JSA Healthcare Nevada, L.L.C.
Form 424B5
June 11, 2014
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As filed pursuant to Rule 424(b)(5)
Under the Securities Act of 1933
Registration No. 333-196630

PROSPECTUS SUPPLEMENT

(to Prospectus dated June 10, 2014)

DaVita HealthCare Partners Inc.

$1,750,000,000

5.125% Senior Notes due 2024

We are offering $1,750 million aggregate principal amount of our 5.125% senior notes due 2024, or the notes. The notes will mature on July 15, 2024.

We will pay interest on the notes on January 15 and July 15 of each year. Interest will accrue on the notes from June 13, 2014 and the first interest payment date will be January 15, 2015.

We may redeem some or all of the notes at any time on or after July 15, 2019 at redemption prices described in this prospectus supplement and prior to such date at a make-whole redemption price described in this prospectus supplement. At any time prior to July 15, 2017, we may also redeem up to 35% of the notes with the net cash proceeds we receive from certain equity offerings at the redemption price set forth in this prospectus supplement.

If a Change of Control (as defined) occurs, we may be required to offer to purchase the notes from the holders as described in this prospectus supplement under the heading Description of Notes Change of control .

The notes will be our unsecured senior obligations and will rank equally in right of payment with our existing and future unsecured senior indebtedness. The notes will be guaranteed by certain of our domestic subsidiaries. The guarantees will be unsecured senior obligations of the guarantors and will rank equally in right of payment with all existing and future unsecured senior indebtedness of the guarantors. The notes and guarantees will be effectively subordinated to all of our and the guarantors existing and future secured indebtedness (including indebtedness under our senior secured credit facilities) to the extent of the value of the collateral securing such indebtedness and structurally subordinated to all existing and future indebtedness and other liabilities of any of our subsidiaries that do not guarantee the notes.

The notes will be issued only in registered form in minimum denominations of $2,000 and integral multiples of $1,000 in excess thereof.

Investing in the notes involves risks. See Risk Factors, beginning on page S-16 for a discussion of certain risks that you should consider in connection with an investment in the notes.

	Per Note	Total
Public offering price (1)	100.00%	$ 1,750,000,000
Underwriting discount	1.25%	$ 21,875,000
Proceeds, before expenses, to us (1)	98.75%	$ 1,728,125,000

(1) Plus accrued interest from June 13, 2014, if settlement occurs after that date.

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

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

The notes will be ready for delivery in book-entry form through the facilities of The Depository Trust Company for the accounts of its participants, including Euroclear Bank S.A./N.V., as operator of the Euroclear System, and Clearstream Banking, *société anonyme*, on or about June 13, 2014.

Joint Book-Running Managers

Wells Fargo Securities **Barclays**

BofA Merrill Lynch **Credit Suisse** **Goldman, Sachs & Co.**
J.P. Morgan **Morgan Stanley** **SunTrust Robinson Humphrey**

Co-Managers

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

The date of this prospectus supplement is June 10 , 2014.

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ABOUT THIS PROSPECTUS SUPPLEMENT

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

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

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

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

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

In this prospectus supplement, unless otherwise stated or the context otherwise requires, references to we, us, our, DaVita, DaVita HealthCare Partners and Company refer to DaVita HealthCare Partners Inc. and its consolidated subsidiaries. If we use a capitalized term in this prospectus supplement and do not define the term in this document, it is defined in the accompanying prospectus.

FORWARD-LOOKING STATEMENTS

This prospectus supplement and the documents deemed to be incorporated by reference in this prospectus supplement contains or may contain statements that are forward-looking statements within the meaning of Section 27A of the Securities Act of 1933, as amended and Section 21E of the Securities Exchange Act of 1934, as amended. We intend these forward-looking statements to be covered by the safe harbor provisions for such statements contained in these documents. All statements that do not concern historical facts are forward-looking statements and include, among other things, statements about our expectations, beliefs, intentions and/or strategies for the future. These forward-looking statements include statements regarding anticipated refinancing transactions, our future operations, financial condition and prospects, expectations for treatment growth rates, revenue per treatment, expense growth, levels of the provision for uncollectible accounts receivable, operating income, cash flow, operating cash flow,

estimated tax rates, capital expenditures, the development of new centers and center acquisitions, government and commercial payment rates, revenue estimating risk and the impact of our related level of indebtedness on our financial performance, including earnings per share. These statements can sometimes be identified by the use of forward looking words such as may, believe, will, should,

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could, would, expect, project, estimate, anticipate, plan, continue, seek, forecast, or intend or c
expressions of the negative thereof.

