fresenius Medical Care, or Fresenius, and our company, account for approximately 62% of outpatient dialysis patients in the United States. Approximately 42% of the centers not

owned by us or Fresenius are owned or controlled by hospitals or non-profit organizations. Hospital-based and non-profit dialysis units typically are more difficult to acquire than physician-owned centers. 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.

Fresenius also manufactures a full line of dialysis supplies and equipment in addition to owning and operating dialysis centers. This may give them cost advantages over us because of their ability to manufacture their own products. Fresenius has been one of our largest suppliers of dialysis products. In January 2010, we entered into an agreement with Fresenius which committed us to purchase a certain amount of dialysis equipment, parts and supplies from them through 2013. In addition, in August 2006, we also entered into a product supply agreement with Gambro Renal Products that requires us to purchase a certain amount of our hemodialysis non-equipment product supplies, such as dialyzers, at fixed prices through 2015. Our purchases of products in the categories generally offered by Fresenius and Gambro Renal Products represent approximately 4% of our total operating expenses. During 2009, we purchased hemodialysis products and supplies from Gambro Renal Products representing approximately 2% of our total operating expenses.

Teammates

As of December 31, 2009, we had approximately 34,000 teammates:

• Licensed professional staff (nurses, dieticians and social workers)	14,000
• Other patient care and center support staff and laboratory personnel	15,000
• Corporate, billing and regional administrative staff	5,000

Our dialysis business requires nurses with specialized training for patients with complex care needs. Recruitment and retention of nurses are continuing concerns for healthcare providers generally because of the disparity between the supply and demand for nurses, which has led to a nursing shortage. We have an active program of investing in our professional healthcare teammates to help ensure we meet our recruitment and retention targets, including expanded training opportunities, tuition reimbursements and other incentives.

Item 1A. Risk Factors.

This Annual Report on Form 10-K contains statements that are forward-looking statements within the meaning of the federal securities laws. These statements involve known and unknown risks and uncertainties including the risks discussed below. The risks discussed below are not the only ones facing our business. Please read the cautionary notice regarding forward-looking statements in Item 7 under the heading "Management's Discussion and Analysis of Financial Condition and Results of Operation".

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 35% of our dialysis and related lab services revenues for the year ended December 31, 2009 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 agreements with our commercial payors, and payors are aggressive in their negotiations with us. In the event that our continued 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. We expect that some of our contracted rates with commercial payors may decrease or that we may experience decreases in patient volume as our negotiations with commercial payors continue. In addition to increasing 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. Commercial payors may restructure their benefits to create disincentives for patients to select or remain with out-of-network providers or may decrease payment rates for out-of-network providers. We, along with others in the kidney care community, are resisting attempts to limit access to out-of-network providers through regulatory, legislative and legal means. Decreases in out-of-network rates and restrictions on out-of-network access combined with decreases in contracted rates could result in a significant decrease in our overall revenue derived from commercial payors. 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.

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, 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 as a result of improved mortality and the current economic recession which has 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 United States as a result of current economic conditions, we could experience a decrease in the number of patients 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. In addition, our continued negotiations with commercial payors 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. 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 implementation of a bundled payment system under MIPPA and other healthcare reform initiatives, could substantially reduce our revenues, earnings and cash flows.

Approximately one-half of our dialysis and related lab services revenues for the year ended December 31, 2009 was generated from patients who have Medicare as their primary payor. Currently, the Medicare ESRD program pays us for dialysis treatment services at a fixed composite rate. The Medicare composite rate is 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, are separately billed.

In July 2008, MIPPA was passed by Congress. This legislation introduced a new payment system for dialysis services beginning in January 2011 whereby ESRD payments will be made under a bundled payment rate which will provide for a fixed rate for all goods and services provided during the dialysis treatment. On September 15, 2009, CMS released the proposed rule regarding the new bundled payment rate system. If the new bundled payment rate system is implemented as proposed, it could have a material adverse effect on our revenues, earnings and cash flows. The initial 2011 bundled rate is required to be set based on a 2% reduction in the payment rate that providers would have received under the historical fee for service payment methodology and based on the lowest average industry pharmaceutical utilization from 2007 to 2009. Among other things, the proposed rule requires dialysis facilities to provide certain oral medications but does not provide funding sufficient to cover our costs for those medications. In addition, all laboratory tests ordered by nephrologists would be included in the bundle, whether or not the laboratory tests are related to ESRD treatment, without funding sufficient to cover our costs for those tests. The proposed rule also includes an expanded list of case-mix adjustors, many of which may be difficult or impossible for dialysis clinics to track, consequently reducing the payment rate for ESRD treatments. The proposed rule also introduced a transition adjustment that would reduce payments to providers by 3%. The combined effect of the adjustments provided in the proposed rule would result in a bundled rate that represents a significantly greater than 2% reduction in the payment rate that we would have received for our services prior to bundling. The proposed rule also requires the new single bundled payment base rate to be adjusted annually for inflation based upon a market basket index, less 1% of such index, beginning in 2012. Also, beginning in 2012, the proposed rule provides that 2% of payments due to providers will be set aside subject to provider satisfaction of certain quality standards. A failure to achieve the required quality standards will result in the forfeiture of the 2% reserve. Dialysis providers have the option to move fully to the bundled payment system in 2011 or to phase in the payment system over three years. Because the bundled rates that will take effect in 2011 have not been set, we cannot predict whether we will be able to reduce our operating costs at a level that will offset any reduction in overall reimbursement for services we provide to Medicare patients. In addition, we experience 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. To the extent the Medicare bundled rates are established at levels that result in lower overall reimbursement for services we provide to Medicare patients, it could have a material adverse effect on our revenues, earnings and cash flows. We also cannot predict whether we will be able to implement the requirements of the final rule within the time frames set in the final rule or whether we will be able to satisfy our Medicare and Medicaid regulatory compliance obligations as processes and systems are modified to comply with the final rule.

In addition, ongoing public policy debates regarding healthcare reform and the extension of coverage to uninsured individuals has recently intensified. While we cannot predict whether the federal government will

enact changes to the healthcare regulatory system in response to the current debate or the potential impact of any such changes, to the extent that any changes to the current healthcare regulatory system result 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.

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

Approximately 15% of our dialysis and related lab services revenues for the year ended December 31, 2009, was generated from patients who have state Medicaid or other non-Medicare government-based programs, such as Medicare-assigned plans or the Veterans Health Administration, as their primary coverage. As state governments and governmental organizations face increasing budgetary pressure, they may propose reductions in payment rates, delays in the timing of payments, limitations on eligibility or other changes to their related programs. For example, some programs, such as certain state Medicaid programs and the Veterans Health Administration, have recently considered, proposed or implemented rate reductions. In January 2009, the Department of Veterans Affairs informally adopted a policy to reduce payment rates for dialysis services to Medicare rates. The informal policy was subsequently withdrawn in July 2009. On February 17, 2010, the Department of Veterans Affairs formally proposed a rule which would materially reduce their payment rates for dialysis services to equal Medicare rates. The proposed rule is subject to a 60 day comment period and we expect to participate in the comment process. We cannot predict when or if the final rule will be effective or what will be included in the final rule. If the proposed rule is implemented in its current form, it 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 a decrease in the number of patients covered by the Veterans Health Administration that we service. Approximately 2% of our dialysis and related lab services revenues for the year ended December 31, 2009 was generated by the Veterans Health Administration. While we cannot predict whether the Department of Veterans Affairs or any other government programs will be successful in reducing their payment rates or the timing of potential reductions, any such reduction could have a material adverse effect on our revenues, earnings and cash flows.

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. If state Medicaid or other non-Medicare government programs reduce the rates paid by these programs for dialysis and related services, delay the timing of payment for services provided, further limit eligibility for coverage or adopt changes to their payment structure which reduces our overall payments from these state Medicaid or non-Medicare government programs, then our revenues, earnings and cash flows could be adversely affected.

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

The administration of EPO and other pharmaceuticals accounted for approximately 30% of our dialysis and related lab services revenues for the year ended December 31, 2009, with EPO accounting for approximately 20% of our dialysis and related lab services revenues for the same period. Changes in clinical practices that result in further decreased utilization of prescribed pharmaceuticals or changes in payment rates for those pharmaceuticals could substantially 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 United States which has created confusion and concern in the nephrology community. In late 2006, the House Ways and Means Committee held a hearing on the issue of the utilization of erythropoiesis stimulating agents, or 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. The FDA held additional hearings to revisit these label changes as they apply to ESRD and has indicated that they

will convene in 2010 to further review ESA labeling. CMS also reviewed its EPO reimbursement policies and in January 2008, changes to the EPO monitoring policy went into effect which further limited reimbursement and which impacted the prescribing habits of our physicians and which has in the past and may in the future result in lower pharmaceutical intensities. Most recently, HHS and CMS have given notice that a meeting of the Medicare Evidence Development & Coverage Advisory Committee, or MedCAC, will be convened on March 24, 2010 to review policies around the administration of ESAs, including, among other things, an evaluation of the efficacy of certain hemoglobin targets in CKD patients. These meetings could result in further restrictions on the utilization and reimbursement for ESAs which could result in decreased EPO utilization. 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 or reimbursement for EPO and other pharmaceuticals could have a material adverse effect on our revenues, earnings and cash flows.

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

Amgen Inc. is the sole supplier of EPO and may unilaterally decide to increase its price for EPO at any time during the term of our agreement with Amgen. Future increases in the cost of EPO without corresponding increases in payment rates for EPO could have a material adverse effect on our earnings and cash flows and ultimately reduce our income. Our agreement with Amgen for EPO includes potential rebates which depend upon the achievement of certain criteria. We cannot predict whether we will continue to receive the rebates for EPO that we currently receive, or whether we will continue to achieve the same levels of rebates within that structure as we have historically achieved. Our agreement with Amgen provides for specific rebates off of list price based on a combination of factors, including process improvement and data submission. Factors that could impact our ability to qualify for rebates provided for in our agreement with Amgen in the future include our ability to develop and implement certain process improvements and track certain data elements. Failure to meet certain targets and earn the specified rebates could have a material adverse effect on our earnings and cash flows. Our agreement with Amgen terminates on December 31, 2010. We cannot predict whether any new agreement with Amgen will include the same or similar rebates as provided in our current agreement.

We are the subject of a number of inquiries by the federal government, any of which could result in substantial penalties against us.

We are the subject of a number of inquiries by the federal government. We have received subpoenas from the U.S. Attorney's Office for the Northern District of Georgia, the U.S. Attorney's Office for the Eastern District of Missouri and the U.S. Attorney's Office for the Eastern District of Texas. We are cooperating with the U.S. Attorney's Offices with respect to each of the subpoenas and producing the requested records. Any negative findings could result in substantial financial penalties against us, exclusion from future participation in the Medicare and Medicaid programs and, in certain cases, criminal penalties. To our knowledge, no proceedings have been initiated by the federal government against us at this time. Although we cannot predict whether or when proceedings might be initiated by the federal government or when these matters may be resolved, it is not unusual for investigations such as these to continue for a considerable period of time. Responding to the subpoenas will continue to require management's attention and significant legal expense. See Note 16 to our consolidated financial statements for additional information regarding these inquiries and subpoenas.

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 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. For example, the subpoena from the U.S. Attorney's Office for the Northern District of Georgia relates to the pharmaceutical products Zemplar, Hectorol, Venofer, Ferrlecit, EPO and other related matters. The subpoena from the U.S. Attorney's Office in the Eastern District of Missouri includes requests for documents regarding the administration of, and billing for, EPO. The subpoena from the Office of Inspector General in Houston, Texas requests records relating to EPO claims submitted to Medicare. In addition, in February 2008 the Attorney General's Office for the State of Nevada notified us that Nevada Medicaid intends to conduct audits of ESRD dialysis providers in Nevada relating to the billing of pharmaceuticals, including EPO. Additional inquiries from various agencies and claims by third parties with respect to this issue would continue to require management's attention and significant legal expense and any negative findings could result in substantial financial penalties against us 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. See Note 16 to our consolidated financial statements for additional information regarding these inquiries and subpoenas.

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.

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, the federal False Claims Act, or FCA, and federal and state laws regarding the collection, use and disclosure of patient health information. The Medicare and Medicaid reimbursement rules related to claims submission, 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. 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 any amounts received from such administration by government or commercial payors, and be subject to substantial penalties under applicable laws or regulations. In addition, fiscal intermediaries have increased their prepayment and post-payment reviews.

We endeavor to comply with all of the requirements for receiving Medicare and Medicaid payments and 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). However, the laws and regulations in this area are complex and subject to varying interpretations. For example, if an enforcement agency were to challenge the level of compensation that we pay our medical directors, we could be required to change our practices, face criminal or civil penalties, pay substantial fines or otherwise experience a material adverse effect as a result of a challenge to

these arrangements. In addition, recent 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 accelerate 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.

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 and cash flows 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 healthcare facilities 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;
- Claims for monetary damages from patients who believe their protected health information has been used or disclosed in violation of federal or state patient privacy laws;
- Mandated practice changes that significantly increase operating expenses; and
- Termination of relationships with medical directors.

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 governments face increasing budgetary pressure, certain states are having difficulty certifying dialysis centers in the normal course resulting in significant delays in certification. If state governments continue to have difficulty 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 December 31, 2009, we owned a controlling interest in numerous dialysis related joint ventures, which represented approximately 16% of our dialysis and related lab services revenues for the year ended December 31, 2009. In addition, we also owned equity interests 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. The subpoena and related requests for documents we received from the United States Attorney's Office for the Eastern District of Missouri included requests for documents related to our joint ventures. See Note 16 to our consolidated financial statements for additional information regarding these inquiries and subpoenas.

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 and exclusion from government healthcare programs. 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 revenue and related refund liabilities that we recognize and if we are unable to accurately estimate our revenue and related refund liabilities, it could impact the timing of our revenue 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 118,000 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 of our revenue recognition and have a significant impact on our operating results.

The ancillary services we provide or the strategic initiatives we invest in 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 include pharmacy services, infusion therapy services, disease management services, vascular access services, ESRD clinical research programs and physician services. Many of these initiatives 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, business performance or in the regulatory environment may impact the economic viability of any of these strategic initiatives. For example, during 2009 and 2008, several of our strategic initiatives generated net operating losses and are expected to generate net operating losses in 2010. If any of our ancillary services or strategic initiatives 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.

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. Medical directors have no obligation to extend their agreements with us. We may take actions to restructure existing relationships or take positions in negotiating extensions of relationships to assure compliance with the safe harbor provisions of the anti-kickback statute, Stark Law and other similar laws. These actions 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.

Current economic conditions, including the current recession, as well as further disruptions in the financial markets could result in substantial declines in our revenues, earnings, cash flows and financial condition.

The current economic recession 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 in the United States as a result of current 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 slow down in collections and a reduction in the amounts we expect to collect. In addition, if the current uncertainty in the financial markets continues, the variable interest rates payable under our credit facilities could be adversely affected or it could be more difficult to obtain or renew such facilities or to obtain other forms of financing in the future. 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.

If we are not able to continue to make acquisitions on reasonable terms, or maintain an acceptable level of non-acquired growth, or if we face significant patient attrition to our competitors, 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 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. 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 them cost advantages over us because of their ability to manufacture their own products. If we are not able to continue to make acquisitions on reasonable terms, continue to maintain acceptable levels of non-acquired growth, or if we face significant patient attrition to our competitors, it could adversely affect our business.

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. Our Senior Secured Credit Facilities are secured by substantially all of our and our wholly-owned subsidiaries' assets. As such, our ability to refinance our debt or seek additional financing could be limited by such security interest. We cannot assure you that we will be able to refinance our indebtedness on commercially reasonable terms or at all. 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.

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

We are subject to interest rate volatility associated with the portions of our borrowings that bear interest at variable rates. As of December 31, 2009, we had approximately $1.9 billion outstanding borrowings under our Senior Secured Credit Facilities, which bears interest at a variable rate. Approximately $0.4 billion of this outstanding debt is subject to interest rate swaps which have the economic effect of fixing the interest rate on an equivalent portion of our debt. The remaining variable rate debt outstanding under our Senior Secured Credit Facilities had a weighted average interest rate of 1.74% at December 31, 2009. As of December 31, 2009, the interest rates were economically fixed on approximately 21% of our variable rate debt and approximately 59% of our total debt. In addition, we have approximately $198 million of available borrowings under our Senior Secured Credit Facilities that would bear interest at the LIBOR-based variable rate plus an interest rate margin of 1.50%. We may also incur additional variable rate debt in the future.

Increases in interest rates would increase our interest expense for the variable portion of our indebtedness, which could negatively impact our earnings and cash flow. For example, it is estimated that a hypothetical

increase in interest rates of 100 basis points across all variable rate maturities would reduce net income by approximately $9.9 million, for the next twelve months given our current interest rates in effect at December 31, 2009. See "Item 7A—Quantitative and Qualitative Disclosures about Market Risk" for more information. In addition, if we seek to refinance our existing indebtedness under our Senior Secured Credit Facilities, we may not be able to do so on acceptable terms and conditions, which could increase our interest expense or impair our ability to service our indebtedness and fund our operations.

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 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 and productivity. 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, 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 during 2010. 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.

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, Fresenius Medical Care, Baxter Healthcare Corporation, NxStage Medical, Inc. and others or to which we have committed obligations to make purchases including Gambro Renal Products. If any of these suppliers are unable to meet our needs for the products they supply, including in the event of a product recall, and we are not able to find adequate alternative sources, our revenues, earnings and cash flows could be

substantially reduced. For example, a recall of heparin by Baxter Healthcare Corporation in 2008 resulted in only one remaining supplier of heparin and the cost to purchase heparin significantly increased. While an alternative supplier has entered the market, it is possible that our heparin costs may continue to increase and since there is no separate reimbursement for this drug under Medicare, cost increases have a direct impact on our profitability. 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.

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

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. In addition, we have in place a shareholder rights plan that would substantially dilute the interest sought by an acquirer that our Board of Directors does not approve.

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 December 31, 2009, these cash bonuses would total approximately $235 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.

Item 1B. Unresolved Staff Comments.

None.

Item 2. Properties.

We own the land and buildings for 25 of our dialysis centers. We also own the buildings for six other dialysis centers and the building at one of our Florida labs and we own one separate land parcel and sublease a total of six properties to third party tenants. Our remaining dialysis centers are located on premises that we lease.

Our leases generally cover periods from five to ten years but in some cases can extend for 15 years and typically contain renewal options of five to ten years at the fair rental value at the time of renewal. Our leases are generally subject to periodic consumer price index increases, or contain fixed escalation clauses. Our outpatient dialysis centers range in size from approximately 500 to 30,000 square feet, with an average size of approximately 6,800 square feet.

The following is a summary of our business, administrative offices, laboratories and pharmacies:

Office	Location	Square Feet	Expiration
Corporate Headquarters*	Denver, CO	69,000	2012
Administrative Office	Vernon Hills, IL	29,000	2013
Administrative Office	Berlingame, CA	3,700	2012
Administrative Office	Norfolk, VA	20,000	2015
Administrative Office	Washington, DC	5,000	2013
Administrative Office	Tempe, AZ	11,000	2016
Administrative Office	Washington, DC	2,000	2013
Administrative Office	Washington, DC	5,000	2013
Business Office	El Segundo, CA	61,000	2013
Business Office	Tacoma, WA	215,000	2013 through 2021
Business Office	Berwyn, PA	57,000	2012
Business Office	Lakewood, CO	82,000	2012
Business Office	Brentwood, TN	95,000	2011
Business Office	Irvine, CA	65,000	2015
DaVita Rx	Orlando, FL	17,000	2013
DaVita Rx	Coppell, TX	53,000	2013
DaVita Rx	San Bruno, CA	7,000	2015
Lab Warehouse	DeLand, FL	11,000	2015
Laboratory	DeLand, FL	40,000	Owned
Laboratory	DeLand, FL	20,000	2013
Laboratory	Ft. Lauderdale, FL	43,000	2015
Laboratory Administrative Office	DeLand, FL	23,000	2011

* As previously announced, our corporate headquarters has been moved to Denver, Colorado. The new lease is effective on March 1, 2010.

Some of our dialysis centers are operating at or near capacity. However, we believe that we have adequate capacity within most of our existing dialysis centers to accommodate additional patient volume through increased hours and/or days of operation, or, if additional space is available within an existing facility, by adding dialysis stations. We can usually relocate existing centers to larger facilities or open new centers if existing centers reach capacity. With respect to relocating centers or building new centers, we believe that we can generally lease space at economically reasonable rates in the areas planned for each of these centers, although there can be no assurances in this regard. Expansion of existing centers or relocation of our dialysis centers is subject to review for compliance with conditions relating to participation in the Medicare ESRD program. In states that require a certificate of need or center license, additional approvals would generally be necessary for expansion or relocation.

Item 3. Legal Proceedings.

Inquiries by the Federal Government

In December 2008, we received a subpoena for documents from the Office of Inspector General, U.S. Department of Health and Human Services, or OIG, relating to the pharmaceutical products Zemplar, Hectorol, Venofer, Ferrlecit and Epogen®, or EPO, as well as other related matters. The subpoena covers the period from January 2003 to the present. We have been in contact with the United States Attorney's Office, or U.S.

Attorney's Office, for the Northern District of Georgia and the U.S. Department of Justice in Washington, DC, since November 2008 relating to this matter, and have been advised that this is a civil inquiry. On June 17, 2009, we learned that the allegations were made as part of a civil qui tam complaint filed by individuals and brought pursuant to the federal False Claims Act. The case remains under seal in the United States District Court for the Northern District of Georgia. We are cooperating with the inquiry and are producing the requested records. To our knowledge, no proceedings have been initiated by the federal government against us at this time. Although we cannot predict whether or when proceedings might be initiated, or when these matters may be resolved, it is not unusual for investigations such as these to continue for a considerable period of time. Responding to the subpoena will continue to require management's attention and significant legal expense. Any negative findings could result in substantial financial penalties against us and exclusion from future participation in the Medicare and Medicaid programs.

In February 2007, we received a request for information from the OIG for records relating to EPO claims submitted to Medicare. In August 2007, we received a subpoena from the OIG seeking similar documents. The requested documents relate to services provided from 2001 to 2004 by a number of our centers. The request and subpoena were sent from the OIG's offices in Houston and Dallas, Texas. We are cooperating with the inquiry and are producing the requested records. We have been in contact with the U.S. Attorney's Office for the Eastern District of Texas, which has stated that this is a civil inquiry related to EPO claims. On July 6, 2009, the United States District Court for the Eastern District of Texas lifted the seal on the civil qui tam complaint related to these allegations and we were subsequently served with a complaint by the relator. We believe that there is some overlap between this issue and the ongoing review of EPO utilization and claims by the U.S. Attorney's Office, for the Eastern District of Missouri in St. Louis described below. To our knowledge, no proceedings have been initiated by the federal government against us at this time. Although we cannot predict whether or when proceedings might be initiated or when these matters may be resolved, it is not unusual for investigations such as these to continue for a considerable period of time. Responding to these inquiries will continue to require management's attention and significant legal expense. Any negative findings could result in substantial financial penalties against us and exclusion from future participation in the Medicare and Medicaid programs.

In March 2005, we received a subpoena from the U.S. Attorney's Office for the Eastern District of Missouri in St. Louis. The subpoena requires production of a wide range of documents relating to our operations, including documents related to, among other things, pharmaceutical and other services provided to patients, relationships with pharmaceutical companies, and financial relationships with physicians and joint ventures. The subpoena covers the period from December 1, 1996 through the present. In October 2005, we received a follow-up request for additional documents related to specific medical director and joint venture arrangements. In February 2006, we received an additional subpoena for documents, including certain patient records relating to the administration and billing of EPO. In May 2007, we received a request for documents related to durable medical equipment and supply companies owned and operated by us. We are cooperating with the inquiry and are producing the requested records. The subpoenas have been issued in connection with a joint civil and criminal investigation. It is possible that criminal proceedings may be initiated against us in connection with this inquiry. To our knowledge, no proceedings have been initiated against us at this time. Although we cannot predict whether or when proceedings might be initiated or when these matters may be resolved, it is not unusual for investigations such as these to continue for a considerable period of time. Responding to the subpoenas will continue to require management's attention and significant legal expense. Any negative findings could result in substantial financial penalties against us, exclusion from future participation in the Medicare and Medicaid programs and criminal penalties.

Other

We have received several notices of claims from commercial payors and other third parties related to historical billing practices and claims against DVA Renal Healthcare (formerly known as Gambro Healthcare) related to historical Gambro Healthcare billing practices and other matters covered by their 2004 settlement agreement with the Department of Justice and certain agencies of the U.S. government. At least one commercial

payor has filed an arbitration demand against us, as described below, and additional commercial payors have threatened litigation. We intend to defend against these claims vigorously; however, we may not be successful and these claims may lead to litigation and any such litigation may be resolved unfavorably.

Several wage and hour claims have been filed against us in the Superior Court of California, each of which has been styled as a class action. In February 2007, June 2008, October 2008 and December 2008, we were served with five separate complaints, including two in October 2008, by various former employees, each of which alleges, among other things, that we failed to provide rest and meal periods, failed to pay compensation in lieu of providing such rest or meal periods, failed to pay the correct amount of overtime, failed to pay the rate on the "wage statement," and failed to comply with certain other California labor code requirements. We have reached a tentative settlement in the complaints served in February 2007 and December 2008 and one of the complaints served in October 2008. That settlement has been partially approved by the court and we are waiting for final court approval of the last part of the settlement. We intend to vigorously defend against the remaining claims and to vigorously oppose the certification of the remaining matters as class actions.

In August 2007, Sheet Metal Workers National Health Fund and Glenn Randle filed a complaint in the United States District Court for the Central District of California against us. The complaint also names as defendants Amgen Inc. and Fresenuis Medical Care Holdings, Inc. The complaint is styled as a class action and alleges four claims against us, including violations of the federal RICO statute, California's unfair competition law, California's false advertising law and for unjust enrichment. The complaint's principal allegations against us are that the defendants engaged in a scheme to unlawfully promote the administration of EPO to hemodialysis patients intravenously, as opposed to subcutaneously, and to over-utilize EPO. On December 17, 2008, the Court dismissed the complaint and allegations in their entirety with permission of plaintiffs to amend the complaint. We were not named as a defendant in plaintiffs' amended complaint. In June 2009, the Court dismissed the remainder of the case. Following the dismissal, plaintiffs filed a notice of appeal. The notice of appeal seeks review by the U. S. Court of Appeals for the Ninth Circuit of all of the district court's dismissal rulings, including the ruling dismissing us as a defendant. We intend to continue to vigorously defend this claim.

In October 2007, we were contacted by the Attorney General's Office for the State of Nevada. The Attorney General's Office informed us that it was conducting a civil and criminal investigation of our operations in Nevada and that the investigation related to the billing of pharmaceuticals, including EPO. In February 2008, the Attorney General's Office informed us that the civil and criminal investigation has been discontinued. The Attorney General's Office further advised us that Nevada Medicaid intends to conduct audits of end stage renal disease (ESRD) dialysis providers in Nevada, including us, and that such audits will relate to the issues that were the subjects of the investigation. To our knowledge, no court proceedings have been initiated against us at this time. Any negative audit findings could result in a substantial repayment by us.

In August 2005, Blue Cross/Blue Shield of Louisiana filed a complaint in the United States District Court for the Western District of Louisiana against Gambro AB, DVA Renal Healthcare (formerly known as Gambro Healthcare) and related entities. The plaintiff sought to bring its claims as a class action on behalf of itself and all entities that paid any of the defendants for health care goods and services from on or about January 1991 through at least December 2004. The complaint alleged, among other things, damages resulting from facts and circumstances underlying Gambro Healthcare's 2004 settlement agreement with the Department of Justice and certain agencies of the U.S. government. In March 2006, the case was dismissed and the plaintiff was compelled to seek arbitration to resolve the matter. In November 2006, the plaintiff filed a demand for class arbitration against us and DVA Renal Healthcare. We intend to vigorously defend against these claims. We also intend to vigorously oppose the certification of this matter as a class action. At this time, we cannot predict the ultimate outcome of this matter or the potential range of damages, if any.

In June 2004, Gambro Healthcare was served with a complaint filed in the Superior Court of California by one of its former employees who worked for its California acute services program. The complaint, which is styled as a class action, alleges, among other things, that DVA Renal Healthcare failed to provide overtime

wages, defined rest periods and meal periods, or compensation in lieu of such provisions and failed to comply with certain other California labor code requirements. We intend to vigorously defend against these claims. We also intend to vigorously oppose the certification of this matter as a class action. At this time, we cannot predict the ultimate outcome of this matter or the potential range of damages, if any.

In addition to the foregoing, we are subject to claims and suits, including from time to time, contractual disputes and professional and general liability claims, as well as audits and investigations by various government entities, in the ordinary course of business. We believe that the ultimate resolution of any such pending proceedings, whether the underlying claims are covered by insurance or not, will not have a material adverse effect on its financial condition, results of operations or cash flows.

Item 4. Submission of Matters to a Vote of Securities Holders.

No matters were submitted to a vote of security holders during the fourth quarter of 2009.

PART II

Item 5. Market for the Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities.

Our common stock is traded on the New York Stock Exchange under the symbol "DVA". The following table sets forth, for the periods indicated, the high and low closing prices for our common stock as reported by the New York Stock Exchange.

	High	Low
Year ended December 31, 2009:		
1st quarter	$ 53.04	$ 42.34
2nd quarter	49.56	42.36
3rd quarter	56.64	47.78
4th quarter	61.55	53.03
Year ended December 31, 2008:		
1st quarter	$ 59.23	$ 42.48
2nd quarter	53.86	47.79
3rd quarter	60.01	52.64
4th quarter	56.75	42.66

The closing price of our common stock on January 29, 2010 was $59.76 per share. According to The Bank of New York, our registrar and transfer agent, as of January 29, 2010, there were 8,315 holders of record of our common stock. We have not declared or paid cash dividends to holders of our common stock since 1994. We have no current plans to pay cash dividends and we are restricted from paying dividends under the terms of our Senior Secured Credit Facilities and the indentures governing our senior and senior subordinated notes. Also, see the heading "Liquidity and capital resources" under "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations" and the notes to our consolidated financial statements.

Stock Repurchases

The following table summarizes our repurchases of our common stock during 2009:

Period	Total Number of Shares Purchased	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs(1)	Approximate Dollar Value of Shares that May Yet Be Purchased Under the Plans or Programs (in millions)
March 1—31, 2009	744,400	$ 43.01	744,400	$ 121.5
September 1—30, 2009	1,108,784	56.25	1,108,784	59.1
October 1—31, 2009	1,049,435	56.32	1,049,435	500.0
Total	2,902,619	$ 52.88	2,902,619	

(1) On September 11, 2003, we announced that the Board of Directors authorized the repurchase of up to $200 million of our common stock, with no expiration date. On November 2, 2004, we announced that the Board of Directors approved an increase in our authorization to repurchase shares of our common stock by an additional $200 million. On May 1, 2008, our Board of Directors authorized an increase of an additional $143.5 million of repurchases of our common stock. On November 3, 2009, we announced that the Board of Directors authorized an increase of an additional $500 million for repurchases of our common stock.

This stock repurchase program has no expiration date. We are authorized to make purchases from time to time in the open market or in privately negotiated transactions, depending upon market conditions and other considerations. However, we are subject to share repurchase limitations under the terms of the Senior Secured Credit Facilities and the indentures governing our senior and senior subordinated notes.

Item 6. Selected Financial Data.

The following financial and operating data should be read in conjunction with "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations" and our consolidated financial statements filed as part of this report. The following table presents selected consolidated financial and operating data for the periods indicated. Effective January 1, 2009, we were required to present consolidated net income attributable to us and to noncontrolling interests on the face of the consolidated statement of income, which changed the presentation of minority interests (noncontrolling interests) in our consolidated statements of income. These consolidated financial results have been recast for all prior periods presented to reflect the retrospective application of adopting these new presentation and disclosure requirements for noncontrolling interests. The operating results of DVA Renal Healthcare are included in our operating results from October 1, 2005, and the operating results of the historical DaVita divested centers are reflected as discontinued operations in our consolidated statements of income for 2005.

	Year ended December 31,				
	2009	2008	2007	2006	2005
	(in thousands, except share data)				
Income statement data:					
Net operating revenues(1)	$ 6,108,800	$ 5,660,173	$ 5,264,151	$ 4,880,662	$ 2,973,918
Operating expenses and charges(2)	5,168,529	4,791,077	4,355,240	4,103,089	2,485,052
Operating income	940,271	869,096	908,911	777,573	488,866
Debt expense(3)	(185,755)	(224,716)	(257,147)	(276,706)	(139,586)
Swap valuations gain, net(4)	—	—	—	—	4,548
Refinancing charges(5)	—	—	—	—	(8,170)
Other income, net(6)	3,708	12,411	22,460	13,033	8,934
Income from continuing operations before income taxes	758,224	656,791	674,224	513,900	354,592
Income tax expense	278,465	235,471	245,581	186,430	123,675
Income from continuing operations	479,759	421,320	428,643	327,470	230,917
Income from discontinued operations, net of tax(7)	—	—	—	1,747	14,376
Gain on disposal of discontinued operations, net of tax(7)	—	—	—	362	8,064
Net income	$ 479,759	$ 421,320	$ 428,643	$ 329,579	$ 253,357
Less: Net income attributable to noncontrolling interests(8)	$ (57,075)	$ (47,160)	$ (46,865)	$ (39,888)	$ (24,714)
Net income attributable to DaVita Inc.	$ 422,684	$ 374,160	$ 381,778	$ 289,691	$ 228,643
Basic earnings per common share from continuing operations attributable to DaVita Inc.(7)	$ 4.08	$ 3.56	$ 3.61	$ 2.79	$ 2.06
Diluted earnings per common share from continuing operations attributable to DaVita Inc.(7)	$ 4.06	$ 3.53	$ 3.55	$ 2.73	$ 1.99
Weighted average shares outstanding:(10)					
Basic	103,604,000	105,149,000	105,893,000	103,520,000	100,762,000
Diluted	104,168,000	105,940,000	107,418,000	105,793,000	104,068,000
Ratio of earnings to fixed charges(9)	3.58:1	3.01:1	2.92:1	2.38:1	2.86:1
Balance sheet data:					
Working capital	$ 1,255,580	$ 965,233	$ 889,917	$ 597,324	$ 664,675
Total assets	7,558,236	7,286,083	6,943,960	6,491,816	6,279,762
Long-term debt	3,532,217	3,622,421	3,683,887	3,730,380	4,085,435
Total DaVita Inc. shareholders' equity(10)	2,135,066	1,767,747	1,504,285	1,139,333	740,122

(1) Net operating revenues include $3,771 in 2005 of Medicare lab recoveries relating to prior years' services.

(2) Operating expenses and charges include $55,275 in 2007 and $37,968 in 2006 of valuation gains on the alliance and product supply agreement with Gambro Renal Products, Inc. Operating expenses and charges in 2007 also includes $6,779 of gains from insurance settlements related to Hurricane Katrina and a fire that destroyed one center.

(3) Debt expense in 2007 and 2006 includes the write-off of approximately $4.4 million and $3.3 million, respectively, of deferred financing costs associated with our principal prepayments on our term loans.

(4) The swap valuation net gains of $4,548 in 2005 represented the accumulated fair value on several swap instruments that were ineffective as cash flow hedges, as a result of the repayment of our prior senior secured credit facilities, as well as changes in the fair values of these swaps until they were redesignated as hedges, and represent changes in the fair value of the swaps during periods in which there was no matching variable rate LIBOR-based interest payments.

(5) Refinancing charges of $8,170 in 2005 represented the write-off of deferred financing costs associated with the extinguishment of our prior senior secured credit facilities.

(6) Other income, net, includes $5,868 in 2007 of gains from the sale of investment securities.

(7) During 2005, we divested a total of 71 outpatient dialysis centers in conjunction with a consent order issued by the Federal Trade Commission on October 4, 2005 in order for us to complete the acquisition of DVA Renal Healthcare. In addition, we completed the sale of three additional centers that were previously pending state regulatory approval in January 2006. The operating results of the historical DaVita divested and held for sale centers were reflected as discontinued operations in our consolidated financial statements for 2005.

(8) Net income attributable to noncontrolling interests includes $1,747 in 2006, and $1,219 in 2005 of income from discontinued operations.

(9) The ratio of earnings to fixed charges was computed by dividing earnings by fixed charges. Earnings for this purpose is defined as pretax income from continuing operations adjusted by adding back fixed charges expensed during the period. Fixed charges include debt expense (interest expense and the write-off and amortization of deferred financing costs), the estimated interest component of rental expense on operating leases, and capitalized interest.

(10) Share repurchases consisted of 2,902,619 shares of common stock for $153,495 in 2009, 4,788,881 shares of common stock for $232,715 in 2008 and 111,300 shares of common stock for $6,350 in 2007. Shares issued in connection with stock awards amounted to 2,104,304 in 2009, 1,314,074 in 2008, 2,480,899 in 2007, 2,620,125 in 2006 and 3,303,451 in 2005.

Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations.

Forward-looking statements

This Management's Discussion and Analysis of Financial Condition and Results of Operations contain statements that are 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. 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 the regulatory environment in which we operate, economic and market conditions, competitive activities, other business conditions, 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 or changes to the structure of payments under the Medicare ESRD program or other government-based programs, including, for example, the implementation of a bundled payment rate system which will lower reimbursement for services we provide to Medicare patients, 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, the resolution of ongoing investigations by various federal and state government agencies, and the risk factors set forth in this Annual Report on Form 10-K. We base our forward-looking statements on information currently available to us, and 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.

The following should be read in conjunction with our consolidated financial statements and "Item 1. Business".

Overview

We are a leading provider of dialysis services in the United States through a network of approximately 1,530 outpatient dialysis centers and approximately 720 hospitals, serving approximately 118,000 patients in 43 states. In 2009, our overall network of dialysis centers increased by 81 centers primarily as a result of opening new centers and acquisitions and the overall number of patients that we serve increased by approximately 5.5%.

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. 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 United States. In addition, over the past several years our teammate turnover has remained relatively constant, although in 2009 we did experience a decrease in our overall teammate turnover. We believe this was a major contributor to our continued clinical performance improvements and also a major driver in our ability to improve productivity in 2009. We will continue to focus on these stakeholders and our clinical outcomes as we believe these are fundamental long-term value drivers.

Approximately 95% of our 2009 consolidated net operating revenues were derived directly from our dialysis and related lab services business. Approximately 84% of our 2009 dialysis and related lab services revenues were derived from outpatient hemodialysis services in the 1,498 centers that we consolidate, which are either wholly-owned or majority-owned. Other dialysis services, which are operationally integrated with our dialysis operations, are peritoneal dialysis, home-based hemodialysis, and hospital inpatient hemodialysis services. These services collectively accounted for the balance of our 2009 dialysis and related lab services revenues. We also generate management fees from management and administrative services to certain third-party-owned dialysis centers and dialysis centers that we own an equity investment in. These management fees represent less than 1% of our dialysis and related lab services revenues.

Our other business operations include ancillary services and strategic initiatives which are primarily aligned with our core business of providing dialysis services to our network of patients. These consist primarily of pharmacy services, infusion therapy services, disease management services, vascular access services, ESRD clinical research programs and physician services. These services generated approximately $317 million of net operating revenues in 2009, or approximately 5% of our consolidated net operating revenues. Overall our ancillary services and strategic initiatives decreased their operating losses from $30 million in 2008 to $18 million in 2009, primarily as a result of improved profitability in our pharmacy and disease management businesses. We currently expect to continue to invest in our ancillary services and strategic initiatives as we work to develop successful new business operations. However, any significant change in market conditions, business performance or in the regulatory environment may impact the economic viability of any of these strategic initiatives. Any unfavorable changes could result in a write-off or an impairment of some or all of our investments, including goodwill, in these strategic initiatives, or could also result in significant termination costs if we were to exit a certain line of business.

The principal drivers of our dialysis and related lab services revenues are:

- the number of treatments, which is primarily a function of the number of chronic patients requiring approximately three treatments per week, as well as, to a lesser extent, the number of treatments for peritoneal dialysis services and home-based dialysis and hospital inpatient dialysis services;
- average dialysis revenue per treatment; and
- the number of laboratory patient tests.

