DAVITA INC
Form 10-K
February 28, 2007
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UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-K

For the Fiscal Year Ended

December 31, 2006

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 x 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 x

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 x 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 is a large accelerated filer, an accelerated filer, or a non-accelerated filer. See definition of accelerated filer and large accelerated filer in Rule 12b-2 of the Exchange Act.

Large accelerated filer x Accelerated filer ¨ Non-accelerated filer ¨

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

As of June 30, 2006, the number of shares of the Registrant s common stock outstanding was approximately 103.6 million shares and the aggregate market value of the common stock outstanding held by non-affiliates based upon the closing price of these shares on the New York Stock Exchange was approximately $5.1 billion.

As of February 1, 2007, the number of shares of the Registrant s common stock outstanding was approximately 104.9 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 $5.8 billion.

Documents incorporated by reference

Portions of the Registrant s proxy statement for its 2007 annual meeting of stockholders are incorporated by reference in Part III of this Form 10-K.

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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, 2006, we operated or provided administrative services to approximately 1,300 outpatient dialysis centers located in 42 states and the District of Columbia, serving approximately 103,000 patients. We also provide acute inpatient dialysis services in approximately 770 hospitals and related laboratory services. All other ancillary services and strategic initiatives, which currently account for approximately 2% of our consolidated revenues, relate to our core business of providing renal care services. On October 5, 2005, we completed our acquisition of DVA Renal Healthcare, Inc. (formerly known as Gambro Healthcare, Inc.) from Gambro, Inc. for approximately $3.06 billion. DVA Renal Healthcare was one of the largest dialysis service providers in the United States, operating 566 outpatient dialysis centers, serving approximately 43,000 patients, and generating annual revenues of approximately $2 billion.

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 and related supplies, tests and medications. Approximately 87% of our total patients are under government-based programs, with approximately 78% of our patients under Medicare and Medicare assigned HMO plans.

ESRD patient base

There are more than 335,000 ESRD dialysis patients in the United States. 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.

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Dialysis Options

Hemodialysis

Hemodialysis, the most common form of ESRD treatment, is usually performed in outpatient facilities (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 typically lasts approximately three and one-half hours. Hemodialysis is usually performed three times per week.

Certain ESRD patients may perform home-based hemodialysis in their home or residence through the use of a hemodialysis machine designed for home therapy. Patients receive training, support and monitoring from registered nurses in order to perform their treatments. Home-based hemodialysis is typically performed with greater frequency than in-center dialysis treatments and on varying schedules.

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

Peritoneal dialysis

A patient generally performs peritoneal dialysis at home. The most common methods of peritoneal dialysis are continuous ambulatory peritoneal dialysis, or CAPD, and continuous cycling peritoneal dialysis, or CCPD. All forms of peritoneal dialysis use the patient s peritoneal, or abdominal, cavity to eliminate fluid and toxins. Because it does not involve going to a center three times a week for treatment, peritoneal dialysis is an alternative to hemodialysis for patients who desire more freedom 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 Services

Outpatient dialysis services

As of December 31, 2006, we operated or provided administrative services to approximately 1,300 outpatient dialysis centers in the United States that are designed specifically for outpatient hemodialysis. In 2006, we added 67 centers primarily as a result of acquisitions, and the opening of new centers, net of divestures and

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closures. Throughout our network of outpatient dialysis centers, we also provide training, supplies and on-call support services to our peritoneal dialysis patients. With the introduction of smaller, easier to use and portable technologies, we are also providing certain patients the option of home-based hemodialysis, as described above.

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

We do not enter into contractual or preferential relationships with our patients that obligate either our patients or us for services. Total patient turnover averages more than 25% per year. However, the overall number of patients that we treat increased by approximately 7% as of December 31, 2006 compared to December 31, 2005. Approximately 87% of the treatments we administer for patients are paid for, at least in part, by government-based programs, principally Medicare, and 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 services, or which would give us any preferential rights other than those related to collecting payments for our services.