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

- risks resulting from the concentration of profits generated by higher-paying commercial payor plans for which there is continued downward pressure on average realized payment rates, and a reduction in the number of patients under such plans, which may result in the loss of revenues or patients,
- a reduction in government payment rates under the Medicare ESRD program or other government-based programs,
- the impact of health care reform legislation that was enacted in the U.S. in March 2010,
- the impact of the Center for Medicare and Medicaid Services (CMS) 2014 Medicare Advantage benchmark structure,
- the impact of the American Taxpayer Relief Act,
- the impact of the sequestration that went into effect on April 1, 2013,
- the impact of disruptions in federal government operations and funding,
- changes in pharmaceutical or anemia management practice patterns, payment policies, or pharmaceutical pricing,
- legal compliance risks, including our continued compliance with complex government regulations and current or potential investigations by various government entities and related government or private-party proceedings, including risks relating to the final resolution of the 2010 and 2011 U.S. Attorney Physician Relationship Investigations, such as restrictions on our business and operations required by a corporate integrity agreement and other settlement terms, and the financial impact thereof,
- continued increased competition from large and medium-sized dialysis providers that compete directly with us,

our ability to maintain contracts with physician medical directors, changing affiliation models for physicians, and the emergence of new models of care introduced by the government or private sector that may erode our patient base and reimbursement rates such as accountable care organizations (ACOs), independent practice associations (IPAs) and integrated delivery systems, or to businesses outside of dialysis and HCP s business,

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

variability of our cash flows,

the risk that we might invest material amounts of capital and incur significant costs in connection with the growth and development of our international operations, yet we might not be able to operate them profitably anytime soon, if at all,

risks arising from the use of accounting estimates, judgments and interpretations in our financial statements,

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loss of key HCP employees, potential disruption from the HCP transaction making it more difficult to maintain business and operational relationships with customers, partners, associated physicians and physician groups, hospitals and others,

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

the risk that the cost of providing services under HCP s agreements may exceed our compensation,

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

the risk that HCP may not be able to successfully establish a presence in new geographic regions or successfully address competitive threats that could reduce its profitability,

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

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

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

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

INDUSTRY AND MARKET DATA

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

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SUMMARY

This summary may not contain all the information that may be important to you. You should read this entire prospectus supplement and the accompanying prospectus, together with the information incorporated by reference herein and therein, including our financial statements and related notes, before making an investment decision. Unless this prospectus supplement indicates otherwise or the context otherwise requires the terms we, our, us, DaVita, DaVita HealthCare Partners and the Company refer to DaVita HealthCare Partners Inc. and its consolidated subsidiaries. Unless otherwise expressly stated or the context otherwise requires, references in this prospectus supplement to our senior secured credit facilities refer to our current senior secured credit facilities as of the date of this prospectus supplement as described under Description of Other Indebtedness Current Senior Secured Credit Facilities and, to the extent entered into after the date of this prospectus supplement, our proposed amended and restated senior secured credit facilities as described under Description of Other Indebtedness-Proposed Amended and Restated Senior Secured Credit Facilities . In this summary, we have presented certain financial measures, such as free cash flow, net debt, pro forma Adjusted EBITDA and Adjusted EBITDA and metrics derived therefrom, that are non-GAAP financial measures. We are presenting these non-GAAP financial measures because we believe that they provide us and readers of this prospectus supplement with useful supplemental information. We do not intend for these non-GAAP financial measures to be a substitute for any GAAP financial information. See Summary Summary Financial and Operating Data for a reconciliation of these non-GAAP financial measures to their most comparable measure calculated and presented in accordance with GAAP.