The total patient base is a relatively stable factor, which we believe is influenced by a demographically growing need for dialysis services, our relationships with referring physicians together with the quality of our clinical care, and our ability to open and acquire new centers. Our year-over-year treatment volume growth was 4.9% in 2009.

Average dialysis and related lab services revenue per treatment is primarily driven by our mix of commercial and government (principally Medicare and Medicaid) patients, the mix and intensity of physician-prescribed pharmaceuticals, commercial and government payment rates, and our billing and collecting operations performance.

On average, payment rates from commercial payors are significantly higher than Medicare, Medicaid and other government program payment rates, and therefore the percentage of commercial patients to total patients represents a major driver of our total average dialysis revenue per treatment. The percentage of commercial patients covered under contracted plans as compared to commercial patients with out-of-network providers can also significantly affect our average dialysis revenue per treatment. In 2009, the growth of our government-based patients, driven primarily by growth in Medicare-assigned plans, which we believe is largely as a result of improved mortality and the current economic recession, outpaced the growth in our commercial patients, which negatively impacted our average dialysis revenue per treatment as a result of receiving lower payment rates associated with these additional government-based patients.

The following table summarizes our dialysis and related lab services revenues for the year ended December 31, 2009:

	Revenues
Medicare and Medicare-assigned plans	57%
Medicaid and Medicaid-assigned plans	6%
Other government-based programs	2%
Total government-based programs	65%
Commercial (including hospital dialysis services)	35%
Total dialysis and related lab services revenues	100%

Government payment rates are principally determined by federal Medicare and state Medicaid policy. These payment rates have historically had limited potential for rate increases and are sometimes at risk of reduction as federal and state governments face increasing budget pressures. Medicare payment rates for dialysis services through 2008 have not been routinely increased to compensate for the impact of inflation. In July 2008, MIPPA was passed by Congress which introduced a new payment system for dialysis services beginning in January 2011 whereby ESRD payments will be made under a bundled payment rate which will provide for a fixed rate for all goods and services provided during the dialysis treatment. The legislation also provided for an increase in the composite rate of 1% effective January 1, 2009 and an additional 1% effective January 1, 2010. On September 15, 2009, CMS released the proposed rule regarding the new bundled payment rate system. The initial 2011 bundled rate is required to be set based on a 2% reduction in the payment rate that providers would have received under the historical fee for service payment methodology and based on the lowest average industry pharmaceutical utilization from 2007 to 2009. The combined effect of the adjustments provided in the proposed rule would result in a bundled rate that represents a significantly greater than 2% reduction in the payment rate that we would have received for our services prior to bundling. The proposed rule also requires, among other things, the new single bundled payment base rate to be adjusted annually for inflation based upon a market basket index, less 1% of such index, beginning in 2012. Dialysis providers have the option to move fully to the bundled payment system in 2011 or to phase in the payment system over three years.

Dialysis payment rates from commercial payors can vary significantly and a major portion of our commercial rates are set at contracted amounts with large payors and are subject to intense negotiation pressure. In 2009, we were successful in maintaining and in some instances increasing average payment rates, resulting in an aggregate increase in average payment rates for patients with commercial plans. However, we are continuously in the process of negotiating agreements with our commercial payors and payors are aggressive in their negotiations. If our negotiations result in overall commercial rate reductions in excess of overall commercial rate increases, this would have a material adverse effect on our operating results. In addition, if there are sustained or increased job losses in the United States as a result of current economic conditions, or depending upon changes to the healthcare regulatory system, we could experience a decrease in the number of patients under commercial plans. We also expect that 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, payors have been attempting to impose restrictions and limitations on non-contracted or out-of-network providers, which could further decrease our commercial rate revenues since rates for out-of-network providers are on average higher than rates for in-network providers.

Approximately 30% of our dialysis and related lab services revenues for the year ended December 31, 2009 were from physician-prescribed pharmaceuticals, with EPO accounting for approximately 20% of our dialysis and related lab services revenues. Therefore, changes in physician practice patterns, pharmaceutical protocols, pharmaceutical intensities and changes in commercial and governmental payment rates for EPO significantly influence our revenue. For example, effective January 2008, changes to the EPO monitoring policy went into effect which further limited reimbursements and impacted the prescribing habits of our physicians, which

resulted in lower pharmaceutical intensities during 2008. In 2009, the intensities of physician-prescribed pharmaceuticals increased slightly from 2008, which helped contribute to an increase in our average dialysis and related lab services revenue per treatment.

Our operating performance with respect to dialysis services billing and collection can also be a significant factor in how much average dialysis and related lab services revenue per treatment we actually realize. Over the past several years we have invested heavily in new systems and processes that we believe have helped improve our operating performance and reduced our regulatory compliance risks and we expect to continue to improve these systems. In 2009, we continued to upgrade our systems and implemented process changes and will continue to do so in 2010 as necessary to improve our billing and collection performance. However, as we implement these system upgrades, our collection performance as well as our dialysis and related lab services revenue per treatment could be negatively impacted.

Our revenue recognition involves significant estimation risks. Our estimates are developed based on the best information available to us and our best judgment as to the reasonably assured collectibility of our billings as of the reporting date based upon our actual historical collection experience. Changes in estimates are reflected in the then-current period financial statements based upon on-going actual experience trends, or subsequent settlements and realizations depending on the nature and predictability of the estimates and contingencies.

Our annual average dialysis and related lab services revenue per treatment was approximately $340, $334 and $334 for 2009, 2008 and 2007, respectively. In 2009, the increase in our average dialysis and related lab services revenue per treatment was primarily due to a 1% increase in the Medicare composite rate, an increase in our commercial payment rates, an increase in our reimbursement rates for EPO and other pharmaceuticals and an increase in the intensities of physician-prescribed pharmaceuticals, partially offset by changes in the mix of our commercial payors. In 2008, the average dialysis and related lab services revenue per treatment was flat as compared to 2007, but was impacted by some commercial rate compression that occurred in late 2007, a decrease in the intensities of physician-prescribed pharmaceuticals offset by changes in mix and rates of some of our other commercial payors. Our ability to negotiate acceptable payment rates with commercial payors, changes in the mix and intensities of physician-prescribed pharmaceuticals, government payment policies regarding reimbursement amounts for dialysis treatments and pharmaceuticals, including the bundling of such services, and changes in the mix of government and commercial payors may materially impact our average dialysis and related lab services revenue per treatment in the future.

The principal drivers of our dialysis and related lab services patient care costs are clinical hours per treatment, labor rates, vendor pricing of pharmaceuticals, utilization levels of pharmaceuticals and business infrastructure, including the operating costs of our dialysis centers, and compliance costs. However, other cost categories can also represent significant cost variability, such as employee benefit costs and insurance costs. Our average clinical hours per treatment have remained relatively stable over the past few years primarily because of improved efficiencies driven by reduced clinical teammate turnover and improved training and processes. In 2009, we were able to reduce our average clinical hours per treatment from 2008 as a result of continued productivity improvements primarily through reduced teammate turnover and the fact that 2008 was negatively impacted by the implementation of new federal guidelines. We continue to strive for improved productivity levels, however we may not be able to sustain our 2009 performance as changes in federal and state policies can adversely impact our ability to achieve optimal productivity levels, as would improvements in the U.S. economy, which could stimulate additional competition for skilled clinical personnel, and result in higher teammate turnover. In 2009 and 2008, we also experienced an increase in our labor rates of approximately 2.5% and 3.5%, respectively, as labor rates have increased consistent with general industry trends, mainly due to the demand for skilled clinical personnel, along with general inflation increases. In 2009, we experienced an increase in our pharmaceutical costs, mainly related to EPO, which increased by approximately 2%. In addition, our agreement with Amgen for the purchase of EPO provides for specific rebates based on a combination of factors, including process improvement and data submission, which could negatively impact our earnings if we are unable to continue to qualify for these rebates. In 2009, we experienced increases in our infrastructure and operating costs of our dialysis centers, primarily due to the number of new centers opened, and general increases in rent, utilities and repairs and maintenance.

General and administrative expenses have remained relatively constant as a percent of consolidated revenues over the past three years. However, this reflects a substantial increase in the dollar amount of spending related to strengthening our dialysis business, improving our regulatory compliance and other operational processes, responding to certain legal matters and supporting the growth in our ancillary services and strategic initiatives. We expect that the level of general and administrative expenses will be sustained and may vary depending upon the level of investment we make in our long-term initiatives, including further investments in our ancillary services and strategic initiatives, and to support our regulatory compliance efforts.

Outlook for 2010. Currently, we still expect our operating income for 2010 to be in the range of $950 million to $1,020 million and we also expect our operating cash flows for 2010 to be in the range of $675 million to $725 million. These projections and the underlying assumptions involve significant risks and uncertainties, and actual results may vary significantly from these current projections. These risks and uncertainties, among others, include those relating to 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 or changes to the structure of payments under the Medicare ESRD program or other government-based programs, including, for example, the implementation of a bundled payment rate system which will lower reimbursement for services we provide to Medicare patients, 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 and the resolution of ongoing investigations by various federal and state government agencies. You should read "Risk Factors" in Item 1A of this Annual Report on Form 10-K and the cautionary language contained in the forward-looking statements and associated risks as discussed on page 38 for more information about these and other potential risks. We undertake no obligation to update or revise these projections, whether as a result of changes in underlying factors, new information, future events or otherwise.

Results of operations

We operate principally as a dialysis and related lab services business but also operate other ancillary services and strategic initiatives. These ancillary services and strategic initiatives consist primarily of pharmacy services, infusion therapy services, disease management services (VillageHealth), vascular access services, ESRD clinical research programs and physician services. The dialysis and related lab services business qualifies as a separately reportable segment and all of the other ancillary services and strategic initiatives have been combined and disclosed in the other segments category.

Following is a summary of consolidated operating results for reference in the discussion that follows.

	Year ended December 31,					
	2009		2008		2007	
	(dollar amounts rounded to nearest million)					
Net operating revenues:						
Current period services	$ 6,109	100%	$ 5,660	100%	$ 5,264	100%
Operating expenses and charges:						
Patient care costs	4,249	70%	3,920	69%	3,590	68%
General and administrative	532	9%	508	9%	491	9%
Depreciation and amortization	229	4%	217	4%	193	4%
Provision for uncollectible accounts	162	3%	146	3%	137	3%
Equity investment income	(2)	—	(1)	—	(1)	—
Valuation gain on alliance and product supply agreement	—	—	—	—	(55)	(1)%
Total operating expenses and charges	5,169	85%	4,791	85%	4,355	83%
Operating income	$ 940	15%	$ 869	15%	$ 909	17%

The following table summarizes consolidated net operating revenues:

	Year ended		
	2009	2008	2007
	(dollar amounts rounded to nearest million)		
Dialysis and related lab services	$ 5,792	$ 5,415	$ 5,130
Other—ancillary services and strategic initiatives	317	245	134
Consolidated net operating revenues	$ 6,109	$ 5,660	$ 5,264

The following table summarizes consolidated operating income:

	Year ended		
	2009	2008(2)	2007(1)(2)
	(dollar amounts rounded to nearest million)		
Dialysis and related lab services	$ 1,000	$ 939	$ 990
Other—ancillary services and strategic initiatives loss	(18)	(30)	(48)
Total segment operating income	982	910	942
Reconciling items:			
Stock-based compensation	(44)	(41)	(34)
Equity investment income	2	1	1
Consolidated operating income	940	869	909
Reconciliation of non-GAAP measures:			
Less: Gains on insurance settlements	—	—	(7)
Valuation gain on the alliance and product supply agreement	—	—	(55)
Non-GAAP consolidated operating income	$ 940	$ 869	$ 847

(1) In 2007, we have excluded valuation gains on the alliance and product supply agreement with Gambro Renal Products Inc. (the Product Supply Agreement) as well as gains on insurance settlements from Hurricane Katrina from non-GAAP adjusted consolidated operating income in 2007 because management believes that this presentation enhances a user's understanding of our normal consolidated operating income by excluding a non-recurring non-cash gain that resulted from the termination of our purchase obligation for dialysis machines from Gambro Renal Products Inc. under the Product Supply Agreement as well as an unusual insurance gain, and as a result is both more meaningful and comparable to our current and prior period results, and more indicative of our normal consolidated operating income.

(2) Certain costs previously reported in ancillary services and strategic initiatives have been reclassified to dialysis and related lab services to conform to the current year presentation.

Consolidated net operating revenues

Consolidated net operating revenues for 2009 increased by approximately $449 million or approximately 7.9% from 2008. This increase was primarily due to an increase in dialysis and related lab services net revenues of approximately $377 million, principally due to increased treatments, and an increase of approximately $72 million in the ancillary services and strategic initiatives net revenues primarily from growth in our pharmacy services, VillageHealth services and from our infusion therapy services.

Consolidated net operating revenues for 2008 increased by approximately $396 million or approximately 7.5% from 2007. This increase was primarily due to an increase in dialysis and related lab services net revenues of approximately $285 million, principally due to increased treatments, and an increase of approximately $111 million in the ancillary services and strategic initiatives net revenues primarily from growth in our pharmacy services, VillageHealth services and from our infusion therapy services.

Consolidated operating income

Consolidated operating income of $940 million for 2009 increased by approximately $71 million from 2008. This increase was primarily attributable to an increase in revenue as a result of non-acquired treatment growth in dialysis and related lab services, as well as an increase in our dialysis revenue per treatment of approximately $6 as described below. Operating income also increased as a result of cost control initiatives, improved productivity and lower operating losses in our ancillary services and strategic initiatives, which losses were reduced by approximately $12 million in 2009, partially offset by the negative impact of higher pharmaceutical, labor and benefit costs, and increases in other operating costs of our dialysis centers.

Consolidated operating income was $869 million for 2008, as compared to $909 million for 2007. Consolidated operating income in 2007 included a valuation gain of $55 million on the Product Supply Agreement and the $7 million insurance settlement related to Hurricane Katrina. Excluding the valuation gain on the Product Supply Agreement and the insurance settlement in 2007, our consolidated operating income for 2008 would have increased by approximately $22 million, compared to the adjusted operating income for 2007. This increase in consolidated operating income for 2008 as compared to adjusted operating income for 2007 was primarily due to treatment growth in dialysis and related lab services revenues, combined with growth in revenue in ancillary services and strategic initiatives outpacing increases in our operating expenses. Our ancillary services and strategic initiatives net operating losses were reduced by approximately $18 million in 2008. However, our consolidated operating income for 2008 was negatively affected by rising labor costs, the absence of a Medicare rate increase, the impact of some commercial rate compression that occurred in late 2007, decreases in intensities of physician-prescribed pharmaceuticals, an increase in the operating costs of our dialysis centers, driven in part by the number of new dialysis centers opened and from centers constructed but pending state and/or federal certification, an increase in pharmaceutical costs (primarily heparin) and an increase in stock-based compensation costs.

Operating segments

Dialysis and Related Lab Services

	Year ended		
	2009	2008	2007
	(dollar amounts rounded to nearest million, except per treatment data)		
Revenues	$ 5,792	$ 5,415	$ 5,130
Segment operating income	$ 1,000	$ 939	$ 990
Dialysis treatments	17,010,450	16,217,107	15,318,995
Average dialysis treatments per treatment day	54,433	51,663	48,942
Average dialysis and related lab services revenue per treatment	$ 340	$ 334	$ 334

Net operating revenues

Dialysis and related lab services net operating revenues for 2009 increased by approximately $377 million or approximately 6.9% from 2008. The increase in net operating revenues was primarily due to an increase in the number of treatments of approximately 4.7%, and an increase in the average dialysis revenue per treatment of approximately $6, or 1.9%. The increase in the number of treatments was primarily due to an increase in non-acquired treatment growth at existing and new centers and growth through acquisitions. The increase in the average dialysis revenue per treatment in 2009, as compared to 2008, was primarily due to a 1% Medicare increase in the Medicare composite rate, an increase in our commercial payment rates, an increase in our reimbursement rates for EPO and other pharmaceuticals, and an increase in the intensities of physician-prescribed pharmaceuticals, partially offset by changes in the mix of our commercial payors.

Dialysis and related lab services net operating revenues for 2008 increased by approximately $285 million or approximately 5.6% from 2007. The increase in net operating revenues was primarily due to an increase in the

number of treatments of approximately 5.7%, offset by a slight decrease in the average dialysis revenue per treatment. The increase in number of treatments was primarily due to an increase in the number of treatment days in 2008, as compared to 2007, and non-acquired treatment growth at existing and new centers and growth through acquisitions. The decrease in the average dialysis revenue per treatment in 2008, as compared to 2007, was primarily due to the impact of some commercial rate compression that occurred in late 2007, decreases in intensity of physician-prescribed pharmaceuticals, partially offset by changes in the mix and rates of some of our other commercial payors.

The following table summarizes our dialysis and related lab services revenues by modality for the year ended December 31, 2009:

	Revenue percentages
Outpatient hemodialysis centers	84%
Peritoneal dialysis and home-based hemodialysis	11%
Hospital inpatient hemodialysis	5%
Total dialysis and related lab services revenues	100%

In addition to reimbursements for dialysis treatments, the other major component of dialysis and related lab services revenues is the administration of EPO and other pharmaceuticals as part of the dialysis treatment, which represents slightly more than 30% of total dialysis and related lab services revenues for the year ended December 31, 2009.

Approximately 65% of our total dialysis and related lab services revenues for the year ended December 31, 2009 were from government-based programs, principally Medicare, Medicaid, and Medicare-assigned plans, representing approximately 88% of our total patients. Approximately 35% of our dialysis and related lab services revenues and 12% of our patients are associated with commercial payors. Less than 1% of our dialysis and related lab services payments are due directly from patients. No single commercial payor accounted for more than 5% of total dialysis and related lab services revenues for the year ended December 31, 2009.

On average we are paid significantly more for services provided to patients covered by commercial healthcare plans than we are for patients covered by Medicare, Medicaid or other government plans such as Medicare-assigned plans. Patients covered by commercial health plans transition to Medicare coverage after a maximum of 33 months. As a patient transitions from commercial coverage to Medicare or Medicaid coverage, the payment rates normally decline substantially. As of December 31, 2009, the Medicare ESRD dialysis treatment rates for our patients were between $150 and $167 per treatment, or an overall average of $159 per treatment, excluding the administration of separately billed pharmaceuticals. Medicare payment rates are insufficient to cover our costs associated with providing dialysis treatments, and therefore we lose money on each Medicare treatment.

Nearly all of our net earnings from dialysis and related lab services are derived from commercial payors, some of which pay at negotiated payment rates as established by contract and others of which pay based on our usual and customary fee schedule. We are continuously in negotiations with commercial payors for contracted rates and some of these payment rates are under downward pressure as we negotiate these rates with large HMOs and insurance carriers and we expect this trend to continue. We also expect that we may experience decreases in patient volume as our negotiations with commercial payors continue. In addition, payors have been attempting to impose restrictions and limitations on non-contracted or out-of-network providers, in which we receive higher payment rates than for in-network providers. If we experience a net overall reduction in our contracted and non-contracted commercial rates as a result of these negotiations or restrictions, it could have a material adverse effect on our operating results.

Our average dialysis and related lab services revenue per treatment can be significantly impacted by several major factors, including our ability to negotiate acceptable payment rates with contracted and non-contracted

commercial payors, changes in the mix and intensities of physician-prescribed pharmaceuticals, government payment policies regarding reimbursement amounts for dialysis treatments and pharmaceuticals, including the bundling of such services and changes in the mix of government and non-government payments.

Operating expenses and charges

Patient care costs. Dialysis and related lab services patient care costs are those costs directly associated with operating and supporting our dialysis centers and consist principally of labor, pharmaceuticals, medical supplies and operating costs of the dialysis centers. The dialysis and related lab services patient care costs on a per treatment basis were $234, $230 and $227 for 2009, 2008, and 2007, respectively. The $4 increase in the per treatment costs in 2009 as compared to 2008 was primarily attributable to higher labor rates and benefit costs, an increase in pharmaceutical costs, an increase in other operating costs of our dialysis centers and a increase in the intensities of physician-prescribed pharmaceuticals, partially offset by improved productivity.

Dialysis and related lab services patient care costs on a per treatment basis increased by approximately $3 in 2008 as compared to 2007. The increase in the per treatment costs was primarily attributable to an increase in labor rates as well as the negative impact on productivity during the year as we implemented new federal guidelines. Additionally, we experienced an increase in the operating costs of our dialysis centers driven in part by the number of new centers opened and from centers constructed but pending state and/or federal certification, and an increase in pharmaceutical costs, partially offset by a decrease in the intensities of physician-prescribed pharmaceuticals.

General and administrative expenses. Dialysis and related lab services general and administrative expenses for the years ended 2009, 2008 and 2007 were approximately $427 million, $402 million and $400 million, respectively. The increase of approximately $25 million in 2009 as compared to 2008 was primarily due to increases in labor and benefit costs, partially offset by the timing of certain other expenditures. The increase in general and administrative expenses of approximately $2 million in 2008 as compared to 2007, was primarily due to increases in labor costs and the timing of certain other expenditures, mainly offset by lower integration costs and lower professional fees.

Depreciation and amortization. Dialysis and related lab services depreciation and amortization expenses for 2009, 2008 and 2007 were approximately $222 million, $210 million and $189 million, respectively. The increase of approximately $12 million in depreciation and amortization for dialysis and related lab services in 2009 as compared to 2008 was primarily due to growth through new center developments and expansions. The increase in depreciation and amortization of approximately $21 million in 2008, as compared to 2007, was primarily due to growth through new center developments and expansions and a change in amortization associated with amendments to the Product Supply Agreement.

Provision for uncollectible accounts receivable. The provision for uncollectible accounts receivable for dialysis and related lab services was 2.7% for 2009 and 2.6% for 2008 and 2007. The increase in the provision for uncollectible accounts in 2009 was primarily to reflect a slowdown in the timing of payments from some of our non-government payors. The current provision level of 2.7% may increase if we encounter problems with our billing and collection process as a result of sustained weakness in the U.S. economy.

Operating income

Dialysis and related lab services operating income for 2009 increased by approximately $61 million as compared to 2008. The increase in the operating income for 2009 as compared to 2008 was primarily due to growth in the number of dialysis treatments, an increase in the dialysis revenue per treatment of approximately $6 as described above. The dialysis and related lab services operating income also increased as a result of certain cost control initiatives and improved productivity, but was negatively impacted primarily by higher labor and benefit costs, an increase in pharmaceutical costs and an increase in other operating costs of our dialysis centers.

Dialysis and related lab services operating income for 2008 decreased by approximately $51 million as compared to 2007. Operating income in 2007 included a valuation gain of $55 million on the Product Supply Agreement and $7 million of insurance settlements relating to Hurricane Katrina as discussed above. Excluding these items, operating income for 2008 would have increased by approximately $11 million as compared to adjusted operating income for 2007. The increase in the operating income for 2008 as compared to adjusted operating income for 2007 was primarily due to growth in the volume of revenue outpacing increases in certain expenditures. However, operating income for 2008 was negatively affected by certain significant items such as a decrease in our dialysis revenue per treatment, lower intensities of physician-prescribed pharmaceuticals, an increase in labor costs and higher operating costs of our dialysis centers primarily associated with the number of new centers that were opened and from centers constructed but pending state and/or federal certification, an increase in pharmaceutical costs (primarily heparin), and the absence of a Medicare rate increase.

Other—Ancillary services and strategic initiatives

	Year ended		
	2009	2008	2007
	(dollar amounts rounded to nearest million)		
Revenues	$ 317	$ 245	$ 134
Segment operating loss	$ (18)	$ (30)	$ (48)

Net operating revenues

The ancillary services and strategic initiatives net operating revenues for 2009 increased by approximately $72 million or 29.5% as compared to 2008, primarily from growth in pharmacy services, VillageHealth services and from our infusion therapy services.

The ancillary services and strategic initiatives net operating revenues for 2008 increased by approximately $111 million or 82.7% as compared to 2007, primarily from growth in pharmacy services, VillageHealth services, vascular access services and a full year of operations of our infusion therapy services which we acquired in the third quarter of 2007.

Operating expenses

Ancillary services and strategic initiatives operating expenses for 2009 increased by approximately $60 million from 2008, primarily due to an increase in volume in our pharmacy business, an increase in labor and benefit costs, partially offset by lower professional fees.

Ancillary services and strategic initiatives operating expenses for 2008 increased by approximately $93 million from 2007, primarily due to an increase in volume in our pharmacy business, an increase in fixed operating expenses, an increase in labor costs and a full year of operations of our infusion therapy services, partially offset by lower professional fees in our VillageHealth business.

Operating loss

Ancillary services and strategic initiatives operating losses for 2009 decreased by approximately $12 million from 2008. The decrease in operating losses was primarily due to volume growth in revenues outpacing increases in operating expenses, primarily associated with our pharmacy business and our VillageHealth business, partially offset by an increase in operating losses associated with certain new initiatives.

Ancillary services and strategic initiatives operating losses for 2008 decreased by approximately $18 million from 2007. The decrease in operating losses was primarily due to growth in revenues outpacing increases in operating expenses, primarily associated with our pharmacy business and our vascular access services.

Corporate level charges

Stock-based compensation. Stock-based compensation of approximately $44 million for 2009 increased by approximately $3 million from 2008. Stock-based compensation for 2008 increased by approximately $7 million from 2007. The increases in both periods resulted from an increase in the aggregate quantity of grants that contributed expense to each of these years.

Debt expense. Debt expense for 2009, 2008, and 2007 consisted of interest expense of approximately $176 million, $215 million, and $243 million, respectively, and amortization of deferred financing costs of approximately $10 million for each year presented. Debt expense for 2007 also included the write-off of approximately $4 million of deferred financing costs associated with the principal prepayments on our term loans. The decrease in interest expense in 2009 as compared to 2008 was primarily attributable to decreases in the LIBOR-based variable interest rates on the unhedged portion of our debt and the result of lower notional amounts of fixed rate swap agreements that contained higher rates. As of December 31, 2009, the notional amounts of our fixed rate swaps were approximately $389 million as compared to approximately $790 million at December 31, 2008. Our overall weighted average effective interest rate in 2009 was 4.86% as compared to 5.82% in 2008. The decrease in interest expense in 2008 as compared to 2007 was primarily attributable to decreases in the LIBOR-based variable interest rates on the unhedged portion of our debt. Our overall weighted average interest rate in 2008 was 5.82% as compared to 6.49% in 2007.

Equity investment income. Equity investment income was approximately $2.4 million in 2009 as compared to $0.8 million in 2008. The increase in equity investment income in 2009 was primarily due to an increase in the number of equity investments and improved profitability at several joint ventures. Equity investment income in 2008 remained flat as compared to 2007.

Other income. Other income was approximately $4 million, $12 million, and $22 million in 2009, 2008, and 2007, respectively, and consisted principally of interest income. The decrease in other income in 2009 was primarily the result of lower average interest rates, partially offset by higher average cash balances. The decrease in other income in 2008 as compared to 2007, was primarily due to the fact that 2007 included gains on the sale of investments of approximately $6 million resulting from the sale of our investment in NxStage Medical Inc. and a decrease in interest rates as well as lower average cash and investment balances.

Provision for income taxes. The provision for income taxes for 2009 represented an effective annualized tax rate of 36.7%, compared with 35.9% and 36.4% in 2008 and 2007, respectively. The effective tax rate in 2008 was lower primarily due to nonrecurring tax benefits associated with transactions occurring in 2008. We currently project the effective income tax rate for 2010 to be in the range of 36.5% to 37.5%.

Impairments and valuation adjustments. We perform impairment or valuation reviews for our property and equipment, amortizable intangible assets with finite useful lives, equity investments in non-consolidated businesses, and our investments in ancillary services and strategic initiatives at least annually and whenever a change in condition indicates that an impairment review is warranted. Such changes include shifts in our business strategy or plans, the quality or structure of our relationships with our partners, or when a center experiences deteriorating operating performance. Goodwill is also assessed at least annually for possible valuation impairment using fair value methodologies. These types of adjustments are charged directly to the corresponding operating segment that incurred the charge. No significant impairments or valuation adjustments were recognized during the periods presented.

Noncontrolling interests

Net income attributable to noncontrolling interests for 2009, 2008 and 2007 were approximately $57 million, $47 million and $47 million, respectively. The increase in noncontrolling interests in 2009 was primarily due to an increase in new dialysis centers having minority partners and growth in the earnings of our existing dialysis joint ventures. The percentage of dialysis and related lab services net operating revenues generated from dialysis related joint ventures was approximately 16% in 2009 compared to 15% in 2008.

Accounts receivable

Our accounts receivable balances at December 31, 2009 and 2008 represented approximately 68 and 70 days of revenue, respectively, net of bad debt allowance. The relative decrease in the days of net revenue in accounts receivable as of December 31, 2009 was a result of improved cash collections on current outstanding balances. Accounts receivable balances of approximately 70 days of revenue is more consistent with our past experience levels and expected trends.

As of December 31, 2009 and 2008, approximately $201 million and $102 million in unreserved accounts receivable, respectively, representing approximately 18% and 9% of our total accounts receivable balance, respectively, were more than six months old. During 2009, we experienced delays in cash collections from certain government payors and certain commercial payors. We anticipate that we will collect these outstanding balances since we believe the delays in collections relate primarily to the timing of payors processing our claims for payment. There were no significant unreserved balances over one year old. Less than 2% of our treatments are classified as "patient pay". Substantially all revenue realized is from government and commercial payors, as discussed above.

Amounts pending approval from third-party payors as of December 31, 2009 and 2008, other than the standard monthly billing, consisted of approximately $46 million and $39 million, respectively, associated with Medicare bad debt claims, classified as "other receivables". Currently, our Medicare bad debt claims are typically paid to us before the Medicare fiscal intermediary audits the claims. However, the payment received from Medicare is subject to adjustment based upon the actual results of the audits. Such audits typically occur one to four years after the claims are filed. As a kidney dialysis provider, our revenue is not subject to cost report settlements, except for potentially limiting the collectibility of these Medicare bad debt claims.

Liquidity and capital resources

Available liquidity. As of December 31, 2009, our cash balance was $539 million and we had undrawn credit under our Senior Secured Credit Facilities totaling $250 million, of which approximately $52 million was committed for outstanding letters of credit. We believe that we will have sufficient liquidity, operating cash flows and access to borrowings to fund our scheduled debt service and other obligations for the foreseeable future. Our primary sources of liquidity are cash from operations and cash from borrowings.

Cash flow from operations during 2009 amounted to $667 million, compared with $614 million for 2008. Cash flow from operations in 2009 included cash interest payments of approximately $186 million and cash tax payments of $162 million. Cash flow from operations in 2008 included cash interest payments of $223 million and cash tax payments of $163 million.

Non-operating cash outflows in 2009 included $275 million for capital asset expenditures, including $161 million for new center developments and relocations, and $114 million for maintenance and information technology. We also spent an additional $88 million for acquisitions. During 2009, we also received $33 million from the maturity and sale of investments. However, these proceeds were either used to repurchase other investments or were used to fund distributions from our deferred compensation plans. In addition, we received $75 million associated with stock option exercises and other share issuances and the related excess tax benefits. We also made distributions to noncontrolling interests of $68 million, and received contributions from noncontrolling interests of $13 million associated with new joint ventures and from additional equity contributions. We also repurchased 2.9 million shares of our common stock for approximately $154 million.

Non-operating cash outflows in 2008 included $318 million for capital asset expenditures, including $213 million for new center developments and relocations and $105 million for maintenance and information technology. We also spent an additional $102 million for acquisitions. During 2008, we also received $43 million from the maturity and sale of investments. However, these proceeds were either used to repurchase other investments or were used to fund distributions from our deferred compensation plans. In addition, we received

$48 million associated with stock option exercises and other share issuances and related excess tax benefits. We also made distributions to noncontrolling interests of $59 million and received contributions from noncontrolling interests of $19 million associated with new joint ventures and from additional equity contributions. We also repurchased 4.8 million shares of our common stock for approximately $233 million.

During 2009, we acquired a total of 19 dialysis centers, opened 78 new dialysis centers, sold or closed eight centers, merged 16 centers into other existing centers, made equity investments in six centers and added two centers under management and administrative service agreements. During 2008, we acquired a total of 20 dialysis centers, opened 86 new dialysis centers, sold or closed nine centers, merged eight centers into other existing centers, ceased operations at one joint venture in which we owned an equity investment and added a net two centers under management and administrative service agreements.

We currently expect to spend approximately $125 million for general maintenance capital asset expenditures in 2010, and approximately $250 million for new center development, relocations and center acquisitions depending upon the availability of certain projects and sufficient project returns which does not include any potential expenditures for our new corporate headquarters. We expect to generate approximately $675 million to $725 million of operating cash flow in 2010. Our actual expenditures for growth and cash flows in 2010 could vary significantly from these expected amounts.

2009 capital structure changes and other items

Our Senior Secured Credit Facilities are guaranteed by substantially all of our direct and indirect wholly-owned subsidiaries and are secured by substantially all of our and our subsidiary guarantors' assets. The Senior Secured Credit Facilities also contain customary affirmative and negative covenants and require compliance with financial covenants, including an interest rate coverage ratio and a leverage ratio that determines the interest rate margins on our term loan A and our revolving line of credit. The Senior Secured Credit Facilities in general also contain limits on the general amount of capital expenditures for internal growth, acquisitions and capital improvements, as described below, as well as limits on the amount of tangible net assets in non-guarantor subsidiaries.

Term Loan A

During 2009, we made mandatory principal payments totaling $61.3 million on our term loan A. As a result of these principal payments, the outstanding balance on term loan A as of December 31, 2009 was $153.1 million and bore interest at LIBOR plus a margin of 1.50%, for an overall weighted average effective rate of 1.74%. The interest rate margin is subject to adjustment depending upon certain financial conditions and could range from 1.50% to 2.25%. Term loan A matures in October 2011 and requires annual principal payments of $87.5 million in 2010 and $65.6 million in 2011, respectively.

Term Loan B

As of December 31, 2009, the outstanding balance of our term loan B was $1.7 billion and bore interest at LIBOR plus a margin of 1.50% for an overall weighted average effective rate of 2.66%, including the impact of our swap agreements. We did not make any principal payments on term loan B during 2009, nor were we required to. Term loan B matures in October 2012 and requires principal payments of $1.7 billion in 2012.

Senior and Senior Subordinated Notes

Our senior and senior subordinated notes, as of December 31, 2009, consisted of $900 million of 6 5/8% senior notes due 2013 and $850 million of 7 1/4% senior subordinated notes due 2015. The notes are guaranteed by substantially all of our direct and indirect wholly-owned subsidiaries and require semi-annual interest payments in March and September. We may redeem some or all of the senior notes at any time on or after March 15, 2009 and some or all of the senior subordinated notes at any time on or after March 15, 2010.

Interest rate swaps

As of December 31, 2009, we maintained a total of eight interest rate swap agreements, with amortizing notional amounts totaling $389 million. These agreements had the economic effect of modifying the LIBOR-based variable interest rate on an equivalent amount of our debt to fixed rates ranging from 3.88% to 4.70%, resulting in an overall weighted average effective interest rate of 5.78% on the hedged portion of our Senior Secured Credit Facilities, including the term loan B margin of 1.50%. The swap agreements expire in 2010 and require quarterly interest payments. During 2009, 2008, and 2007 we accrued net cash (obligations) benefits of approximately ($17.3) million, $(4.2) million, and $14.5 million, respectively, from these swaps, which are included in debt expense. We estimate that approximately $8.9 million of existing unrealized pre-tax losses in other comprehensive income at December 31, 2009 will be reclassified into income in 2010. As of December 31, 2009 and 2008, the total fair value of these swaps were liabilities of $10.8 million and $21.9 million, respectively. The 2009 amount was included in other current liabilities. The 2008 amount was primarily included in other long-term liabilities. Also during 2009, we recorded approximately $8.0 million, net of tax, as an increase to other comprehensive income for amounts reclassified into income, net of swap valuation losses. In 2008, we recorded $10.4 million, net of tax, as reductions to other comprehensive income for swap valuation losses, net of amounts reclassified into income.

As of December 31, 2009, the interest rates were economically fixed on approximately 21% of our variable rate debt and approximately 59% of our total debt.

As a result of the swap agreements, our overall weighted average effective interest rate on the Senior Secured Credit Facilities was 2.63%, based upon the current margins in effect of 1.50%, as of December 31, 2009.

Our overall weighted average effective interest rate in 2009 was 4.86% and as of December 31, 2009 was 4.68%.

Stock repurchases

During 2009, we repurchased a total of 2,902,619 shares of our common stock for $153.5 million, or an average price of $52.88 per share, pursuant to previously announced authorizations by the Board of Directors. On November 3, 2009, we announced that our Board of Directors authorized an increase of an additional $500 million of share repurchases of our common stock. As a result of these transactions the total outstanding authorization for share repurchases as of December 31, 2009 was $500 million. We have not repurchased any additional shares of our common stock from January 1, 2010 through February 25, 2010. This stock repurchase program has no expiration date.

Stock-based compensation

Stock-based compensation recognized in a period represents the amortization during that period of the estimated grant-date fair value of stock-based awards over their vesting terms, adjusted for expected forfeitures. Shares issued upon exercise of stock awards are generally issued from shares in treasury. We have utilized the Black-Scholes-Merton valuation model for estimating the grant date fair value of stock options and stock-settled stock appreciation rights granted in all prior periods. During 2009, we granted 4,211,840 stock-settled stock appreciation rights with a grant-date fair value of $50.9 million and a weighted-average expected life of approximately 3.5 years, and also granted 48,135 stock units with a grant-date fair value of $2.6 million and a weighted-average expected life of approximately 2.5 years.

For the years ended December 31, 2009 and 2008, we recognized $44.4 million and $41.2 million, respectively, in stock-based compensation expense for stock options, stock-settled stock appreciation rights, stock units and discounted employee stock plan purchases, which is primarily included in general and

administrative expenses. The estimated tax benefits recorded for this stock-based compensation in 2009 and 2008 were $16.8 million and $15.6 million, respectively. As of December 31, 2009, there was $80.0 million of total estimated unrecognized compensation cost related to nonvested stock-based compensation arrangements under our equity compensation and stock purchase plans. We expect to recognize this cost over a weighted average remaining period of 1.4 years.

During the years ended December 31, 2009 and 2008, we received $63.7 million and $35.6 million, respectively, in cash proceeds from stock option exercises and $18.2 million and $14.0 million, respectively, in total actual tax benefits upon the exercise of stock awards.

2008 capital structure changes

Term Loan A

During 2008, we made mandatory principal payments totaling $14.9 million on our term loan A. As a result of these principal payments, the outstanding balance on term loan A as of December 31, 2008 was $214.4 million and bore interest at LIBOR plus a margin of 1.50%, for an overall weighted average effective rate of 1.97%. The interest rate margin is subject to adjustment depending upon certain financial conditions and could range from 1.50% to 2.25%.

Term Loan B

As of December 31, 2008, the outstanding balance of our term loan B was $1.7 billion and bore interest at LIBOR plus a margin of 1.50% for an overall weighted average effective rate of 3.63%, including the impact of our swap agreements. We did not make any principal payments on term loan B during 2008, nor were we required to.

Senior and Senior Subordinated Notes

Our senior and senior subordinated notes, as of December 31, 2008, consisted of $900 million of 6 5/8% senior notes due 2013 and $850 million of 7 1/4% senior subordinated notes due 2015. The notes are guaranteed by substantially all of our direct and indirect wholly-owned subsidiaries and require semi-annual interest payments in March and September. We may redeem some or all of the senior notes at any time on or after March 15, 2009 and some or all of the senior subordinated notes at any time on or after March 15, 2010.

Stock repurchases

During 2008, we repurchased a total of 4,788,881 shares of our common stock for $232.7 million, or an average price of $48.59 per share, pursuant to previously announced authorizations by the Board of Directors. On May 1, 2008, our Board of Directors authorized an increase of an additional $143.5 million of share repurchases of our common stock. As a result of these transactions the total outstanding authorization for share repurchases as of December 31, 2008 was $153.5 million. This stock repurchase program had no expiration date.