Hospital inpatient dialysis services

We provide inpatient dialysis services, excluding physician services, to patients in approximately 770 hospitals. We render these services for a per-treatment fee 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. Inpatient dialysis services are required for patients with acute kidney failure resulting from trauma, patients in the early stages of ESRD, and ESRD patients who require hospitalization for other reasons. In 2006, acute inpatient dialysis services accounted for approximately 5% of our total dialysis treatments.

ESRD laboratory services

We own two separately incorporated licensed clinical laboratories, located in Florida, specializing in ESRD patient testing. These specialized laboratories provide routine laboratory tests 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 own 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.

Ancillary services and strategic initiatives

Ancillary services and strategic initiatives, which currently account for less than 2% of our total revenues, consist of the following:

Pharmacy. DaVita Rx is a wholly-owned full-service pharmacy which provides oral medications to DaVita s patients with chronic kidney disease, or CKD, and patients with ESRD. The main objectives of

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the pharmacy are to improve clinical outcomes, patient compliance, and to provide service excellence by providing our patients a convenient way to fill their prescription needs. Revenues are recognized as prescriptions are filled and shipped to patients.

Vascular access services. We provide management and administrative services to physician-owned vascular access clinics that provide surgical and interventional radiology services for dialysis patients. Management fees generated from these services are included in management fee income.

Disease management services. We provide advanced care management services to employers, health plans and government agencies for employees/members diagnosed with chronic kidney disease, including renal failure. 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 can include additional fees for cost savings recognized by certain customers.

ESRD clinical research programs. DaVita Clinical Research conducts research trials 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.

Management fee income. We currently operate or provide management and administrative services to 38 outpatient dialysis centers, which are wholly-owned or majority-owned by third parties, under management services agreements. Management fees are established by contract and are typically based on a percentage of revenues, or cash collections generated by the centers.

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 have clinical nurses who serve as service specialists who are trained to assist our outpatient clinics at a local level with education and quality outcome management. We have also established a Physician Council made up of a panel of physicians who also serve as our medical directors. The Physician Council acts as an advisory panel to our Chief Executive Officer on issues relating to, among other things, quality care practices, and standards of medical appropriateness. We also maintain a Physician Laboratory Advisory Committee which provides clinical review and input to both of our laboratories. In addition, we established a Quality Council in 2006 under the supervision of our Chief Medical Officer and Director of Quality Management. The Quality Council, composed of teammates specializing in clinical services and operations, coordinates and prioritizes directives from the Physician Council and management.

Sources of revenue concentrations and risks

Our dialysis revenue represents 98% of our total net operating revenues with the balance of our revenues from ancillary services and strategic initiatives. Dialysis revenue is derived from dialysis and dialysis related services, which includes the administration of pharmaceuticals and related laboratory services.

The sources of our dialysis revenue are government-based programs, including Medicare, Medicaid and Medicare assigned HMO plans, commercial payors, which consist principally of commercial insurance plans, and direct payments from patients established by single patient agreements with patients not covered by other contracts.

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The following table summarizes our dialysis revenue and patient percentages by payor type for the year ended December 31, 2006:

	Revenues	Patient Percentages
Medicare and Medicare assigned HMO plans	58%	78%
Medicaid	4%	6%
Other government-based programs	3%	3%
Total government-based programs	65%	87%
Commercial	35%	13%
Total dialysis revenue	100%	100%

The following table summarizes our dialysis revenue by source for the year ended December 31, 2006:

	Revenue Percentages
Outpatient hemodialysis centers	82%
Peritoneal dialysis and home-based hemodialysis	9%
Hospital inpatient hemodialysis	6%
Laboratory Services	3%
Total dialysis revenue	100%

Medicare revenue

Under the Medicare ESRD program, payment rates for dialysis are established by Congress. The Medicare composite rate set by the Centers for Medicare and Medicaid Services, or CMS, includes payment for the dialysis treatment, supplies used for that treatment, specified laboratory tests and certain pharmaceuticals. The Medicare composite rate is subject to regional differences based upon several factors, including differences in wage levels. We are paid separately for other services and pharmaceuticals, including Epogen, or EPO, vitamin D analogs, and iron supplements. Pharmaceuticals are generally paid at average sale price plus 6% based upon prices set by Medicare. The Medicare payment rates are not sufficient to cover the average cost of providing a dialysis treatment.