Our Company

Our Company consists of two major divisions, Kidney Care and HealthCare Partners (HCP). Our Kidney Care division is comprised of our U.S. dialysis and related lab services business, our ancillary services and strategic initiatives including our international operations, and our corporate support expenses. Our HCP division is comprised of our HCP business. Our largest line of business is our U.S. dialysis and related lab services business, which is a leading provider of kidney dialysis services in the U.S. for patients suffering from chronic kidney failure, also known as end stage renal disease (ESRD). Our other major line of business is HCP, which is a patient-and physician-focused integrated health care delivery and management company with nearly three decades of providing coordinated, outcomes-based medical care in a cost-effective manner.

U.S. dialysis and related lab services business

Our U.S. dialysis and related lab services business is a leading provider of kidney dialysis services for patients suffering from chronic kidney failure or ESRD. As of March 31, 2014, we provided dialysis and administrative services in the U.S. through a network of 2,098 outpatient dialysis centers in 46 states and the District of Columbia, serving a total of approximately 165,000 patients. We also provide acute inpatient dialysis services in approximately 1,000 hospitals and related laboratory services throughout the U.S. Our U.S. dialysis and related lab services business accounted for approximately 65% of our consolidated net revenues for the twelve months ended March 31, 2014. All references in this prospectus supplement or the accompanying prospectus to dialysis and related lab services refer only to our U.S. dialysis and related lab services business.

HealthCare Partners business

HCP is a patient- and physician-focused integrated health care delivery and management company with nearly three decades of experience providing coordinated, outcomes-based medical care in a cost-effective manner. Through capitation contracts with some of the nation s leading health plans, as of March 31, 2014, HCP had approximately 795,000 members under its care in southern California, central and south Florida, southern Nevada, central New

Mexico and central Arizona. Of these, approximately 292,000 individuals were patients enrolled in Medicare Advantage. The remaining approximately 503,000 individuals were managed care members whose health coverage is provided through their employer or who have individually acquired health coverage directly from a health plan or as a result of their eligibility for Medicaid benefits. In addition to its managed care

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business, during the twelve months ended March 31, 2014, HCP provided care in all markets, except Arizona, to over 448,000 patients whose health coverage is structured on a fee-for-service (FFS) basis, including patients enrolled through traditional Medicare and Medicaid programs, preferred provider organizations and other third-party payors.

The patients of HCP s associated physicians, physician groups and independent practice associations (IPAs) benefit from an integrated approach to medical care that places the physician at the center of patient care. As of March 31, 2014, HCP delivered services to its members via a network of over 3,000 associated group and other network primary care physicians, 217 network hospitals, and several thousand associated group and network specialists. Together with hundreds of case managers, registered nurses and other care coordinators, these medical professionals utilize a comprehensive information technology system, sophisticated risk management techniques and clinical protocols to provide high-quality, cost-effective care to HCP s members.

Ancillary services and strategic initiatives businesses

As of March 31, 2014, our ancillary services and strategic initiatives consisted primarily of pharmacy services, disease management services, vascular access services, ESRD clinical research, physician services, direct primary care and our international dialysis operations. Our ancillary services and strategic initiatives, including our international operations accounted for approximately 8% of our consolidated net revenues for the twelve months ended March 31, 2014, and relate primarily to our core business of providing kidney care services. As of March 31, 2014, we provided dialysis and administrative services to a total of 75 outpatient dialysis centers located in ten countries outside the U.S.