Interest rate swaps

As of December 31, 2008, we maintained a total of nine interest rate swap agreements, with amortizing notional amounts totaling $790 million. These agreements had the economic effect of modifying the LIBOR-based variable interest rate on an equivalent amount of our debt to fixed rates ranging from 3.08% to 4.27%, resulting in a weighted average effective interest rate of 5.54%, on the hedged portion of our Senior Secured Credit Facilities, including the term loan B margin of 1.50%.

As of December 31, 2008, the interest rates were economically fixed on approximately 41% of our variable rate debt and approximately 69% of our total debt.

As a result of the swap agreements our overall weighted average effective interest rate on our Senior Secured Credit Facilities was 3.48%, based upon the current margins in effect of 1.50%, as of December 31, 2008.

At December 31, 2008 our overall weighted average effective interest rate was 5.10%.

Off-balance sheet arrangements and aggregate contractual obligations

In addition to the debt obligations reflected on our balance sheet, we have commitments associated with operating leases and letters of credit as well as potential obligations associated with our equity investments and to dialysis centers that are wholly-owned by third parties. Substantially all of our facilities are leased. We have potential acquisition obligations for several joint ventures and for some of our non-wholly-owned subsidiaries in the form of put provisions. These put provisions, if exercised, would require us to purchase the third-party owners' noncontrolling interests at either the appraised fair market value or a predetermined multiple of earnings or cash flow attributable to the noncontrolling interests put to us, which is intended to approximate fair value. The methodology we use to estimate the fair value of the noncontrolling interests subject to put provisions assumes either the higher of a liquidation value of net assets or an average multiple of earnings, based on historical earnings, patient mix and other performance indicators, as well as other factors. The estimate of the fair values of the noncontrolling interests subject to put provisions is a critical accounting estimate that involves significant judgments and assumptions and may not be indicative of the actual values at which the noncontrolling interests may ultimately be settled, which could vary significantly from our current estimates. The estimated fair values of noncontrolling interests subject to put provisions can also fluctuate and the implicit multiple of earnings at which these noncontrolling interests obligations may be settled will vary depending upon market conditions including potential purchasers' access to the capital markets, which can impact the level of competition for dialysis and non-dialysis related businesses, the economic performance of these businesses and the restricted marketability of the third-party owners' noncontrolling interests. The amount of noncontrolling interests subject to put provisions that contractually employ a predetermined multiple of earnings rather than fair value are immaterial. For additional information see Note 22 to our consolidated financial statements.

We also have potential cash commitments to provide operating capital advances as needed to several other dialysis centers that are wholly-owned by third parties or centers in which we own an equity investment, as well as to physician–owned vascular access clinics that we operate under management and administrative services agreements.

The following is a summary of these contractual obligations and commitments as of December 31, 2009 (in millions):

	Less Than 1 year	2-3 years	4-5 years	After 5 years	Total
Scheduled payments under contractual obligations:					
Long-term debt	$ 100	$ 1,774	$ 901	$ 850	$ 3,625
Interest payments on senior and senior subordinated notes	121	243	153	31	548
Capital lease obligations	—	2	1	2	5
Operating leases	216	374	283	439	1,312
	$ 437	$ 2,393	$ 1,338	$ 1,322	$ 5,490
Potential cash requirements under existing commitments:					
Letters of credit	$ 52	$ —	$ —	$ —	$ 52
Noncontrolling interests subject to put provisions	169	56	52	55	332
Pay-fixed swaps potential obligations	11	—	—	—	11
Operating capital advances	7	—	—	—	7
Income tax liabilities for unrecognized tax benefits	19	—	—	—	19
	$ 258	$ 56	$ 52	$ 55	$ 421

Not included above are interest payments related to our Senior Secured Credit Facilities. Our Senior Secured Credit Facilities as of December 31, 2009 bear interest at LIBOR plus current margins of 1.50%. The term loan A and the revolving line of credit are adjustable depending upon our achievement of certain financial ratios. At December 31, 2009, our Senior Secured Credit Facilities had an overall weighted average effective interest rate of 2.63%, including the effects of our swap agreements. Interest payments are due at the maturity of specific debt tranches within each term loan, which can range in maturity from one month to twelve months. Future interest payments will depend upon the amount of mandatory principal payments and principal prepayments, as well as changes in the LIBOR-based interest rates and changes in the interest rate margins. Assuming no principal prepayments on our Senior Secured Credit Facilities during 2010 and no changes in the effective interest rate, including the interest rate margin, approximately $49 million of interest would be required to be paid in 2010.

The pay-fixed swap obligations represent the estimated fair market values of our interest rate swap agreements as reported by various broker dealers that are based upon relevant observable market inputs as well as other current market conditions that existed as of December 31, 2009, and represent the estimated potential obligation that we would be required to pay based upon the estimated future settlement of each specific tranche within the swap agreements. The actual amount of our obligation associated with these swaps in the future will depend upon changes in the LIBOR-based interest rates that can fluctuate significantly depending upon market conditions, and other relevant factors that can affect the fair market value of these swap agreements.

In addition to the above commitments, we are obligated to purchase a certain amount of our hemodialysis products and supplies at fixed prices through 2015 from Gambro Renal Products, Inc. in connection with the Product Supply Agreement. Our total expenditures for the years ended December 31, 2009 and 2008 on such products were approximately 2% of our total operating costs in each year. In January 2010, we entered into an agreement with Fresenius which committed us to purchase a certain amount of dialysis equipment, parts and supplies from them through 2013.

The actual amount of purchases in future years from Gambro Renal Products and Fresenius will depend upon a number of factors, including the operating requirements of our centers, the number of centers we acquire, growth of our existing centers, and in the case of the Product Supply Agreement, Gambro Renal Products' ability to meet our needs.

Settlements of approximately $15 million of existing income tax liabilities for unrecognized tax benefits are excluded from the above table as reasonably reliable estimates of their timing cannot be made.

Contingencies

The information in Note 16 of the Notes to Consolidated Financial Statements of this report is incorporated by reference in response to this item.

Critical accounting estimates and judgments

Our consolidated financial statements and accompanying notes are prepared in accordance with United States generally accepted accounting principles. These accounting principles require us to make estimates, judgments and assumptions that affect the reported amounts of revenues, expenses, assets, liabilities, and contingencies. All significant estimates, judgments and assumptions are developed based on the best information available to us at the time made and are regularly reviewed and updated when necessary. Actual results will generally differ from these estimates. Changes in estimates are reflected in our financial statements in the period of change based upon on-going actual experience trends, or subsequent settlements and realizations depending on the nature and predictability of the estimates and contingencies. Interim changes in estimates are applied prospectively within annual periods. Certain accounting estimates, including those concerning revenue recognition and accounts receivable, impairments of long-lived assets, accounting for income taxes, quarterly

variable compensation accruals, purchase accounting valuation estimates, fair value estimates and stock-based compensation are considered to be critical to evaluating and understanding our financial results because they involve inherently uncertain matters and their application requires the most difficult and complex judgments and estimates.

Revenue recognition and accounts receivable. There are significant estimating risks associated with the amount of revenue that we recognize in a given reporting period. Payment rates are often subject to significant uncertainties related to wide variations in the coverage terms of the commercial healthcare plans under which we receive payments. In addition, ongoing insurance coverage changes, geographic coverage differences, differing interpretations of contract coverage, and other payor issues complicate the billing and collection process. Net revenue recognition and allowances for uncollectible billings require the use of estimates of the amounts that will ultimately be realized considering, among other items, retroactive adjustments that may be associated with regulatory reviews, audits, billing reviews and other matters.

Revenues associated with Medicare and Medicaid programs are recognized based on (a) the payment rates that are established by statute or regulation for the portion of the payment rates paid by the government payor (e.g., 80% for Medicare patients) and (b) for the portion not paid by the primary government payor, the estimated amounts that will ultimately be collectible from other government programs paying secondary coverage (e.g., Medicaid secondary coverage), the patient's commercial health plan secondary coverage, or the patient.

Commercial healthcare plans, including contracted managed-care payors, are billed at our usual and customary rates; however, revenue is recognized based on estimated net realizable revenue for the services provided. Net realizable revenue is estimated based on contractual terms for the patients under healthcare plans with which we have formal agreements, non-contracted healthcare plan coverage terms if known, estimated secondary collections, historical collection experience, historical trends of refunds and payor payment adjustments (retractions), inefficiencies in our billing and collection processes that can result in denied claims for payments, slow down in collections, a reduction in the amounts that we expect to collect and regulatory compliance issues. Determining applicable primary and secondary coverage for our more than 118,000 patients at any point in time, together with the changes in patient coverages that occur each month, requires complex, resource-intensive processes. Collections, refunds and payor retractions typically continue to occur for up to three years or longer after services are provided.

We generally expect our range of dialysis and related lab services revenues estimating risk to be within 1% of its revenue, which can represent as much as 6% of consolidated operating income. Changes in estimates are reflected in the then-current financial statements based on on-going actual experience trends, or subsequent settlements and realizations depending on the nature and predictability of the estimates and contingencies. Changes in revenue estimates for prior periods are separately disclosed and reported if material to the current reporting period and longer term trend analyses, and have not been significant.

Lab service revenues for current period dates of services are recognized at the estimated net realizable amounts to be received.

Impairments of long-lived assets. We account for impairments of long-lived assets, which include property and equipment, equity investments in non-consolidated businesses, amortizable intangible assets with finite useful lives and goodwill, in accordance with the provisions of applicable accounting guidance. Impairment reviews are performed at least annually and whenever a change in condition occurs which indicates that the carrying amounts of assets may not be recoverable.

Such changes include changes in our business strategies and plans, changes in the quality or structure of our relationships with our partners and deteriorating operating performance of individual dialysis centers or other operations. We use a variety of factors to assess the realizable value of assets depending on their nature and use. Such assessments are primarily based upon the sum of expected future undiscounted net cash flows over the

expected period the asset will be utilized, as well as market values and conditions. The computation of expected future undiscounted net cash flows can be complex and involves a number of subjective assumptions. Any changes in these factors or assumptions could impact the assessed value of an asset and result in an impairment charge equal to the amount by which its carrying value exceeds its actual or estimated fair value.

Accounting for income taxes. We estimate our income tax provision to recognize our tax expense for the current year, and our deferred tax liabilities and assets for future tax consequences of events that have been recognized in our financial statements, measured using enacted tax rates and laws expected to apply in the periods when the deferred tax liabilities or assets are expected to be realized. We are required to assess our tax positions on a more-likely-than-not criteria and to also determine the actual amount of benefit to recognize in the financial statements. Deferred tax assets are assessed based upon the likelihood of recoverability from future taxable income and, to the extent that recovery is not likely, a valuation allowance is established. The allowance is regularly reviewed and updated for changes in circumstances that would cause a change in judgment about the realizability of the related deferred tax assets. These calculations and assessments involve complex estimates and judgments because the ultimate tax outcome can be uncertain and future events unpredictable.

Variable compensation accruals. We estimate variable compensation accruals quarterly based upon the annual amounts expected to be earned and paid out resulting from the achievement of certain teammate-specific and/or corporate financial and operating goals. Our estimates, which include compensation incentives for bonuses, and other awards, are updated periodically based on changes in our economic condition or cash flows that could ultimately impact the actual final award. Actual results reflected in each fiscal quarter may vary due to the subjectivity involved in anticipating fulfillment of specific and/or corporate goals, as well as the final determination and approval of amounts by our Board of Directors.

Purchase accounting valuation estimates. We make various assumptions and estimates regarding the valuation of tangible and intangible assets, liabilities and contractual as well as non-contractual contingencies associated with our acquisitions. These assumptions can have a material effect on our balance sheet valuations and the related amount of depreciation and amortization expense that will be recognized in the future. Long-lived tangible and intangible assets are subject to our regular ongoing impairment assessments.

Fair value estimates. We have recorded certain assets, liabilities and noncontrolling interests subject to put provisions at fair value. The FASB defines fair value which is measured based upon certain valuation techniques that include inputs and assumptions that market participants would use in pricing assets, liabilities and noncontrolling interests subject to put provisions. We have measured the fair values of our applicable assets, liabilities and noncontrolling interests subject to put provisions based upon certain market inputs and assumptions that are either observable or unobservable in determining fair values and have also classified these assets, liabilities and noncontrolling interests subject to put provisions into the appropriate fair value hierarchy levels. The fair value of our investments available for sale are based upon quoted market prices from active markets and the fair value of our swap agreements are based upon valuation models and a variety of techniques as reported by various broker dealers that are based upon relevant observable market inputs such as current interest rates, forward yield curves, and other credit and liquidity market conditions. For our noncontrolling interests subject to put provisions we have estimated the fair values of these based upon either the higher of a liquidation value of net assets or an average multiple of earnings based on historical earnings, patient mix and other performance indicators, as well as other factors. The estimate of the fair values of the noncontrolling interests subject to put provisions involves significant judgments and assumptions and may not be indicative of the actual values at which the noncontrolling interests may ultimately be settled, which could vary significantly from our current estimates. The estimated fair values of the noncontrolling interests subject to put provisions can also fluctuate and the implicit multiple of earnings at which these noncontrolling interests obligations may be settled will vary depending upon market conditions including potential purchasers' access to the capital markets, which can impact the level of competition for dialysis and non-dialysis related businesses, the economic performance of these businesses and the restricted marketability of the third-party owners' noncontrolling interests.

Stock-based compensation. Stock-based compensation recognized in a period represents the amortization during that period of the estimated grant-date fair value of stock-based awards over their vesting terms, adjusted for expected forfeitures. Stock-based compensation recognized in our consolidated financial statements for the years ended December 31, 2009, 2008 and 2007 include compensation costs for stock-based awards granted prior to, but not fully vested as of December 31, 2006, and stock-based awards granted thereafter. We estimate the grant-date fair value of stock awards using complex option pricing models that rely heavily on estimates from us about uncertain future events, including the expected term of the awards, the expected future volatility of our stock price, and expected future risk-free interest rates.

Significant new accounting standards

On June 29, 2009, the Financial Accounting Standards Board (FASB) established the FASB Accounting Standards Codification (Codification) as the single source of authoritative U.S. generally accepted accounting principles (GAAP) for all nongovernmental entities. Rules and interpretive releases of the Securities and Exchange Commission (SEC) are also sources of authoritative U.S. GAAP for SEC registrants. The Codification does not change U.S. GAAP but takes previously issued FASB standards and other U.S. GAAP authoritative pronouncements, changes the way the standards are referred to, and includes them in specific topic areas. The Codification is effective for financial statements issued for interim and annual periods ending after September 15, 2009. The adoption of the Codification did not have any impact on our consolidated financial statements.

Effective for our first annual reporting period that begins after November 15, 2009, the FASB is eliminating the quantitative approach previously required for determining the primary beneficiary of a variable interest entity, and requiring additional disclosures about an enterprise's involvement in variable interest entities. An enterprise will be required to perform an analysis to determine whether the enterprise's variable interest or interests give it a controlling financial interest in a variable interest entity by having both the power to direct the activities of a variable interest entity that most significantly impact the entity's economic performance and the obligation to absorb losses of the entity, or the right to receive benefits from the entity. In addition, the FASB is establishing new guidance for determining whether an entity is a variable interest entity, requiring an ongoing reassessment of whether an enterprise is the primary beneficiary of a variable interest entity, and adding an additional reconsideration event for determining whether an entity is a variable interest entity when any changes in facts and circumstances occur such that the holders of the equity investment at risk, as a group, lose the power from voting rights or similar rights concerning those investments to direct the activities of the entity that most significantly impact the entity's economic performance. We are currently in the process of assessing the expected impact of this standard on our consolidated financial statements.

Effective May 28, 2009, the FASB issued requirements relating to the accounting for and disclosure of events that occur after the balance sheet date but before financial statements are issued or are available to be issued. These requirements set forth the period after the balance sheet date during which management of a reporting entity should evaluate events or transactions that may occur for potential recognition or disclosure in the financial statements, the circumstances under which an entity should recognize events or transactions occurring after the balance sheet date in its financial statements, and the disclosures that an entity should make about events or transactions that occurred after the balance sheet date. These requirements do not apply to subsequent events or transactions that are within the scope of other applicable principles of GAAP that provide different guidance on the accounting treatment for subsequent events or transactions. These requirements were effective for interim and annual periods ending after June 15, 2009. See Note 1 to the consolidated financial statements for further details.

Effective January 1, 2009, we are required to provide enhanced disclosures about our derivative and hedging activities. We are required to provide additional disclosures about (a) how and why we use derivative instruments, (b) how derivative instruments and related hedged items are accounted for, and (c) how derivative instruments and related hedged items affect our financial position, financial performance, and cash flows. These requirements did not have a material impact on our consolidated financial statements. See Note 13 to the consolidated financial statements for the disclosure of these items.

Effective January 1, 2009, we are required to treat noncontrolling interests as a separate component of equity, but apart from our equity, and not as a liability or other item outside of equity. We are also required to identify and present consolidated net income attributable to us and to noncontrolling interests on the face of the consolidated statement of income. Previously, we had reported minority interests (noncontrolling interests) as a reduction to operating income. In addition, changes in our ownership interest while we retain a controlling financial interest should be accounted for as equity transactions. We were also required to expand disclosures in the financial statements to include a reconciliation of the beginning and ending balances of the equity attributable to us and the noncontrolling owners and a schedule showing the effects of changes in our ownership interest in a subsidiary on the equity attributable to us. This change did not have a material impact on our consolidated financial statements; however, it did change the presentation of minority interests (noncontrolling interests) in our consolidated financial statements. In conjunction with adopting these requirements, we are required to classify securities with redemption features that are not solely within our control such as our noncontrolling interests that are subject to put provisions outside of permanent equity and to measure these noncontrolling interests at fair value. See Note 22 to our consolidated financial statements for further details. The consolidated financial statements have been recast for all prior periods presented for the retrospective application of these presentation and disclosure requirements.

All business combinations consummated after January 1, 2009, are required to be accounted for under the acquisition method (previously referred to as the purchase method). Under the acquisition method, the acquirer recognizes the assets acquired, the liabilities assumed, contractual contingencies, as well as any noncontrolling interests in the acquiree at their fair values at the acquisition date. Noncontractual contingencies are recognized at the acquisition date at their fair values only if it is more likely than not that they meet the definition of an asset or a liability. Transaction costs are excluded from the acquisition cost and are expensed as incurred. Any contingent consideration included by the acquirer as part of the purchase price must also be measured at fair value at the acquisition date and is classified as either equity or a liability. A company that obtains control but acquires less than 100% of an acquiree is required to record 100% of the fair value of the acquiree assets, liabilities, and noncontrolling interests at the acquisition date. The adoption of these requirements did not have a material impact on our consolidated financial statements.

In December 2008, the FASB required public entities to provide additional disclosures about transfers of financial assets and required public enterprises to provide additional disclosures about their involvement in variable interest entities and certain special purpose entities. Because these requirements impact disclosures and not the accounting treatment for transfers of financial assets and interests in variable interest entities, these requirements did not impact our financial condition or results of operations.

Effective January 1, 2008, the FASB established a framework for measuring fair value and also required additional disclosures about fair value measurements. These requirements applied to assets and liabilities that are carried at fair value on a recurring basis. Effective January 1, 2009 the FASB issued additional requirements relating to nonfinancial assets and liabilities that are not recognized or disclosed at fair value in the financial statements on a recurring basis (at least annually). See note 23 to our consolidated financial statements for the impact of these requirements. The adoption of these requirements relating to nonfinancial assets and liabilities did not have a material impact on our consolidated financial statements.

Effective January 1, 2008, the FASB allows companies the alternative to measure certain financial assets and liabilities at fair value on an instrument-by-instrument basis that are currently not required to be measured at fair value. This provision is also designed to reduce the volatility in earnings caused by measuring related assets and liabilities differently and establishes presentation and disclosure requirements designed to facilitate comparisons between companies that choose different measurement attributes for similar types of assets and liabilities. The adoption of this provision did not have a material impact on our consolidated financial statements.

Item 7A. Quantitative and Qualitative Disclosures about Market Risk.

Interest rate sensitivity

The tables below provide information about our financial instruments that are sensitive to changes in interest rates. For our debt obligations the table presents principal repayments and current weighted average interest rates on our debt obligations as of December 31, 2009. The variable rates presented reflect the weighted average LIBOR rates in effect for all debt tranches plus margins in effect at the end of 2009 including the economic effects of our swap agreements. Term loan A and revolving line of credit interest rate margins are subject to adjustment depending upon changes in certain of our financial ratios including a leverage ratio. The margins currently in effect at December 31, 2009 were 1.50% on all of the outstanding balances under our Senior Secured Credit Facilities. For our interest rate swap agreements, the table below presents the notional amounts by contract maturity date and the related interest rate terms of the agreements (to pay fixed rates, and to receive LIBOR).

	Expected maturity date								
	2010	2011	2012	2013	2014	Thereafter	Total	Fair Value	Average interest rate
	(dollars in millions)								
Long-term debt:									
Fixed rate	$ 2	$ 1	$ 1	$ 901	$ 1	$ 852	$ 1,758	$ 1,765	6.88%
Variable rate	$ 98	$ 67	$ 1,707	$ —	$ —	$ —	$ 1,872	$ 1,829	2.62%

	Notional amount	Contract maturity date					Pay fixed	Receive variable	Fair value
		2010	2011	2012	2013	2014			
		(dollars in millions)							
Swaps:									
Pay-fixed swaps	$ 389	$ 389	$ —	$ —	$ —	$ —	3.88% to 4.70%	LIBOR	$ (10.8)

Our Senior Secured Credit Facilities, which include the term loan A and the term loan B, consist of various individual tranches that can range in maturity from one month to twelve months and each specific tranche bears interest at a LIBOR rate that is determined by the maturity of that specific tranche plus an interest rate margin, which is currently 1.50% at December 31, 2009. LIBOR-based interest rates are reset as each specific tranche matures and a new tranche is re-established and can fluctuate significantly depending upon market conditions including the credit and capital markets. Any increase in the LIBOR-based interest rates on the unhedged portion of our Senior Secured Credit Facilities, which totaled approximately $1.5 billion as of December 31, 2009 will have a negative impact on our overall earnings.

As of December 31, 2009, we maintained a total of eight interest rate swap agreements, with amortizing notional amounts totaling $389 million. These agreements had the economic effect of modifying the LIBOR-based variable interest rate on an equivalent amount of our debt to fixed rates ranging from 3.88% to 4.70%, resulting in an overall weighted average effective interest rate of 5.78% on the hedged portion of our Senior Secured Credit Facilities, including the term loan B margin of 1.50%. The swap agreements expire in 2010 and require quarterly interest payments. During 2009, we accrued net cash obligations of $17.3 million from these swaps, which are included in debt expense. As of December 31, 2009, the total fair value of these swaps was a liability of $10.8 million. During 2009, we recorded $8.0 million, net of tax, as an increase to other comprehensive income for amounts reclassified into income, net of swap valuation losses.

As of December 31, 2009, the interest rates were economically fixed on approximately 21% of our variable rate debt and approximately 59% of our total debt.

As a result of the swap agreements, our overall weighted average effective interest rate on the Senior Secured Credit Facilities was 2.63%, based upon the current margins in effect of 1.50% as of December 31, 2009.

Our overall weighted average effective interest rate in 2009 was 4.86% and as of December 31, 2009 was 4.68%.

One means of assessing exposure to debt-related interest rate changes is a duration-based analysis that measures the potential loss in net income resulting from a hypothetical increase in interest rates of 100 basis points across all variable rate maturities (referred to as a "parallel shift in the yield curve"). Under this model, with all else constant, it is estimated that such an increase would have reduced net income by approximately $8.5 million, $7.1 million, and $5.5 million, net of tax, for the years ended December 31, 2009, 2008, and 2007, respectively.

Exchange rate sensitivity

We are currently not exposed to any foreign currency exchange rate risk.

Item 8. Financial Statements and Supplementary Data.

See the Index to Financial Statements and Index to Financial Statement Schedules included at "Item 15. Exhibits, Financial Statement Schedules."

Item 9. Changes in and Disagreements with Accountants on Accounting and Financial Disclosure.

None.

Item 9A. Controls and Procedures.

Management has established and maintains disclosure controls and procedures designed to ensure that information required to be disclosed in the reports that it files or submits pursuant to the Securities Exchange Act of 1934, as amended, or Exchange Act, is recorded, processed, summarized and reported within the time periods specified in the Securities and Exchange Commission's rules and forms, and that such information is accumulated and communicated to our management including our Chief Executive Officer and Chief Financial Officer as appropriate to allow for timely decisions regarding required disclosures.

At the end of the period covered by this report, we carried out an evaluation, under the supervision and with the participation of our Chief Executive Officer and Chief Financial Officer, of the effectiveness of the design and operation of our disclosure controls and procedures in accordance with the Exchange Act requirements. Based upon that evaluation, the Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures are effective for timely identification and review of material information required to be included in our Exchange Act reports, including this report on Form 10-K. Management recognizes that these controls and procedures can provide only reasonable assurance of desired outcomes, and that estimates and judgments are still inherent in the process of maintaining effective controls and procedures.

There has not been any change in our internal control over financial reporting that was identified during the evaluation that occurred during the fourth fiscal quarter and that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

Item 9B. Other Information.

None.

PART III

Item 10. Directors, Executive Officers and Corporate Governance.

In 2002, we adopted a Corporate Governance Code of Ethics that applies to our principal executive officer, principal financial officer, principal accounting officer or controller, and to all of our financial accounting and legal professionals who are directly or indirectly involved in the preparation, reporting and fair presentation of our financial statements and Exchange Act Reports. The Code of Ethics is posted on our website, located at http://www.davita.com. We also maintain a Corporate Code of Conduct that applies to all of our employees, which is posted on our website.

Under our Corporate Governance Guidelines all Board Committees including the Audit Committee, Nominating and Governance Committee and the Compensation Committee, which are comprised solely of Independent Directors as defined within the listing standards of the New York Stock Exchange, have written charters that outline the committee's purpose, goals, membership requirements and responsibilities. These charters are regularly reviewed and updated as necessary by our Board of Directors. All Board Committee charters as well as the Corporate Governance Guidelines are posted on our website located at http://www.davita.com.

The other information required to be disclosed by this item will appear in, and is incorporated by reference from, the sections entitled "Proposal No. 1. Election of Directors", "Corporate Governance", and "Security Ownership of Certain Beneficial Owners and Management" included in our definitive proxy statement relating to our 2010 annual stockholder meeting.

Item 11. Executive Compensation.

The information required by this item will appear in, and is incorporated by reference from, the sections entitled "Executive Compensation" and "Compensation Committee Interlocks and Insider Participations" included in our definitive proxy statement relating to our 2010 annual stockholder meeting. The information required by Item 407(e)(5) of Regulation S-K will appear in and is incorporated by reference from the section entitled "Compensation Committee Report" included in our definitive proxy statement relating to our 2010 annual stockholder meeting; however, this information shall not be deemed to be "filed".

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters.

The following table provides information about our common stock that may be issued upon the exercise of stock options, stock-settled stock appreciation rights, restricted stock units and other rights under all of our existing equity compensation plans as of December 31, 2009, including our omnibus 2002 Equity Compensation Plan and our Employee Stock Purchase Plan, and the terminated 1999 Non-Executive Officer and Non-Director Equity Compensation Plan. The material terms of these plans are described in Note 17 to the Consolidated Financial Statements. The 1999 Non-Executive Officer and Non-Director Equity Compensation Plan was not required to be approved by our shareholders.

Plan category	Number of shares to be issued upon exercise of outstanding options, warrants and rights (a)	Weighted average exercise price of outstanding options, warrants and rights (b)	Number of shares remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a)) (c)	Total of shares reflected in columns (a) and (c) (d)
Equity compensation plans approved by shareholders	13,472,013	$ 49.15	5,004,344	18,476,357
Equity compensation plans not requiring shareholder approval	20,084	$ 50.98	—	20,084
Total	13,492,097	$ 49.16	5,004,344	18,496,441

Other information required to be disclosed by Item 12 will appear in, and is incorporated by reference from, the section entitled "Security Ownership of Certain Beneficial Owners and Management" included in our definitive proxy statement relating to our 2010 annual stockholder meeting.

Item 13. Certain Relationships and Related Transactions and Director Independence.

The information required by this item will appear in, and is incorporated by reference from, the section entitled "Certain Relationships and Related Transactions" and the section entitled "Corporate Governance" included in our definitive proxy statement relating to our 2010 annual stockholder meeting.

Item 14. Principal Accounting Fees and Services.

The information required by this item will appear in, and is incorporated by reference from, the section entitled "Ratification of Appointment of Independent Registered Public Accounting Firm" included in our definitive proxy statement relating to our 2010 annual stockholder meeting.

PART IV

Item 15. Exhibits, Financial Statement Schedules.

(a) Documents filed as part of this Report:

(1) *Index to Financial Statements:*

(2) *Index to Financial Statement Schedules:*

(3) *Exhibits:*

2.1	Stock Purchase Agreement dated as of December 6, 2004, among Gambro AB, Gambro, Inc. and DaVita Inc.(9)
2.2	Amended and Restated Asset Purchase Agreement effective as of July 28, 2005, by and among DaVita Inc., Gambro Healthcare, Inc. and Renal Advantage Inc., a Delaware corporation, formerly known as RenalAmerica, Inc.(12)
3.1	Amended and Restated Certificate of Incorporation of Total Renal Care Holdings, Inc., or TRCH, dated December 4, 1995.(1)
3.2	Certificate of Amendment of Certificate of Incorporation of TRCH, dated February 26, 1998.(2)
3.3	Certificate of Amendment of Certificate of Incorporation of DaVita Inc. (formerly Total Renal Care Holdings, Inc.), dated October 5, 2000.(4)
3.4	Certificate of Amendment of Amended and Restated Certificate of Incorporation of DaVita Inc., as amended dated May 30, 2007.(23)
3.5	Amended and Restated Bylaws for DaVita Inc. dated as of March 2, 2007.(25)
4.1	Indenture for the 6 5/8% Senior Notes due 2013 dated as of March 22, 2005.(3)
4.2	Indenture for the 7 1/4% Senior Subordinated Notes due 2015 dated as of March 22, 2005.(3)

4.3	First Supplemental Indenture, dated October 5, 2005, by and among DaVita Inc., the Guarantors, the persons named as Additional Guarantors and The Bank of New York Trust Company, N.A., as Trustee.(11)
4.4	First Supplemental Indenture, dated October 5, 2005, by and among DaVita Inc., the Guarantors, the persons named as Additional Guarantors and The Bank of New York Trust Company, N.A., as Trustee.(13)
4.5	Rights Agreement, dated as of November 14, 2002, between DaVita Inc. and the Bank of New York, as Rights Agent.(21)
4.6	Second Supplemental Indenture (Senior), dated February 9, 2007, by and among DaVita Inc., the Guarantors, the persons named as Additional Guarantors and The Bank of New York Trust Company, N.A., as Trustee.(22)
4.7	Second Supplemental Indenture (Senior Subordinated), dated February 9, 2007, by and among DaVita Inc., the Guarantors, the persons named as Additional Guarantors and The Bank of New York Trust Company, N.A., as Trustee.(22)
4.8	Registration Rights Agreement for the 6 5/8% Senior Notes due 2013 dated as of February 23, 2007.(26)
10.1	Employment Agreement, dated as of October 19, 2009, by and between DaVita Inc. and Kim M. Rivera.✓*
10.2	Employment Agreement, dated as of June 15, 2000, by and between DaVita Inc. and Joseph C. Mello.(6)*
10.3	Second Amendment to Mr. Mello's Employment Agreement, effective December 12, 2008.(33)*
10.4	Employment Agreement, effective as of August 16, 2004, by and between DaVita Inc. and Tom Usilton.(7)*
10.5	Amendment to Mr. Usilton's Employment Agreement, dated February 12, 2007.(24)*
10.6	Second Amendment to Mr. Usilton's Employment Agreement, effective December 12, 2008.(32)*
10.7	Employment Agreement, effective as of November 18, 2004, by and between DaVita Inc. and Joseph Schohl.(14)*
10.8	Amendment to Mr. Schohl's Employment Agreement, effective December 30, 2008.(32)*
10.9	Employment Agreement, dated as of October 31, 2005, effective October 24, 2005, by and between DaVita Inc. and Dennis Kogod.(13)*
10.10	Amendment to Mr. Kogod's Employment Agreement, effective December 12, 2008.(32)*
10.11	Employment Agreement, effective September 22, 2005, by and between DaVita Inc. and James Hilger.(15)*
10.12	Amendment to Mr. Hilger's Employment Agreement, effective December 12, 2008.(32)*
10.13	Employment Agreement effective February 13, 2008, by and between DaVita Inc. and Richard K. Whitney.(28)*
10.14	Amendment to Equity Award Agreement, entered into on December 11, 2009, between DaVita Inc. and Richard K. Whitney.✓*
10.15	Employment Agreement, effective July 25, 2008, between DaVita Inc. and Kent J. Thiry.(29)*
10.16	Employment Agreement, effective August 1, 2008, between DaVita Inc. and Allen Nissenson.(30)*
10.17	Employment Agreement, effective March 3, 2008, between DaVita Inc. and David Shapiro.(32)*
10.18	Amendment to Mr. Shapiro's Employment Agreement, effective December 4, 2008.(32)*
10.19	Form of Indemnity Agreement.(20)*

10.20	Form of Indemnity Agreement.(14)*
10.21	Executive Incentive Plan (as Amended and Restated effective January 1, 2009).(34)*
10.22	Executive Retirement Plan.(32)*
10.23	Post-Retirement Deferred Compensation Arrangement.(14)*
10.24	Amendment No. 1 to Post Retirement Deferred Compensation Arrangement.(32)*
10.25	DaVita Voluntary Deferral Plan.(11)*
10.26	Deferred Bonus Plan (Prosperity Plan).(31)
10.27	Amendment No. 1 to Deferred Bonus Plan (Prosperity Plan).(32)*
10.28	Amended and Restated Employee Stock Purchase Plan.(27)*
10.29	Severance Plan.(33)*
10.30	Change in Control Bonus Program.(32)*
10.31	First Amended and Restated Total Renal Care Holdings, Inc. 1999 Non-Executive Officer and Non-Director Equity Compensation Plan.(5)
10.32	Non-Management Director Compensation Philosophy and Plan.(28)*
10.33	Amended and Restated 2002 Equity Compensation Plan.(10)*
10.34	Amended and Restated 2002 Equity Compensation Plan.(19)*
10.35	Amended and Restated 2002 Equity Compensation Plan.(27)*
10.36	Amended and Restated 2002 Equity Compensation Plan.(32)*
10.37	Form of Non-Qualified Stock Option Agreement—Employee (DaVita Inc. 1999 Non-Executive Officer and Non-Director Equity Compensation Plan.(18)*
10.38	Form of Non-Qualified Stock Option Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(7)*
10.39	Form of Non-Qualified Stock Option Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(16)*
10.40	Form of Non-Qualified Stock Option Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(18)*
10.41	Form of Restricted Stock Units Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(7)*
10.42	Form of Restricted Stock Units Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(16)*
10.43	Form of Restricted Stock Units Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(18)*
10.44	Form of Restricted Stock Units Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(32)*
10.45	Form of Stock Appreciation Rights Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(16)*
10.46	Form of Stock Appreciation Rights Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(18)*
10.47	Form of Stock Appreciation Rights Agreement—Board (DaVita Inc. 2002 Equity Compensation Plan).(30)*
10.48	Form of Restricted Stock Units Agreement—Board (DaVita Inc. 2002 Equity Compensation Plan).(30)*

10.49	Form of Non-Qualified Stock Option Agreement—Board (DaVita Inc. 2002 Equity Compensation Plan).(30)*
10.50	Credit Agreement, dated as of October 5, 2005, among DaVita Inc., the Guarantors party thereto, the Lenders party thereto, Bank of America, N.A., Wachovia Bank, National Association, Bear Stearns Corporate Lending Inc., The Bank of New York, The Bank of Nova Scotia, The Royal Bank of Scotland plc, WestLB AG, New York Branch as Co-Documentation Agents, Credit Suisse, Cayman Islands Branch, as Syndication Agent, JPMorgan Chase Bank, N.A., as Administrative Agent and Collateral Agent, JPMorgan Securities Inc., as Sole Lead Arranger and Bookrunner and Credit Suisse, Cayman Islands Branch, as Co-Arranger.(11)
10.51	Credit Agreement, dated as of October 5, 2005, as Amended and Restated as of February 23, 2007, by and among DaVita Inc., the Guarantors party thereto, the Lenders party thereto and JPMorgan Chase Bank, N.A.(26)
10.52	Amendment Agreement, dated February 23, 2007, by and among DaVita Inc., the Guarantors party thereto, the Lenders party thereto and JPMorgan Chase Bank, N.A.(26)
10.53	Security Agreement, dated as of October 5, 2005, by DaVita Inc., the Guarantors party thereto and JPMorgan Chase Bank, N.A., as Collateral Agent.(11)
10.54	Corporate Integrity Agreement between the Office of Inspector General of the Department of Health and Human Services and Gambro Healthcare, Inc. effective as of December 1, 2004.(11)
10.55	Amended and Restated Alliance and Product Supply Agreement, dated as of August 25, 2006, among Gambro Renal Products, Inc., DaVita Inc. and Gambro AB.(17)**
10.56	Letter dated March 19, 2007 from Willard W. Brittain, Jr. to Peter T. Grauer, Lead Independent Director of the Company.(22)
10.57	Dialysis Organization Agreement between DaVita Inc. and Amgen USA Inc. dated December 20, 2007.(31)**
12.1	Computation of Ratio of Earnings to Fixed Charges.✓
14.1	DaVita Inc. Corporate Governance Code of Ethics.(8)
21.1	List of our subsidiaries.✓
23.1	Consent of KPMG LLP, independent registered public accounting firm.✓
24.1	Powers of Attorney with respect to DaVita. (Included on Page II-1).
31.1	Certification of the Chief Executive Officer, dated February 25, 2010, pursuant to Rule 13a-14(a) or 15d-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.✓
31.2	Certification of the Chief Financial Officer, dated February 25, 2010, pursuant to Rule 13a-14(a) or 15d-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.✓
32.1	Certification of the Chief Executive Officer, dated February 25, 2010, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.✓
32.2	Certification of the Chief Financial Officer, dated February 25, 2010, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.✓
101.INS	XBRL Instance Document.***
101.SCH	XBRL Taxonomy Extension Schema Document.***
101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document.***
101.DEF	XBRL Taxonomy Extension Definition Linkbase Document.***
101.LAB	XBRL Taxonomy Extension Label Linkbase Document.***
101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document.***

✓ Included in this filing.

* Management contract or executive compensation plan or arrangement.
** Portions of this exhibit are subject to a request for confidential treatment and have been redacted and filed separately with the SEC.
*** XBRL information is furnished and not filed as a part of a registration statement or prospectus for purposes of Section 11 or 12 of the Securities and Exchange Act of 1933, is deemed not filed for purposes of Section 18 of the Securities and Exchange Act of 1934, and otherwise is not subject to liability under these sections.

(1) Filed on March 18, 1996 as an exhibit to the Company's Transitional Report on Form 10-K for the transition period from June 1, 1995 to December 31, 1995.
(2) Filed on March 31, 1998 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 1997.
(3) Filed on March 25, 2005 as an exhibit to the Company's Current Report on Form 8-K.
(4) Filed on March 20, 2001 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 2000.
(5) Filed on February 28, 2003 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 2002.
(6) Filed on August 15, 2001 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2001.
(7) Filed on November 8, 2004 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2004.
(8) Filed on February 27, 2004 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 2003.
(9) Filed on December 8, 2004 as an exhibit to the Company's Current Report on Form 8-K.
(10) Filed on May 4, 2005 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2005.
(11) Filed on November 8, 2005 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2005.
(12) Filed on October 11, 2005 as an exhibit to the Company's Current Report on Form 8-K.
(13) Filed on November 4, 2005 as an exhibit to the Company's Current Report on Form 8-K.
(14) Filed on March 3, 2005 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 2004.
(15) Filed on August 7, 2006 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ending June 30, 2006.
(16) Filed on July 6, 2006 as an exhibit to the Company's Current Report on Form 8-K.
(17) Filed on November 3, 2006 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2006.
(18) Filed on October 18, 2006 as an exhibit to the Company's Current Report on Form 8-K.
(19) Filed on July 31, 2006 as an exhibit to the Company's Current Report on Form 8-K.
(20) Filed on December 20, 2006 as an exhibit to the Company's Current Report on Form 8-K.
(21) Filed on November 19, 2002 as an exhibit to the Company's Current Report on Form 8-K.
(22) Filed on May 3, 2007 as an exhibit to the Company's Quarterly Report as Form 10-Q for the quarter ended March 31, 2007.
(23) Filed on August 6, 2007 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2007.
(24) Filed on February 16, 2007 as an exhibit to the Company's Current Report on Form 8-K.
(25) Filed on March 8, 2007 as an exhibit to the Company's Current Report on Form 8-K.
(26) Filed on February 28, 2007 as an exhibit to the Company's Current Report on Form 8-K.
(27) Filed on June 4, 2007 as an exhibit to the Company's Current Report on Form 8-K.
(28) Filed on May 8, 2008 as an exhibit to the Company's Quarterly Report on Form 10-Q for the first quarter ended March 31, 2008.
(29) Filed on July 31, 2008 as an exhibit to the Company's Current Report on Form 8-K.