ESRD patients receiving dialysis 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, 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 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%, and 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 the 20% portion of the ESRD composite rate that Medicare does not pay.

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The Medicare composite payment rates set by Congress for dialysis treatments that were in effect for 2006 were between $147 and $162 per treatment, with an average rate of $155 per treatment. Unlike Medicare payment rates for most other medical services, Medicare composite payment rates for dialysis have not been routinely increased to compensate for the impact of inflation. Since 1972, the Medicare composite payment rate has declined over 75% in inflation-adjusted dollars. Congress and CMS have addressed the impact of inflation more consistently since 2000, with increases of 1.2% in 2000, 2.4% in 2001, 1.6% in each of 2005 and 2006, and a 1.6% increase that will be effective on April 1, 2007.

However, although the 2005 composite payment rate increased under the Medicare Prescription Drug Improvement and Modernization Act, or MMA, separate payment rates for pharmaceuticals were reduced. While the MMA committed that aggregate payments for dialysis services would not be reduced by the payment changes, the changes resulted in a net reduction of average Medicare payment rates to the Company of 1.3%. CMS also implemented a case-mix adjustment methodology in April 2005 designed to link payments more closely to illness severity.

In 2005, CMS issued revised rules with regard to payment for separately billable pharmaceuticals furnished by ESRD facilities. Effective January 1, 2006, payments for pharmaceuticals furnished by ESRD facilities were set at the average sales price, or ASP, plus 6 percent. CMS adjusted payment amounts quarterly for 2006, based on ASP data reported by the drug manufacturers. Increases in drug prices are generally not reflected in our payment rates for a minimum of at least a quarter after the prices are adjusted. While these rates resulted in lower payments to ESRD providers for pharmaceuticals, the composite rate was concurrently increased, substantially offsetting the impact of the reduction in pharmaceutical payments. Effective January 1, 2006, CMS increased the Medicare composite payment rate by 1.6%, and will further increase the Medicare composite payment rate by 1.6% effective April 1, 2007, as discussed above.

During 2005, the Company contracted with CMS to participate in two Medicare demonstration programs an ESRD demonstration project in California s Riverside and San Bernardino counties; and a CKD demonstration project in New York, including Nassau and Suffolk counties and the Queens Borough of New York City. The CKD project is for three years and became effective November 2005. The ESRD demonstration project is for four years and became effective January 2006. Under the ESRD demonstration project, the Company s revenue is capitated for all medical services required by enrollees in the program. The Company is at risk for medical costs in excess of the capitation payments. Under the CKD demonstration project, the Company is paid a management fee for program enrollees. 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 employer group health plan or private insurance plan, if any, is responsible for payment. Although commercial payment rates vary significantly, average commercial payment rates are more than double Medicare rates. Commercial payment rates are the result of negotiations between us, insurers, third-party administrators and, occasionally individuals. More common payment methods include a single lump-sum per treatment (standardized rates) and separate payments for treatments and pharmaceuticals if used

as part of the treatment (unbundled rates).

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Our commercial payors consist principally of commercial insurance plans, including more than 1,200 with whom we have contracted rates. Approximately 13% of our dialysis revenue is associated with non-contracted commercial payors for the year ended December 31, 2006. Less then 1% of our dialysis services and related dialysis services payments are received directly from patients. No single commercial payor accounted for more than 5% of total dialysis revenue for the year ended December 31, 2006.