Recent Developments

Tender Offer and Consent Solicitation for Our 2018 Notes

We have commenced a cash tender offer to purchase any and all of our outstanding 6-3/8% Senior Notes due 2018, or the 2018 Notes and a concurrent consent solicitation to approve amendments to the indenture governing the 2018 Notes, to eliminate substantially all of the restrictive covenants and certain events of default. We refer to this tender offer and consent solicitation, together, as the Offer. As of March 31, 2014, $775 million aggregate principal amount of the 2018 Notes was outstanding. Pursuant to the current terms of the Offer, the total consideration payable for 2018 Notes tendered and accepted by us for purchase in the Offer, excluding accrued interest, will be $1,051.25 per $1,000 principal amount of 2018 Notes, which total consideration includes a consent payment of $30.00 per $1,000 principal amount of 2018 Notes validly tendered and not withdrawn prior to June 17, 2014, which is the consent payment deadline. The terms of the Offer provide that only 2018 Notes that are tendered and not withdrawn prior to the consent payment deadline will be eligible to receive the consent payment and that any 2018 Notes tendered after the consent payment deadline and prior to the expiration of the Offer (midnight at the end of July 1, 2014, unless extended or earlier terminated) will be eligible to receive the total consideration less the consent payment. The Offer is being made on the terms and subject to the conditions set forth in an Offer to Purchase and Consent Solicitation Statement.

The consummation of this offering is not conditioned on the consummation of the Offer. The Offer is conditioned on, among other things, our receipt of funds from the issuance of senior unsecured indebtedness and borrowings under our proposed amended and restated senior secured credit facilities (described below) sufficient to fund the purchase of all of the outstanding 2018 Notes pursuant to the Offer, including the consent payments, repay borrowings outstanding and pay other amounts payable under our existing credit facilities and pay fees and expenses related to the foregoing. Holders of 2018 Notes are not obligated to tender their 2018 Notes to us pursuant to the Offer. Accordingly, we cannot assure you that any 2018 Notes will be purchased in the Offer or the amount of any 2018 Notes that may be purchased in the Offer or that the Offer will be completed on the terms currently contemplated, or at all. If any 2018 Notes are not purchased in the Offer, we currently intend to use net proceeds from borrowings under our proposed

amended and restated senior secured credit facilities or from other senior unsecured indebtedness to redeem any 2018 Notes that remain outstanding in accordance with

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the indenture governing the 2018 Notes. Under the terms of that indenture, the redemption price for the 2018 Notes is currently 104.781% of the principal amount, plus accrued and unpaid interest, if any, to the redemption date. This prospectus supplement is not a solicitation for acceptance of the Offer.

Proposed Amended and Restated Senior Secured Credit Facilities

We have commenced a syndication process pursuant to which we are seeking to enter into amended and restated senior secured credit facilities, which we are planning to enter into subsequent to the closing of this offering. We anticipate that the proposed amended and restated senior secured credit facilities will provide for an aggregate borrowing capacity of up to $5,500 million (and that we will have the right to request an increase in the borrowing capacity by up to $1,500 million or more, subject to lender participation and other specific conditions), comprised of:

- a five-year $1,000 million revolving credit facility,
- a five-year $1,000 million term loan A, and
- a seven-year $3,500 million term loan B.

We currently estimate that we will borrow a total of approximately $4,500 million of term loans under our proposed amended and restated senior secured credit facilities and expect that we will use the proceeds from such terms loans to purchase 2018 Notes tendered pursuant to the Offer (or, if any 2018 Notes are not purchased pursuant to the Offer, to redeem such 2018 Notes), to repay all remaining borrowings outstanding and pay other amounts payable under our current senior secured credit facilities, and to pay fees and expenses related to the foregoing. In addition, accrued and unpaid interest on the 2018 Notes that we purchase in the Offer or redeem will be paid from other available cash. Any remaining net proceeds from such term loans will be used for general corporate purposes. Pending such uses, the net proceeds may be invested in short term investments.

The proposed amended and restated senior secured credit facilities are contingent upon the closing of this offering, the repayment of all borrowings and payment of other amounts payable under our current senior secured credit facilities, and other conditions, including final documentation, and we can give no assurance that our proposed amended and restated senior secured credit facilities will become effective as proposed or at all. Whether or not we enter into the proposed amended and restated senior secured credit facilities as contemplated above, we may choose to seek additional funding through additional senior unsecured indebtedness or other funding sources to finance all or a portion of the cost of repurchasing or redeeming the 2018 Notes or paying the other amounts described in the preceding paragraph.