(30) Filed on November 6, 2008 as an exhibit to the Company's Quarterly Report on Form 10-Q for the third quarter ended September 30, 2008.
(31) Filed on February 29, 2008 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 2007.
(32) Filed on February 27, 2009 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 2008
(33) Filed on May 7, 2009 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2009.
(34) Filed on June 18, 2009 as an exhibit to the Company's Current Report on Form 8-K.

DAVITA INC.

MANAGEMENT'S REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING

Management is responsible for establishing and maintaining an adequate system of internal control over financial reporting designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with U.S. generally accepted accounting principles and which includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the Company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with U.S. generally accepted accounting principles, and that receipts and expenditures of the Company are being made only in accordance with authorizations of management and directors of the Company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the Company's assets that could have a material effect on the financial statements.

During the last fiscal year, the Company conducted an evaluation, under the oversight of the Chief Executive Officer and Chief Financial Officer, of the effectiveness of the design and operation of the Company's internal control over financial reporting. This evaluation was completed based on the criteria established in the report titled "Internal Control—Integrated Framework" issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

Based upon our evaluation under the COSO framework, we have concluded that the Company's internal control over financial reporting was effective as of December 31, 2009.

The Company's independent registered public accounting firm, KPMG LLP, has issued an attestation report on the Company's internal control over financial reporting, which report is included in this Annual Report.

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Shareholders
DaVita Inc.:

We have audited the accompanying consolidated balance sheets of DaVita Inc. and subsidiaries as of December 31, 2009 and 2008, and the related consolidated statements of income, equity and comprehensive income, and cash flows for each of the years in the three-year period ended December 31, 2009. These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of DaVita Inc. and subsidiaries as of December 31, 2009 and 2008, and the results of their operations and their cash flows for each of the years in the three-year period ended December 31, 2009, in conformity with U.S. generally accepted accounting principles.

As discussed in Note 1 to the consolidated financial statements, the Company adopted Financial Accounting Standards Board (FASB) Statement of Financial Accounting Standards No. 160, Noncontrolling Interests in Consolidated Financial Statements (included in FASB ASC Topic 810, Consolidation), on a prospective basis except for the presentation and disclosure requirements which were applied retrospectively for all periods presented effective January 1, 2009.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), DaVita Inc.'s internal control over financial reporting as of December 31, 2009, based on criteria established in *Internal Control—Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO), and our report dated February 25, 2010 expressed an unqualified opinion on the effectiveness of the Company's internal control over financial reporting.

/s/ KPMG LLP

Seattle, Washington
February 25, 2010

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Shareholders
DaVita Inc.:

We have audited DaVita Inc.'s internal control over financial reporting as of December 31, 2009, based on criteria established in *Internal Control—Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). DaVita Inc.'s management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying "Management's Report on Internal Control Over Financial Reporting". Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audit also included performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, DaVita Inc. maintained, in all material respects, effective internal control over financial reporting as of December 31, 2009, based on criteria established in *Internal Control—Integrated Framework* issued by COSO.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of DaVita Inc. and subsidiaries as of December 31, 2009 and 2008, and the related consolidated statements of income, equity and comprehensive income, and cash flows for each of the years in the three-year period ended December 31, 2009, and our report dated February 25, 2010 expressed an unqualified opinion on those consolidated financial statements.

/s/ KPMG LLP

Seattle, Washington
February 25, 2010

DAVITA INC.

CONSOLIDATED STATEMENTS OF INCOME
(dollars in thousands, except per share data)

	Year ended December 31,		
	2009	2008	2007
Net operating revenues	$ 6,108,800	$ 5,660,173	$ 5,264,151
Operating expenses and charges:			
Patient care costs	4,248,668	3,920,487	3,590,344
General and administrative	531,531	508,240	491,236
Depreciation and amortization	228,986	216,917	193,470
Provision for uncollectible accounts	161,786	146,229	136,682
Equity investment income	(2,442)	(796)	(1,217)
Valuation gain on alliance and product supply agreement	—	—	(55,275)
Total operating expenses and charges	5,168,529	4,791,077	4,355,240
Operating income	940,271	869,096	908,911
Debt expense	(185,755)	(224,716)	(257,147)
Other income, net	3,708	12,411	22,460
Income before income taxes	758,224	656,791	674,224
Income tax expense	278,465	235,471	245,581
Net income	479,759	421,320	428,643
Less: Net income attributable to noncontrolling interests	(57,075)	(47,160)	(46,865)
Net income attributable to DaVita Inc.	$ 422,684	$ 374,160	$ 381,778
Earnings per share:			
Basic earnings per share attributable to DaVita Inc.	$ 4.08	$ 3.56	$ 3.61
Diluted earnings per share attributable to DaVita Inc.	$ 4.06	$ 3.53	$ 3.55
Weighted average shares for earnings per share:			
Basic	103,603,885	105,149,448	105,893,052
Diluted	104,167,685	105,939,725	107,418,240

See notes to consolidated financial statements.

DAVITA INC.

CONSOLIDATED BALANCE SHEETS
(dollars in thousands, except per share data)

	December 31, 2009	December 31, 2008
ASSETS		
Cash and cash equivalents	$ 539,459	$ 410,881
Short-term investments	26,475	35,532
Accounts receivable, less allowance of $229,317 and $211,222	1,105,903	1,075,457
Inventories	70,041	84,174
Other receivables	263,456	239,165
Other current assets	40,234	33,761
Income tax receivable	—	32,130
Deferred income taxes	256,953	217,196
Total current assets	2,302,521	2,128,296
Property and equipment, net	1,104,925	1,048,075
Amortizable intangibles, net	136,732	160,521
Equity investments	22,631	19,274
Long-term investments	7,616	5,656
Other long-term assets	32,615	47,330
Goodwill	3,951,196	3,876,931
	$ 7,558,236	$ 7,286,083
LIABILITIES AND EQUITY		
Accounts payable	$ 176,657	$ 282,883
Other liabilities	461,092	495,239
Accrued compensation and benefits	286,121	312,216
Current portion of long-term debt	100,007	72,725
Income taxes payable	23,064	—
Total current liabilities	1,046,941	1,163,063
Long-term debt	3,532,217	3,622,421
Other long-term liabilities	87,692	101,442
Alliance and product supply agreement, net	30,647	35,977
Deferred income taxes	334,855	244,884
Total liabilities	5,032,352	5,167,787
Commitments and contingencies		
Noncontrolling interests subject to put provisions	331,725	291,397
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; 103,062,698 and 103,753,673 shares outstanding)	135	135
Additional paid-in capital	621,685	584,358
Retained earnings	2,312,134	1,889,450
Treasury stock, at cost (31,799,585 and 31,108,610 shares)	(793,340)	(691,857)
Accumulated other comprehensive loss	(5,548)	(14,339)
Total DaVita Inc. shareholders' equity	2,135,066	1,767,747
Noncontrolling interests not subject to put provisions	59,093	59,152
Total equity	2,194,159	1,826,899
	$ 7,558,236	$ 7,286,083

See notes to consolidated financial statements.

DAVITA INC.

CONSOLIDATED STATEMENTS OF CASH FLOW
(dollars in thousands)

	Year ended December 31,		
	2009	2008	2007
Cash flows from operating activities:			
Net income.	$ 479,759	$ 421,320	$ 428,643
Adjustments to reconcile net income to cash provided by operating activities:			
Depreciation and amortization	228,986	216,917	193,470
Valuation gain on alliance and product supply agreement	—	—	(55,275)
Stock-based compensation expense	44,422	41,235	34,149
Tax benefits from stock award exercises	18,241	13,988	32,788
Excess tax benefits from stock award exercises	(6,950)	(8,013)	(25,541)
Deferred income taxes	50,869	94,912	18,601
Equity investment income, net	(204)	(796)	(1,217)
Loss (gain) on disposal of assets	9,761	15,216	(2,825)
Non-cash debt expense and non-cash rent charges	11,184	11,794	12,713
Changes in operating assets and liabilities, net of effect of acquisitions and divestitures:			
Accounts receivable	(32,313)	(149,939)	15,911
Inventories	15,115	(2,715)	11,271
Other receivables and other current assets	(35,104)	(40,960)	(61,049)
Other long-term assets	7,288	(11,929)	(14,528)
Accounts payable	(104,879)	57,422	(9,216)
Accrued compensation and benefits	(9,138)	(31,602)	9,691
Other current liabilities	(43,543)	8,871	657
Income taxes	44,578	(30,087)	(12,942)
Other long-term liabilities	(11,362)	8,067	5,764
Net cash provided by operating activities	666,710	613,701	581,065
Cash flows from investing activities:			
Additions of property and equipment	(274,605)	(317,962)	(272,212)
Acquisitions	(87,617)	(101,959)	(127,094)
Proceeds from asset sales	7,697	530	12,289
Purchase of investments available-for-sale	(2,062)	(2,009)	(52,085)
Purchase of investments held-to-maturity	(22,664)	(21,048)	(23,061)
Proceeds from the sale of investments available-for-sale	16,693	21,291	32,274
Proceeds from maturities of investments held-to-maturity	16,380	21,355	4,795
Purchase of equity investments	(2,100)	—	(17,550)
Distributions received on equity investments	2,547	908	1,134
Purchase of intangible assets	(329)	(65)	(2,291)
Other investment activity	—	1,220	(2,942)
Net cash used in investing activities	(346,060)	(397,739)	(446,743)
Cash flows from financing activities:			
Borrowings	18,767,592	17,089,018	13,113,640
Payments on long-term debt	(18,828,824)	(17,102,569)	(13,160,942)
Deferred financing costs	(42)	(130)	(4,511)
Purchase of treasury stock	(153,495)	(232,715)	(6,350)
Excess tax benefits from stock award exercises	6,950	8,013	25,541
Stock award exercises and other share issuances, net	67,908	40,247	62,902
Distributions to noncontrolling interests	(67,748)	(59,357)	(48,029)
Contributions from noncontrolling interests	13,071	19,074	14,735
Proceeds from sales of additional noncontrolling interests	9,375	10,701	5,536
Purchases from noncontrolling interests	(6,859)	(24,409)	—
Net cash (used in) provided by financing activities	(192,072)	(252,127)	2,522
Net increase (decrease) in cash and cash equivalents	128,578	(36,165)	136,844
Cash and cash equivalents at beginning of year	410,881	447,046	310,202
Cash and cash equivalents at end of year	$ 539,459	$ 410,881	$ 447,046

See notes to consolidated financial statements.

DAVITA INC.

CONSOLIDATED STATEMENTS OF EQUITY AND COMPREHENSIVE INCOME
(dollars and shares in thousands)

	Non-controlling interests subject to put provisions	DaVita Inc. Shareholders' Equity								Non-controlling interests not subject to put provisions	Comprehensive income
		Common stock				Treasury stock		Accumulated other comprehensive income (loss)	Total		
		Shares	Amount	Additional paid-in capital	Retained earnings	Shares	Amount				
Balance at December 31, 2006	$ 191,871	134,862	$ 135	$ 523,500	$ 1,129,621	(30,226)	$ (526,920)	$ 12,997	$ 1,139,333	$ 37,079	
Comprehensive income:											
Net income	30,157				381,778				381,778	16,708	$ 428,643
Unrealized losses on interest rate swaps, net of tax								(7,169)	(7,169)		(7,169)
Less reclassification of net swap realized gains into net income, net of tax								(8,858)	(8,858)		(8,858)
Unrealized gains on investments, net of tax								4,211	4,211		4,211
Less reclassification of net investment realized gains into net income, net of tax								(3,692)	(3,692)		(3,692)
Total comprehensive income											$ 413,135
Cumulative effect of change in accounting principle SFAS Interpretation No (FIN) 48					3,891				3,891		
Stock purchase shares issued				3,831		124	2,160		5,991		
Stock unit shares issued				(1,848)		120	2,098		250		
Stock options and SSARs exercised				13,429		2,361	41,268		54,697		
Stock-based compensation expense				34,149					34,149		
Excess tax benefits from stock awards exercised				27,428					27,428		
Distributions to noncontrolling interests	(28,553)									(19,476)	
Contributions from noncontrolling interests	9,124									5,611	
Sales and assumptions of additional noncontrolling interests	6,061									7,281	
Changes in fair value of noncontrolling interests	121,374			(121,374)					(121,374)	—	
Other adjustments to noncontrolling interests	433									975	
Purchase of treasury stock						(111)	(6,350)		(6,350)		
Balance at December 31, 2007	$ 330,467	134,862	$ 135	$ 479,115	$ 1,515,290	(27,732)	$ (487,744)	$ (2,511)	$ 1,504,285	$ 48,178	

DAVITA INC.

CONSOLIDATED STATEMENTS OF EQUITY
AND
COMPREHENSIVE INCOME—(Continued)
(dollars and shares in thousands)

	Non-controlling interests subject to put provisions	DaVita Inc. Shareholders' Equity								Non-controlling interests not subject to put provisions	Comprehensive income
		Common stock				Treasury stock					
		Shares	Amount	Additional paid-in capital	Retained earnings	Shares	Amount	Accumulated other comprehensive income (loss)	Total		
Stock purchase shares issued				2,981		98	1,730		4,711		
Stock unit shares issued				(2,670)		181	3,544		874		
Stock options and SSARs exercised				12,278		1,133	23,328		35,606		
Stock-based compensation expense				41,235					41,235		
Excess tax benefits from stock awards exercised				8,165					8,165		
Distributions to noncontrolling interests	(40,016)									(19,341)	
Contributions from noncontrolling interests	7,305									11,769	
Sales and assumptions of additional noncontrolling interests	9,389									4,726	
Purchases from noncontrolling interests	(2,347)									(2,334)	
Changes in fair value of noncontrolling interests	(43,254)			43,254					43,254	—	
Other adjustments to noncontrolling interests	(548)									(605)	
Purchase of treasury stock						(4,789)	(232,715)		(232,715)		
Balance at December 31, 2008	$ 291,397	134,862	$ 135	$ 584,358	$ 1,889,450	(31,109)	$ (691,857)	$ (14,339)	$ 1,767,747	$ 59,152	
Comprehensive income:											
Net income	38,381				422,684				422,684	18,694	$ 479,759
Unrealized losses on interest rate swaps, net of tax								(2,578)	(2,578)		(2,578)
Less reclassification of net swap realized losses into net income, net of tax								10,542	10,542		10,542
Unrealized gains on investments, net of tax								986	986		986
Less reclassification of net investment realized gains into net income, net of tax								(159)	(159)		(159)
Total comprehensive income											$ 488,550
Stock purchase shares issued				2,135		107	2,387		4,522		
Stock unit shares issued				(1,570)		69	1,570		—		
Stock options and SSARs exercised				15,598		2,036	48,055		63,653		
Stock-based compensation expense				44,422					44,422		

DAVITA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
(dollars in thousands, except per share data)

1. Organization and summary of significant accounting policies

Organization

DaVita Inc. principally operates kidney dialysis centers and provides related lab services primarily in dialysis centers and in contracted hospitals across the United States. The Company also operates other ancillary services and strategic initiatives which relate primarily to its core business of providing renal care services. As of December 31, 2009, the Company operated or provided administrative services to 1,530 outpatient dialysis centers located in 43 states and the District of Columbia, serving approximately 118,000 patients. The Company's dialysis and related lab services business qualifies as a separately reportable segment and all other ancillary services and strategic initiatives have been combined and disclosed in the other segments category.

Basis of presentation

These consolidated financial statements are prepared in accordance with United States generally accepted accounting principles. The financial statements include DaVita and its subsidiaries, partnerships and other entities in which it maintains a 100%, majority voting, or other controlling financial interest (collectively, the Company). All significant intercompany transactions and balances have been eliminated. Non-marketable equity investments are recorded under the equity or cost method of accounting based upon whether the Company has significant influence over the investee. The Company has evaluated subsequent events through February 25, 2010, which is the date these consolidated financial statements were issued.

Use of estimates

The preparation of financial statements in conformity with United States generally accepted accounting principles requires the use of estimates and assumptions that affect the reported amounts of revenues, expenses, assets, liabilities and contingencies. Although actual results in subsequent periods will differ from these estimates, such estimates are developed based on the best information available to management and management's best judgments at the time made. All significant assumptions and estimates underlying the amounts reported in the financial statements and accompanying notes are regularly reviewed and updated. Changes in estimates are reflected in the financial statements based upon on-going actual experience trends, or subsequent settlements and realizations depending on the nature and predictability of the estimates and contingencies. Interim changes in estimates related to annual operating costs are applied prospectively within annual periods.

The most significant assumptions and estimates underlying these financial statements and accompanying notes involve revenue recognition and provisions for uncollectible accounts, impairments and valuation adjustments, accounting for income taxes, quarterly variable compensation accruals, purchase accounting valuation estimates, fair value estimates and stock-based compensation. Specific estimating risks and contingencies are further addressed within these notes to the consolidated financial statements.

Net operating revenues and accounts receivable

Revenues associated with Medicare and Medicaid programs are recognized based on: (a) the payment rates that are established by statute or regulation for the portion of the payment rates paid by the government payor (e.g., 80% for Medicare patients) and (b) for the portion not paid by the primary government payor, estimates of the amounts ultimately collectible from other government programs paying secondary coverage (e.g., Medicaid

secondary coverage), the patient's commercial health plan secondary coverage, or the patient. Revenues associated with commercial health plans are estimated based on contractual terms for the patients under healthcare plans with which the Company has formal agreements, non-contracted health plan coverage terms if known, estimated secondary collections, historical collection experience, historical trends of refunds and payor payment adjustments (retractions), inefficiencies in the Company's billing and collection processes that can result in denied claims for payments, and regulatory compliance issues.

Operating revenues are recognized in the period services are provided. Revenues consist primarily of payments from Medicare, Medicaid and commercial health plans for dialysis and ancillary services provided to patients. A usual and customary fee schedule is maintained for the Company's dialysis treatments and other patient services; however, actual collectible revenue is normally recognized at a discount from the fee schedule.

Commercial revenue recognition involves significant estimating risks. With many larger, commercial insurers the Company has several different contracts and payment arrangements, and these contracts often include only a subset of the Company's centers. It is often not possible to determine which contract, if any, should be applied prior to billing. In addition, for services provided by non- contracted centers, final collection may require specific negotiation of a payment amount, typically at a significant discount from the Company's usual and customary rates.

Services covered by Medicare and Medicaid are less subject to estimating risk. Both Medicare and Medicaid rates use prospective payment methods established in advance with definitive terms. Medicare payments for bad debt claims are subject to individual center profitability, as established by cost reports, and require evidence of collection efforts. As a result, billing and collection of Medicare bad debt claims are often delayed significantly, and final payment is subject to audit.

Medicaid payments, when Medicaid coverage is secondary, can also be difficult to estimate. For many states, Medicaid payment terms and methods differ from Medicare, and may prevent accurate estimation of individual payment amounts prior to billing.

Net revenue recognition and allowances for uncollectible billings require the use of estimates of the amounts that will ultimately be realized considering, among other items, retroactive adjustments that may be associated with regulatory reviews, audits, billing reviews and other matters.

The Company's range of revenue estimating risk for the dialysis and related lab services segment is generally expected to be within 1% of its revenue. Changes in revenue estimates for prior periods are separately disclosed, if material.

Management and administrative support services are provided to dialysis centers and physician practices and clinics that the Company does not own or in which the Company does not maintain a controlling ownership interest. The management fees are principally determined as a percentage of the managed operations' revenues or cash collections and in some cases an additional component based upon a percentage of operating income. Management fees are included in net operating revenues as earned, and represent less than 1% of total consolidated operating revenues.

Other income, net

Other income includes interest income on cash investments and other non-operating gains and losses from investment transactions.

DAVITA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)
(dollars in thousands, except per share data)

Cash and cash equivalents

Cash equivalents are highly liquid investments with maturities of three months or less at date of purchase.

Inventories

Inventories are stated at the lower of cost (first-in, first-out) or market and consist principally of pharmaceuticals and dialysis-related supplies. Rebates related to inventory purchases are recorded when earned and are based on certain achievement factors such as process improvements, data submission and some combination of these factors.

Property and equipment

Property and equipment is stated at cost less accumulated depreciation and amortization and is further reduced by any impairments. Maintenance and repairs are charged to expense as incurred. Depreciation and amortization expenses are computed using the straight-line method over the useful lives of the assets estimated as follows: buildings, 20 to 40 years; leasehold improvements, the shorter of their economic useful life or the expected lease term; and equipment and information systems, principally 3 to 8 years. Disposition gains and losses are included in current operating expenses.

Investments

Based upon the Company's intentions and ability to hold certain assets until maturity, the Company classifies certain debt securities as held-to-maturity and measures them at amortized cost. Based upon the Company's other strategies involving investments, the Company classifies equity securities that have readily determinable fair values and certain other debt securities as available for sale and measures them at fair value. Unrealized gains or losses from available for sale investments are recorded in other comprehensive income until realized.

Amortizable intangibles

Amortizable intangible assets and liabilities include non-competition and similar agreements, lease agreements, hospital acute services contracts, deferred debt issuance costs and the Alliance and Product Supply Agreement, each of which have finite useful lives. Non-competition and similar agreements are amortized over the terms of the agreements, typically ten years, using the straight-line method. Lease agreements and hospital acute service contracts are amortized straight-line over the term of the lease and the contract period, respectively. Deferred debt issuance costs are amortized to debt expense over the term of the related debt using the effective interest method. The Alliance and Product Supply Agreement intangible liability is being amortized using the straight-line method over the term of the agreement, which is ten years.

Goodwill

Goodwill represents the difference between the fair value of acquired businesses and the fair value of the identifiable tangible and intangible net assets acquired. Goodwill is not amortized, but is assessed for valuation impairment as circumstances warrant and at least annually. An impairment charge would be recorded to the extent the book value of goodwill exceeds its fair value. The Company operates several reporting units for goodwill impairment assessments.

DAVITA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)
(dollars in thousands, except per share data)

Impairment of long-lived assets

Long-lived assets, including property and equipment, equity investments in non-consolidated businesses, and amortizable intangible assets with finite useful lives, are reviewed for possible impairment at least annually and whenever significant events or changes in circumstances indicate that an impairment may have occurred, including changes in our business strategy and plans, changes in the quality or structure of our relationships with our partners and deteriorating operating performance of individual dialysis centers or other operations. An impairment is indicated when the sum of the expected future undiscounted net cash flows identifiable to an asset or asset group is less than its carrying value. Impairment losses are determined from actual or estimated fair values, which are based on market values, net realizable values or projections of discounted net cash flows, as appropriate. Impairment charges are included in operating expenses.

Income taxes

Federal and state income taxes are computed at current enacted tax rates, less tax credits using the asset and liability method. Deferred taxes are adjusted both for items that do not have tax consequences and for the cumulative effect of any changes in tax rates from those previously used to determine deferred tax assets or liabilities. Tax provisions include amounts that are currently payable, changes in deferred tax assets and liabilities that arise because of temporary differences between the timing of when items of income and expense are recognized for financial reporting and income tax purposes, changes in the recognition of tax positions and any changes in the valuation allowance caused by a change in judgment about the realizability of the related deferred tax assets. A valuation allowance is established when necessary to reduce deferred tax assets to amounts expected to be realized.

The Company uses a recognition threshold of more-likely-than not and a measurement attribute on all tax positions taken or expected to be taken in a tax return in order to be recognized in the financial statements. Once the recognition threshold is met, the tax position is then measured to determine the actual amount of benefit to recognize in the financial statements.

Self insurance

The Company maintains insurance reserves for professional and general liability and workers' compensation in excess of certain individual and or aggregate amounts not covered by third-party carriers. The Company estimates the self-insured retention portion of professional and general liability and workers' compensation risks using third-party actuarial calculations that are based upon historical claims experience and expectations for future claims.

Noncontrolling interests

Noncontrolling interests represent the equity interests of third-party owners in consolidated entities which are majority-owned. As of December 31, 2009, third parties held noncontrolling ownership interests in 137 consolidated entities. See discussion below on the retrospective application of adopting the presentation and disclosure requirements relating to noncontrolling interests.

Stock-based compensation

The Company's stock-based compensation awards are measured at their estimated fair value on the date of grant and recognized as compensation expense on the straight-line method over their individual requisite service periods. The Company implemented these requirements for all stock-based awards using the modified prospective transition method.

Interest rate swap agreements

The Company has entered into several interest rate swap agreements as a means of hedging its exposure to and volatility from variable-based interest rate changes. These agreements are designated as cash flow hedges and are not held for trading or speculative purposes, and have the economic effect of converting portions of the Company's variable rate debt to a fixed rate. See Note 13 to the consolidated financial statements for further details.

Fair value estimates

The Company measures the fair value of certain assets, liabilities and noncontrolling interests subject to put provisions based upon certain valuation techniques that include observable or unobservable market inputs and assumptions that market participants would use in pricing these assets, liabilities and noncontrolling interests subject to put provisions. The Company also has classified its assets, liabilities and noncontrolling interests subject to put provisions into the appropriate fair value hierarchy levels as defined by the FASB. See Note 23 to the consolidated financial statements for further details.

New accounting standards

On June 29, 2009, the Financial Accounting Standards Board (FASB) established the FASB Accounting Standards Codification (Codification) as the single source of authoritative U.S. generally accepted accounting principles (GAAP) for all nongovernmental entities. Rules and interpretive releases of the Securities and Exchange Commission (SEC) are also sources of authoritative U.S. GAAP for SEC registrants. The Codification does not change U.S. GAAP but takes previously issued FASB standards and other U.S. GAAP authoritative pronouncements, changes the way the standards are referred to, and includes them in specific topic areas. The Codification is effective for financial statements issued for interim and annual periods ending after September 15, 2009. The adoption of the Codification did not have any impact on the Company's consolidated financial statements.

Effective January 1, 2009, the Company is required to treat noncontrolling interests as a separate component of equity, but apart from the Company's equity, and not as a liability or other item outside of equity. The Company is also required to identify and present consolidated net income attributable to the Company and to noncontrolling interests on the face of the consolidated statement of income. Previously, the Company had reported minority interests (noncontrolling interests) as a reduction to operating income. In addition, changes in the Company's ownership interest while the Company retains a controlling financial interest should be accounted for as equity transactions. The Company was also required to expand disclosures in the financial statements to include a reconciliation of the beginning and ending balances of the equity attributable to the Company and the noncontrolling owners and a schedule showing the effects of changes in the Company's ownership interest in a subsidiary on the equity attributable to the Company. This change did not have a material impact on the Company's consolidated financial statements; however, it did change the presentation of minority interests (noncontrolling interests) in the Company's consolidated financial statements. In conjunction with adopting these requirements, the Company was required to classify securities with redemption features that are not solely within the Company's control such as the Company's noncontrolling interests that are subject to put provisions outside of permanent equity and to measure these noncontrolling interests at fair value. See Note 22 to the Company's consolidated financial statements for further details. These consolidated financial statements have been recast for all prior periods presented for the retrospective application of these presentation and disclosure requirements.

DAVITA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)
(dollars in thousands, except per share data)

The effects of the change upon the retrospective application of these presentation and disclosure requirements were as follows:

Consolidated income statements:

	2008	2007
Operating income:		
Operating income as previously reported	$ 821,765	$ 862,209
Reclassification of noncontrolling interests	47,331	46,702
Operating income as adjusted	$ 869,096	$ 908,911
Income taxes:		
Income taxes as previously reported	$ 235,300	$ 245,744
Income taxes associated with noncontrolling interests	171	(163)
Income taxes as adjusted	$ 235,471	$ 245,581

Consolidated balance sheet:

	2008				
	Income tax receivable	Minority interest	Noncontrolling interests not subject to put provisions	Noncontrolling interests subject to put provisions	Additional paid in capital
Balances as previously reported	$ 32,138	$ 165,846	$ —	$ —	$ 769,069
Net change	(8)	(165,846)	59,152	291,397	(184,711)
Balances as adjusted	$ 32,130	$ —	$ 59,152	$ 291,397	$ 584,358

Consolidated statements of cash flow:

	2008	2007
Cash flows from operating activities:		
Net cash provided by operating activities as previously reported	$ 555,931	$ 533,036
Reclassification of distributions to noncontrolling interests to cash flows from financing activities	57,770	48,029
Net cash provided by operating activities as adjusted	$ 613,701	$ 581,065

2. Earnings per share

Basic net income per share is calculated by dividing net income by the weighted average number of common shares and vested stock units outstanding. Diluted net income per share includes the dilutive effect of stock options, stock-settled stock appreciation rights and unvested stock units under the treasury stock method.

DAVITA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)
(dollars in thousands, except per share data)

The reconciliations of the numerators and denominators used to calculate basic and diluted net income per share are as follows:

	Year ended December 31,		
	2009	2008	2007
	(shares in thousands)		
Basic:			
Net income attributable to DaVita Inc.	$ 422,684	$ 374,160	$ 381,778
Weighted average shares outstanding during the year	103,595	105,140	105,848
Vested stock units	9	9	45
Weighted average shares for basic earnings per share calculation	103,604	105,149	105,893
Basic net income per share attributable to DaVita Inc	$ 4.08	$ 3.56	$ 3.61
Diluted:			
Net income attributable to DaVita Inc.	$ 422,684	$ 374,160	$ 381,778
Weighted average shares outstanding during the year	103,595	105,140	105,848
Vested stock units	9	9	45
Assumed incremental shares from stock plans	564	791	1,525
Weighted average shares for diluted earnings per share calculation	104,168	105,940	107,418
Diluted net income per share attributable to DaVita Inc	$ 4.06	$ 3.53	$ 3.55
Shares subject to anti-dilutive awards excluded from calculation(1)	9,912	10,053	260

(1) Shares associated with stock options and stock-settled stock appreciation rights that are excluded from the diluted denominator calculation because they are anti-dilutive under the treasury stock method.

3. Accounts receivable

Approximately 18% and 9% of the accounts receivable balances as of December 31, 2009 and 2008, respectively, were more than six months old, and there were no significant balances over one year old. Approximately 2% and 1% of our accounts receivable as of December 31, 2009 and 2008, respectively, relate to amounts due from patients. Accounts receivable are principally from Medicare and Medicaid programs and commercial insurance plans.

4. Other receivables

Other receivables were comprised of the following:

	December 31,	
	2009	2008
Supplier rebates and other non-trade receivables	$ 195,753	$ 172,604
Medicare bad debt claims	45,600	38,700
Operating advances under management and administrative services agreements	22,103	27,861
	$ 263,456	$ 239,165

Operating advances under management and administrative services agreements are generally unsecured.

DAVITA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)
(dollars in thousands, except per share data)

5. Other current assets

Other current assets consist principally of prepaid expenses and operating deposits.

6. Property and equipment

Property and equipment were comprised of the following:

	December 31, 2009	December 31, 2008
Land	$ 11,771	$ 11,771
Buildings	34,294	33,833
Leasehold improvements	997,668	873,306
Equipment and information systems	999,305	928,795
New center and capital asset projects in progress	32,280	36,875
	2,075,318	1,884,580
Less accumulated depreciation and amortization	(970,393)	(836,505)
	$ 1,104,925	$ 1,048,075

Depreciation and amortization expense on property and equipment was $214,515, $201,006 and $178,990 for 2009, 2008 and 2007, respectively.

Interest on debt incurred during the development of new centers and other capital asset projects is capitalized as a component of the asset cost based on the respective in-process capital asset balances. Interest capitalized was $3,627, $4,189 and $3,878 for 2009, 2008 and 2007, respectively.

7. Amortizable intangibles

Amortizable intangible assets were comprised of the following:

	December 31, 2009	December 31, 2008
Noncompetition and other agreements	$ 291,022	$ 285,270
Lease agreements	8,156	8,637
Deferred debt issuance costs	72,656	72,748
	371,834	366,655
Less accumulated amortization	(235,102)	(206,134)
Total amortizable intangible assets	$ 136,732	$ 160,521

Amortizable intangible liabilities were comprised of the following:

	December 31, 2009	December 31, 2008
Alliance and product supply agreement commitment (See Note 22)	$ 68,200	$ 68,200
Less accumulated amortization	(37,553)	(32,223)
	$ 30,647	$ 35,977

DAVITA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)
(dollars in thousands, except per share data)

Net amortization expense from noncompetition and other agreements and the amortizable intangible liabilities was $14,471, $15,911 and $14,480 for 2009, 2008 and 2007, respectively. Lease agreements which are amortized to rent expense were $565 in 2009, $1,420 in 2008 and $2,240 in 2007, respectively. Deferred debt issuance costs are amortized to debt expense as described in Note 13 to the consolidated financial statements.

Scheduled amortization charges from intangible assets and liabilities as of December 31, 2009 were as follows:

	Noncompetition and other agreements	Deferred debt issuance costs	Alliance and Product Supply Agreement liability
2010	$ 20,100	$ 9,390	$ (5,330)
2011	19,660	8,922	(5,330)
2012	18,935	6,423	(5,330)
2013	16,817	2,741	(5,330)
2014	15,133	2,290	(5,330)
Thereafter	15,844	477	(3,997)

8. Equity investments

Equity investments in non-consolidated businesses were $22,631 and $19,274 at December 31, 2009 and 2008, respectively. During 2009, 2008 and 2007, the Company recognized income of $2,442, $796 and $1,217, respectively, relating to equity investments in non-consolidated businesses under the equity method of accounting. See Note 17, section *Changes in DaVita Inc.'s ownership interest in consolidated subsidiaries* to the consolidated financial statements for additional information regarding equity investment transactions.

In 2009, the Company also contributed $1,100 to an existing joint venture in which the Company owns a 50% equity investment. On December 31, 2007, the Company acquired a 50% equity investment in a joint venture that operated six dialysis centers for $17,550.

9. Investments in debt and equity securities

Based on the Company's intentions and strategy involving investments, the Company classifies certain debt securities as held-to-maturity and records them at amortized cost. Equity securities that have readily determinable fair values and other debt securities classified as available for sale are recorded at fair value.

The Company's investments consist of the following:

	December 31, 2009			December 31, 2008		
	Held to maturity	Available for sale	Total	Held to maturity	Available for sale	Total
Certificates of deposit, money market funds and U.S. treasury notes due within one year	$ 25,275	$ —	$ 25,275	$ 19,355	$ —	$ 19,355
Investments in mutual funds	—	8,816	8,816	—	21,833	21,833
	$ 25,275	$ 8,816	$ 34,091	$ 19,355	$ 21,833	$ 41,188
Short-term investments	$ 25,275	$ 1,200	$ 26,475	$ 19,355	$ 16,177	$ 35,532
Long-term investments	—	7,616	7,616	—	5,656	5,656
	$ 25,275	$ 8,816	$ 34,091	$ 19,355	$ 21,833	$ 41,188

DAVITA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)
(dollars in thousands, except per share data)

The cost of the certificates of deposit, money market funds and U.S. treasury notes at December 31, 2009 and 2008 approximates fair value. As of December 31, 2009 and 2008, the available for sale investments included $205 and $1,558, respectively, of gross pre-tax unrealized losses. During 2009 and 2008 the Company recorded gross pre-tax unrealized gains (losses) of $1,614 and $(1,922), respectively, in other comprehensive income associated with changes in the fair value of these investments. During 2009, the Company sold investments in mutual funds for net proceeds of $16,693, and recognized a pre-tax gain of $261, or $159 after tax, that was previously recorded in other comprehensive income. In 2009, the Company also purchased approximately $6,300 of investments that are classified as held to maturity, net of investments routinely reinvested as required for VillageHealth, see discussion below. During 2008, the Company sold investments in mutual funds for net proceeds of $21,291 and recognized a pre-tax gain of $486, or $297 after-tax, that was also previously recorded in other comprehensive income. These pre-tax gains are included in other income. See Note 18 to the consolidated financial statements for further details.

As of December 31, 2009, investments totaling $22,275 classified as held to maturity are used to maintain certain capital requirements of the special needs plans of VillageHealth, which is a wholly-owned subsidiary of the Company. As of December 31, 2009, the Company discontinued the VillageHealth special needs plans and is in process of paying out all incurred claims. The Company also expects to liquidate its investments that are currently held to maintain certain capital requirements as soon as all of the claims are paid and the various state regulatory agencies approve the release of these investments. The investments in mutual funds classified as available for sale are held within a trust to fund existing obligations associated with several of the Company's non-qualified deferred compensation plans.

During 2007, the Company sold its investment of $20,000, or two million shares in NxStage Medical, Inc., for net proceeds of $25,868 and recognized a pre-tax gain of $5,868, or $3,628 after tax, that was previously recorded in other comprehensive income. The pre-tax gain is included in other income.

10. Goodwill

Changes in the book value of goodwill were as follows:

	Year ended December 31,	
	2009	2008
Balance at January 1	$ 3,876,931	$ 3,767,933
Acquisitions	78,199	89,234
Sales of and purchases from noncontrolling interests	(3,293)	20,141
Divestitures	(641)	—
DVA Renal Healthcare income tax adjustments	—	(642)
Other adjustments	—	265
Balance at December 31	$ 3,951,196	$ 3,876,931

As of December 31, 2009, there was $3,882,254 and $68,942 of goodwill associated with the dialysis and related lab services business and the ancillary services and strategic initiatives, respectively.

As of December 31, 2008, there was $3,808,942 and $67,989 of goodwill associated with the dialysis and related lab services business and the ancillary services and strategic initiatives, respectively.

DAVITA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)
(dollars in thousands, except per share data)

11. Other liabilities

Other accrued liabilities were comprised of the following:

	December 31,	
	2009	2008
Payor refunds and retractions	$ 320,187	$ 361,205
Insurance and self-insurance accruals	59,734	55,844
Accrued interest	36,881	44,308
Accrued non-income tax liabilities	11,581	8,920
Interest rate swaps	10,792	18
Other	21,917	24,944
	$ 461,092	$ 495,239

12. Income taxes

A reconciliation of the beginning and ending liability for unrecognized tax benefits that do not meet the more-likely-than-not threshold were as follows:

	Year ended December 31,	
	2009	2008
Balance beginning	$ 10,887	$ 25,744
Additions for tax positions related to current year	6,939	1,934
Additions for tax positions related to prior years	14,941	463
Reductions for tax positions related to prior years	(1,738)	(17,254)
Settlements	(336)	—
Balance ending	$ 30,693	$ 10,887

As of December 31, 2009, it is reasonably possible that $18,342 of unrecognized tax benefits may be recognized within the next 12 months, primarily related to the filing of tax accounting method changes. These changes will have no impact on the Company's effective tax rate. As of December 31, 2009, unrecognized tax benefits totaling $12,351 would affect the Company's effective tax rate, if recognized.

The Company recognizes accrued interest and penalties related to unrecognized tax benefits in its income tax expense. At December 31, 2009 and 2008, the Company had approximately $3,226 and $1,402, respectively, accrued for interest and penalties related to unrecognized tax benefits, net of federal tax benefits.

The Company and its subsidiaries file U.S. federal income tax returns and various state returns. The Company is no longer subject to U.S. federal, state and local examinations by tax authorities for years before 2004.