Revenue from EPO and other pharmaceuticals

Approximately 30% of our total dialysis revenue for the year ended December 31, 2006 is 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 a 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 separately billable under the Medicare payment program, accounts for approximately 25% of our dialysis revenue for the year ended December 31, 2006. Changes in the levels of physician-prescribed EPO, and commercial and government payment rates related to EPO can significantly influence our revenues and operating earnings. CMS issued a new payment coverage policy for EPO, which became effective April 1, 2006, and was subsequently revised effective October 1, 2006. This new policy limits payments based on EPO doses for certain patients.

Furthermore, EPO is produced by a single manufacturer, Amgen, and any interruption of supply or product cost increases could adversely affect our operations. We have entered into an agreement with Amgen that provides for EPO pricing for a fixed time period that includes potential discounts depending upon the achievement of certain clinical and other criteria. Our agreement with Amgen also provides for specific rebates and incentives, which are based on a variety of factors, including patient outcomes, process improvement, data submission, purchase volume growth and some combination of these factors.

Amgen has also developed a new product, darbepoetin alfa, also known as Aranesp®, that could potentially replace EPO or reduce its use with dialysis patients. In addition, Roche has developed and is seeking approval for CERA, a pharmaceutical also used to treat anemia. Unlike EPO, which is generally administered in conjunction with each dialysis treatment, Aranesp® and CERA can be administered less frequently. The FDA has approved Aranesp® for use with dialysis patients. However, we cannot predict when, or whether, these alternatives to EPO will be marketed to the dialysis industry, how Medicare or other payors will reimburse dialysis providers for their use, whether physicians will prescribe these alternatives instead of EPO or how it will impact our revenues and earnings.

Physician relationships

An ESRD patient generally seeks treatment at a 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 a dialysis center. Over 2,800 nephrologists currently refer patients to our centers. As is typical in the dialysis industry, one or a few physicians, including the 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 treatment at a dialysis center be under the general supervision of a director who is a physician. We have engaged physicians or groups of physicians to serve as medical directors for each of our centers. At some 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

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dialysis training programs. We have contracts with approximately 1,020 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 and responsibilities and the physician s professional qualifications and experience, among others.

Our medical director agreements generally include covenants not to compete. Also, when we acquire a center from one or more physicians, or where one or more physicians own interests in centers as co-owners with us, these physicians have agreed to refrain from owning interests in 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 expire at the same time as the corresponding medical director agreements, although some continue for a period of time beyond expiration. We have from time to time experienced 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, quality assurance programs, and patient care.

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.

Because a significant number of dialysis patients are covered for treatment under government-based programs, 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 II 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.

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. We expect that our industry will continue to be subject to significant government regulation and scrutiny, the scope and

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application of which are difficult to predict. This regulation and scrutiny could adversely impact us in a material way.

CMS continues to study the regulations applicable to Medicare certification to provide dialysis services. On February 4, 2005, CMS published a proposed rule that would revise the conditions of coverage for ESRD facilities. The revised requirements would, among other things, establish performance expectations for facilities, eliminate many procedural requirements from the current conditions of coverage, and promote continuous quality improvement. The proposed regulations are still subject to revision based on public comments in the rulemaking process and would not become effective until issued as final regulation. We do not know what changes may be made in a final rule or when a final rule might be published, and accordingly we cannot predict what impact it might 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 these laws 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 $25,000 or both. Under the U.S. Sentencing Guidelines, an individual may be fined up to $250,000 and an organization may be fined up to $500,000 upon conviction for an offense described in any federal 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 these laws 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. Some state anti-kickback statutes also include criminal penalties. The federal statute expressly prohibits traditionally criminal transactions, such as kickbacks, rebates or bribes for patient referrals. Court decisions have also held that the statute is violated whenever one of the purposes of remuneration is to induce referrals. If any of our practices were to be found to violate the anti-kickback statute, it could have a material adverse impact on our earnings and subject us to any of the penalties described above.

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 do 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 are subject to greater scrutiny by enforcement agencies.