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The Offering

The summary below describes some of the principal terms of the notes and the related indenture. Certain of the terms described below are subject to important limitations and exceptions. For a more detailed description of the terms of the notes and the related indenture, see the section entitled Description of Notes. As used in this section, references to the Company , our , we and similar references mean DaVita HealthCare Partners Inc. and not any of its subsidiaries.

Issuer	DaVita HealthCare Partners Inc.
Notes Offered	$1,750,000,000 aggregate principal amount of 5.125% Senior Notes due 2024.
Maturity Date	The notes will mature on July 15, 2024.
Interest	The notes will bear interest at 5.125% per year. Interest will accrue from June 13, 2014.
Interest Payment Dates	January 15 and July 15 of each year, commencing January 15, 2015.
Guarantees	The notes initially will be guaranteed by each of our domestic restricted subsidiaries that guarantees our senior secured credit facilities.
Ranking	The notes will be unsecured senior obligations of the Company. The notes will rank equally in right of payment with all of the Company s existing and future unsecured senior indebtedness, will be effectively subordinated to all of the Company s existing and future secured indebtedness (including indebtedness under its senior secured credit facilities) to the extent of the value of the collateral securing such indebtedness, will be structurally subordinated to all existing and future indebtedness and other liabilities (including trade payables) of the Company s subsidiaries that do not guarantee the notes, and will rank senior in right of payment to any of the Company s existing and future unsecured indebtedness that is expressly subordinated in right of payment to the notes. The guarantees of the notes will be unsecured senior obligations of the guarantors. Each guarantor s guarantee of the notes will rank

equally in right of payment with all of such guarantor s existing and future unsecured senior indebtedness, will be effectively subordinated to all of such guarantor s existing and future secured indebtedness (including its guarantee of indebtedness under the Company s senior secured credit facilities) to the extent of the value of the collateral securing such indebtedness, will be structurally subordinated to all existing and future indebtedness and other liabilities (including trade payables) of any of such guarantor s subsidiaries that do not guarantee the notes, and will rank senior in right of payment to any existing and future unsecured indebtedness of such guarantor that is expressly subordinated in right of payment to its guarantee of the notes.

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As of March 31, 2014, after giving effect to the issuance of the notes offered hereby and the application of the proceeds therefrom to the repayment of a portion of the term loans under our current senior secured credit facilities and to pay related fees and expenses as if they had occurred on that date, the Company and the guarantors would have had total secured debt of approximately $3,678 million, excluding the debt discounts associated with our term loans, and approximately $267 million of additional secured debt available to be borrowed under our current senior secured credit facilities, after giving effect to outstanding letters of credit of approximately $83 million, and the notes and the guarantees of the notes would have been structurally subordinated to approximately $319 million of indebtedness and other liabilities (including trade payables, but excluding liabilities owed to the Company or a guarantor of the notes) of the Company s non-guarantor subsidiaries, and the total assets of our non-guarantor subsidiaries would have accounted for approximately 14% of our consolidated total assets at that date.

If, after the issuance of the notes offered hereby and the application of the proceeds therefrom on the terms described below under Use of Proceeds, we were able to enter into our proposed amended and restated senior secured credit facilities, make the initial borrowings thereunder and apply the proceeds thereof to the payment of all remaining amounts payable under our current senior secured credit facilities and to purchase all of the outstanding 2018 Notes in the Offer, all as contemplated under Summary Recent Developments , then, after giving effect to all of the foregoing transactions as if they had occurred on March 31, 2014, as of that date the Company and the guarantors would have had total secured debt of approximately $4,553 million, excluding the debt discounts associated with our term loans, and approximately $917 million of additional secured debt available to be borrowed under our proposed amended and restated senior secured credit facilities, after giving effect to outstanding letters of credit of approximately $83 million.

Optional Redemption

At any time prior to July 15, 2017, the Company may redeem up to 35% of the notes with the net cash proceeds of certain equity offerings at the redemption price set forth under Description of Notes Optional redemption, plus accrued and unpaid interest to the date of redemption.

At any time prior to July 15, 2019, the Company may redeem the notes, in whole or in part, at a make whole redemption price as set forth under Description of Notes Optional redemption, plus accrued and unpaid interest to the date of redemption.