DAVITA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)
(dollars in thousands, except per share data)

Income tax expense consisted of the following:

	Year ended December 31,		
	2009	2008	2007
Current:			
Federal	$ 193,181	$ 118,764	$ 196,556
State	34,415	20,595	30,424
Deferred:			
Federal	44,376	81,306	14,945
State	6,493	14,806	3,656
	$ 278,465	$ 235,471	$ 245,581

Deferred tax assets and liabilities arising from temporary differences were as follows:

	December 31,	
	2009	2008
Receivables	$ 142,315	$ 108,275
Alliance and product supply agreement	11,922	13,995
Accrued liabilities	125,992	117,474
Other	62,208	65,635
Deferred tax assets	342,437	305,379
Valuation allowance	(14,191)	(12,588)
Net deferred tax assets	328,246	292,791
Intangible assets	(317,306)	(262,029)
Property and equipment	(84,041)	(55,747)
Other	(4,801)	(2,703)
Deferred tax liabilities	(406,148)	(320,479)
Net deferred tax liabilities	$ (77,902)	$ (27,688)

At December 31, 2009, the Company had state net operating loss carryforwards of approximately $169,497 that expire through 2029, and federal net operating loss carryforwards of $10,657 that expire through 2029. The utilization of these losses may be limited in future years based on the profitability of certain separate-return entities. The valuation allowance increase of $1,603 relates to changes in the estimated tax benefit of federal and state operating losses of separate-return entities.

The reconciliation between our effective tax rate from continuing operations and the U.S. federal income tax rate is as follows:

	Year ended December 31,		
	2009	2008	2007
Federal income tax rate	35.0%	35.0%	35.0%
State taxes, net of federal benefit	3.7	3.7	3.5
Changes in deferred tax valuation allowances	0.2	0.3	0.2
Other	0.8	(0.3)	0.4
Impact of noncontrolling interests primarily attributable to non-tax paying entities	(3.0)	(2.8)	(2.7)
Effective tax rate	36.7%	35.9%	36.4%

DAVITA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)
(dollars in thousands, except per share data)

13. Long-term debt

Long-term debt was comprised of the following:

	December 31, 2009	December 31, 2008
Senior Secured Credit Facilities:		
Term loan A	$ 153,125	$ 214,375
Term loan B	1,705,875	1,705,875
Senior and senior subordinated notes	1,750,000	1,750,000
Acquisition obligations and other notes payable	15,891	15,266
Capital lease obligations	4,635	5,873
Total principal debt outstanding	3,629,526	3,691,389
Premium on the 6 3/8% senior notes	2,698	3,757
	3,632,224	3,695,146
Less current portion	(100,007)	(72,725)
	$ 3,532,217	$ 3,622,421

Scheduled maturities of long-term debt at December 31, 2009 were as follows:

2010	100,007
2011	67,589
2012	1,707,625
2013	901,374
2014	495
Thereafter	852,436

Senior Secured Credit Facility

The Senior Secured Credit Facilities are guaranteed by substantially all of the Company's direct and indirect wholly-owned subsidiaries and are secured by substantially all of the Company's and its subsidiary guarantors' assets. The Senior Secured Credit Facilities also contain customary affirmative and negative covenants and require compliance with financial covenants, including an interest rate coverage ratio, and a leverage ratio that determines the interest rate margins on term loan A and the revolving line of credit. The Senior Secured Credit Facilities in general also contain limits on the general amount of capital expenditures for internal growth, acquisitions and capital improvements, redemptions or acquisitions of capital stock, the payment of dividends and distributions in cash as well as limits on the amount of tangible net assets in non-guarantor subsidiaries. However, the limitations on capital expenditures for internal growth will not apply during the periods in which the Company's leverage ratio is less than 3.5:1. The Company's leverage ratio at December 31, 2009 was less than 3.5:1.

Term Loans

Term loan A and term loan B total outstanding borrowings each consist of various individual tranche amounts that can range in maturity from one month to twelve months. Each specific tranche bears interest at a LIBOR rate determined by the maturity of that specific tranche and the interest rates are reset as each specific tranche matures. The overall weighted average interest rate for each term loan is determined based upon the LIBOR interest rates in effect for all of the individual tranches plus the interest rate margin.

DAVITA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)
(dollars in thousands, except per share data)

Term Loan A

Term loan A currently bears interest at LIBOR plus a margin of 1.50%, for an overall weighted average effective rate of 1.74% at December 31, 2009. The interest rate margin is subject to adjustment depending upon certain financial conditions and could range from 1.50% to 2.25%. Term loan A matures in October 2011 and requires annual principal payments of $87,500 in 2010 and $65,625 in 2011, respectively.

During 2009 and 2008, the Company made principal payments totaling $61,250 and $14,875, respectively, on term loan A.

Term Loan B

Term loan B bears interest at LIBOR plus a margin of 1.50% for an overall weighted average effective rate of 2.66%, including the impact of the Company's swap agreements at December 31, 2009. Term loan B matures in October 2012 and requires principal payments of $1,705,875 in year 2012. During 2009 and 2008, the Company did not make, nor was the Company required to make, any principal payments on Term loan B.

Revolving Lines of Credit

The Company has an undrawn revolving line under the Senior Secured Credit Facilities totaling $250,000, of which approximately $51,889 was committed for outstanding letters of credit. The Company also has other undrawn revolving lines of credit totaling $3,300 associated with several of its joint ventures.

Senior and Senior Subordinated Notes

The Company's senior and senior subordinated notes, as of December 31, 2009 and 2008, consisted of $900,000 of 6 5/8% senior notes due 2013 and $850,000 of 7 1/4% senior subordinated notes due 2015. The effective interest rate for $400,000 of the 6 5/8% senior notes is 6.45%. The notes are guaranteed by substantially all of the Company's direct and indirect wholly-owned subsidiaries and require semi-annual interest payments in March and September. The Company may redeem some or all of the senior notes at any time on or after March 15, 2009 and some or all of the senior subordinated notes at any time on or after March 15, 2010.

Interest rate swaps

Effective January 1, 2009, the Company was required to provide enhanced disclosures about the Company's derivative and hedging activities. The Company is required to provide additional disclosures about (a) how and why the Company uses derivative instruments, (b) how derivative instruments and related hedged items are accounted for, and (c) how derivative instruments and related hedged items affect the Company's financial position, financial performance, and cash flows. These requirements did not have a material impact on the Company's consolidated financial statements. The Company has elected to provide comparative disclosures for the prior period presented.

The Company has entered into several interest rate swap agreements as a means of hedging its exposure to and volatility from variable-based interest rate changes as part of its overall risk management strategy. These agreements are not held for trading or speculative purposes, and have the economic effect of converting portions of our variable rate debt to a fixed rate. These agreements are designated as cash flow hedges, and as a result, hedge-effective gains or losses resulting from changes in the fair values of these swaps are reported in other comprehensive income until such time as each specific swap tranche is realized, at which time the amounts are reclassified into net income. Net amounts paid or received for each specific swap tranche that have settled have been reflected as adjustments to debt expense. These agreements do not contain credit-risk contingent features.

DAVITA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)
(dollars in thousands, except per share data)

As of December 31, 2009, the Company maintained a total of eight interest rate swap agreements with amortizing notional amounts totaling $388,900. These agreements had the economic effect of modifying the LIBOR-based variable interest rate on an equivalent amount of the Company's debt to fixed rates ranging from 3.88% to 4.70%, resulting in an overall weighted average effective interest rate of 5.78% on the hedged portion of the Company's Senior Secured Credit Facilities, including the term loan B margin of 1.50%. The swap agreements expire in 2010 and require quarterly interest payments. The Company estimates that approximately $8,900 of existing unrealized pre-tax losses in other comprehensive income at December 31, 2009 will be reclassified into income over the next twelve months.

The following table summarizes our derivative instruments as of December 31, 2009 and 2008:

	Interest rate swap liabilities			
	December 31, 2009		December 31, 2008	
Derivatives designated as hedging instruments	Balance sheet location	Fair value	Balance sheet location	Fair value
Current settlement of interest rate swap agreements	Other current liabilities	$ 10,792	Other current liabilities	$ 18
Interest rate swap agreements	Other long-term liabilities	—	Other long-term liabilities	21,886
Total		$ 10,792		$ 21,904

The following table summarizes the effects of our interest rate swap agreements for the years ended December 31, 2009, 2008 and 2007:

	Amount of gains (losses) recognized in OCI on interest rate swap agreements			Location of (losses) gains reclassified from accumulated OCI into income	Amount of gains (losses) reclassified from accumulated OCI into income		
	Years ended December 31,				Years ended December 31,		
Derivatives designated as cash flow hedges	2009	2008	2007		2009	2008	2007
Interest rate swap agreements	$ (4,220)	$ (21,190)	$ (11,733)	Debt expense	$ (17,253)	$ (4,239)	$ 14,498
Tax expense benefit (expense)	1,642	8,243	4,564		6,711	1,649	(5,640)
Total	$ (2,578)	$ (12,947)	$ (7,169)		$ (10,542)	$ (2,590)	$ 8,858

As of December 31, 2009, the Company's interest rates were economically fixed on approximately 21% of its variable rate debt and approximately 59% of its total debt.

As a result of the swap agreements, the Company's overall weighted average effective interest rate on the Senior Secured Credit Facilities was 2.63%, based upon the current margins in effect of 1.50%, as of December 31, 2009.

The Company's overall weighted average effective interest rate in 2009 was 4.86% and as of December 31, 2009 was 4.68%.

Debt expense

Debt expense consisted of interest expense of $176,100, $214,944 and $242,720, amortization of deferred financing costs of $9,655, $9,772 and $9,808 for 2009, 2008 and 2007, respectively, and in 2007 included the

(dollars in thousands, except per share data)

write-off of $4,371 of deferred financing costs. Debt expense in 2007 also included $248 of other costs associated with the amendment and reinstatement of the Senior Secured Credit Facilities. The interest expense amounts are net of capitalized interest.

14. Leases

The majority of the Company's facilities are leased under non-cancelable operating leases, ranging in terms from five to 15 years, which contain renewal options of five to ten years at the fair rental value at the time of renewal. The Company leases are generally subject to periodic consumer price index increases or contain fixed escalation clauses. The Company also leases certain equipment under capital leases.

Future minimum lease payments under non-cancelable operating leases and capital leases are as follows:

	Operating leases	Capital leases
2010	$ 215,993	$ 851
2011	197,042	852
2012	176,378	870
2013	152,512	835
2014	130,718	579
Thereafter	439,217	2,801
	$ 1,311,860	6,788
Less portion representing interest		(2,153)
Total capital lease obligations, including current portion		$ 4,635

Rent expense under all operating leases for 2009, 2008, and 2007 was $248,792, $225,531 and $200,626, respectively. Rent expense is recorded on a straight-line basis, over the term of the lease, for leases that contain fixed escalation clauses or include abatement provisions. Leasehold improvement incentives are deferred and amortized to rent expense over the term of the lease. The net book value of property and equipment under capital leases was $5,432, $6,612 and $7,191 at December 31, 2009, 2008 and 2007, respectively. Capital lease obligations are included in long-term debt. See Note 13 to the consolidated financial statements.

15. Employee benefit plans

The Company has a savings plan for substantially all employees which has been established pursuant to the provisions of Section 401(k) of the Internal Revenue Code, or IRC. The plan allows for employees to contribute a percentage of their base annual salaries on a tax-deferred basis not to exceed IRC limitations. The Company does not provide any matching contributions.

The Company also maintains a voluntary compensation deferral plan, the DaVita Voluntary Deferral Plan. This plan is non-qualified and permits certain employees whose annualized base salary equals or exceeds a minimum annual threshold amount as set by the Company to elect to defer all or a portion of their annual bonus payment and up to 50% of their base salary into a deferral account maintained by the Company. Total contributions to this plan in 2009 and 2008 were $2,062, and $1,993, respectively. Deferred amounts are generally paid out in cash at the participant's election either in the first or second year following retirement or in a specified future period at least three to four years after the deferral election was effective. During 2009 and

2008, the Company distributed $601 and $764, respectively, to participants. Participants are credited with their proportional amount of annual earnings from the plan. The assets of this plan are held in a "rabbi trust" and as such are subject to the claims of the Company's general creditors in the event of its bankruptcy. As of December 31, 2009 and 2008, the total fair value of assets held in trust were $7,246 and $4,556, respectively.

As part of the acquisition of DVA Renal Healthcare on October 5, 2005, the Company acquired an Executive Retirement Plan for certain members of management. This plan is non-qualified and contributions to the plan were made at the discretion of DVA Renal Healthcare based upon a pre-determined percentage of a participant's base salary. Effective November 2005, all contributions to this plan were discontinued and the balance of the plan assets will be paid out upon termination of each individual participant. During 2009 and 2008, the Company distributed $241 and $142, respectively, to participants. As of December 31, 2009 and 2008, the total fair value of assets held in trust was $1,570 and $1,490, respectively.

The Company maintained a non-qualified deferred compensation plan for key employees. Company contributions were discretionary and were deposited into a rabbi trust. Participants in the plan were subject to a vesting period and typically receive annual distributions from the plan commencing one year after grant date, although in certain situations distributions are paid upon termination or retirement. Participants also had the option to direct their balances into certain investment funds and were credited with their proportional amount of earnings from the investments. The assets of this plan were held in the rabbi trust and were subject to the claims of the Company's general creditors in the event of its bankruptcy. There were no contributions to this plan in 2009. In 2008, the Company contributed $16 to this plan. During 2009, the Company distributed $15,851, including earnings, to eligible participants, which were the total assets held in trust. In 2008, the Company distributed $5,263 to eligible participants.

The Company also maintained another non-qualified deferred compensation plan for certain employees. Company contributions to the plan were discretionary and were deposited into a rabbi trust that was not subject to general creditors claims in the event of bankruptcy by the Company. Participants in the plan were subject to a vesting period and were credited with their proportional amount of earnings from the investments within the plan. In 2008, the Company distributed $15,122, including earnings to all eligible participants. The distribution was the total assets held by trust.

The fair value of all of the assets held in plan trusts as of December 31, 2009, and 2008 totaled $8,816 and $21,833, respectively. These assets are available for sale and as such are recorded at fair market value with changes in the fair market values being recorded in other comprehensive income. Any fair market value changes to the corresponding liability balance will be recorded as compensation expense. See Note 9 to the consolidated financial statements.

Most of the Company's outstanding employee stock plan awards include a provision accelerating the vesting of the award in the event of a change of control. The Company also maintains a change of control protection program for its 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 employees in the event of a change of control. Based on the market price of the Company's common stock and shares outstanding on December 31, 2009, these cash bonuses would total approximately $235,000 if a control transaction occurred at that price and the Company's Board of Directors did not modify the program. This amount has not been accrued at December 31, 2009, and would only be accrued upon a change of control. These change of control provisions may affect the price an acquirer would be willing to pay for the Company.

DAVITA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)
(dollars in thousands, except per share data)

16. Contingencies

The majority of the Company's revenues are from government programs and may be subject to adjustment as a result of: (1) examination by government agencies or contractors, for which the resolution of any matters raised may take extended periods of time to finalize; (2) differing interpretations of government regulations by different fiscal intermediaries or regulatory authorities; (3) differing opinions regarding a patient's medical diagnosis or the medical necessity of services provided; and (4) retroactive applications or interpretations of governmental requirements. In addition, the Company's revenues from commercial payors may be subject to adjustment as a result of potential claims for refunds, as a result of government actions or as a result of other claims by commercial payors.

Inquiries by the Federal Government

In December 2008, the Company received a subpoena for documents from the Office of Inspector General, U.S. Department of Health and Human Services, or OIG, relating to the pharmaceutical products Zemplar, Hectorol, Venofer, Ferrlecit and Epogen®, or EPO, as well as other related matters. The subpoena covers the period from January 2003 to the present. The Company has been in contact with the United States Attorney's Office, or U.S. Attorney's Office, for the Northern District of Georgia and the U.S. Department of Justice in Washington, DC, since November 2008 relating to this matter, and has been advised that this is a civil inquiry. On June 17, 2009, the Company learned that the allegations were made as part of a civil qui tam complaint filed by individuals and brought pursuant to the federal False Claims Act. The case remains under seal in the United States District Court for the Northern District of Georgia. The Company is cooperating with the inquiry and is producing the requested records. To the Company's knowledge, no proceedings have been initiated by the federal government against the Company at this time. Although the Company cannot predict whether or when proceedings might be initiated, or when these matters may be resolved, it is not unusual for investigations such as these to continue for a considerable period of time. Responding to the subpoena will continue to require management's attention and significant legal expense. Any negative findings could result in substantial financial penalties against the Company and exclusion from future participation in the Medicare and Medicaid programs.

In February 2007, the Company received a request for information from the OIG for records relating to EPO claims submitted to Medicare. In August 2007, the Company received a subpoena from the OIG seeking similar documents. The requested documents relate to services provided from 2001 to 2004 by a number of the Company's centers. The request and subpoena were sent from the OIG's offices in Houston and Dallas, Texas. The Company is cooperating with the inquiry and is producing the requested records. The Company has been in contact with the U.S. Attorney's Office for the Eastern District of Texas, which has stated that this is a civil inquiry related to EPO claims. On July 6, 2009, the United States District Court for the Eastern District of Texas lifted the seal on the civil qui tam complaint related to these allegations and the Company was subsequently served with a complaint by the relator. We believe that there is some overlap between this issue and the ongoing review of EPO utilization and claims by the U.S. Attorney's Office, for the Eastern District of Missouri in St. Louis described below. To the Company's knowledge, no proceedings have been initiated by the federal government against the Company at this time. Although the Company cannot predict whether or when proceedings might be initiated or when these matters may be resolved, it is not unusual for investigations such as these to continue for a considerable period of time. Responding to these inquiries will continue to require management's attention and significant legal expense. Any negative findings could result in substantial financial penalties against the Company and exclusion from future participation in the Medicare and Medicaid programs.

In March 2005, the Company received a subpoena from the U.S. Attorney's Office for the Eastern District of Missouri in St. Louis. The subpoena requires production of a wide range of documents relating to our

operations, including documents related to, among other things, pharmaceutical and other services provided to patients, relationships with pharmaceutical companies, and financial relationships with physicians and joint ventures. The subpoena covers the period from December 1, 1996 through the present. In October 2005, the Company received a follow-up request for additional documents related to specific medical director and joint venture arrangements. In February 2006, the Company received an additional subpoena for documents, including certain patient records relating to the administration and billing of EPO. In May 2007, the Company received a request for documents related to durable medical equipment and supply companies owned and operated by the Company. The Company is cooperating with the inquiry and is producing the requested records. The subpoenas have been issued in connection with a joint civil and criminal investigation. It is possible that criminal proceedings may be initiated against the Company in connection with this inquiry. To the Company's knowledge, no proceedings have been initiated against the Company at this time. Although the Company cannot predict whether or when proceedings might be initiated or when these matters may be resolved, it is not unusual for investigations such as these to continue for a considerable period of time. Responding to the subpoenas will continue to require management's attention and significant legal expense. Any negative findings could result in substantial financial penalties against the Company, exclusion from future participation in the Medicare and Medicaid programs and criminal penalties.

Other

The Company has received several notices of claims from commercial payors and other third parties related to historical billing practices and claims against DVA Renal Healthcare (formerly known as Gambro Healthcare) related to historical Gambro Healthcare billing practices and other matters covered by their 2004 settlement agreement with the Department of Justice and certain agencies of the U.S. government. At least one commercial payor has filed an arbitration demand against the Company, as described below, and additional commercial payors have threatened litigation. The Company intends to defend against these claims vigorously; however, the Company may not be successful and these claims may lead to litigation and any such litigation may be resolved unfavorably.

Several wage and hour claims have been filed against the Company in the Superior Court of California, each of which has been styled as a class action. In February 2007, June 2008, October 2008 and December 2008, the Company was served with five separate complaints, including two in October 2008, by various former employees, each of which alleges, among other things, that the Company failed to provide rest and meal periods, failed to pay compensation in lieu of providing such rest or meal periods, failed to pay the correct amount of overtime, failed to pay the rate on the "wage statement," and failed to comply with certain other California labor code requirements. The Company has reached a tentative settlement in the complaints served in February 2007 and December 2008 and one of the complaints served in October 2008. That settlement has been partially approved by the court and the Company is waiting for final court approval of the last part of the settlement. The Company intends to vigorously defend against the remaining claims and to vigorously oppose the certification of the remaining matters as class actions.

In August 2007, Sheet Metal Workers National Health Fund and Glenn Randle filed a complaint in the United States District Court for the Central District of California against the Company. The complaint also names as defendants Amgen Inc. and Fresenuis Medical Care Holdings, Inc. The complaint is styled as a class action and alleges four claims against the Company, including violations of the federal RICO statute, California's unfair competition law, California's false advertising law and for unjust enrichment. The complaint's principal allegations against the Company are that the defendants engaged in a scheme to unlawfully promote the administration of EPO to hemodialysis patients intravenously, as opposed to subcutaneously, and to over-utilize EPO. On December 17, 2008, the Court dismissed the complaint and allegations in their entirety with permission

of plaintiffs to amend the complaint. The Company was not named as a defendant in plaintiffs' amended complaint. In June 2009, the Court dismissed the remainder of the case. Following the dismissal, plaintiffs filed a notice of appeal. The notice of appeal seeks review by the U. S. Court of Appeals for the Ninth Circuit of all of the district court's dismissal rulings, including the ruling dismissing the Company as a defendant. The Company intends to continue to vigorously defend this claim.

In October 2007, the Company was contacted by the Attorney General's Office for the State of Nevada. The Attorney General's Office informed the Company that it was conducting a civil and criminal investigation of the Company's operations in Nevada and that the investigation related to the billing of pharmaceuticals, including EPO. In February 2008, the Attorney General's Office informed the Company that the civil and criminal investigation has been discontinued. The Attorney General's Office further advised the Company that Nevada Medicaid intends to conduct audits of end stage renal disease (ESRD) dialysis providers in Nevada, including the Company, and that such audits will relate to the issues that were the subjects of the investigation. To the Company's knowledge, no court proceedings have been initiated against the Company at this time. Any negative audit findings could result in a substantial repayment by the Company.

In August 2005, Blue Cross/Blue Shield of Louisiana filed a complaint in the United States District Court for the Western District of Louisiana against Gambro AB, DVA Renal Healthcare (formerly known as Gambro Healthcare) and related entities. The plaintiff sought to bring its claims as a class action on behalf of itself and all entities that paid any of the defendants for health care goods and services from on or about January 1991 through at least December 2004. The complaint alleged, among other things, damages resulting from facts and circumstances underlying Gambro Healthcare's 2004 settlement agreement with the Department of Justice and certain agencies of the U.S. government. In March 2006, the case was dismissed and the plaintiff was compelled to seek arbitration to resolve the matter. In November 2006, the plaintiff filed a demand for class arbitration against the Company and DVA Renal Healthcare. The Company intends to vigorously defend against these claims. The Company also intends to vigorously oppose the certification of this matter as a class action. At this time, the Company cannot predict the ultimate outcome of this matter or the potential range of damages, if any.

In June 2004, Gambro Healthcare was served with a complaint filed in the Superior Court of California by one of its former employees who worked for its California acute services program. The complaint, which is styled as a class action, alleges, among other things, that DVA Renal Healthcare failed to provide overtime wages, defined rest periods and meal periods, or compensation in lieu of such provisions and failed to comply with certain other California labor code requirements. The Company intends to vigorously defend against these claims. The Company also intends to vigorously oppose the certification of this matter as a class action. At this time, the Company cannot predict the ultimate outcome of this matter or the potential range of damages, if any.

In addition to the foregoing, the Company is subject to claims and suits, including from time to time, contractual disputes and professional and general liability claims, as well as audits and investigations by various government entities, in the ordinary course of business. The Company believes that the ultimate resolution of any such pending proceedings, whether the underlying claims are covered by insurance or not, will not have a material adverse effect on its financial condition, results of operations or cash flows.

17. DaVita Inc. stock-based compensation and shareholders' equity

Stock-based compensation

Stock-based compensation recognized in a period represents the amortization during that period of the estimated grant-date fair value of stock-based awards over their vesting terms, adjusted for expected forfeitures. Shares issued upon exercise of stock awards are generally issued from shares held in treasury.

DAVITA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)
(dollars in thousands, except per share data)

Stock-based compensation plans and agreements

On May 29, 2007, the Company's stockholders approved an amendment and restatement of the Company's Employee Stock Purchase Plan to increase the number of shares of common stock available for issuance under that plan by 800,001 shares, and approved an amendment and restatement of the Company's 2002 Equity Compensation Plan to increase the number of shares of common stock available for issuance under that plan by 6,000,000 shares and, among other things, to remove certain available share recycling features, to change the limit on the maximum number of shares of common stock that may be subject to awards granted to any single recipient in any consecutive twenty-four month period so that such limit applies only to awards of stock options and stock appreciation rights, and to provide additional exceptions from the three year minimum vesting period generally applicable to grants of restricted stock units and other full share awards.

The Company's stock-based compensation plans and agreements are described below.

2002 Plan. The DaVita Inc. 2002 Equity Compensation Plan (the 2002 Plan) is the Company's omnibus equity compensation plan and provides for grants of stock-based awards to employees, directors and other individuals providing services to the Company, except that incentive stock options may only be awarded to employees. The 2002 Plan mandates a maximum award term of five years, and stipulates that stock options and stock appreciation rights be granted with prices not less than the fair market value on the date of grant. The 2002 Plan further requires that full share awards such as restricted stock units reduce shares available under the 2002 Plan at a rate of 3.0:1. The Company's nonqualified stock options, stock appreciation rights and stock units awarded under the 2002 Plan generally vest over 48 to 60 months from the date of grant. At December 31, 2009, there were 13,316,104 stock options and stock-settled stock appreciation rights and 69,696 stock units outstanding and 4,041,592 shares available for future grants under the 2002 Plan.

Predecessor plans. Various prior stock-based compensation plans were terminated upon shareholder approval of the 2002 Plan in 2002, and the 1999 Non-Executive Officer and Non-Director Equity Compensation Plan (the 1999 Plan) expired in 2009, both except with respect to option awards then outstanding. Stock options granted under these terminated plans were generally issued with exercise prices equal to the market price of the stock on the date of grant, vested over four years from the date of grant, and bore maximum award terms of five to 10 years. For these terminated plans, there were only 20,084 stock options remaining outstanding under the 1999 Plan as of December 31, 2009.

Deferred stock unit agreements. During 2001 through 2003, the Company made nonqualified stock unit awards to members of the Board of Directors and certain key executive officers under stand-alone contractual deferred stock unit agreements. These awards vested over one to four years and were settled in stock when they vested or at a later date at the election of the recipient. The last 63,636 shares subject to these agreements were issued to their recipients in 2008.

DAVITA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)
(dollars in thousands, except per share data)

A combined summary of the status of awards under these stock-based compensation plans and agreements, including base shares for stock appreciation rights and shares subject to stock option and stock unit awards, is as follows:

	Year ended December 31, 2009				
	Stock options and stock appreciation rights			Stock units	
	Awards	Weighted average exercise price	Weighted average remaining contractual life	Awards	Weighted average remaining contractual life
Outstanding at beginning of year	12,739,134	$ 47.75		104,085	
Granted	4,211,840	46.97		48,135	
Exercised	(2,621,042)	37.31		(73,801)	
Forfeited	(993,744)	49.74		(8,723)	
Outstanding at end of period	13,336,188	$ 49.41	3.0	69,696	4.1
Awards exercisable at end of period	4,473,520	$ 50.93	2.0	8,810	4.8
Weighted-average fair value of awards granted during 2009	$ 12.08			$ 54.31	
Weighted-average fair value of awards granted during 2008	$ 11.01			$ 51.13	
Weighted-average fair value of awards granted during 2007	$ 13.89			$ 54.69	

Range of exercise prices	Awards outstanding	Weighted average exercise price	Awards exercisable	Weighted average exercise price
$ 0.00–$ 0.00	69,696	$ —	8,810	$ —
$30.01–$40.00	250	32.20	250	32.20
$40.01–$50.00	7,324,263	46.52	1,844,556	47.94
$50.01–$60.00	5,957,175	52.85	2,603,091	52.94
$60.01–$70.00	54,500	61.12	25,623	61.02
Total	13,405,884	$ 49.15	4,482,330	$ 50.83

For the years ended December 31, 2009, 2008, and 2007, the aggregate intrinsic value of stock awards exercised was $46,896, $35,957 and $86,283, respectively. At December 31, 2009, the aggregate intrinsic value of stock awards outstanding was $128,668 and the aggregate intrinsic value exercisable was $35,533.

Estimated fair value of stock-based compensation awards

The Company has estimated the grant-date fair value of stock option and stock-settled stock appreciation rights awards using the Black-Scholes-Merton valuation model and stock unit awards at intrinsic value on the date of grant. The following assumptions were used in estimating these values and determining the total stock-based compensation attributable to the current period:

Expected term of the awards: The expected term of awards granted represents the period of time that they are expected to remain outstanding from the date of grant. The Company determines the expected term of its

(dollars in thousands, except per share data)

stock awards based on its historical experience with similar awards, considering the Company's historical exercise and post-vesting termination patterns, and the terms expected by peer companies in near industries.

Expected volatility: Expected volatility represents the volatility anticipated over the expected term of the award. The Company determines the expected volatility for its awards based on the volatility of the price of its common stock over the most recent retrospective period commensurate with the expected term of the award, considering the volatility expectations implied by the market price of its exchange-traded options and the volatilities expected by peer companies in near industries.

Expected dividend yield: The Company has not paid dividends on its common stock and does not currently expect to pay dividends during the term of stock awards granted.

Risk-free interest rate: The Company bases the expected risk-free interest rate on the implied yield currently available on stripped interest coupons of U.S. Treasury issues with a remaining term equivalent to the expected term of the award.

A summary of the weighted average valuation inputs described above used for estimating the grant-date fair value of stock options and stock-settled stock appreciation rights granted in the periods indicated is as follows:

	Year ended December 31,		
	2009	2008	2007
Expected term	3.5 years	3.4 years	3.7 years
Expected volatility	32%	27%	25%
Expected dividend yield	0.0%	0.0%	0.0%
Risk-free interest rate	1.8%	2.4%	4.4%

The Company estimates expected forfeitures based upon historical experience with separate groups of employees that have exhibited similar forfeiture behavior in the past. Stock-based compensation expense is recorded only for awards that are expected to vest.

Employee stock purchase plan

The Employee Stock Purchase Plan entitles qualifying employees to purchase up to $25 of the Company's common stock during each calendar year. The amounts used to purchase stock are accumulated through payroll withholdings or through optional lump sum payments made in advance of the first day of the purchase right period. This compensatory plan allows employees to purchase stock for the lesser of 100% of the fair market value on the first day of the purchase right period or 85% of the fair market value on the last day of the purchase right period. Purchase right periods begin on January 1 and July 1, and end on December 31. Payroll withholdings and lump-sum payments related to the plan, included in accrued compensation and benefits that were used to purchase the Company's common stock were $4,280, $4,522, and $4,711 at December 31, 2009, 2008 and 2007, respectively. Subsequent to December 31, 2009, 2008 and 2007, 86,213, 107,340 and 98,353 shares, respectively, were issued to satisfy obligations under the plan. At December 31, 2009, there were 962,752 shares available for future grants under this plan.

The fair value of employees' purchase rights was estimated as of the beginning dates of the purchase right periods using the Black-Scholes-Merton valuation model with the following weighted average assumptions for purchase right periods in 2009, 2008 and 2007, respectively: expected volatility of 34%, 24% and 23%; risk-free interest rate of 0.2%, 2.5% and 4.9%, and no dividends. Using these assumptions, the weighted average estimated fair value of these purchase rights was $13.90, $13.65 and $13.96 for 2009, 2008 and 2007, respectively.

DAVITA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)
(dollars in thousands, except per share data)

Stock-based compensation expense and proceeds

For the years ended December 31, 2009, 2008 and 2007, the Company recognized $44,422, $41,235 and $34,149, respectively, in stock-based compensation expense for stock options, stock settled stock appreciation rights, stock units and discounted employee stock plan purchases, which is primarily included in general and administrative expenses. The estimated tax benefits recorded for this stock-based compensation in 2009, 2008 and 2007 were $16,810, $15,609 and $12,820, respectively. As of December 31, 2009, there was $79,957 of total estimated unrecognized compensation cost related to nonvested stock-based compensation arrangements under the Company's equity compensation and stock purchase plans. The Company expects to recognize this cost over a weighted average remaining period of 1.4 years.

During the years ended December 31, 2009, 2008 and 2007, the Company received $63,653, $35,606 and $54,697 in cash proceeds from stock option exercises and $18,241, $13,988 and $32,788 in total actual tax benefits upon the exercise of stock awards, respectively.

Stock repurchases

During 2009 and 2008, the Company repurchased a total of 2,902,619 and 4,788,881shares of its common stock for $153,495 and $232,715, or an average price of $52.88 and $48.59 per share respectively, pursuant to previously announced authorizations by the Board of Directors. On November 3, 2009, the Company announced that its Board of Directors authorized an increase of an additional $500,000 of share repurchases of its common stock. As a result of these transactions the total outstanding authorization for share repurchases as of December 31, 2009 was $500,000. The Company has not repurchased any additional shares of its common stock through February 25, 2010. This stock repurchase program has no expiration date.

Shareholder rights plan

The Company's Board of Directors approved a shareholder rights plan on November 14, 2002. This plan is designed to assure that DaVita's shareholders receive fair treatment in the event of any proposed takeover of DaVita.

Pursuant to this plan, the Board approved the declaration of a dividend distribution of one common stock purchase right for each outstanding share of its common stock payable on December 10, 2002 to holders of record of DaVita common stock on November 29, 2002. This rights distribution was not taxable to DaVita shareholders. As a result of the stock split that occurred during the second quarter of 2004, two-thirds of a right are now attached to each share of the Company's common stock. Two-thirds of a right will also attach to each newly issued or reissued share of common stock. These rights will become exercisable if a person or group acquires, or announces a tender offer for, 15% or more of DaVita's outstanding common stock. The triggering person's stock purchase rights will become void at that time and will not become exercisable.

Each right initially entitles its holder to purchase one share of common stock from the Company at a price of $125.00. If the rights become exercisable, and subject to adjustment for authorized shares available, each purchase right will then entitle its holder to purchase $125.00 of common stock at a price per share equal to 50% of the average daily closing price of the Company's common stock for the immediately preceding 30 consecutive trading days. If DaVita is acquired in a merger or other business combination transaction after the rights become exercisable, provisions will be made to allow the holder of each right to purchase $125.00 of common stock from the acquiring company at a price equal to 50% of the average daily closing price of that company's common stock for the immediately preceding 30 consecutive trading days.

DAVITA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)
(dollars in thousands, except per share data)

The Board of Directors may elect to redeem the rights at $0.01 per purchase right at any time prior to, or exchange common stock for the rights at an exchange ratio of one share per right at any time after, a person or group acquires or announces a tender offer for 15% or more of DaVita's outstanding common stock. The exercise price, number of shares, redemption price or exchange ratio associated with each right may be adjusted as appropriate upon the occurrence of certain events, including any stock split, stock dividend or similar transaction. These purchase rights will expire no later than November 14, 2012.

Charter documents & Delaware law

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

The Company is also subject to Section 203 of the Delaware General Corporation Law that, subject to exceptions, would prohibit the Company 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 restrictions may discourage, delay or prevent a change in the control of the Company.

Changes in DaVita Inc.'s ownership interest in consolidated subsidiaries

The effects of changes in DaVita Inc.'s ownership interest on the Company's equity are as follows:

	Year ended December 31, 2009
Net income attributable to DaVita Inc.	$ 422,684
Decrease in paid-in capital for sales of noncontrolling interest in eleven joint ventures, respectively	(529)
Decrease in paid-in capital for the purchase of a noncontrolling interest in six joint ventures, respectively	(3,721)
Net transfer from noncontrolling interests	(4,250)
Change from net income attributable to DaVita Inc. and transfers (to) from noncontrolling interests	$ 418,434

During 2009, the Company contributed cash and assets in two centers that were previously wholly-owned in exchange for an equity investment of 40% in a newly formed joint venture valued at $3,600. The Company recognized a pre-tax loss of $1,928 and deconsolidated these centers as a result of the transaction. In 2009, the Company also sold its controlling financial interest in one entity that contained one center which was previously wholly-owned to an existing joint venture in which the Company owns a 50% equity investment for $1,750 and recognized a pre-tax loss of $1,408. The Company deconsolidated this entity as a result of this transaction. The Company was also required to contribute $1,000 to the joint venture. The estimated fair values of the retained equity investments for both of these transactions were based upon valuation techniques as determined by an outside appraiser. The recognized pre-tax losses for both transactions were recorded in patient care costs in the consolidated statement of income.

DAVITA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)
(dollars in thousands, except per share data)

18. Other comprehensive income

Charges and credits to other comprehensive income have been as follows:

	2007		
	Before tax amount	Tax (expense) benefit	Net-of-tax amount
Unrealized losses on interest rate swaps	$ (11,733)	$ 4,564	$ (7,169)
Less reclassification of net swap realized gains into net income	(14,498)	5,640	(8,858)
Net swap activity	(26,231)	10,204	(16,027)
Unrealized gains on investments	6,892	(2,681)	4,211
Less reclassification of net investment realized gains into net income	(6,042)	2,350	(3,692)
Net investment activity	850	(331)	519
Total	$ (25,381)	$ 9,873	$ (15,508)

	2008		
	Before tax amount	Tax (expense) benefit	Net-of-tax amount
Unrealized losses on interest rate swaps	$ (21,190)	$ 8,243	$ (12,947)
Less reclassification of net swap realized losses into net income	4,239	(1,649)	2,590
Net swap activity	(16,951)	6,594	(10,357)
Unrealized losses on investments	(1,922)	748	(1,174)
Less reclassification of net investment realized gains into net income	(486)	189	(297)
Net investment activity	(2,408)	937	(1,471)
Total	$ (19,359)	$ 7,531	$ (11,828)

	2009		
	Before tax amount	Tax (expense) benefit	Net-of-tax amount
Unrealized losses on interest rate swaps	$ (4,220)	$ 1,642	$ (2,578)
Less reclassification of net swap realized losses into net income	17,253	(6,711)	10,542
Net swap activity	13,033	(5,069)	7,964
Unrealized gains on investments	1,614	(628)	986
Less reclassification of net investment realized gains into net income	(261)	102	(159)
Net investment activity	1,353	(526)	827
Total	$ 14,386	$ (5,595)	$ 8,791

DAVITA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)
(dollars in thousands, except per share data)

Changes in accumulated other comprehensive income (loss) has been as follows:

	Interest rate swaps	Investment securities	Accumulated other comprehensive income
Balance December 31, 2007	(3,030)	519	(2,511)
Net activity	(10,357)	(1,471)	(11,828)
Balance December 31, 2008	$ (13,387)	$ (952)	$ (14,339)
Net activity	7,964	827	8,791
Balance December 31, 2009	$ (5,423)	$ (125)	$ (5,548)

19. Acquisitions and divestitures

Acquisitions

All business combinations consummated after January 1, 2009, are required to be accounted for under the acquisition method (previously referred to as the purchase method). Under the acquisition method, the acquirer recognizes the assets acquired, the liabilities assumed, contractual contingencies, as well as any noncontrolling interests in the acquiree at their fair values at the acquisition date. Noncontractual contingencies are recognized at the acquisition date at their fair values only if it is more likely than not that they meet the definition of an asset or a liability. Transaction costs are excluded from the acquisition cost and are expensed as incurred. Any contingent consideration included by the acquirer as part of the purchase price must also be measured at fair value at the acquisition date and is classified as either equity or a liability. A Company that obtains control but acquires less than 100% of an acquiree is required to record 100% of the fair value of the acquiree assets, liabilities, and noncontrolling interests at the acquisition date. The adoption of these requirements did not have a material impact on the Company's consolidated financial statements.