Some medical directors and other referring physicians own our common stock, which they either purchased in the open market or received from us as consideration in an acquisition of dialysis centers from them. 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.

While nearly all of our stock option arrangements with referring physicians were terminated in 2000, a few medical directors still hold options to acquire our common stock because we did not have the contractual right to terminate their options. It is possible that CMS could view these interests as prohibited arrangements that must be restructured and which could subject us to possible criminal, civil or administrative sanctions.

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Our medical directors refer patients to our centers and these arrangements 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 believe, however, that our agreements do not violate the federal anti-kickback statute. We also note that there is little guidance available as to what constitutes fair market value for medical director services. Although the final Phase II, Stark II regulations (described below) created a so-called safe harbor method of establishing the fair market value of physician compensation, this methodology, which is not required by the rule, is very restrictive, and has been challenged in court. Regardless of the outcome of the challenge, we do not believe that this method produces a reasonable estimate of the fair market value of dialysis facility medical director services.

We own a controlling interest in approximately 85 dialysis related joint ventures, representing approximately 15% of our dialysis revenue. 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. Notwithstanding these efforts, since the arrangements do not satisfy all of the requirements for safe harbor protection, these arrangements could be challenged.

We lease space for approximately 330 of our centers from entities in which physicians hold ownership interests and we sublease space to referring physicians at approximately 160 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.

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 arms-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 do not violate the anti-kickback statute.

If any of our business transactions or arrangements including those described above were found to violate the federal anti-kickback statute we could face criminal, civil and administrative sanctions, including possible exclusion from participation in Medicare, Medicaid and other state and federal healthcare programs.

Stark II

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 (including hospitals) providing designated health services , from referring Medicare patients to such entities for the furnishing of such services, with limited exceptions. Stark Law designated health services include equipment and supplies, home health services, outpatient prescription drugs, inpatient and outpatient hospital services and clinical

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laboratory services. The Stark Law also prohibits the 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; and therefore, unlike the federal anti-kickback statute, intent to violate the law is not required. Sanctions for violation of the Stark Law include denial of payment for the 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. Knowing violations of the Stark Law may also serve as the basis for liability under the False Claims Act. The types of financial arrangements between a physician and an entity that trigger the self-referral prohibitions of the Stark Law are broad and include ownership and investment interests and compensation arrangements.

CMS has adopted regulations under the Stark Law applicable to clinical laboratory services (Stark I) and implementing the Stark Law s application to all designated health services (sometimes referred to as Stark II or the Stark II Regulations). The Stark II Regulations include additional guidance regarding CMS s interpretation of the Stark Law. CMS anticipates issuing additional regulations regarding Medicaid enforcement.

Under Stark II, financial relationship is defined as an ownership or investment interest in, or a compensation arrangement with, an entity providing designated health services, and includes certain indirect financial relationships. 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 materially satisfy the personal services compensation arrangement exception to the Stark II prohibition. The Stark II regulations provide a safe harbor method of establishing the fair market value of physician compensation. CMS recognizes that compensation to medical directors which exceeds amounts determined by the Stark II safe harbor method does not necessarily exceed fair market value, but that such compensation is not assured of a favorable finding upon review. None of our medical director agreements establishes compensation using the Stark II safe harbor method. 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, even though these amounts exceed amounts determined using the Stark II safe harbor method, an enforcement agency could potentially challenge the level of compensation that we pay our medical directors. Accordingly, we could in the future be required to change our practices, face criminal or civil penalties, pay substantial fines, return certain payments received from governmental payors and beneficiaries or otherwise experience a material adverse effect as a result of a challenge to these arrangements. For example, DVA Renal Healthcare s relationships with its medical directors were reviewed in connection with the investigation by the United States Attorney s office for the Eastern District of Missouri that was resolved in December 2004 and may be subject to ongoing review by the Office of Inspector General, or OIG, under a corporate integrity agreement (see description on page 16).

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 materially satisfy the requirements for this exception.