At any time on and after July 15, 2019, the Company may redeem the notes, in whole or in part, at the redemption prices set forth under Description of Notes Optional redemption, plus accrued and unpaid interest to the date of redemption.

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Change of Control

If a Change of Control (as defined under Description of notes Certain definitions) occurs and the Company has not previously exercised its right to redeem all of the outstanding notes as described under Description of Notes Optional redemption, the Company must offer to purchase the notes at a price equal to 101% of the principal amount thereof plus any accrued and unpaid interest.

Covenants

The indenture governing the notes, which we refer to as the indenture, will, among other things, restrict our ability and the ability of our Restricted Subsidiaries (as defined under Description of notes Certain definitions) to:

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

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

Use of Proceeds

We intend to use the net proceeds from this offering to repay, concurrently with the closing of this offering, a portion of our borrowings outstanding under our current senior secured credit facilities and to pay fees and expenses related to this offering. Pending such uses, the net proceeds of this offering may be invested

	in short-term investments. See Use of Proceeds.
No Public Market	The notes are a new series of securities for which there is currently no established trading market. The underwriters have advised us that they presently intend to make a market in the notes. However, you should be aware that they are not obligated to make a market and may discontinue their market-making activities at any time without notice. As a result, a liquid market for the notes may not be available if you try to sell your notes. We do not intend to apply for a listing of the notes on any securities exchange or any automated dealer quotation system.
Form	The notes will be represented by global notes registered in the name of Cede & Co., the nominee of The Depository Trust Company, or DTC. Beneficial interests in the global notes will be

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	shown on, and transfers will be effected through, records maintained by DTC and its direct and indirect participants.
Risk Factors	See Risk Factors beginning on page S-16 of this prospectus supplement for important information regarding us and an investment in the notes.

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Summary Financial and Operating Data

The summary consolidated financial information as of and for each of the three years ended December 31, 2013 is derived from our audited consolidated financial statements. The summary consolidated financial information as of and for the three months ended March 31, 2014 and March 31, 2013 and the twelve months ended March 31, 2014 is unaudited. The results for the three months ended March 31, 2014 and the three months ended March 31, 2013 are not necessarily indicative of the results that may be expected for the year ended December 31, 2014 or any future period. Our unaudited interim financial information as of and for the three months ended March 31, 2014 and March 31, 2013 and our unaudited twelve month financial information as of the end of a particular quarter reflect all adjustments that our management considers necessary for a fair statement of the financial position and results of operations for such periods in accordance with U.S. generally accepted accounting principles, or GAAP. The unaudited financial information for the twelve months ended March 31, 2014 has been derived by adding our financial information for the year ended December 31, 2013 to the financial information for the three months ended March 31, 2014 and subtracting the financial information for the three months ended March 31, 2013.

The summary financial information should be read in conjunction with our consolidated financial statements and the related notes and the Management s Discussion and Analysis of Financial Condition and Results of Operations sections included in our Annual Report on Form 10-K for the year ended December 31, 2013 and our quarterly report on Form 10-Q for the quarter ended March 31, 2014, which we have filed with the Securities and Exchange Commission, or SEC, and are incorporated by reference in this prospectus supplement.

	Years ended December 31,			Three months ended March 31,		Twelve months ended March 31,
	2011	2012	2013	2013	2014	2014
	(dollars rounded to nearest millions)					
Statement of income data:						
Net operating revenues[1]	$ 6,732	$ 8,186	$ 11,764	$ 2,830	$ 3,043	$ 11,977
Operating expenses and charges:						
Patient care costs	4,634	5,584	8,198	1,961	2,180	8,417
General and administrative	685	889	1,177	284	284	1,176
Depreciation and amortization	264	342	529	126	142	545
Provision for uncollectible accounts	3	4	5	1	3	7
Equity investment income	(9)	(16)	(35)	(9)	(7)	(32)
Loss contingency reserve and other legal settlements		86	397	300		97
Contingent earn-out obligation adjustment			(57)			(57)
Total operating expenses and charges	5,577	6,889	10,214	2,663	2,602	10,153
Operating income	1,155	1,297	1,550	167	441	1,824
Debt expense	(241)	(289)	(430)	(106)	(106)	(430)