The total acquisition amounts were as follows:

	Year ended December 31,		
	2009	2008	2007
Cash paid, net of cash acquired	$ 87,617	$ 101,959	$ 127,094
Deferred purchase price and other acquisition obligations	338	2,286	1,195
Aggregate purchase cost	$ 87,955	$ 104,245	$ 128,289
Number of chronic dialysis centers acquired	19	20	16

During 2009, 2008, and 2007, the Company acquired dialysis businesses consisting of 19 centers, 20 centers and 16 centers for a total of $87,955, $93,024 and $57,783, respectively, in cash and deferred purchase price obligations. In 2009, the Company also acquired additional ownership interests in several existing majority-owned joint ventures for $6,859. In 2008, the Company also acquired an 80% ownership interest in one vascular access clinic for $11,221 and in addition, purchased additional ownership interests in several existing majority-owned joint ventures for $24,409. In 2007, the Company also acquired an 85% ownership interest in HomeChoice Partners for $70,506 in cash and deferred purchase price obligations. HCP provides infusion therapy services to patients with acute or chronic conditions that can be treated at home or at an ambulatory infusion site. The assets and liabilities for all acquisitions were recorded at their estimated fair values at the dates of the acquisitions and are included in the Company's financial statements and operating results from the designated effective dates of the acquisitions.

DAVITA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)
(dollars in thousands, except per share data)

The initial purchase cost allocations for acquired businesses are recorded at fair values based upon the best information available to management and are finalized when identified pre-acquisition contingencies have been resolved and other information arranged to be obtained has been received, but in no case in excess of one year from the acquisition date. Adjustments to purchase accounting for prior acquisitions and payments for acquisitions in process have been included in the periods recognized.

The aggregate purchase cost allocations for dialysis and other related businesses were as follows:

	Year ended December 31,		
	2009	2008	2007
Tangible assets, principally leasehold improvements and equipment	$ 11,140	$ 7,972	$ 20,085
Amortizable intangible assets	6,703	9,988	12,271
Goodwill	78,199	89,234	105,609
Noncontrolling interest, net purchased (assumed)	(7,567)	(2,732)	(7,987)
Liabilities assumed	(520)	(217)	(1,689)
Aggregate purchase cost	$ 87,955	$ 104,245	$ 128,289

Amortizable intangible assets acquired during 2009, 2008 and 2007 had weighted-average estimated useful lives of seven, nine and eight years, respectively. The total amount of goodwill deductible for tax purposes associated with these acquisitions for 2009, 2008, and 2007 was approximately $72,000, $109,000 and $106,000, respectively.

Pro forma financial information

The following summary, prepared on a pro forma basis, combines the results of operations as if all acquisitions in 2009 and 2008 had been consummated as of the beginning of 2008, after including the impact of certain adjustments such as amortization of intangibles, interest expense on acquisition financing and income tax effects.

	Year ended December 31,	
	2009	2008
	(unaudited)	
Pro forma net revenues	$ 6,141,217	$ 5,761,318
Pro forma net income attributable to DaVita Inc.	424,493	379,132
Pro forma income from continuing operations attributable to DaVita Inc.	424,493	379,132
Pro forma basic net income per share attributable to DaVita Inc.	4.10	3.61
Pro forma diluted net income per share attributable to DaVita Inc.	4.08	3.58

20. Variable interest entities

Effective for the Company's first annual reporting period that begins after November 15, 2009, the FASB is eliminating the quantitative approach previously required for determining the primary beneficiary of a variable interest entity, and requiring additional disclosures about an enterprise's involvement in variable interest entities. An enterprise will be required to perform an analysis to determine whether the enterprise's variable interest or interests give it a controlling financial interest in a variable interest entity by having both the power to direct the activities of a variable interest entity that most significantly impact the entity's economic performance and the obligation to absorb losses of the entity, or the right to receive benefits from the entity. In addition, the FASB is establishing new guidance for determining whether an entity is a variable interest entity, requiring an ongoing

reassessment of whether an enterprise is the primary beneficiary of a variable interest entity, and adding an additional reconsideration event for determining whether an entity is a variable interest entity when any changes in facts and circumstances occur such that the holders of the equity investment at risk, as a group, lose the power from voting rights or similar rights concerning those investments to direct the activities of the entity that most significantly impact the entity's economic performance. The Company is currently in the process of assessing the expected impact of this standard on its consolidated financial statements.

In December 2008, the FASB required public entities to provide additional disclosures about transfers of financial assets and required public enterprises to provide additional disclosures about their involvement in variable interest entities and certain special purpose entities. Because these requirements impact disclosures and not the accounting treatment for transfers of financial assets and interests in variable interest entities, these requirements did not impact the Company's consolidated financial condition or results of operations.

The Company is deemed to be the primary beneficiary of all of the variable interest entities ("VIEs") with which it is associated. These VIEs are principally operating subsidiaries owned by related party nominee owners for the Company's benefit in jurisdictions in which the Company does not qualify for direct ownership under applicable regulations or joint ventures that require subordinated support in addition to their equity capital to finance operations. These include dialysis operating entities in New York and other states and physician practice management entities in various states.

Under the terms of the applicable arrangements, the Company bears most of the economic risks and rewards of ownership for these operating VIEs. The Company has contractual arrangements with its respective related party nominee owners which indemnify them from the economic losses, and entitle the Company to the economic benefits, that may result from ownership of such VIEs. DaVita manages these VIE subsidiaries and provides operating and capital funding as necessary to accomplish its operational and strategic objectives. Accordingly, since the Company bears the majority of the risks and rewards attendant to their ownership, the Company consolidates these variable interest entities as their primary beneficiary.

Total assets of these consolidated operating VIEs were approximately $21,000 and their liabilities to unrelated third parties were approximately $18,000 at December 31, 2009.

The Company also sponsors certain deferred compensation plans whose trusts qualify as VIEs and as their primary beneficiary the Company consolidates each of these plans. The assets of these plans are recorded in short-term or long-term investments with matching offsetting liabilities in accrued compensation and benefits and other long-term liabilities. See Note 9 to the consolidated financial statements for disclosures on the assets of these consolidated non-qualified deferred compensation plans.

21. Concentrations

Approximately 65% of the Company's total dialysis and related lab services revenues in 2009, 65% in 2008 and 64% in 2007 are from government-based programs, principally Medicare and Medicaid. Accounts receivable, and other receivables, from Medicare and Medicaid-assigned plans were approximately $467,900 and $467,400, respectively as of December 31, 2009 and 2008. No other single payor accounted for more than 5% of total accounts receivable.

A significant physician-prescribed pharmaceutical administered during dialysis, EPO, is provided by a sole supplier and accounted for approximately 20% of net operating revenues. Although the Company currently receives discounted prices for EPO, the supplier has unilateral pricing discretion and in the future the Company may not be able to achieve the same cost levels historically obtained.

22. Noncontrolling interests subject to put provisions and other commitments

Noncontrolling interests subject to put provisions

The Company has potential obligations to purchase the interests held by third parties in several of its joint ventures and non-wholly-owned subsidiaries. These obligations are in the form of put provisions and are exercisable at the third-party owners' discretion within specified periods as outlined in each specific put provision. If these put provisions were exercised, the Company would be required to purchase the third-party owners' noncontrolling interests at either the appraised fair market value or a predetermined multiple of earnings or cash flow attributable to the noncontrolling interests put to the Company, which is intended to approximate fair value. The methodology the Company uses to estimate the fair values of the noncontrolling interests subject to put provisions assumes either the higher of a liquidation value of net assets or an average multiple of earnings, based on historical earnings, patient mix and other performance indicators, as well as other factors. The estimated fair values of the noncontrolling interests subject to put provisions can fluctuate and the implicit multiple of earnings at which these noncontrolling interest obligations may be settled will vary significantly depending upon market conditions including potential purchasers' access to the capital markets, which can impact the level of competition for dialysis and non-dialysis related businesses, the economic performance of these businesses and the restricted marketability of the third-party owners' noncontrolling interests. The amounts of noncontrolling interests subject to put provisions that contractually employ a predetermined multiple of earnings rather than fair value are immaterial.

Additionally, the Company has certain other potential commitments to provide operating capital to several dialysis centers that are wholly-owned by third parties or centers in which the Company owns an equity investment as well as to physician-owned vascular access clinics that the Company operates under management and administrative service agreements of approximately $7,200.

Certain consolidated joint ventures are contractually scheduled to dissolve after terms ranging from ten to fifty years. Accordingly, the noncontrolling interests in these joint ventures are considered mandatorily redeemable instruments, for which the classification and measurement requirements as defined by FASB have been indefinitely deferred. Future distributions upon dissolution of these entities would be valued below the related noncontrolling interest carrying balances in the consolidated balance sheet.

Other commitments

In conjunction with the acquisition of DVA Renal Healthcare, Inc., formerly known as Gambro Healthcare, Inc., which occurred in October 2005, the Company entered into an Alliance and Product Supply Agreement (the Product Supply Agreement) with Gambro AB and Gambro Renal Products, Inc (Gambro Renal Products). The Product Supply Agreement has an initial term of seven years and will automatically renew for three additional one-year periods if the Company has not negotiated the terms of an extension during the initial term. Because the Product Supply Agreement results in higher costs for most of the products covered by the Product Supply Agreement than would otherwise be available to the Company, the Product Supply Agreement represented an intangible liability initially valued at $162,100 as of the acquisition date.

The Product Supply Agreement committed the Company to purchase a significant majority of its hemodialysis products, supplies and equipment at fixed prices through 2015. The agreement was amended in 2006 (the Amended Product Supply Agreement) to reduce the Company's purchase obligations for certain hemodialysis product supplies and equipment, and in 2007, the Company terminated its obligation to purchase certain dialysis machines under the Amended Product Supply Agreement. As a result of this termination the Company recorded a net valuation gain of $55,275 in 2007. This valuation gain represents the difference in the amortized original fair value of the Amended Product Supply Agreement and that of the Amended Product

(dollars in thousands, except per share data)

Supply Agreement as adjusted for the termination of the obligation to purchase certain dialysis machines as of June 30, 2007. We continue to be subject to the Product Supply Agreement's requirements to purchase a significant majority of our hemodialysis non-equipment product supplies, such as dialyzers, from Gambro at fixed prices.

During 2009, 2008 and 2007, the Company purchased $87,983, $83,360 and $90,696 of hemodialysis product supplies from Gambro Renal Products, representing 2% of the Company's total operating costs, for all years presented.

The centers acquired from Gambro Healthcare were subject to a five-year Corporate Integrity Agreement in connection with its December 2004 settlement with the U.S. Government that imposed significant specific compliance operating and reporting requirements, and requires an annual audit by an independent reporting organization. The corporate integrity agreement expired on November 30, 2009. The Company submitted its final annual report to the Office of the Inspector General, U.S. Department of Health and Human Services on January 14, 2010. On February 16, 2010, the Company was informed by the OIG that it has received the Company's final annual report and determined that DVA Renal Healthcare, a wholly-owned subsidiary of the Company, complied with the terms of the corporate integrity agreement during the final reporting period and that the Fifth Annual Report is complete. The five year term of the corporate integrity agreement has now concluded and DVA Renal Healthcare is no longer subject to its terms.

In January 2010, the Company entered into an agreement with Fresenius which committed the Company to purchase a certain amount of dialysis equipment, parts and supplies from them through 2013.

Other than operating leases, disclosed in Note 14 to the consolidated financial statements, and the letters of credit and the interest rate swap agreements, disclosed in Note 13 to the consolidated financial statements, or as described above the Company has no off balance sheet financing arrangements as of December 31, 2009.

23. Fair values of financial instruments

Effective January 1, 2008, the FASB established a framework for measuring assets and liabilities at fair value and also required additional disclosures about fair value measurements. These requirements applied to assets and liabilities that are carried at fair value on a recurring basis. Effective January 1, 2009 the FASB issued additional requirements relating to nonfinancial assets and liabilities that are not recognized or disclosed at fair value in the financial statements on a recurring basis at least annually. The adoption of these requirements relating to nonfinancial assets and liabilities did not have a material impact on the Company's consolidated financial statements.

The following table summarizes the Company's assets and liabilities measured at fair value on a recurring basis as of December 31, 2009:

	Total	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Assets				
Available for sale securities	$ 8,816	$ 8,816	$ —	$ —
Liabilities				
Interest rate swap agreements	$ 10,792	$ —	$ 10,792	$ —
Temporary equity				
Noncontrolling interests subject to put provisions	$ 331,725	$ —	$ —	$ 331,725

DAVITA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)
(dollars in thousands, except per share data)

The available for sale securities represent investments in various open-ended registered investment companies, or mutual funds, and are recorded at fair value based upon the quoted market prices as reported by each mutual fund. See Note 9 to the consolidated financial statements for further discussion.

The interest rate swap agreements are recorded at fair value based upon valuation models and a variety of techniques as reported by various broker dealers that are based upon relevant observable market inputs such as current interest rates, forward yield curves, and other credit and liquidity market conditions. The Company does not believe the ultimate amount that could be realized upon settlement of these interest rate swap agreements would be materially different than the fair values currently reported. See Note 13 to the consolidated financial statements for further discussion.

See Note 22 to the consolidated financial statements for a discussion of the Company's methodology for estimating the fair value of noncontrolling interests subject to put obligations.

Effective January 1, 2008, the FASB allowed companies the alternative to measure certain financial assets and liabilities at fair value on an instrument-by-instrument basis that are currently not required to be measured at fair value. This provision was also designed to reduce the volatility in earnings caused by measuring related assets and liabilities differently and established presentation and disclosure requirements designed to facilitate comparisons between companies that choose different measurement attributes for similar types of assets and liabilities. The Company did not elect to measure certain assets and liabilities at fair value on an instrument-by-instrument basis.

Other financial instruments consist primarily of cash, accounts receivable, notes receivable, accounts payable, other accrued liabilities and debt. The balances of the non-debt financial instruments are presented in the consolidated financial statements at December 31, 2009 and 2008 at their approximate fair values due to the short-term nature of their settlements. Borrowings under the Company's Senior Secured Credit Facilities totaled $1,859,000 as of December 31, 2009, and the fair value was $1,817,173 based upon quoted market prices. The fair value of the Company's senior and senior subordinated notes was approximately $1,756,625 at December 31, 2009 based upon quoted market prices, as compared to the carrying amount of $1,750,000.

24. Segment reporting

The Company operates principally as a dialysis and related lab services business but also operates other ancillary services and strategic initiatives. These ancillary services and strategic initiatives consist primarily of pharmacy services, infusion therapy services, disease management services, vascular access services, ESRD clinical research programs and physician services. For internal management reporting the dialysis and related lab services business and each of the ancillary services and strategic initiatives have been defined as separate operating segments by management since separate financial information is regularly produced and reviewed by the Company's chief operating decision maker in making decisions about allocating resources and assessing financial results. The Company's chief operating decision maker is its Chief Executive Officer. The dialysis and related lab services business qualifies as a separately reportable segment and all of the other ancillary services and strategic initiatives operating segments have been combined and disclosed in the other segments category.

The Company's operating segment financial information is prepared on an internal management reporting basis that the Chief Executive Officer uses to allocate resources and analyze the performance of the operating segments. For internal management reporting, segment operations include direct segment operating expenses with the exception of stock-based compensation expense and equity investment income.

DAVITA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)
(dollars in thousands, except per share data)

The following is a summary of segment revenues, segment operating margin (loss), and a reconciliation of segment margin to income before income taxes:

	Years ended December 31,		
	2009	2008(2)	2007(2)
Segment revenues:			
Dialysis and related lab services(1)	$ 5,791,698	$ 5,415,363	$ 5,130,181
Other—Ancillary services and strategic initiatives	317,102	244,810	133,970
Consolidated revenues	$ 6,108,800	$ 5,660,173	$ 5,264,151
Segment operating margin (loss):			
Dialysis and related lab services	$ 999,961	$ 939,391	$ 990,049
Other—Ancillary services and strategic initiatives	(17,710)	(29,856)	(48,206)
Total segment margin	982,251	909,535	941,843
Reconciliation of segment margin to income before income taxes:			
Stock-based compensation	(44,422)	(41,235)	(34,149)
Equity investment income	2,442	796	1,217
Consolidated operating income	940,271	869,096	908,911
Debt expense	(185,755)	(224,716)	(257,147)
Other income	3,708	12,411	22,460
Consolidated income before income taxes	$ 758,224	$ 656,791	$ 674,224

(1) Includes management fees for providing management and administrative services to dialysis centers in which the Company either owns an equity investment or are wholly-owned by third parties.

(2) Certain costs previously reported in the Ancillary Services and Strategic Initiatives have been reclassified to the dialysis and related lab services to conform to the current year presentation.

Depreciation and amortization expense for the dialysis and related lab services for 2009, 2008 and 2007 were $221,907, $210,143 and $189,215, respectively, and were $7,079, $6,774 and $4,255, respectively, for the ancillary services and strategic initiatives.

Summary of assets by segment is as follows:

	December 31,	
	2009	2008
Segment assets		
Dialysis and related lab services	$ 7,334,235	$ 7,031,550
Other—Ancillary services and strategic initiatives	224,001	254,533
Consolidated assets	$ 7,558,236	$ 7,286,083

In 2009 and 2008, the total amount of expenditures for property and equipment for the dialysis and related lab services were $271,817 and $313,414, respectively, and were $2,788 and $4,548, respectively, for the ancillary services and strategic initiatives.

DAVITA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)
(dollars in thousands, except per share data)

25. Supplemental cash flow information

The table below provides supplemental cash flow information:

	Year ended December 31,		
	2009	2008	2007
Cash paid:			
Income taxes	$ 161,671	$ 163,147	$ 205,955
Interest	186,280	222,558	245,325
Non-cash investing and financing activities:			
Fixed assets acquired under capital lease obligations	—	—	2,769
Liabilities assumed in conjunction with common stock acquisitions	—	—	1,653
Assets exchanged for equity investments	2,618	—	—
Assets received for additional noncontrolling interests	51	—	—

26. Selected quarterly financial data (unaudited)

	2009				2008			
	December 31	September 30	June 30	March 31	December 31	September 30	June 30	March 31
Net operating revenues	$ 1,568,204	$ 1,573,915	$ 1,519,041	$ 1,447,640	$ 1,461,010	$ 1,447,135	$ 1,407,304	$ 1,344,724
Operating income	238,712	245,001	235,954	220,604	223,109	221,772	218,434	205,781
Income before income taxes	194,563	200,465	190,139	173,057	169,364	169,748	166,101	151,578
Net income attributable to DaVita Inc.	109,724	110,930	105,819	96,211	98,365	93,910	94,951	86,934
Basic earnings per share attributable to DaVita Inc.	1.07	1.07	1.02	0.93	0.95	0.90	0.91	0.81
Diluted earnings per share attributable to DaVita Inc.	$ 1.06	$ 1.06	$ 1.02	$ 0.92	$ 0.94	$ 0.89	$ 0.90	$ 0.80

27. Condensed consolidating financial statements

The following information is presented in accordance with Rule 3-10 of Regulation S-X. The operating and investing activities of the separate legal entities included in the Company's consolidated financial statements are fully interdependent and integrated. Revenues and operating expenses of the separate legal entities include intercompany charges for management and other services. The senior notes and the senior subordinated notes were issued by the Company and are guaranteed by substantially all of its direct and indirect wholly-owned subsidiaries. Each of the guarantor subsidiaries has guaranteed the notes on a joint and several, full and unconditional basis. Non-wholly-owned subsidiaries, joint ventures, partnerships and third parties are not guarantors of these obligations.

DAVITA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)
(dollars in thousands, except per share data)

Condensed Consolidating Statements of Income

	DaVita Inc.	Guarantor Subsidiaries	Non-Guarantor Subsidiaries	Consolidating Adjustments	Consolidated Total
For the year ended December 31, 2009					
Net operating revenues	$ 401,058	$ 5,100,716	$ 1,032,676	$ (425,650)	$ 6,108,800
Operating expenses	246,578	4,484,083	863,518	(425,650)	5,168,529
Operating income	154,480	616,633	169,158	—	940,271
Debt (expense)	(188,109)	(179,294)	(1,304)	182,952	(185,755)
Other income, net	186,189	—	471	(182,952)	3,708
Income tax expense	60,414	212,571	5,480	—	278,465
Equity earnings in subsidiaries	330,538	103,430	—	(433,968)	—
Net income	422,684	328,198	162,845	(433,968)	479,759
Less: Net income attributable to noncontrolling interests	—	—	—	(57,075)	(57,075)
Net income attributable to DaVita Inc.	$ 422,684	$ 328,198	$ 162,845	$ (491,043)	$ 422,684
For the year ended December 31, 2008					
Net operating revenues	$ 363,112	$ 4,808,324	$ 881,810	$ (393,073)	$ 5,660,173
Operating expenses	228,729	4,208,769	746,652	(393,073)	4,791,077
Operating income	134,383	599,555	135,158	—	869,096
Debt (expense)	(227,535)	(189,506)	(2,520)	194,845	(224,716)
Other income, net	206,527	—	729	(194,845)	12,411
Income tax expense	43,763	188,888	2,820	—	235,471
Equity earnings in subsidiaries	304,548	81,459	—	(386,007)	—
Net income	374,160	302,620	130,547	(386,007)	421,320
Less: Net income attributable to noncontrolling interests	—	—	—	(47,160)	(47,160)
Net income attributable to DaVita Inc.	$ 374,160	$ 302,620	$ 130,547	$ (433,167)	$ 374,160
For the year ended December 31, 2007					
Net operating revenues	$ 365,728	$ 4,534,153	$ 754,163	$ (389,893)	$ 5,264,151
Operating expenses	208,042	3,919,932	617,159	(389,893)	4,355,240
Operating income	157,686	614,221	137,004	—	908,911
Debt (expense)	(259,745)	(256,050)	(4,002)	262,650	(257,147)
Other income, net	284,038	—	1,072	(262,650)	22,460
Income tax expense (benefit)	70,972	175,691	(1,082)	—	245,581
Equity earnings in subsidiaries	270,771	87,185	—	(357,956)	—
Net income	381,778	269,665	135,156	(357,956)	428,643
Less: Net income attributable to noncontrolling interests	—	—	—	(46,865)	(46,865)
Net income attributable to DaVita Inc.	$ 381,778	$ 269,665	$ 135,156	$ (404,821)	$ 381,778

DAVITA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)
(dollars in thousands, except per share data)

Condensed Consolidating Balance Sheets

	DaVita Inc.	Guarantor Subsidiaries	Non-Guarantor Subsidiaries	Consolidating Adjustments	Consolidated Total
As of December 31, 2009					
Cash and cash equivalents	$ 534,550	$ —	$ 4,909	$ —	$ 539,459
Accounts receivable, net	—	961,946	143,957	—	1,105,903
Other current assets	15,619	597,086	44,454	—	657,159
Total current assets	550,169	1,559,032	193,320	—	2,302,521
Property and equipment, net	11,232	900,969	192,724	—	1,104,925
Amortizable intangible assets, net	30,212	101,931	4,589	—	136,732
Investments in subsidiaries	5,130,035	509,733	—	(5,639,768)	—
Receivables from subsidiaries	293,062	—	138,482	(431,544)	—
Other long-term assets and investments	7,700	19,528	35,634	—	62,862
Goodwill	—	3,622,885	328,311	—	3,951,196
Total assets	$ 6,022,410	$ 6,714,078	$ 893,060	$ (6,071,312)	$ 7,558,236
Current liabilities	$ 170,061	$ 781,870	$ 95,010	$ —	$ 1,046,941
Payables to parent	—	418,529	13,015	(431,544)	—
Long-term debt and other long-term liabilities	3,507,753	458,779	18,879	—	3,985,411
Noncontrolling interests subject to put provisions	209,530	—	—	122,195	331,725
Total DaVita Inc. shareholders' equity	2,135,066	5,054,900	584,868	(5,639,768)	2,135,066
Noncontrolling interest not subject to put provisions	—	—	181,288	(122,195)	59,093
Total equity	2,135,066	5,054,900	766,156	(5,761,963)	2,194,159
Total liabilities and equity	$ 6,022,410	$ 6,714,078	$ 893,060	$ (6,071,312)	$ 7,558,236
As of December 31, 2008					
Casb and cash equivalents	$ 397,576	$ —	$ 13,305	$ —	$ 410,881
Accounts receivable, net	—	933,906	141,551	—	1,075,457
Other current assets	22,112	573,070	46,776	—	641,958
Total current assets	419,688	1,506,976	201,632	—	2,128,296
Property and equipment, net	15,175	864,725	168,175	—	1,048,075
Amortizable intangible assets, net	39,990	114,237	6,294	—	160,521
Investments in subsidiaries	4,866,399	464,377	—	(5,330,776)	—
Receivables from subsidiaries	320,338	—	90,754	(411,092)	—
Other long-term assets and investments	13,320	14,815	44,125	—	72,260
Goodwill	—	3,571,669	305,262	—	3,876,931
Total assets	$ 5,674,910	$ 6,536,799	$ 816,242	$ (5,741,868)	$ 7,286,083
Current liabilities	$ 106,370	$ 990,024	$ 66,669	$ —	$ 1,163,063
Payables to parent	—	386,460	24,632	(411,092)	—
Long-term debt and other long-term liabilities	3,616,082	368,774	19,868	—	4,004,724
Noncontrolling interests subject to put provisions	184,711	—	—	106,686	291,397
Total DaVita Inc. shareholders' equity	1,767,747	4,791,541	539,235	(5,330,776)	1,767,747
Noncontrolling interest not subject to put provisions	—	—	165,838	(106,686)	59,152
Total equity	1,767,747	4,791,541	705,073	(5,437,462)	1,826,899
Total liabilities and equity	$ 5,674,910	$ 6,536,799	$ 816,242	$ (5,741,868)	$ 7,286,083

DAVITA INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)
(dollars in thousands, except per share data)

Condensed Consolidating Statements of Cash Flows

	DaVita Inc.	Guarantor Subsidiaries	Non-Guarantor Subsidiaries	Consolidating Adjustments	Consolidated Total
For the year ended December 31, 2009					
Cash flows from operating activities					
Net income.	$ 422,684	$ 328,198	$ 162,845	$ (433,968)	$ 479,759
Changes in operating assets and liabilities and non cash items included in net income	(115,305)	(72,610)	(59,102)	433,968	186,951
Net cash provided by operating activities	307,379	255,588	103,743	—	666,710
Cash flows from investing activities					
Additions of property and equipment	(1,748)	(213,046)	(59,811)	—	(274,605)
Acquisitions	—	(87,617)	—	—	(87,617)
Proceeds from asset sales	—	7,697	—	—	7,697
Other items	11,631	(3,166)	—	—	8,465
Net cash provided by (used in) by investing activities	9,883	(296,132)	(59,811)	—	(346,060)
Cash flows from financing activities					
Long-term debt	(60,619)	(1,512)	899	—	(61,232)
Intercompany borrowing	(41,032)	100,429	(59,397)	—	—
Other items	(78,637)	(58,373)	6,170	—	(130,840)
Net cash (used in) provided by financing activities	(180,288)	40,544	(52,328)	—	(192,072)
Net increase (decrease) in cash and cash equivalents	136,974	—	(8,396)	—	128,578
Cash and cash equivalents at beginning of the year	397,576	—	13,305	—	410,881
Cash and cash equivalents at the end of the year	$ 534,550	$ —	$ 4,909	$ —	$ 539,459
For the year ended December 31, 2008					
Cash flows from operating activities					
Net income.	$ 374,160	$ 302,620	$ 130,547	$ (386,007)	$ 421,320
Changes in operating assets and liabilities and non cash items included in net income	(614,540)	431,232	(10,318)	386,007	192,381
Net cash (used in) provided by operating activities	(240,380)	733,852	120,229	—	613,701
Cash flows from investing activities					
Additions of property and equipment	(2,546)	(271,561)	(43,855)	—	(317,962)
Acquisitions	(439)	(92,299)	(9,221)	—	(101,959)
Proceeds from asset sales	—	530	—	—	530
Other items	19,281	2,371	—	—	21,652
Net cash provided by (used in) investing activities	16,296	(360,959)	(53,076)	—	(397,739)
Cash flows from financing activities					
Long-term debt	(17,675)	(424)	4,548	—	(13,551)
Intercompany borrowing	380,763	(358,761)	(22,002)	—	—
Other items	(184,585)	(13,708)	(40,283)	—	(238,576)
Net cash provided by (used in) financing activities	178,503	(372,893)	(57,737)	—	(252,127)
Net (decrease) increase in cash and cash equivalents	(45,581)	—	9,416	—	(36,165)
Cash and cash equivalents at beginning of the year	443,157	—	3,889	—	447,046
Cash and cash equivalents at the end of the year	$ 397,576	$ —	$ 13,305	$ —	$ 410,881
For the year ended December 31, 2007					
Cash flows from operating activities					
Net income	$ 381,778	$ 269,665	$ 135,156	$ (357,956)	$ 428,643
Changes in operating assets and liabilities and non cash items included in net income	(283,596)	108,534	(30,472)	357,956	152,422
Net cash provided by operating activities	98,182	378,199	104,684	—	581,065
Cash flows from investing activities				—	
Additions of property and equipment	(3,501)	(220,264)	(48,447)	—	(272,212)
Acquisitions	(69,701)	(57,393)	—	—	(127,094)
Proceeds from asset sales	—	12,289	—	—	12,289
Other items	(19,811)	(39,915)	—	—	(59,726)
Net cash used in investing activities	(93,013)	(305,283)	(48,447)	—	(446,743)
Cash flows from financing activities				—	
Long-term debt	(49,961)	2,212	447	—	(47,302)
Intercompany borrowing	110,937	(80,664)	(30,273)	—	—
Other items	77,582	5,536	(33,294)	—	49,824
Net cash provided by (used in) financing activities	138,558	(72,916)	(63,120)	—	2,522
Net increase (decrease) in cash and cash equivalents	143,727	—	(6,883)	—	136,844
Cash and cash equivalents at the beginning of the year	299,430	—	10,772		310,202
Cash and cash equivalents at the end of the year	$ 443,157	$ —	$ 3,889	$ —	$ 447,046

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, we have duly caused this Annual Report on Form 10-K to be signed on our behalf by the undersigned, thereunto duly authorized, in the City of El Segundo, State of California, on February 25, 2010.

DAVITA INC.

By: /s/ KENT J. THIRY
Kent J. Thiry
Chairman and Chief Executive Officer

KNOW ALL MEN BY THESE PRESENT, that each person whose signature appears below constitutes and appoints Kent J. Thiry, Richard K. Whitney, and Kim M. Rivera, and each of them his or her true and lawful attorneys-in-fact and agents with full power of substitution and resubstitution, for him or her and in his or her name, place and stead, in any and all capacities, to sign any and all amendments to this Annual Report on Form 10-K, and to file the same, with all exhibits thereto, and other documents in connection therewith, with the Securities and Exchange Commission, granting unto said attorneys-in-fact and agents, and each of them, full power and authority to do and perform each and every act and thing requisite or necessary to be done in and about the premises, as fully to all intents and purposes as he or she might or could do in person, hereby ratifying and confirming all that said attorneys-in-fact and agents or any of them, or their or his or her substitute or substitutes, may lawfully do or cause to be done by virtue hereof.

Pursuant to the requirements of the Securities Exchange Act of 1934, this Annual Report on Form 10-K has been signed by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/s/ KENT J. THIRY Kent J. Thiry	Chairman and Chief Executive Officer (Principal Executive Officer)	February 25, 2010
/s/ RICHARD K. WHITNEY Richard K. Whitney	Chief Financial Officer (Principal Financial Officer)	February 25, 2010
/s/ JAMES K. HILGER James K. Hilger	Vice President and Controller (Principal Accounting Officer)	February 25, 2010
/s/ PAMELA M. ARWAY Pamela M. Arway	Director	February 25, 2010
/s/ CHARLES G. BERG Charles G. Berg	Director	February 25, 2010
/s/ WILLARD W. BRITTAIN Willard W. Brittain	Director	February 25, 2010
/s/ PAUL J. DIAZ Paul J. Diaz	Director	February 25, 2010
/s/ PETER T. GRAUER Peter T. Grauer	Director	February 25, 2010
/s/ JOHN M. NEHRA John M. Nehra	Director	February 25, 2010
/s/ WILLIAM L. ROPER William L. Roper	Director	February 25, 2010
/s/ ROGER J. VALINE Roger J. Valine	Director	February 25, 2010
/s/ RICHARD C. VAUGHAN Richard C. Vaughan	Director	February 25, 2010

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Shareholders
DaVita Inc.:

Under date of February 25, 2010, we reported on the consolidated balance sheets of DaVita Inc. and subsidiaries as of December 31, 2009 and 2008, and the related consolidated statements of income, equity and comprehensive income, and cash flows for each of the years in the three-year period ended December 31, 2009, which are included in the Annual Report on Form 10-K. In connection with our audits of the aforementioned consolidated financial statements, we also audited the related consolidated financial statement Schedule II-Valuation and Qualifying Accounts included in the Annual Report on Form 10-K. This financial statement schedule is the responsibility of the Company's management. Our responsibility is to express an opinion on this financial statement schedule based on our audits.

In our opinion, such financial statement schedule, when considered in relation to the basic consolidated financial statements taken as a whole, presents fairly, in all material respects, the information set forth therein.

As discussed in Note 1 to the consolidated financial statements, the Company adopted Financial Accounting Standards Board (FASB) Statement of Financial Accounting Standards No. 160, Noncontrolling Interests in Consolidated Financial Statements (included in FASB ASC Topic 810, Consolidation), on a prospective basis except for the presentation and disclosure requirements which were applied retrospectively for all periods presented effective January 1, 2009.

/s/ KPMG LLP

Seattle, Washington
February 25, 2010

DAVITA INC.

SCHEDULE II—VALUATION AND QUALIFYING ACCOUNTS

Description	Balance at beginning of year	Amounts charged to income	Amounts written off	Balance at end of year
		(in thousands)		
Allowance for uncollectible accounts:				
Year ended December 31, 2007	$ 171,757	$ 136,682	$ 112,486	$ 195,953
Year ended December 31, 2008	$ 195,953	$ 146,229	$ 130,960	$ 211,222
Year ended December 31, 2009	$ 211,222	$ 161,786	$ 143,691	$ 229,317

EXHIBIT INDEX

2.1	Stock Purchase Agreement dated as of December 6, 2004, among Gambro AB, Gambro, Inc. and DaVita Inc.(9)
2.2	Amended and Restated Asset Purchase Agreement effective as of July 28, 2005, by and among DaVita Inc., Gambro Healthcare, Inc. and Renal Advantage Inc., a Delaware corporation, formerly known as RenalAmerica, Inc.(12)
3.1	Amended and Restated Certificate of Incorporation of Total Renal Care Holdings, Inc., or TRCH, dated December 4, 1995.(1)
3.2	Certificate of Amendment of Certificate of Incorporation of TRCH, dated February 26, 1998.(2)
3.3	Certificate of Amendment of Certificate of Incorporation of DaVita Inc. (formerly Total Renal Care Holdings, Inc.), dated October 5, 2000.(4)
3.4	Certificate of Amendment of Amended and Restated Certificate of Incorporation of DaVita Inc., as amended dated May 30, 2007.(23)
3.5	Amended and Restated Bylaws for DaVita Inc. dated as of March 2, 2007.(25)
4.1	Indenture for the 6 5/8% Senior Notes due 2013 dated as of March 22, 2005.(3)
4.2	Indenture for the 7 1/4% Senior Subordinated Notes due 2015 dated as of March 22, 2005.(3)
4.3	First Supplemental Indenture, dated October 5, 2005, by and among DaVita Inc., the Guarantors, the persons named as Additional Guarantors and The Bank of New York Trust Company, N.A., as Trustee.(11)
4.4	First Supplemental Indenture, dated October 5, 2005, by and among DaVita Inc., the Guarantors, the persons named as Additional Guarantors and The Bank of New York Trust Company, N.A., as Trustee.(13)
4.5	Rights Agreement, dated as of November 14, 2002, between DaVita Inc. and the Bank of New York, as Rights Agent.(21)
4.6	Second Supplemental Indenture (Senior), dated February 9, 2007, by and among DaVita Inc., the Guarantors, the persons named as Additional Guarantors and The Bank of New York Trust Company, N.A., as Trustee.(22)
4.7	Second Supplemental Indenture (Senior Subordinated), dated February 9, 2007, by and among DaVita Inc., the Guarantors, the persons named as Additional Guarantors and The Bank of New York Trust Company, N.A., as Trustee.(22)
4.8	Registration Rights Agreement for the 6 5/8% Senior Notes due 2013 dated as of February 23, 2007.(26)
10.1	Employment Agreement, dated as of October 19, 2009, by and between DaVita Inc. and Kim M. Rivera.✓*
10.2	Employment Agreement, dated as of June 15, 2000, by and between DaVita Inc. and Joseph C. Mello.(6)*
10.3	Second Amendment to Mr. Mello's Employment Agreement, effective December 12, 2008.(33)*
10.4	Employment Agreement, effective as of August 16, 2004, by and between DaVita Inc. and Tom Usilton.(7)*
10.5	Amendment to Mr. Usilton's Employment Agreement, dated February 12, 2007.(24)*
10.6	Second Amendment to Mr. Usilton's Employment Agreement, effective December 12, 2008. (32)*
10.7	Employment Agreement, effective as of November 18, 2004, by and between DaVita Inc. and Joseph Schohl.(14)*
10.8	Amendment to Mr. Schohl's Employment Agreement, effective December 30, 2008. (32)*

10.9	Employment Agreement, dated as of October 31, 2005, effective October 24, 2005, by and between DaVita Inc. and Dennis Kogod.(13)*
10.10	Amendment to Mr. Kogod's Employment Agreement, effective December 12, 2008. (32)*
10.11	Employment Agreement, effective September 22, 2005, by and between DaVita Inc. and James Hilger.(15)*
10.12	Amendment to Mr. Hilger's Employment Agreement, effective December 12, 2008. (32)*
10.13	Employment Agreement effective February 13, 2008, by and between DaVita Inc. and Richard K. Whitney.(28)*
10.14	Amendment to Equity Award Agreement, entered into on December 11, 2009, between DaVita Inc. and Richard K. Whitney.✓*
10.15	Employment Agreement, effective July 25, 2008, between DaVita Inc. and Kent J. Thiry.(29)*
10.16	Employment Agreement, effective August 1, 2008, between DaVita Inc. and Allen Nissenson.(30)*
10.17	Employment Agreement, effective March 3, 2008, between DaVita Inc. and David Shapiro. (32)*
10.18	Amendment to Mr. Shapiro's Employment Agreement, effective December 4, 2008. (32)*
10.19	Form of Indemnity Agreement.(20)*
10.20	Form of Indemnity Agreement.(14)*
10.21	Executive Incentive Plan (as Amended and Restated effective January 1, 2009).(34)*
10.22	Executive Retirement Plan.(32)*
10.23	Post-Retirement Deferred Compensation Arrangement.(14)*
10.24	Amendment No. 1 to Post Retirement Deferred Compensation Arrangement.(32)*
10.25	DaVita Voluntary Deferral Plan.(11)*
10.26	Deferred Bonus Plan (Prosperity Plan).(31)
10.27	Amendment No. 1 to Deferred Bonus Plan (Prosperity Plan).(32)*
10.28	Amended and Restated Employee Stock Purchase Plan.(27)*
10.29	Severance Plan.(33)*
10.30	Change in Control Bonus Program.(32)*
10.31	First Amended and Restated Total Renal Care Holdings, Inc. 1999 Non-Executive Officer and Non-Director Equity Compensation Plan.(5)
10.32	Non-Management Director Compensation Philosophy and Plan.(28)*
10.33	Amended and Restated 2002 Equity Compensation Plan.(10)*
10.34	Amended and Restated 2002 Equity Compensation Plan.(19)*
10.35	Amended and Restated 2002 Equity Compensation Plan.(27)*
10.36	Amended and Restated 2002 Equity Compensation Plan.(32)*
10.37	Form of Non-Qualified Stock Option Agreement—Employee (DaVita Inc. 1999 Non-Executive Officer and Non-Director Equity Compensation Plan.(18)*
10.38	Form of Non-Qualified Stock Option Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(7)*
10.39	Form of Non-Qualified Stock Option Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(16)*
10.40	Form of Non-Qualified Stock Option Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(18)*

10.41	Form of Restricted Stock Units Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(7)*
10.42	Form of Restricted Stock Units Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(16)*
10.43	Form of Restricted Stock Units Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(18)*
10.44	Form of Restricted Stock Units Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(32)*
10.45	Form of Stock Appreciation Rights Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(16)*
10.46	Form of Stock Appreciation Rights Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(18)*
10.47	Form of Stock Appreciation Rights Agreement – Board (DaVita Inc. 2002 Equity Compensation Plan).(30)*
10.48	Form of Restricted Stock Units Agreement – Board (DaVita Inc. 2002 Equity Compensation Plan).(30)*
10.49	Form of Non-Qualified Stock Option Agreement - Board (DaVita Inc. 2002 Equity Compensation Plan).(30)*
10.50	Credit Agreement, dated as of October 5, 2005, among DaVita Inc., the Guarantors party thereto, the Lenders party thereto, Bank of America, N.A., Wachovia Bank, National Association, Bear Stearns Corporate Lending Inc., The Bank of New York, The Bank of Nova Scotia, The Royal Bank of Scotland plc, WestLB AG, New York Branch as Co-Documentation Agents, Credit Suisse, Cayman Islands Branch, as Syndication Agent, JPMorgan Chase Bank, N.A., as Administrative Agent and Collateral Agent, JPMorgan Securities Inc., as Sole Lead Arranger and Bookrunner and Credit Suisse, Cayman Islands Branch, as Co-Arranger.(11)
10.51	Credit Agreement, dated as of October 5, 2005, as Amended and Restated as of February 23, 2007, by and among DaVita Inc., the Guarantors party thereto, the Lenders party thereto and JPMorgan Chase Bank, N.A.(26)
10.52	Amendment Agreement, dated February 23, 2007, by and among DaVita Inc., the Guarantors party thereto, the Lenders party thereto and JPMorgan Chase Bank, N.A.(26)
10.53	Security Agreement, dated as of October 5, 2005, by DaVita Inc., the Guarantors party thereto and JPMorgan Chase Bank, N.A., as Collateral Agent.(11)
10.54	Corporate Integrity Agreement between the Office of Inspector General of the Department of Health and Human Services and Gambro Healthcare, Inc. effective as of December 1, 2004.(11)
10.55	Amended and Restated Alliance and Product Supply Agreement, dated as of August 25, 2006, among Gambro Renal Products, Inc., DaVita Inc. and Gambro AB.(17)**
10.56	Letter dated March 19, 2007 from Willard W. Brittain, Jr. to Peter T. Grauer, Lead Independent Director of the Company.(22)
10.57	Dialysis Organization Agreement between DaVita Inc. and Amgen USA Inc. dated December 20, 2007.(31)**
12.1	Computation of Ratio of Earnings to Fixed Charges.✓
14.1	DaVita Inc. Corporate Governance Code of Ethics.(8)
21.1	List of our subsidiaries.✓
23.1	Consent of KPMG LLP, independent registered public accounting firm.✓
24.1	Powers of Attorney with respect to DaVita. (Included on Page II-1).