Some medical directors and other referring physicians own our common stock, which they either purchased in the open market or received from us as consideration in an acquisition of dialysis centers from them. There is a Stark II exception for investments in large publicly traded companies, which we believe covers these investment interests.

While nearly all of our stock option arrangements with referring physicians were terminated in 2000, a few medical directors still hold options to acquire our common stock because we did not have the contractual right to terminate their options. Under the Stark II regulations, these stock options constitute financial relationships that

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must meet an applicable exception if the physician makes referrals to DaVita for designated health services. It is possible that CMS could view these interests as prohibited arrangements that must be restructured or for which we could be subject to other significant penalties or prohibited from accepting referrals from those medical directors.

Some of our medical directors also own equity interests in entities that operate our dialysis centers. The Stark II exception applicable to physician ownership interests in entities to which they make referrals does not encompass the kinds of ownership arrangements that referring physicians hold in several of our subsidiaries that operate dialysis centers. Accordingly, it is possible that CMS could require us to restructure some of these arrangements or could seek to impose substantial fines or additional penalties on us, prohibit us from accepting referrals from those physician owners and/or force us to return certain amounts paid by CMS and program beneficiaries. We believe that the language and legislative history of Stark II and the Stark II regulations indicate that Congress did not intend to include dialysis services and the services and items provided incident to dialysis services as a part of designated health services. The final Stark II regulations exempt from the referral prohibition referrals for clinical laboratory services that are included in the ESRD composite rate. The final Stark II regulations also exempt EPO and certain other dialysis-related outpatient prescription drugs furnished in (or by, in the case of EPO) an ESRD facility. The Final Phase II regulations also confirmed that home dialysis supplies are not considered designated health services. Accordingly, referrals for composite rate laboratory tests and these dialysis related medications and home dialysis supplies do not violate the Stark II prohibition.

While the Stark II designated health services include inpatient and outpatient hospital services, our arrangements with hospitals for the provision of dialysis services to hospital inpatients and outpatients do not involve prohibited referrals to DaVita and do not create material indirect financial relationships between the hospitals and the physicians providing services for DaVita. This is because under the final Stark II regulations in situations involving such services furnished under arrangements it is the hospital, rather than DaVita, that is considered to be receiving referrals for, furnishing and billing for the designated health services.

Because the Stark II regulations do not expressly address all of our operations, it is possible that CMS could interpret Stark II to apply to parts of our operations. Consequently, it is possible that CMS could determine that Stark II requires us 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 designated health services from these physicians. If CMS were to interpret Stark II to apply to aspects of our operations and we could not achieve compliance with Stark II it would have a material adverse effect on our operations. We could be subject to monetary penalties and serious administrative sanctions for non-compliance and be forced not to accept referrals from important referral sources. While the rules and interpretations surrounding the Stark II and various state self-referral prohibitions are complicated and while refunds for billing errors may be necessary from time to time, we do not believe that the Company has presented or caused to be presented any claims for a designated health service furnished pursuant to prohibited referrals for which there was no applicable exception that would have a material adverse effect on us.

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 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

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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 or 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 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.

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 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, at least two federal district courts have also determined that an alleged violation of the federal anti-kickback statute or the Stark I self-referral prohibition are sufficient to state a claim for relief 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, or HIPAA, among other things, allows individuals who lose or change jobs to transfer their insurance, limits exclusions for preexisting conditions and establishes a pilot program for medical savings accounts. In addition, HIPAA also expanded federal attempts to combat healthcare fraud and abuse by making amendments to the Social Security Act and the federal criminal code. Among other things, HIPAA created a Health Care Fraud Abuse Control Account, under which advisory opinions are issued by the OIG regarding the application of the anti-kickback statute; criminal penalties for Medicare and Medicaid fraud were extended to other federal healthcare programs; the exclusion authority of the OIG was expanded; Medicare and Medicaid civil monetary penalty provisions were extended to other federal healthcare programs; the amounts of civil monetary penalties were increased; and a criminal healthcare fraud statute was established.

HIPAA also includes provisions relating to the privacy of medical information. These provisions require us to maintain extensive policies and procedures, and to implement administrative safeguards with respect to private health information in our possession. HIPAA also includes

provisions relating to standards for security of electronic protected health information, electronic transactions and electronic signatures. We believe we are in substantial compliance with these requirements.

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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 New York statute prohibits publicly-held companies from owning the health facility license required to operate a dialysis center in New York. Although we own substantially all of the assets, including the fixed assets, of our affiliated New York dialysis centers, the licenses are held by privately-owned companies with which we have agreements to provide a broad range of administrative services, including billing and collecting. The New York State Department of Health has approved these types of arrangements; however, we cannot guarantee that they will not be challenged as prohibited under the relevant statute. We are currently working closely with other industry representatives to effectuate a change in New York law that would allow for direct ownership of dialysis centers by publicly held companies.

We have a similar management relationship with physician practices in several states which prohibit the corporate practice of medicine, and with a privately-owned company in New Jersey for several New Jersey dialysis centers. We have had difficulty securing licenses for new centers in New Jersey in our own name because the New Jersey Department of Aging and Senior Services refuses to grant new licenses to companies that have more than a small number of outstanding adverse survey issues throughout all of their centers in the entire United States, regardless of the respective size of the companies operations.

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.

Although we have implemented a company-wide corporate compliance program, as discussed below, and believe we are in material compliance with current applicable laws and regulations, 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.

Corporate compliance program

We have implemented a company-wide corporate compliance program as part of our commitment to comply with all applicable laws, regulations, and DVA Renal Healthcare s corporate integrity agreement (discussed below) 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.

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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 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 President-West and to the Compliance Committee of our Board of Directors.

Corporate Integrity Agreement

On December 1, 2004, DVA Renal Healthcare, 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 DVA Renal Healthcare s Medicare and Medicaid billing practices and its relationships with physicians and pharmaceutical manufacturers. In connection with the settlement agreement, DVA Renal Healthcare, without admitting liability, made a one time payment of approximately $310 million and entered into a five year corporate integrity agreement with OIG. DVA Renal Healthcare and its subsidiaries continue to be subject to the corporate integrity agreement. The corporate integrity agreement requires, among other things, that DVA Renal Healthcare designate a compliance liaison for each dialysis center owned or operated by DVA Renal Healthcare or any of its subsidiaries and provide compliance training for each of its employees and credentialed physicians. DVA Renal Healthcare has a compliance officer and a separate compliance committee made up of members of senior management, consistent with the requirements of the corporate integrity agreement. Certain types of employees are also required to complete additional specialized training in areas such as billing and reimbursement issues. Furthermore, DVA Renal Healthcare is required to review all of its arrangements or transactions with any actual or potential source of healthcare business to ensure compliance with federal anti-kickback statute. It has also engaged an independent review organization to conduct an annual review of a sample of DVA Renal Healthcare s claims for reimbursement from federal healthcare programs to verify compliance with applicable laws and regulations. DVA Renal Healthcare must submit to the OIG an annual report with respect to the status of, and findings regarding, its compliance activities, including a copy of all reports prepared by the independent review organization. In addition, DVA Renal Healthcare must notify the OIG of any ongoing government investigations or legal proceedings and report to the OIG any substantial overpayment or any probable violations of the laws applicable to any federal healthcare program.

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 $1.6 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 of operation 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 initially more predictable. To a limited extent, we enter into agreements to provide administrative services to third-party-owned centers in return for management fees, typically based on a percentage of revenues.

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The table below shows the growth of our Company by number of dialysis centers.

	2006	2005	2004	2003	2002
Number of centers at beginning of year	1,233	658	566	515	495
Acquired centers	26	609(1)	51	27	11
Developed centers	55	46	44	30	19
Net change in third-party centers with management services agreements		4(1)	5	(1)	