31.1	Certification of the Chief Executive Officer, dated February 25, 2010, pursuant to Rule 13a-14(a) or 15d-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.✓
31.2	Certification of the Chief Financial Officer, dated February 25, 2010, pursuant to Rule 13a-14(a) or 15d-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.✓
32.1	Certification of the Chief Executive Officer, dated February 25, 2010, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.✓
32.2	Certification of the Chief Financial Officer, dated February 25, 2010, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.✓
101.INS	XBRL Instance Document.***
101.SCH	XBRL Taxonomy Extension Schema Document.***
101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document.***
101.DEF	XBRL Taxonomy Extension Definition Linkbase Document.***
101.LAB	XBRL Taxonomy Extension Label Linkbase Document.***
101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document.***

✓ Included in this filing.

* Management contract or executive compensation plan or arrangement.

** Portions of this exhibit are subject to a request for confidential treatment and have been redacted and filed separately with the SEC.

*** XBRL information is furnished and not filed as a part of a registration statement or prospectus for purposes of Section 11 or 12 of the Securities and Exchange Act of 1933, is deemed not filed for purposes of Section 18 of the Securities and Exchange Act of 1934, and otherwise is not subject to liability under these sections.

(1) Filed on March 18, 1996 as an exhibit to the Company's Transitional Report on Form 10-K for the transition period from June 1, 1995 to December 31, 1995.

(2) Filed on March 31, 1998 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 1997.

(3) Filed on March 25, 2005 as an exhibit to the Company's Current Report on Form 8-K.

(4) Filed on March 20, 2001 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 2000.

(5) Filed on February 28, 2003 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 2002.

(6) Filed on August 15, 2001 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2001.

(7) Filed on November 8, 2004 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2004.

(8) Filed on February 27, 2004 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 2003.

(9) Filed on December 8, 2004 as an exhibit to the Company's Current Report on Form 8-K.

(10) Filed on May 4, 2005 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2005.

(11) Filed on November 8, 2005 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2005.

(12) Filed on October 11, 2005 as an exhibit to the Company's Current Report on Form 8-K.

(13) Filed on November 4, 2005 as an exhibit to the Company's Current Report on Form 8-K.

(14) Filed on March 3, 2005 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 2004.

(15) Filed on August 7, 2006 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ending June 30, 2006.

(16) Filed on July 6, 2006 as an exhibit to the Company's Current Report on Form 8-K.

(17) Filed on November 3, 2006 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2006.
(18) Filed on October 18, 2006 as an exhibit to the Company's Current Report on Form 8-K.
(19) Filed on July 31, 2006 as an exhibit to the Company's Current Report on Form 8-K.
(20) Filed on December 20, 2006 as an exhibit to the Company's Current Report on Form 8-K.
(21) Filed on November 19, 2002 as an exhibit to the Company's Current Report on Form 8-K.
(22) Filed on May 3, 2007 as an exhibit to the Company's Quarterly Report as Form 10-Q for the quarter ended March 31, 2007.
(23) Filed on August 6, 2007 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2007.
(24) Filed on February 16, 2007 as an exhibit to the Company's Current Report on Form 8-K.
(25) Filed on March 8, 2007 as an exhibit to the Company's Current Report on Form 8-K.
(26) Filed on February 28, 2007 as an exhibit to the Company's Current Report on Form 8-K.
(27) Filed on June 4, 2007 as an exhibit to the Company's Current Report on Form 8-K.
(28) Filed on May 8, 2008 as an exhibit to the Company's Quarterly Report on Form 10-Q for the first quarter ended March 31, 2008.
(29) Filed on July 31, 2008 as an exhibit to the Company's Current Report on Form 8-K.
(30) Filed on November 6, 2008 as an exhibit to the Company's Quarterly Report on Form 10-Q for the third quarter ended September 30, 2008.
(31) Filed on February 29, 2008 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 2007.
(32) Filed on February 27, 2009 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 2008
(33) Filed on May 7, 2009 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2009.
(34) Filed on June 18, 2009 as an exhibit to the Company's Current Report on Form 8-K.

EMPLOYMENT AGREEMENT

This Employment Agreement (this "Agreement") is entered into effective October 19, 2009 (the "Effective Date"), by and between DaVita Inc. ("Employer") and Kim M. Rivera ("Employee").

In consideration of the mutual covenants and agreements hereinafter set forth and for other good and valuable consideration, the parties hereto, intending to be legally bound hereby, agree as follows:

Section 1. Employment and Duties. Employer hereby employs Employee to serve as Vice President, General Counsel, and Secretary. Employee accepts such employment on the terms and conditions set forth in this Agreement. Employee shall perform the duties of Vice President, General Counsel, and Secretary or any additional or different duties or jobs as the Company deems appropriate. Initially, Employee shall work out of Employer's El Segundo, California headquarters, although the location is subject to change to suit business needs. Employee will be allowed to maintain a home office in northern California and work there from time to time. Employee agrees to devote substantially all of her time, energy, and ability to the business of Employer on a full-time basis and shall not engage in any other business activities during the term of this Agreement, including but not limited to providing consulting services to any investment firm, such as a hedge fund, provided however, Employee may continue to serve on the board of directors of the Latino Community Foundation, a non-profit corporation. Employee may pursue normal charitable activities so long as such activities do not require a substantial amount of time and do not interfere with her ability to perform her duties. Employee agrees that she shall not serve on the board of directors of any other not-for-profit or for-profit company without the express written approval of the Chief Executive Officer or the Board of Directors. Employee shall at all times observe and abide by the Employer's policies and procedures as in effect from time to time.

Section 2. Compensation. In consideration of the services to be performed by Employee hereunder, Employee shall receive the following compensation and benefits:

2.1 Base Salary. Employer shall pay Employee a base salary of $400,000 per annum, less standard withholdings and authorized deductions. Employee shall be paid consistent with Employer's payroll schedule. The base salary will be reviewed from time to time. Employer, in its sole discretion, may increase the base salary as a result of any such review. Employer may not reduce Employee's base salary unless the Employee authorizes it in writing or the Employer is reducing the base salary of other similarly-situated executives by a similar percentage.

2.2 Benefits. Employee and/or her family, as the case may be, shall be eligible for participation in and shall receive all benefits under Employer's health and welfare benefit plans (including, without limitation, medical, prescription, dental, disability, and life insurance) under the same terms and conditions applicable to most executives at similar levels of compensation and responsibility.

2.3 Performance Bonus.

(a) Employee shall be eligible to receive a discretionary performance bonus (the "Bonus") between zero and $300,000, payable in a manner consistent with Employer's practices and procedures. The amount of the Bonus, if any, will be decided by the Chief Executive Officer and/or the Board of Directors or the Compensation Committee of the Board in his/her/its sole discretion.

(b) In deciding on the amount of the Annual Performance Bonus, if any, the Chief Executive Officer and/or the Board of Directors or the Compensation Committee of the Board may consider the competitive market for the services provided by employees who are performing the same or similar duties as Employee is providing Employer and who have similar background and experience.

(c) Employee must be employed by Employer (or an affiliate) on the date any Bonus is paid to be eligible to receive such Bonus and, if Employee is not employed by Employer (or an affiliate) on the date any Bonus is paid for any reason whatsoever, Employee shall not be entitled to receive such Bonus.

2.4 Signing Bonus. Employer shall pay Employee a signing bonus of $50,000, less standard withholdings and authorized deductions, within her first month of employment.

2.5 Monthly Payment. Employer shall pay Employee $8,000 a month housing allowance, less standard deductions and authorized withholdings, for the first twelve months of Employee's employment to help off-set the costs of maintaining two homes during this transitional period.

2.6 Vacation. Employee shall have vacation, subject to the approval of the Chief Executive Officer.

2.7 Stock Appreciation Rights. Employer shall issue a grant to Employee of stock-settled Stock Appreciation Rights ("SSARS") on a base number of 60,000 shares of DaVita common stock, upon approval. This grant shall have a five-year term and vest 25% on the first anniversary date of the grant, 8.33% on the 20th month of the grant, and 8.33% every 4 months thereafter. The exercise price shall be the closing price as reported on the New York Stock Exchange on the Effective Date, the date on which Employee has begun her employment with Employer and has begun to perform the services set forth within this Agreement, or on the date that appropriate approval has been obtained, whichever is later. The terms of the SSARS grant will be reflected in a separate agreement to be signed by Employer and Employee.

2.8 Restricted Stock Units. On the Effective Date, on the date on which Employee has begun her employment with Employer and has begun to perform the services set forth within this Agreement, or on the date appropriate approval has been given, whichever date is later, Employee will receive 5,000 shares of Employer's restricted stock units, entitling Employee to the same number of full shares of DaVita common stock, subject to the following vesting conditions: such restricted stock units shall vest over a five-year period, one-third vesting on the third anniversary date of the grant, 11.11% at 40th month of the grant, then 11.11% every 4 months thereafter until the 60th month. The terms of the restricted stock units will be reflected in a separate Restricted Stock Units Agreement to be signed by Employer and Employee.

2.9 Management Share Ownership Policy. Employee shall review and understand the terms of the Management Share Ownership Policy with respect to all equity-based awards.

2.10 Indemnification. Employer agrees to indemnify and defend Employee against and in respect of any and all claims, actions, or demands relating to or in any way arising out of Employee's employment with Employer, to the extent permitted by the Company's By-laws and applicable law.

2.11 Reimbursement. Employer also agrees to reimburse Employee in accordance with Employer's reimbursement policies for travel and entertainment expenses, as well as other business-related expenses, incurred in the performance of her duties hereunder.

2.12 Changes to Benefit Plans. Employer reserves the right to modify, suspend, or discontinue any and all of its health and welfare benefit plans, practices, policies, and programs at any time without recourse by Employee so long as such action is taken generally with respect to all other similarly-situated peer executives and does not single out Employee.

Section 3. Provisions Relating to Termination of Employment.

3.1 Employment Is At-Will. Employee's employment with Employer is "at will" and is terminable by Employer or by Employee at any time and for any reason or no reason, subject to the notice requirements set forth below.

3.2 Termination for Material Cause. Employer may terminate Employee's employment without advanced notice for Material Cause (as defined below). Upon termination for Material Cause, Employee shall (i) be entitled to receive the Base Salary and benefits as set forth in Section 2.1 and Section 2.2, respectively, through the effective date of such termination and (ii) not be entitled to receive any other compensation, benefits, or payments of any kind, except as otherwise required by law or by the terms of any benefit or retirement plan or other arrangement that would, by its terms, apply.

3.3 Other Termination. Employer may terminate the employment of Employee for any reason or for no reason at any time upon at least thirty (30) days' advance written notice. If Employer terminates the employment of Employee for reasons other than for death, Material Cause, or Disability, or if Employee resigns within sixty (60) days following a Good Cause Event (as defined below), and contingent upon Employee's execution of the Employer's standard Waiver and Release Agreement and Noncompetition Agreement within twenty-eight days of the termination of Employee's employment, Employee shall be entitled to (i) salary continuation for the twelve-month period following the termination of her employment (the "Severance Period"), subject to Employer's payroll practices and procedures, and (ii) if Employee's employment is terminated after April in a given year, receive a payment equal to the Bonus paid in the year prior to the termination of Employee's employment, pro-rated for the number of months served in the year Employee's employment is terminated, to be paid in equal installments over the Severance Period, subject to Employer's payroll practices and procedures (if Employee's employment is terminated within her first year, she shall receive 50 percent of her Bonus potential, pro-rated for the number of months served in the year Employee's employment is terminated). Employee's severance is made pursuant to the terms and conditions of the DaVita Inc. Severance Plan, including the Offset;Mitigation provision, as those provisions exist at the time of the termination of Employee's employment. For purposes of this provision, an Employee's employment has been terminated when Employee is no longer providing services for Employer after a specific date or the level of bona fide services that Employee would perform (as an employee or independent contractor) after a specific date would permanently decrease to no more than 20% of the average level of bona fide services performed over the immediately preceding thirty-six month period (or the full period of service if Employee was employed for less than thirty-six months).

3.4. Voluntary Resignation. Employee may resign from Employer at any time upon at least ninety (90) days' advance written notice. If Employee resigns from Employer for reasons other than a Good Cause Event, Employee shall (i) be entitled to receive the base salary and benefits as set forth in Section 2.1 and Section 2.2, respectively, through the effective date of such termination and (ii) not be entitled to receive any other compensation, benefits, or payments of any kind, except as otherwise required by law or by the terms of any benefit or retirement plan or other arrangement that would, by its terms, apply. In the event Employee resigns from Employer at any time, Employer shall have the right to make such resignation effective as of any date before the expiration of the required notice period.

3.5 Disability. Upon thirty (30) days' advance notice (which notice may be given before the completion of the periods described herein), Employer may terminate Employee's employment for Disability (as defined below).

3.6 Definitions. For the purposes of this Agreement, the following terms shall have the meanings indicated:

(a) "Disability" shall mean the inability, for a period of six (6) months, to adequately perform Employee's regular duties, with or without reasonable accommodation, due to a physical or mental illness, condition, or disability.

(b) "Good Cause Event" shall mean the occurrence of the following events without Employee's express written consent: (i) Employer materially diminishes the scope of Employee's duties and responsibilities; or (ii) Employer materially reduces Employee's base compensation. Notwithstanding the above, the occurrence of any such condition shall not constitute Good Cause unless the Employee provides notice to Employer of the

existence of such condition not later than 90 days after the initial existence of such condition, and Employer shall have failed to remedy such condition within 30 days after receipt of such notice.

(c) "Material Cause" shall mean any of the following: (i) conviction of a felony or plea of no contest to a felony; (ii) any act of fraud or dishonesty in connection with the performance of her duties; (iii) repeated failure or refusal by Employee to follow policies or directives reasonably established by the Chief Executive Officer of Employer or his/her designee that goes uncorrected for a period of ten (10) consecutive days after written notice has been provided to Employee; (iv) a material breach of this Agreement; (v) any gross or willful misconduct or gross negligence by Employee in the performance of her duties; (vi) egregious conduct by Employee that brings Employer or any of its subsidiaries or affiliates into public disgrace or disrepute; (vii) an act of unlawful discrimination, including sexual harassment; (viii) a violation of the duty of loyalty or of any fiduciary duty; or (ix) exclusion or notice of exclusion of Employee from participating in any federal health care program. Before the Employer may discharge Employee for an act of fraud or dishonesty in connection with the performance of her duties, Employee shall have a right to contest her termination to the entire Board of Directors.

3.7 Notice of Termination. Any purported termination of Employee's employment by Employer or by Employee shall be communicated by a written Notice of Termination to the other party hereto in accordance with Section 5 hereof. A "Notice of Termination" shall mean a written notice that indicates the specific termination provision in this Agreement.

3.8 Effect of Termination. Upon termination, this Agreement shall be of no further force and effect and neither party shall have any further right or obligation hereunder; provided, however, that no termination shall modify or affect the rights and obligations of the parties that have accrued prior to termination; and provided further, that the rights and obligations of the parties under Section 3, Section 4, and Section 5 shall survive termination of this Agreement.

3.9 Notwithstanding any provision herein to the contrary, in the event that any payment to be made to Employee hereunder (whether pursuant to this Section 3 or any other Section) as a result of Employee's termination of employment is determined to constitute "deferred compensation" subject to Section 409A of the Internal Revenue Code, and Employee is a "Key Employee" under the DaVita Inc. Key Employee Policy for 409A Arrangements at the time of Employee's termination of employment, all such deferred compensation payments payable during the first six (6) months following Employee's termination of employment shall be delayed and paid in a lump sum during the seventh calendar month following the calendar month during which Employee's termination of employment occurs.

Section 4: Confidentiality and Non-Solicitation. Employee, contemporaneously herewith, shall enter into a Confidentiality and Non-Solicitation Agreement, the terms of which are incorporated herein and made a part hereof as though set forth in this Agreement. If Employee transfers to Colorado, she shall enter into a Non-Competition, Non-Solicitation, and Confidentiality Agreement.

Section 5. Miscellaneous.

5.1 Entire Agreement; Amendment. This Agreement represents the entire understanding of the parties hereto with respect to the employment of Employee and supersedes all prior agreements with respect thereto. This Agreement may not be altered or amended except in writing executed by both parties hereto.

5.2 Assignment; Benefit. This Agreement is personal and may not be assigned by Employee. This Agreement may be assigned by Employer and shall inure to the benefit of and be binding upon the successors and assigns of Employer.

5.3. Applicable Law; Venue. This Agreement shall be governed by the laws of the State of California, without regard to the principles of conflicts of laws. Both parties agree that any action relating to this Agreement

shall be brought in a state or federal court of competent jurisdiction located in the State of California and both parties agree to exclusive venue in the State of California.

5.4 Notice. Notices and all other communications provided for in this Agreement shall be in writing and shall be deemed to have been duly given when delivered or mailed by United States registered mail, return receipt requested, postage prepaid, addressed to Employer at its principal office and to Employee at Employee's principal residence as shown in Employer's personnel records, provided that all notices to Employer shall be directed to the attention of the Chief Executive Officer, or to such other address as either party may have furnished to the other in writing in accordance herewith, except that notice of change of address shall be effective only upon receipt.

5.5 Construction. Each party has cooperated in the drafting and preparation of this Agreement. Hence, in any construction to be made of this Agreement, the same shall not be construed against any party on the basis that the party was the drafter. The captions of this Agreement are not part of the provisions hereof and shall have no force or effect.

5.6 Execution. This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument. Photographic or facsimile copies of such signed counterparts may be used in lieu of the originals for any purpose.

5.7 Legal Counsel. Employee and Employer recognize that this is a legally binding contract and acknowledge and agree that they have had the opportunity to consult with legal counsel of their choice.

5.8 Waiver. The waiver by any party of a breach of any provision of this Agreement by the other shall not operate or be construed as a waiver of any other or subsequent breach of such or any provision.

5.9 Invalidity of Provision. In the event that any provision of this Agreement is determined to be illegal, invalid, or void for any reason, the remaining provisions hereof shall continue in full force and effect.

5.10 Approval by DaVita Inc. as to Form. The parties acknowledge and agree that this Agreement shall take effect and be legally binding upon the parties only upon full execution hereof by the parties and upon approval by DaVita Inc. as to the form of hereof.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement effective as of the date and year first written above.

DAVITA INC.

By /s/ Kent J. Thiry
Kent J. Thiry
Chairman and Chief Executive Officer

EMPLOYEE

By /s/ Kim M. Rivera
Kim M. Rivera

Approved by DaVita Inc. as to Form:

/s/ Lisa A. Barr
Lisa Barr
Assistant General Counsel - Labor

SECOND AMENDMENT TO STOCK APPRECIATION RIGHTS AGREEMENTS

This Second Amendment to Stock Appreciation Rights Agreements is entered into this 11 th day of December, 2009, by and between DaVita Inc., a Delaware corporation (the "Company"), and Richard K. Whitney (the "Employee").

WHEREAS, the Company and the Employee previously entered into five Stock Appreciation Rights Agreements (each an "SAR Agreement"), dated as of February 14, 2008, February 15, 2008, February 19, 2008, February 20, 2008 and February 21, 2008, respectively (the "Grant Dates"), copies of which are attached hereto as Exhibits 1 through 5, pursuant to the Company's 2002 Equity Compensation Plan; and

WHEREAS, each SAR Agreement was amended by that certain Amendment to Stock Appreciation Rights Agreements dated November 2008, a copy of which is attached hereto as Exhibit 6.

WHEREAS, the Company and the Employee desire to further amend each SAR Agreement pursuant to Section 10 thereof;

NOW, THEREFORE, in consideration of the mutual covenants and agreements hereinafter set forth and for other good and valuable consideration, the parties hereto, intending to be legally bound hereby, agree as follows:

Section 2(b) of each SAR Agreement is amended in its entirety, effective as of the date first written above, to provide as follows:

"(b) In the case of the termination of the Grantee's employment with the Company ("Severance"), the SAR shall terminate on the Expiration Date."

IN WITNESS WHEREOF, the parties hereto have executed this Second Amendment to Stock Appreciation Rights Agreements as of the date and year first written above.

COMPANY

By /s/ Kent J. Thiry
Kent J. Thiry
Chief Executive Officer

EMPLOYEE

By /s/ Richard K. Whitney
Richard K. Whitney

Exhibit 12.1

DAVITA INC.

RATIO OF EARNINGS TO FIXED CHARGES

The ratio of earnings to fixed charges is computed by dividing earnings by fixed charges. Earnings for this purpose are defined as pretax income from continuing operations adjusted by adding back fixed charges expensed during the period less noncontrolling interests. Fixed charges include debt expense (interest expense and the amortization of deferred financing costs), the estimated interest component of rent expense on operating leases, and capitalized interest.

	Year ended December 31,				
	2009	2008	2007	2006	2005
			(dollars in thousands)		
Earnings adjusted for fixed charges:					
Income from continuing operations before income taxes(1)	$ 758,224	$ 656,791	$ 674,224	$ 513,900	$ 354,592
Add:					
Debt expense	185,755	224,716	257,147	276,706	139,586
Interest portion of rent expense	81,122	72,562	64,613	60,395	35,189
Less: Noncontrolling interests(1)	(57,803)	(47,331)	(46,702)	(38,141)	(23,495)
	209,074	249,947	275,058	298,960	151,280
	$ 967,298	$ 906,738	$ 949,282	$ 812,860	$ 505,872
Fixed charges:					
Debt expense	$ 185,755	$ 224,716	$ 257,147	$ 276,706	$ 139,586
Interest portion of rent expense	81,122	72,562	64,613	60,395	35,189
Capitalized interest	3,627	4,189	3,878	4,708	1,912
	$ 270,504	$ 301,467	$ 325,638	$ 341,809	$ 176,687
Ratio of earnings to fixed charges	3.58	3.01	2.92	2.38	2.86

(1) The Company has changed the presentation of earnings attributable to noncontrolling interests for all prior periods presented.

SUBSIDIARIES OF THE COMPANY

Name	Structure	Jurisdiction of Incorporation
Aberdeen Dialysis, LLC	Limited Liability Company	DE
Alamosa Dialysis, LLC	Limited Liability Company	DE
American Fork Dialysis, LLC	Limited Liability Company	DE
Amery Dialysis, LLC	Limited Liability Company	DE
Animas Dialysis, LLC	Limited Liability Company	DE
Arcadia Gardens Dialysis, LLC	Limited Liability Company	DE
Astro, Hobby, West Mt. Renal Care Limited Partnership	Limited Partnership	DE
Austin Dialysis Centers, L.P.	Limited Partnership	DE
Bear Creek Dialysis, L.P.	Limited Partnership	DE
Beverly Hills Dialysis Partnership	Partnership	CA
Bluegrass Dialysis, LLC	Limited Liability Company	DE
Bright Dialysis Center, LLC	Limited Liability Company	DE
Brighton Dialysis Center, LLC	Limited Liability Company	DE
Bruno Dialysis, LLC	Limited Liability Company	DE
Buford Dialysis, LLC	Limited Liability Company	DE
Canyon Springs Dialysis, LLC	Limited Liability Company	DE
Canyonlands Dialysis, LLC	Limited Liability Company	DE
Capelville Dialysis, LLC	Limited Liability Company	DE
Capital Dialysis Partnership	Partnership	CA
Carroll County Dialysis Facility, Inc.	Corporation	MD
Carroll County Dialysis Facility Limited Partnership	Limited Partnership	MD
Cascades Dialysis, LLC	Limited Liability Company	DE
Centennial LV, LLC	Limited Liability Company	DE
Central Carolina Dialysis Centers, LLC	Limited Liability Company	DE
Central Georgia Dialysis, LLC	Limited Liability Company	DE
Central Iowa Dialysis Partners, LLC	Limited Liability Company	DE
Central Kentucky Dialysis Centers, LLC	Limited Liability Company	DE
Cherry Valley Dialysis, LLC	Limited Liability Company	DE
Chicago Heights Dialysis, LLC	Limited Liability Company	DE
Chipeta Dialysis, LLC	Limited Liability Company	DE
Clinton Township Dialysis, LLC	Limited Liability Company	DE
Columbus-RNA-DaVita, LLC	Limited Liability Company	DE
Commerce Township Dialysis Center, LLC	Limited Liability Company	DE
Continental Dialysis Center, Inc.	Corporation	VA
Continental Dialysis Center of Springfield-Fairfax, Inc.	Corporation	VA
Creek Dialysis, LLC	Limited Liability Company	DE
Dallas-Fort Worth Nephrology, L.P.	Limited Partnership	DE
Dallas-Fort Worth Nephrology II, LLC	Limited Liability Company	DE
DaVita Dakota Dialysis Center, LLC	Limited Liability Company	DE
DaVita El Paso East, L.P.	Limited Partnership	DE
DaVita Nephrology Medical Associates of California, Inc.	Corporation	CA
DaVita Nephrology Medical Associates of Pennsylvania, P.C.	Professional Corporation	PA
DaVita Nephrology Medical Associates of Washington, P.C.	Professional Corporation	WA
DaVita of New York, Inc.	Corporation	NY
DaVita-Riverside, LLC	Limited Liability Company	DE

Name	Structure	Jurisdiction of Incorporation
DaVita-Riverside II, LLC	Limited Liability Company	DE
DaVita Rx, LLC	Limited Liability Company	DE
DaVita Tidewater, LLC	Limited Liability Company	DE
DaVita Tidewater-Virginia Beach, LLC	Limited Liability Company	DE
DaVita VillageHealth, Inc	Corporation	DE
DaVita VillageHealth Insurance of Alabama, Inc.	Corporation	AL
DaVita VillageHealth of Georgia, Inc.	Corporation	GA
DaVita VillageHealth of Ohio, Inc.	Corporation	OH
DaVita VillageHealth of Virginia, Inc.	Corporation	VA
DaVita-West, LLC	Limited Liability Company	DE
Decker Dialysis, LLC	Limited Liability Company	DE
Dialysis Holdings, Inc.	Corporation	DE
Dialysis of Des Moines, LLC	Limited Liability Company	DE
Dialysis of North Atlanta, LLC	Limited Liability Company	DE
Dialysis of Northern Illinois, LLC	Limited Liability Company	DE
Dialysis Specialists of Dallas, Inc.	Corporation	TX
DNP Management Company, LLC	Limited Liability Company	DE
Downriver Centers, Inc.	Corporation	MI
Downtown Houston Dialysis Center, L.P.	Limited Partnership	DE
Durango Dialysis Center, LLC	Limited Liability Company	DE
DVA Healthcare of Maryland, Inc.	Corporation	MD
DVA Healthcare of Massachusetts, Inc.	Corporation	MA
DVA Healthcare of New London, LLC	Limited Liability Company	TN
DVA Healthcare of Norwich, LLC	Limited Liability Company	TN
DVA Healthcare of Pennsylvania, Inc.	Corporation	PA
DVA Healthcare of Tuscaloosa, LLC	Limited Liability Company	TN
DVA Healthcare Procurement Services, Inc.	Corporation	CA
DVA Healthcare Renal Care, Inc.	Corporation	NV
DVA Healthcare-Southwest Ohio, LLC	Limited Liability Company	TN
DVA Laboratory Services, Inc.	Corporation	FL
DVA of New York, Inc.	Corporation	NY
DVA Renal Healthcare, Inc.	Corporation	TN
DVA/Washington University Healthcare of Greater St. Louis, LLC		
	Limited Liability Company	DE
East Dearborn Dialysis, LLC	Limited Liability Company	DE
East End Dialysis Center, Inc.	Corporation	VA
East Ft. Lauderdale, LLC	Limited Liability Company	DE
East Houston Kidney Center, L.P.	Limited Partnership	DE
Elberton Dialysis Facility, Inc.	Corporation	GA
Elk Grove Dialysis Center, LLC	Limited Liability Company	DE
Empire State DC, Inc.	Corporation	NY
Falcon, LLC	Limited Liability Company	DE
Fields Dialysis, LLC	Limited Liability Company	DE
Five Star Dialysis, LLC	Limited Liability Company	DE
Flamingo Park Kidney Center, Inc.	Corporation	FL
Forester Dialysis, LLC	Limited Liability Company	DE
Freehold Artificial Kidney Center, LLC	Limited Liability Company	NJ
Fullerton Dialysis Center, LLC	Limited Liability Company	DE
Give Life Dialysis, LLC	Limited Liability Company	DE

Name	Structure	Jurisdiction of Incorporation
Grand Home Dialysis, LLC	Limited Liability Company	DE
Greater Las Vegas Dialysis LLC	Limited Liability Company	DE
Greater Los Angeles Dialysis Centers, LLC	Limited Liability Company	DE
Green Desert Dialysis, LLC	Limited Liability Company	DE
Greenwood Dialysis, LLC	Limited Liability Company	DE
Griffin Dialysis, LLC	Limited Liability Company	DE
Hanford Dialysis, LLC	Limited Liability Company	DE
Hawaiian Gardens Dialysis, LLC	Limited Liability Company	DE
Hialeah Kidney Dialysis, LLC	Limited Liability Company	DE
Historic Dialysis, LLC	Limited Liability Company	DE
HomeChoice Partners, Inc	Corporation	DE
Honey Dialysis, LLC	Limited Liability Company	DE
Houston Acute Dialysis, L.P.	Limited Partnership	DE
Houston Kidney Center/Total Renal Care Integrated Service Network Limited Partnership	Limited Partnership	DE
Huntington Artificial Kidney Center, Ltd.	Limited Liability Company	NY
Huntington Park Dialysis, LLC	Limited Liability Company	DE
Indian River Dialysis Center, LLC	Limited Liability Company	DE
Ionia Dialysis, LLC	Limited Liability Company	DE
Jedburg Dialysis, LLC	Limited Liability Company	DE
Kidney Centers of Michigan, LLC	Limited Liability Company	DE
Kidney Home Center, LLC	Limited Liability Company	DE
Knickerbocker Dialysis, Inc.	Corporation	NY
Las Vegas Pediatric Dialysis, LLC	Limited Liability Company	DE
Lawrenceburg Dialysis, LLC	Limited Liability Company	DE
Liberty RC, Inc.	Corporation	NY
Limon Dialysis, LLC	Limited Liability Company	DE
Lincoln Park Dialysis Services, Inc.	Corporation	IL
Little Rock Dialysis Centers, LLC	Limited Liability Company	DE
Lockport Dialysis, LLC	Limited Liability Company	DE
Long Beach Dialysis Center, LLC	Limited Liability Company	DE
Lord Baltimore Dialysis, LLC	Limited Liability Company	DE
Los Angeles Dialysis Center	Partnership	CA
Maple Grove Dialysis, LLC	Limited Liability Company	DE
Maples Dialysis, LLC	Limited Liability Company	DE
Marysville Dialysis Center, LLC	Limited Liability Company	DE
Mason-Dixon Dialysis Facilities, Inc.	Corporation	MD
Memorial Dialysis Center, L.P.	Limited Partnership	DE
Mena Dialysis Center, LLC	Limited Liability Company	DE
Middlesex Dialysis Center, LLC	Limited Liability Company	DE
Miramar Dialysis Center, LLC	Limited Liability Company	DE
Moncrief Dialysis Center/Total Renal Care Limited Partnership	Limited Partnership	DE
Morro Dialysis, LLC	Limited Liability Company	DE
Mountain West Dialysis Services, LLC	Limited Liability Company	DE
Muskogee Dialysis, LLC	Limited Liability Company	DE
Natomas Dialysis, LLC	Limited Liability Company	DE
Nephrology Medical Associates of Georgia, LLC	Limited Liability Company	GA
Neptune Artificial Kidney Center, LLC	Limited Liability Company	NJ

Name	Structure	Jurisdiction of Incorporation
New Bay Dialysis, LLC	Limited Liability Company	DE
New Hope Dialysis, LLC	Limited Liability Company	DE
New Springs Dialysis, LLC	Limited Liability Company	DE
North Austin Dialysis, LLC	Limited Liability Company	DE
North Colorado Springs Dialysis, LLC	Limited Liability Company	DE
Ohio River Dialysis, LLC	Limited Liability Company	DE
Open Access Lifeline, LLC	Limited Liability Company	DE
Orange Dialysis, LLC	Limited Liability Company	CA
Palomar Dialysis, LLC	Limited Liability Company	DE
Patient Pathways, LLC	Limited Liability Company	DE
PDI Holdings, Inc.	Corporation	DE
Physicians Choice Dialysis of Alabama, LLC	Limited Liability Company	DE
Physicians Dialysis Acquisitions, Inc.	Corporation	DE
Physicians Dialysis, Inc.	Corporation	DE
Physicians Dialysis of Houston, LLP	Limited Liability Partnership	TX
Physicians Dialysis of Lancaster, LLC	Limited Liability Company	PA
Physicians Dialysis Ventures, Inc.	Corporation	DE
Pike Dialysis, LLC	Limited Liability Company	DE
Pittsburg Dialysis Partners, LLC	Limited Liability Company	DE
Platte Dialysis, LLC	Limited Liability Company	DE
Plumas Dialysis, LLC	Limited Liability Company	DE
Princeton Dialysis, LLC	Limited Liability Company	DE
Red Willow Dialysis, LLC	Limited Liability Company	DE
Renal Clinic Of Houston, LLC	Limited Liability Company	DE
Renal Life Link, Inc.	Corporation	DE
Renal Treatment Centers—California, Inc.	Corporation	DE
Renal Treatment Centers—Illinois, Inc.	Corporation	DE
Renal Treatment Centers, Inc.	Corporation	DE
Renal Treatment Centers—Mid-Atlantic, Inc.	Corporation	DE
Renal Treatment Centers—Northeast, Inc.	Corporation	DE
Renal Treatment Centers—Southeast, L.P.	Limited Partnership	DE
Renal Treatment Centers—West, Inc.	Corporation	DE
Riddle Dialysis, LLC	Limited Liability Company	DE
Ripley Dialysis, LLC	Limited Liability Company	DE
Rita Ranch Dialysis, LLC	Limited Liability Company	DE
River Valley Dialysis, LLC	Limited Liability Company	DE
RMS Lifeline, Inc.	Corporation	DE
RNA-DaVita Dialysis, LLC	Limited Liability Company	DE
Robinson Dialysis, LLC	Limited Liability Company	DE
Rochester Dialysis Center, LLC	Limited Liability Company	DE
Rocky Mountain Dialysis Services, LLC	Limited Liability Company	DE
Physicians Choice Dialysis of Alabama, LLC	Limited Liability Company	DE
Roose Dialysis, LLC	Limited Liability Company	DE
Ross Clark Circle Dialysis, LLC	Limited Liability Company	DE
Physicians Choice Dialysis of Alabama, LLC	Limited Liability Company	DE
Royale Dialysis, LLC	Limited Liability Company	DE
RTC Holdings, Inc.	Corporation	DE
RTC TN, Inc.	Corporation	DE
SafeHarbor Dialysis, LLC	Limited Liability Company	DE

Name	Structure	Jurisdiction of Incorporation
SAKDC-DaVita Dialysis Partners, L.P.	Limited Partnership	DE
Sandusky Dialysis, LLC	Limited Liability Company	DE
San Marcos Dialysis, LLC	Limited Liability Company	DE
Santa Fe Springs Dialysis, LLC	Limited Liability Company	DE
Seneca Dialysis, LLC	Limited Liability Company	DE
Shadow Dialysis, LLC	Limited Liability Company	DE
Shayano Dialysis, LLC	Limited Liability Company	DE
Shining Star Dialysis, Inc.	Corporation	NJ
Siena Dialysis Center, LLC	Limited liability Company	DE
Soledad Dialysis Center, LLC	Limited Liability Company	DE
Somerville Dialysis Center, LLC	Limited Liability Company	DE
South Central Florida Dialysis Partners, LLC	Limited Liability Company	DE
South Shore Dialysis Center, L.P.	Limited Partnership	DE
Southcrest Dialysis, LLC	Limited Liability Company	DE
Southeastern Indiana Dialysis, LLC	Limited Liability Company	DE
Southern Colorado Joint Ventures, LLC	Limited Liability Company	DE
Southern Hills Dialysis Center, LLC	Limited Liability Company	DE
Southwest Atlanta Dialysis Centers, LLC	Limited Liability Company	DE
St. Luke's Dialysis, LLC	Limited Liability Company	DE
Star Dialysis, LLC	Limited Liability Company	DE
Steam Dialysis, LLC	Limited Liability Company	DE
Strongsville Dialysis, LLC	Limited Liability Company	DE
Sugarloaf Dialysis, LLC	Limited Liability Company	DE
Summit Dialysis Center, L.P.	Limited Partnership	DE
Sun City Dialysis Center, LLC	Limited Liability Company	DE
Sun City West Dialysis Center LLC	Limited Liability Company	DE
Sunset Dialysis, LLC	Limited Liability Company	DE
Taylor Dialysis, LLC	Limited Liability Company	DE
Tel-Huron Dialysis, LLC	Limited Liability Company	DE
Tennessee Valley Dialysis Center, LLC	Limited Liability Company	DE
The Woodlands Dialysis Center, L.P.	Limited Partnership	DE
Total Acute Kidney Care, Inc.	Corporation	FL
Total Renal Care/Eaton Canyon Dialysis Center Partnership	Partnership	CA
Total Renal Care, Inc.	Corporation	CA
Total Renal Care North Carolina, LLC	Limited Liability Company	DE
Total Renal Care/Piedmont Dialysis Center Partnership	Partnership	CA
Total Renal Care Texas Limited Partnership	Limited Partnership	DE
Total Renal Laboratories, Inc.	Corporation	FL
Total Renal Research, Inc.	Corporation	DE
Transmountain Dialysis, L.P.	Limited Partnership	DE
TRC-Dyker Heights, L.P.	Limited Partnership	NY
TRC El Paso Limited Partnership	Limited Partnership	DE
TRC-Four Corners Dialysis Clinics, LLC	Limited Liability Company	NM
TRC-Georgetown Regional Dialysis LLC	Limited Liability Company	DC
TRC-Indiana LLC	Limited Liability Company	IN
TRC-Petersburg, LLC	Limited Liability Company	DE
TRC of New York, Inc.	Corporation	NY
TRC West, Inc.	Corporation	DE
Tree City Dialysis, LLC	Limited Liability Company	DE

Name	Structure	Jurisdiction of Incorporation
Tulsa Dialysis, LLC	Limited Liability Company	DE
Turlock Dialysis Center, LLC	Limited Liability Company	DE
Tustin Dialysis Center, LLC	Limited Liability Company	DE
University Dialysis Center, LLC	Limited Liability Company	DE
Upper Valley Dialysis, L.P	Limited Partnership	DE
Urbana Dialysis, LLC	Limited Liability Company	DE
USC-DaVita Dialysis Center, LLC	Limited Liability Company	CA
UT Southwestern DVA Healthcare, LLP	Limited Liability Partnership	TX
Valley Springs Dialysis, LLC	Limited Liability Company	DE
Verde Dialysis, LLC	Limited Liability Company	DE
VillageHealth DM, LLC	Limited Liability Company	DE
Wauseon Dialysis, LLC	Limited Liability Company	DE
Wesley Chapel Dialysis, LLC	Limited Liability Company	DE
West Broomfield Dialysis, LLC	Limited Liability Company	DE
West Elk Grove Dialysis, LLC	Limited Liability Company	DE
West Monroe Dialysis, LLC	Limited Liability Company	DE
West Pensacola Dialysis, LLC	Limited Liability Company	DE
West Sacramento Dialysis, LLC	Limited Liability Company	DE
Weston Dialysis Center, LLC	Limited Liability Company	DE
Weston Dialysis Center, LLC	Limited Liability Company	DE
Willowbrook Dialysis Center, L.P.	Limited Partnership	DE
Wood Dialysis, LLC	Limited Liability Company	DE
Wyandotte Central Dialysis, LLC	Limited Liability Company	DE
Wyler Dialysis, LLC	Limited Liability Company	DE
Ybor City Dialysis, LLC	Limited Liability Company	DE
Yucaipa Dialysis, LLC	Limited Liability Company	DE
Zephyrhills Dialysis Center, LLC	Limited Liability Company	DE

Exhibit 23.1

Consent of Independent Registered Public Accounting Firm

The Board of Directors and Shareholders
DaVita Inc.:

We consent to the incorporation by reference in the registration statements on Forms S-8 (No. 33-84610, No. 33-83018, No. 33-99862, No. 33-99864, No. 333-01620, No. 333-34693, No. 333-34695, No. 333-46887, No. 333-75361, No. 333-56149, No. 333-30734, No. 333-30736, No. 333-63158, No. 333-42653, No. 333-86550, No. 333-86556, No. 333-144097 and No. 333-158220) and Form S-3 (No. 333-69227) of DaVita Inc. of our reports dated February 25, 2010, with respect to the consolidated balance sheets of DaVita Inc. as of December 31, 2009 and 2008, and the related consolidated statements of income, equity and comprehensive income, and cash flows for each of the years in the three-year period ended December 31, 2009, and related financial statement schedule, and the effectiveness of internal control over financial reporting as of December 31, 2009, which reports appear in the December 31, 2009 annual report on Form 10-K of DaVita Inc.

As discussed in Note 1 to the consolidated financial statements, the Company adopted Financial Accounting Standards Board (FASB) Statement of Financial Accounting Standards No. 160, Noncontrolling Interests in Consolidated Financial Statements (included in FASB ASC Topic 810, Consolidation), on a prospective basis except for the presentation and disclosure requirements which were applied retrospectively for all periods presented effective January 1, 2009.

/s/ KPMG LLP

Seattle, Washington
February 25, 2010

Exhibit 31.1

SECTION 302 CERTIFICATION

I, Kent J. Thiry, certify that:

1. I have reviewed this annual report on Form 10-K of DaVita Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and we have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

(d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

/s/ KENT J. THIRY
Kent J. Thiry
Chief Executive Officer

Date: February 25, 2010

Exhibit 31.2

SECTION 302 CERTIFICATION

I, Richard K. Whitney, certify that:

1. I have reviewed this annual report on Form 10-K of DaVita Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and we have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

(d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

/s/ RICHARD K. WHITNEY
Richard K. Whitney
Chief Financial Officer

Date: February 25, 2010

CERTIFICATION OF CHIEF EXECUTIVE OFFICER
PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Annual Report of DaVita Inc. (the "Company") on Form 10-K for the year ending December 31, 2009 as filed with the Securities and Exchange Commission on the date hereof (the "Periodic Report"), I, Kent J. Thiry, Chief Executive Officer of the Company, certify, pursuant to 18.U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, that:

1. The Periodic Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

2. The information contained in the Periodic Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ KENT J. THIRY
Kent J. Thiry
Chief Executive Officer

February 25, 2010

CERTIFICATION OF CHIEF FINANCIAL OFFICER
PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Annual Report of DaVita Inc. (the "Company") on Form 10-K for the year ending December 31, 2009 as filed with the Securities and Exchange Commission on the date hereof (the "Periodic Report"), I, Richard K. Whitney, Chief Financial Officer of the Company, certify, pursuant to 18.U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, that:

1. The Periodic Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

2. The information contained in the Periodic Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ RICHARD K. WHITNEY
Richard K. Whitney
Chief Financial Officer

February 25, 2010

Charles Robbins REALTOR

Residential Office
2144 S. MacArthur Boulevard
Springfield, IL 62704
Telephone (217) 525-2112
Fax # (217) 525-2275

Commercial Development Office
2144 S. MacArthur Boulevard
Springfield, IL 62704
Telephone (217) 525-7755
Fax # (217) 525-6545

www.charlesrobbins.com E-mail: ros@charlesrobbins.com

November 24, 2010

RE: Letter of Intent: 2930 S. 6th Street, Springfield, Illinois 62703

Dear Mr Furling:

USI Real Estate Brokerage Services Inc. and Charles Robbins Realtor have been authorized by DaVita Inc. to provide this letter of Intent to lease the above mentioned property under the terms and conditions below

LOCATION: 2930 South Sixth Street, Springfield, Illinois 62703

TENANT: "Total Renal Care, Inc. or related entity to be named".

LANDLORD: **2636 South Sixth Street LLC % William Furling III, Springfield, IL 62703**

INITIAL SPACE REQUIREMENTS: Approximately 6100 contiguous usable square feet. No load factor added

PRIMARY TERM: 10 years

POSSESSION AND COMMENCEMENT: Tenant shall take possession of the premises upon the later of completion of Landlords required work (if any) or mutual lease execution. In any event, the rent and term shall commence the earlier of seven (7) months from possession or until:

a. Leasehold Improvements within the Premises have been completed in accordance with the final construction documents (except for nominal punch list items); and

b. A Certificate of Occupancy for the Premises has been obtained from the City of Springfield, IL; and

c. Tenant has obtained all necessary licenses and permits.

FAILURE TO DELIVER PREMISES: If Landlord has not delivered the premises to Tenant with all base building items substantially completed by ninety (90) days from lease execution, Tenant may elect to terminate the lease by written notice to Landlord. Landlord shall deliver premises to Tenant 90 days after the latter of issuance of Certification of Need date or TIF approval date unless Tenant elects to forfeit TIF reimbursement.

LEASE FORM: The Tenant shall provide its standard lease form

USE:

The use is for a Dialysis Clinic, related medical, office and distribution of pharmaceuticals. Please verify that the use and parking are permitted within the building's zoning.

BASE BUILDING:

The following items must be delivered by the Landlord to the premises as part of the base building:

- A 2" dedicated water meter and line
- A 4" sewer line to a municipal sewer system
- Minimum 400 to 800 , 120/208 volt 3 phase, 4 wire electrical service
- Gas service, at a minimum, will be rated to have 6" of water column pressure and supply 800,000-BTU's
- HVAC rooftop Units/Systems and all associated cost with unit

Please refer to the attached Exhibit B regarding additional base building improvements and site development requirements.

TENANT IMPROVEMENTS:

Please describe whether Leasehold Improvements will be provided on a "Turnkey" or "Allowance" basis and the amount included within the Base Rent schedule. Furthermore, state if Landlord is willing to amortize additional improvements into the rent over the lease term. Landlord will with the cooperation of Tenant submit eligible improvement to City of Springfield for reimbursement from TIF funds. Reimbursement can be up to 1/3 of eligible expenses. Landlord will reimburse Tenant for its build out expense to the extent that TIF funds are paid to Landlord.

OPTION TO RENEW:

Tenant desires three (3) five (5) year options to renew the lease. Option Rent shall be the lesser of 95% of fair market value, or, the rent during the prior term escalated by the increase in the CPI-U over the prior term, capped at two percent (2%) annually with prior written notice due six (6) months.

RIGHT OF FIRST REFUSAL ON ADJACENT SPACE:

Tenant shall have the right of first offer on any adjacent space that may become available during the initial term of the lease and any extension thereof.

RENTAL RATE:

10 years $13 per foot per year with 2% per year escalation..

HOLDING OVER:

In the event Tenant remains in possession of the Premises after the expiration of the term of this Lease, then Tenant shall be obligated to pay rent at 125% the then current rate.

PARKING:

Tenant requires five (5) designated spaces for its use.

CONCESSIONS:

TIF reimbursement as outlined above

COMMON AREA EXPENSES AND REAL ESTATE TAXES:

Real Estate Taxes 2010 were $2.77 /sqft/yr Insurance costs for 2010 were $0.40 /sqft/yr CAM costs for 2010 were $1.42/sqft/yr to include utilities (water and exterior lighting), landscape, snow removal, maintenance, utilities, security ect.

SIGNAGE:	Tenant shall have the right to install building signage at the Premises, subject to Landlord's consent, which consent shall not be unreasonably withheld, and subject to compliance by Tenant with all applicable laws and regulations. Landlord, at Landlord's expense will furnish Tenant with space for Tenant's designated names on the building directory board in the lobby of the building and will put Tenant's name on any other directory board which may be part of the building or complex.
BUILDING HOURS:	Tenant requires building hours of 24 hours a day, 7 days a week.
SUBLEASE/ASSIGNMENT:	Tenant will have the right at any time to sublease or assign its interest in this Lease to any majority owned subsidiaries or related entities of DaVita Inc. without the consent of the Landlord.
GOVERNMENTAL COMPLIANCE:	Landlord shall represent and warrant to Tenant that Landlord, at Landlord's sole expense, will cause Tenant's Premises, the Building and parking facilities to be in full compliance with any governmental laws, ordinances, regulations or orders relating to, but not limited to, compliance with the Americans with Disabilities Act (ADA), and environmental conditions relating to the existence of asbestos and/or other hazardous materials, or soil and ground water conditions, and shall indemnify and hold Tenant harmless from any claims, liabilities and cost arising from environmental conditions not caused by Tenant(s).
ROOF RIGHTS:	If the building does not have cable television service, then Tenant will need the right to place a satellite dish on the roof at no additional fee.
RADIUS RESTRICTION:	Landlord shall not lease space to another Dialysis clinic or similar facility at the property or at any of the other properties Landlord controls within five (5) miles of the subject property.
EARLY TERMINATION OPTION:	No Early Termination Option
SECURITY DEPOSIT:	The client, by company policy, does not provide security deposits.
CORPORATE GUARANTEE:	A corporate guarantee from DaVita Inc. will be required
CONTINGENCIES	Tenant will need to apply for a Certificate of Need for the final location. If Tenant does not get the Certificate of Need by April 30, 2011, the Lease will be null and void. If they do get the Certificate of Need, then they will go forward with the lease based on satisfying the other contingencies that are in their standard Lease Document.
	Tenant CON Obligation. Landlord and Tenant understand and agree that the establishment of any chronic outpatient dialysis facility in the State of Illinois is subject to the requirements of the Illinois Health Facilities Planning Act, 20 ILCS 3960/1 et seq. and, thus, the Tenant cannot establish a dialysis facility on the Premises or execute a binding real estate lease in connection therewith unless Tenant obtains a Certificate of Need (CON) permit from the Illinois Health Facilities Planning Board (the "Planning Board"). Tenant agrees to proceed using

its commercially reasonable best efforts to submit an application for a CON permit and to prosecute said application to obtain the CON permit from the Planning Board. Based on the length of the Planning Board review process, Tenant does not expect to receive a CON permit prior to April 30, 2011. In light of the foregoing facts, the parties agree that they shall promptly proceed with due diligence to negotiate the terms of a definitive lease agreement and execute such agreement prior to approval of the CON permit provided, however, the lease shall not be binding on either party prior to the approval of the CON permit and the lease agreement shall contain a contingency clause indicating that the lease agreement is not effective pending CON approval. Assuming CON permit approval is granted, the effective date of the lease agreement shall be the first day of the calendar month following CON permit approval. In the event that the Planning Board does not award Tenant a CON permit to establish a dialysis center on the Premises by April 30, 2011 neither party shall have any further obligation to the other party with regard to the negotiations, lease or Premises contemplated by this Letter of Intent.

BROKERAGE FEE: Landlord agrees that it recognizes DSI Real Estate Brokerage Services Inc. and Charles Robbins Realtor as the client's sole representatives and a brokerage fee of five percent (5%) of the gross rent due over the term shall be paid to DSI, or its designated local affiliate, per separate commission agreement. The client shall retain the right to offset rent for future to pay the Real Estate Commission.

Please submit your response to this Request for Proposal via e-mail and hard copy no later than Monday November 15, 2010 to:

Ronald D. Lashley
Charles Robbins Realtor
2144 S. Macarthur Blvd.
Springfield, Illinois 62704

It should be understood that this Letter of Intent is subject to the terms of Exhibit A attached hereto.

Agreed to and accepted this 24th Day of November 2010

By: _____ Attorney

2636 South Sixth Street LLC % William Furling III,
Springfield, IL 62703

("Landlord")

Agreed to and accepted this 24th Day of November 2010

By: Cindy Ensley, Reg Operations Director

On behalf of Total Renal Care, Inc a wholly owned subsidiary of DaVita, Inc. ("Tenant")

Thank you for your time and cooperation in this matter.

Very truly yours,

Ronald D. Ladley

Cc: USI Real Estate Brokerage Services

EXHIBIT A

NON-BINDING NOTICE

NOTICE: THE PROVISONS CONTAINED IN THIS LETTER OF INTENT ARE AN EXPRESSION OF THE PARTIES' INTEREST ONLY. SAID PROVISIONS TAKEN TOGETHER OR SEPERATELY ARE NEITHER AN OFFER WHICH BY AN "ACCEPTANCE" CAN BECOME A CONTRACT, NOR A CONTRACT. BY ISSUING THIS LETTER OF INTENT, NEITHER TENANT NOR LANDLORD (OR USI) SHALL BE BOUND TO ENTER INTO ANY (GOOD FAITH OR OTHERWISE) NEGOTIATIONS OF ANY KIND WHATSOEVER. TENANT RESERVES THE RIGHT TO NEGOTIATE WITH OTHER PARTIES. NEITHER TENANT, LANDLORD OR USI INTENDS ON THE PROVISIONS CONTAINED IN THIS LETTER OF INTENT TO BE BINDING IN ANY MANNER, AS THE ANALYSIS FOR AN ACCEPTABLE TRANSACTION WILL INVOLVE ADDITIONAL MATTERS NOT ADDRESSED IN THIS LETTER, INCLUDING, WITHOUT LIMITATION, THE TERMS OF ANY COMPETING PROJECTS, OVERALL ECONOMIC AND LIABILITY PROVISIONS CONTAINED IN ANY LEASE DOCUMENT AND INTERNAL APPROVAL PROCESSES AND PROCEDURES. THE PARTIES UNDERSTAND AND AGREE THAT A CONTRACT WITH RESPECT TO THE PROVISIONS IN THIS LETTER OF INTENT WILL NOT EXIST UNLESS AND UNTIL THE PARTIES HAVE EXECUTED A FORMAL, WRITTEN LEASE AGREEMENT APPROVED IN WRITING BY THEIR RESPECTIVE COUNSEL. USI IS ACTING SOLELY IN THE CAPACITY OF SOLICITING, PROVIDING AND RECEIVING INFORMATION AND PROPOSALS AND NEGOTIATING THE SAME ON BEHALF OF OUR CLIENTS. UNDER NO CIRCUMSTANCES WHATSOEVER DOES USI HAVE ANY AUTHORITY TO BIND OUR CLIENTS TO ANY ITEM, TERM OR COMBINATION OF TERMS CONTAINED HEREIN. THIS LETTER OF INTENT IS SUBMITTED SUBJECT TO ERRORS, OMISSIONS, CHANGE OF PRICE, RENTAL OR OTHER TERMS; ANY SPECIAL CONDITIONS IMPOSED BY OUR CLIENTS; AND WITHDRAWAL WITHOUT NOTICE. WE RESERVE THE RIGHT TO CONTINUE SIMULTANEOUS NEGOTIATIONS WITH OTHER PARTIES ON BEHALF OF OUR CLIENT. NO PARTY SHALL HAVE ANY LEGAL RIGHTS OR OBLIGATIONS WITH RESPECT TO ANY OTHER PARTY, AND NO PARTY SHOULD TAKE ANY ACTION OR FAIL TO TAKE ANY ACTION IN DETRIMENTAL RELIANCE ON THIS OR ANY OTHER DOCUMENT OR COMMUNICATION UNTIL AND UNLESS A DEFINITIVE WRITTEN LEASE AGREEMENT IS PREPARED AND SIGNED BY TENANT AND LANDLORD.

Exhibit B

FOR EXISTING BUILDING]
[SUBJECT TO MODIFICATION BASED ON INPUT FROM LESSEE'S PROJECT MANAGER WITH RESPECT TO EACH CENTER PROJECT]

SCHEDULE A - TO WORK LETTER

MINIMUM BASE BUILDING IMPROVEMENT REQUIREMENTS
(Note: Sections with an Asterisk (*) have specific requirements for 1.1.2 in California and other select States – see end of document for changes to that section)

At a minimum, the Lessor shall provide the following Base Building Improvements to meet Lessee's requirements for an Existing Base Building Improvements at Lessor's sole cost.

All MBBI work completed by the Lessor will need to be coordinated and approved by the Lessee and there Consultants prior to any work being completed, including shop drawings and submittals reviews

1.0 - Building Codes & Design *

All Minimum Base Building Improvements (MBBI) are to be performed in accordance with all local, state, and federal building codes including any related amendments, fire and life safety codes, ADA regulations, State Department of Public Health, and other applicable and codes as it pertains to Dialysis. All Lessor's work will have Governmental Authorities Having Jurisdiction ("GAHJ") approved architectural and engineering (Mechanical, Plumbing, Electrical, Structural, Civil, Environmental) plans and specifications prepared by a licensed architect and engineer.

Lessee shall have full control over the selection of the General Contractor for the tenant improvement work.

2.0 - Zoning & Permitting

Building and premises must be zoned to perform services as a dialysis clinic. Lessor to provide all Zoning information related to the base building. Any new Zoning changes/variances necessary for use of the premises as a dialysis clinic shall be the responsibility of the Lessee with the assistance of the Lessor to secure Zoning change/variance. Permitting of the interior construction of the space will be by the Lessee.

3.0 - Common Areas

Lessee will have access and use of all common areas i.e. Lobbies Hallways, Corridors, Restrooms, Stairwells, Utility Rooms, Roof Access, Emergency Access Points and Elevators. All common areas must be code and ADA compliant (Life Safety, ADA, etc.) per current federal, state and local code requirements.

4.0 - Demolition

Lessor will be responsible for demolition of all interior partitions, doors and frames, plumbing, electrical, mechanical systems (other than what is designated for reuse by Lessee) and finishes of the existing building from slab to roof deck to create a "Vanilla box" condition. Space shall be broom clean and ready for interior improvements specific to the buildout of a dialysis facility. Building to be free and clear of any components, asbestos or material that is in violation of any EPA standards of acceptance and local hazardous material jurisdiction standards.

5.0 - Foundation and Floor *

Existing Foundations and Slab on Grade in Lessee space must be free of cracks and settlement issues. Any cracks and settlement issues evident at any time prior commencement of tenant improvement work shall be subject to inspection by a Licensed Structural Engineer stating that such cracks and / or settlement issues are within limits of the structural integrity and performance anticipated for this concrete and reinforcement design for the term of the lease. Lessor to confirm that the site does not contain expansive soils and to confirm the depth of the water table. Existing concrete slabs shall contain control joints and structural reinforcement.

All repairs will be done by Lessor at his cost and be done prior to Lessee acceptance of space for construction. Any issues with slab during Lessee construction will be brought up to Lessee attention and cost associated with slab issue to repair will be paid by Lessor.

Any slab replacement will be of the same thickness of the adjacent slab (or a minimum of 5") with a minimum concrete strength of 3,000-psi with wire or fiber mesh, and/or rebar reinforcement over vapor barrier and granular fill. Infill slab/trenches will be pinned to existing slab at 24" O.C. with # 4bars or greater x 16" long or as designed per higher standards by Lessee's structural engineer depending on soils and existing slab condition

Existing Concrete floor shall not have more than 3-lbs of moisture per 1000sf/24 hours is emitted per completed calcium chloride testing results. Means and methods to achieve this level will be sole responsibility of the Lessor.

6.0 - Structural *

Existing exterior walls, lintels, floor and roof framing shall remain as-is and be free of defects. Should any defects be found repairs will be made by Lessor at his cost. Any repairs will meet with current codes and approved by a Structural Engineer and Lessee.

Lessor shall supply Lessee (if available) structural engineering drawings of space

7.0 – Existing Exterior Walls

All exterior walls shall be in good shape and properly maintained. Any damaged drywall and or insulation will be replaced by Lessor prior to Lessee taking possession.

It will be the Lessor's responsibility for all cost to bring exterior walls up to code before Lessee takes possession.

7.0 - Demising walls

New or Existing demising walls shall be a 1 or 2hr fire rated wall depending on local codes, state and or regulatory requirements (NFPA 101 – 2000) whichever is more stringent. If it does not meet this, Lessor will bring demising wall up to meet the ratings/UL requirements. Walls to be fire caulked in accordance with UL standards at floor and roof deck. Demising walls will have sound attenuation batts from floor to underside of deck.

At Lessee's option and as agreed upon by Lessor, any new demising wall interior drywall to lessee's space shall not be installed until after Lessee's improvements are complete in the wall.

8.0 - Roof Covering *

The roof shall be properly sloped for drainage and flashed for proper water shed. The roof, roof drains and downspouts shall be properly maintained to guard against roof leaks and can properly drain. Lessor will provide Lessee the information on the Roof and Contractor holding warranty. Lessor to provide minimum of R30 roof insulation at roof deck. If the R30 value is not meet, Lessor to increase R-Value by having installed additional insulation to meet GAHJ requirements to the underside of the roof structure/deck.

Any new penetrations made during buildout will be at the Lessee's cost. Lessor shall grant Lessee that right to conceal or remove existing skylights as deemed appropriate by Lessee and their Consultants.

9.0 - Canopy *

Lessor shall allow Lessee to design and construct a canopy structure for patient drop off and if allowed local code.

10.0 – Waterproofing and Weatherproofing

Lessor shall provide complete water tight building shell inclusive but not limited to. Flashing and/or sealant around windows, doors, parapet walls, Mechanical / Plumbing / Electrical penetrations. Lessor shall properly seal the building's exterior walls, footings, slabs as required in high moisture conditions such as (including but not limited to) finish floor sub-grade, raised planters, and high water table. Lessor shall be responsible for replacing any damaged items and repairing any deficiencies exposed during / after construction of tenant improvement.

11.0 - Windows

Any single pane window systems must be replaced by Lessor with code compliant Energy efficient thermal pane windows with thermally broken aluminum frames. Broken, missing and/or damaged glass or frames will be replaced by Lessor. Lessor shall allow Lessee, at Lessee's discretion, to tint the existing windows (per manufactures recommendations) per Lessee's tenant improvement design.

12.0 - Thermal Insulation

Lessor to replace any missing and/or damaged wall or ceiling insulation with R-13, 19 or R30 insulation.

13.0 - Exterior Doors

American Disabilities Act (ADA), Local Codes and State Department of Health requirements for egress. If not Lessor at his cost will need to bring them up to code, this will include installing push paddles and/or panic hardware or any other hardware for egress. Any missing weather stripping, damage to doors or frames will be repaired or replaced by Lessor.

Lessor will provide, if not already present, a front entrance and rear door to space. Should one not be present at each of the locations Lessor, to have them installed per the following criteria:

- Front/ Patient Entry Doors: Provide Storefront with insulated glass doors and Aluminum framing to be 42" width including push paddle/panic bar hardware, continuous hinge and lock mechanism. Door to be prepped to accept power assist opener and push button keypad lock provided by Lessee.

- Service Doors: Provide 72" wide double door (Alternates for approval by Lessee's Project Manager to include: 60" Roll up door, or a 48" wide single door or double door with 36" and 24" doors) with 20 gauge insulated hollow metal (double doors), Flush bolts, T astragal, Heavy Duty Aluminum threshold, continuous hinge each leaf, prepped for panic bar hardware (as required by code) painted with rust inhibiting paint and prepped to receive a push button keypad lock provided by Lessee. Door to have a 10" square vision panel cut out with insulated glass installed if requested by Lessee.

Any doors that are designated to be provided modified or prepared by Lessor, Lessor shall provide to Lessee, prior to door fabrication, submittals containing specification information, hardware and shop drawings for review and acceptance by Lessee and Lessee's architect.

14.0 - Utilities

All utilities to be provided at designated utility entrance points into the building at locations approved by the Lessee at a common location for access. Lessor is responsible for all tap/connection and impact fees for all new utilities required for a dialysis facility. All Utilities to be coordinated with Lessee's Architect.

15.0 - Plumbing *

Lessor to provide a segregated/d dedicated 2" water line, if not already present (and not tied-in to any other lessees spaces, fire suppression systems, or irrigation systems) with a shut off valve, 2 (two) 2" backflow preventors in

parallel (with drain under BFP's), and 2" meter (1 1/2" meter under special circumstances which must be approved by Lessee) to provide a continuous minimum 50 psi (maximum of 80psi), with a minimum flow rate of 30 gallons per minute to Lessee space. Lessor to provide Lessee with the most recent water flow and pressure test results (gallons per minute and psi) for approval. Lessor shall perform water flow and pressure test prior to lease execution. Lessor shall stub the dedicated water line into the Lessee space to a location on Lessee plans. Lessor to provide and pay for all tap fees related to new sanitary sewer and water services in accordance with local building and regulatory agencies. Lessor may elect to dedicate the existing 2" line and 2" meter (1-1/2" meter if approved by Lessee), if existing, to Lessee for Lessee's exclusive and dedicated use. Lessor shall then be responsible to install a new water line and water meter(s) for use by adjacent tenant(s) as needed to meet adjacent tenant water requirements and water demands. Lessor shall be responsible for all fees and costs associated with the line, tap, meter and impact fees related to this work.

All existing hose bibs will be in proper working condition prior to Lessees possession of space.

Existing Sanitary sewer line will need to be a four-inch (4") minimum line to Lessee space and have an invert level of 42" minimum or a sanitary lines(s) that will adequately support the drainage requirements leaving the space. Lift station/sewage ejectors will not be permitted. The sanitary sewer line feeding the demised space will need to be video scoped for integrity with a copy available for Lessee and his architect to review. Sewer line to receive a power rod with high pressure cleaning to insure flow integrity from facility inlet to city main.

If the Sanitary line is not a 4" line, Lessor will have installed a new line to a location per Lessee plans to support the drainage requirements (with a minimum invert level of 42") and to meet local code. All cost associated with line, tap and impact fees will be Lessor responsibility.

Sanitary sampling manhole if required by local municipality on new line.

16.0 - Fire Suppression and Alarm System

Existing Fire Sprinkler Systems and fire alarm control panel shall be maintained by Lessor. Lessor to provide pertinent information on systems for Lessee Engineers for design. Lessor to provide current vendor for system and monitoring company.

If a Sprinkler System is not present and is required by Lessee usage based on NFPA 101, 2000, Lessor to provide cost, to be included in lease rate, for the design and installation of a complete turnkey sprinkler system (less drops and heads in lessee space) that meets all local building and life safety codes for the entire building. This system will be on a dedicated water line independent of Lessee's water line requirements, including municipal approved shop drawings, service drops and sprinkler heads at heights per Lessee's reflective ceiling plan, flow control switches wired and tested, alarms including wiring and an electrically/telephonically controlled fire alarm control panel connected to a monitoring systems for emergency dispatch.

Existing Fire Alarm system shall be maintained and in good working order by Lessor prior to Lessee acceptance of space. Lessor to provide pertinent information on systems for Lessee's design. Lessor to provide current vendor for system and monitoring company. If FA Panel is unable to accommodate Lessee requirements Lessor to upgrade panel at Lessor's cost.

Fire Suppression and Alarm system equipment shall be equipped for double detection activation per GAHJ.

17.0 – Electrical;

Service size to be determined by Lessee's engineer dependant on facility size and gas availability (400amp to 800amp service) 120/208 volt, 3 phase, 4 wire. Existing service to be a combined single service for Lessee space. Lessee will not accept multiple services to obtain the necessary amperage. Should this not be available Lessor to upgrade to meet the following criteria:

Provide new service (preferably underground) with a dedicated meter via a new CT cabinet. Service size to be determined by Lessee's engineer dependant on facility size and gas availability (400amp to 800amp service) 120/208 volt, 3 phase, 4 wire to a load center in the Lessee's utility room (location to be per Code and to a location per Lessee plans) for Lessee's exclusive use in powering equipment, appliances, lighting, heating, cooling and miscellaneous use. Transformer coordination with utility company, transformer pad, and underground conduit sized for service, circuit termination cabinet, grounding rod, main panel with breaker, conduit and wire inclusive of excavation, trenching and restoration. Lessee's Engineer shall have the final approval on the electrical service size and location. If 480V power is supplied, Lessor to provide step down transformer to Lessee requirements above.

If combined service meter cannot be provided then Lessor shall provide written verification from Power Utility supplier stating multiple meters are allowed for use by the facility for the duration of the lease term

Lessor will allow Lessee to have installed, at Lessee cost, Transfer Switch for temporary generator hook-up, or permanent generator.

18.0 - Gas Service

Existing Natural gas service at a minimum to have a 6" water column pressure and be able to supply 800,000-BTU's. Natural gas line shall be individually metered and sized per demand.

19.0 - Mechanical /Heating Ventilation Air Conditioning *

Lessor to provide a detailed report from a HVAC company on all existing HVAC units i.e. age, CFM's, cooling capacity, service records etc for review by Lessee. HVAC Units, components and equipment that Lessee intends to reuse shall be left in place "as is" by Lessor. Lessor shall allow Lessee, at Lessee's discretion to remove, relocate, replace or modify existing unit(s) as needed to meet HVAC code requirements and design layout requirements.

If determined by Lessee that the units need to be replaced and or additional units are needed, Lessor will be responsible for the cost of the replacement/additional HVAC units. Lessee will complete the all work with the replacement/additional HVAC Units. Units replaced or added will meet the design requirements as stated below.

The criteria is as follows: Equipment to be Carrier or Trane. Equipment will be new and come with a full warranty on parts (minimum of 5yrs) including labor. Supply air shall be provided to the Premises sufficient for cooling at the rate of 325 square feet per ton to meet Lessee's demands for dialysis facility. Ductwork shall be extended 5' into the space for supply and return air. System to be a ducted return air design. All ductwork to externally lined except for the drops from the units. Work to include, but not limited to, the purchase of the units, installation, roof framing, mechanical curbs, flashings, gas & electrical hook-up, thermostats and start-up. Anticipate minimum up to five (5) zones with programmable thermostat. Lessee's engineer shall have the final approval on the sizes, tonnages, zoning, location and number of HVAC units based on design criteria and local and state codes.

20.0 - Telephone

If in a multi tenant building Lessor to provide a 1" conduit from Building Demark location to phone room location in Lessee space.

21.0 – Cable or Satellite TV

Lessor to have Cable TV extend to Lessee space if available. Lessor will also allow for a satellite dish on the roof regardless if cable is present or not at Lessee's costs. Lessor will need to grant right of access to cable company for new service.

22.0 - Handicap Accessibility *

Full compliance with ADA and all local jurisdictions' handicap requirements. Lessor shall comply with all ADA regulations affecting the Building and entrance to Lessee space including, but not limited to, the elevator, exterior and interior doors, concrete curb cuts, ramps and walk approaches to / from the parking lot, parking lot striping for

four (4) dedicated handicap stalls for a unit up to 20 station clinic and six (6) HC stalls for units over 20 stations inclusive of pavement markings and stall signs with current local provisions for handicap parking stalls, delivery areas and walkways.

Lessor shall provide pavement marking, curb ramp and accessible path of travel for a dedicated delivery access in the rear of the building. The delivery access shall link the path from the driveway paving to the designated Lessee delivery door and also link to the accessible path of travel.

23.0 - Generator

Lessor to allow a generator to be installed onsite if required by code or Lessee chooses to provide one.

24.0 – Existing Site Lighting

Lessor to provide adequate lighting per code and to illuminate all parking, pathways, for new and existing building access points. Parking lot lighting to be on a timer (and be programmed per Lessee business hours of operation) or photocell. Parking lot lighting shall be connected to and powered by Lessor house panel and equipped. If new lighting is provided it will need to be code compliant with an 90 minute battery back up at all access points.

25.0 – Exterior Building Lighting

Lessor to provide adequate lighting per code and to illuminate the building main and service entrance/exits with related sidewalks. Lighting shall be connected to and powered by Lessor house panel and equipped with a code compliant 90 minute battery back up at all access points.

26.0 – Parking Lot

Provide adequate amount of ADA curb cuts, handicap and standard parking stalls in accordance with dialysis use and overall building uses. Stalls to receive striping, lot to receive traffic directional arrows and concrete parking bumpers. Bumpers to be anchored in place onto the asphalt per stall layout.

27.0 – Refuse Enclosure

If an area is not designated, lessor to provide Refuse area for Lessee dumpsters. Lessor to provide a minimum 6" thick reinforced concrete pad approx 100 to 150SF based and an 8' x 12' apron way to accommodate dumpster and vehicle weight. Enclosure to be provided as required by local codes

28.0 - Signage

Lessor to allow for an illuminated façade mounted sign and rights to add signage to existing Pylon/monument sign. Final sign layout to be approved by Lessee and the City.

Section IX, Financial Feasibility
Criterion 1120.130 – Financial Viability Waiver

All project capital expenses, including the lease with 2636 South Sixth Street LLC, shall be funded through internal resources. A copy of DaVita's 2009 10-K Statement evidencing sufficient internal resources to fund the project is attached at Attachment – 39A.

Attachment – 40

Section X, Economic Feasibility Review Criteria
Criterion 1120.140(a), Reasonableness of Financing Arrangements

Attached at Attachment 42-A is a letter from Kent J. Thiry, Chief Executive Officer of DaVita, Inc. and Total Renal Care, Inc., attesting that the total estimated project costs and related costs will be funded in total with cash and cash equivalents.

Attachment – 42A

DaVita.

Casa Nueva
1551 Wewatta Street
Denver, CO 80202-6173
Tel: 303-405-2100
www.davita.com

December 17, 2010

Dale Galassie
Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: Reasonableness of Financing Arrangements

Dear Chairman Galassie:

I hereby certify under penalty of perjury as provided in § 1-109 of the Illinois Code of Civil Procedure, 735 ILCS 5/1-109 and pursuant to 77 Ill. Admin. Code § 1120.140(a) that the total estimated project costs and related costs will be funded in total with cash and cash equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation.

Sincerely,

Kent J. Thiry
Chief Executive Officer
DaVita, Inc.
Total Renal Care, Inc.

Subscribed and sworn to me
This 17th day of December, 2010

Tara L. Motley
Notary Public

"OFFICIAL SEAL"
Tara L Motley
Notary Public, State of Illinois
My Commission Expires 6/11/2013

Attachment – 42A

Section X, Economic Feasibility Review Criteria
Criterion 1120.140(b), Conditions of Debt Financing

This project will be funded in total with cash and cash equivalents. Accordingly, this criterion is not applicable.

Section X, Economic Feasibility Review Criteria
Criterion 1120.310(c), Reasonableness of Project and Related Costs

1. The Cost and Gross Square Feet by Department is provided in the table below.

Table 1120.310(c)
COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE

Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Cost/Square Foot Mod.	Gross Sq. Ft. New	Gross Sq. Ft. Circ.*	Gross Sq. Ft. Mod.	Gross Sq. Ft. Circ.*	Const. $ (A x C)	Mod. $ (B x E)	
ESRD		$124.75			6,100			$761,000	$761,000
Contingency		$12.46			6,100			$76,100	$76,100
TOTALS		$137.21			6,100			$837,100	$837,100

* Include the percentage (%) of space for circulation

2. As shown in Table 1120.310(c) below, the project costs are below the State Standard.

Table 1120.310(c)

	Proposed Project	State Standard	Above/Below State Standard
Modernization Costs	$761,000	$145 per gross square foot x 6,100 gross square feet = $884,500	Below State Standard
Contingencies	$76,100	10 - 15% of Modernization Costs = 10 – 15% x $761,000 = $76,100 - $114,150	Below State Standard
Architectural/Engineering Fees	$61,000	7.18 – 10.78% x (Modernization Costs + Contingencies) = 7.18 – 10.78% x ($761,000 + $76,100) = 7.18 – 10.78% x 837,100 = $60,104 - $90,239	Meets State Standard
Consulting and Other Fees	$48,000	No State Standard	No State Standard
Moveable Equipment	$471,161	$39,945 per station $39,945 x 12 = $479,340	Below State Standard

Section X, Economic Feasibility Review Criteria
Criterion 1120.310(d), Projected Operating Costs

Operating Expenses: $1,789,999

Treatments: 6,965

Operating Expense per Treatment: $257

Attachment – 42D

Section X, Economic Feasibility Review Criteria
Criterion 1120.310(e), Total Effect of Project on Capital Costs

Capital Costs: $117,228

Treatments: 6,965

Capital Costs per Treatment: $16.83

Section XI, Safety Net Impact Statement

1. This criterion is required for all substantive and discontinuation projects. The Applicants are a safety net provider of dialysis services to residents of the State of Illinois and submit the following information regarding the amount of charity and Medicaid care provided over the most recent three years.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**2007**	**2008**	**2009**
Inpatient			
Outpatient	8	10	19
Total	**8**	**10**	**19**
Charity (cost In dollars)			
Inpatient			
Outpatient	$244,745	$321,510	$597,263
Total	**$244,745**	**$321,510**	**$597,263**
MEDICAID			
Medicaid (# of patients)	**2007**	**2008**	**2009**
Inpatient			
Outpatient	204	214	220
Total	**204**	**214**	**220**
Medicaid (revenue)			
Inpatient			
Outpatient	$8,929,985	$9,073,985	$9,212,781
Total	**$8,929,985**	**$9,073,985**	**$9,212,781**

2. The proposed project will not impact the ability of other health care providers or health care systems to cross-subsidize safety net services. As set forth throughout this application, the existing facilities located within 30 minutes normal travel time of the proposed facility are quickly approaching the HFSRB 80% standard utilization rate and are projected to be operating at 100% capacity prior to the projected completion date of the proposed facility. The proposed facility is necessary to allow the existing facilities to operate at their optimum capacity while at the same time accommodating the growing demand for dialysis services. Accordingly, the proposed dialysis facility will not impact other providers' ability to cross-subsidize safety net services.

3. The proposed project is for the establishment of a 12-station dialysis facility. There will be no discontinuation of any services. Accordingly, this criterion is not applicable.

Section XII, Charity Care Information

The table below provides charity care information for all dialysis facilities located in the State of Illinois that are owned or operated by the Applicants.

CHARITY CARE			
	2007	2008	2009
Net Patient Revenue	**$163,965,043**	**$157,223,604**	**$166,573,387**
Amount of Charity Care (charges)	$250,518	$297,508	$575,803
Cost of Charity Care	$244,745	$321,510	$597,263