Debt redemption charges		(11)				
Other income	3	4	5	1	2	6
Income from continuing operations before income taxes	917	1,001	1,125	62	337	1,400
Income tax expense	326	360	381	15	125	491
Income from continuing operations	591	641	744	47	212	909
Discontinued operations	(18)		13	13		
Net income	573	641	757	60	212	909
Less: Net income attributable to noncontrolling interests	(95)	(105)	(124)	(30)	(29)	(122)
Net income attributable to DaVita HealthCare Partners Inc.	$ 478	$ 536	$ 633	$ 30	$ 183	$ 787

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	Years ended December 31,			Three months ended March 31,		Twelve months ended March 31,
	2011	2012	2013	2013	2014	2014
	(dollars rounded to nearest millions)					
Balance sheet data (at end of period):						
Cash and cash equivalents	$ 394	$ 534	$ 946	$ 700	$ 1,108	
Working capital	1,128	871	1,010	866	1,141	
Total assets	8,904	16,015	17,099	16,413	17,398	
Long-term debt	4,418	8,327	8,141	8,277	8,072	
Total DaVita HealthCare Partners Inc. shareholders equity	2,141	3,763	4,432	3,799	4,660	

	Years ended December 31,			Three months ended March 31,		Twelve months ended March 31,
	2011	2012	2013	2013	2014	2014
	(dollars rounded to nearest millions, except per treatment data)					
Other financial data:						
Net cash provided by (used in):						
Operating activities	$ 1,180	$ 1,101	$ 1,773	$ 379	$ 419	$ 1,813
Investing activities	(1,399)	(4,832)	(877)	(146)	(196)	(927)
Financing activities	(247)	3,872	(483)	(67)	(62)	(478)
Free cash flow [3]	855	715	1,366	299	337	1,403
Capital expenditures	400	550	618	117	127	627
Adjusted EBITDA [4]	1,534	2,337	2,511	596	587	2,504
Operating data:						
Centers [2]	1,820	1,990	2,147	2,032	2,173	2,173
Patients [2]	143,000	155,000	168,000	159,000	170,000	170,000
U.S. dialysis treatments	19,599,472	22,053,597	23,637,584	5,628,799	5,975,627	23,984,413
Average U.S. dialysis revenue per treatment	$ 330	$ 332	$ 340	$ 340	$ 341	$ 340
HCP capitated membership:						
Total		724,000	764,000	742,000	795,000	795,000
Member months		1,442,600	8,973,400	2,239,400	2,373,000	9,106,900
Adjusted data [5]:						
Interest expense [6]						$ 409
Total debt [7]						8,489
Net debt [8]						7,494
Ratio of total debt to Adjusted EBITDA [4]						3.4x
Ratio of net debt to Adjusted EBITDA [4]						3.0x
						6.1x

Ratio of Adjusted EBITDA to interest expense [4]	
Ratio of earnings to fixed charges [9]	3.1x

(1) On January 1, 2012, we adopted FASB s ASU No. 2011-07, *Health Care Entities Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts*. This standard was applied retrospectively to all prior periods presented. Upon adoption of this standard, we changed our presentation of our provision for uncollectible accounts related to patient services revenues as a deduction from our patient services operating revenues.

(2) Includes international operations.

(3) Free cash flow represents net cash provided by operating activities less income distributions to noncontrolling interest and capital expenditures for routine maintenance and information technology. We believe free cash flow is a useful adjunct to cash flow from operating activities and other measurements under GAAP, since free cash flow is a meaningful measure of our ability to fund

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acquisition and development activities and meet our debt service requirements. In addition, free cash flow excluding income distributions to noncontrolling interests is not a measure of financial performance computed in accordance with GAAP and should not be considered as a substitute for cash flows from operating, investing or financing activities, or other cash flow data prepared in conformity with GAAP, or as a measure of liquidity. In addition, free cash flow may not be comparable to similarly titled measures of other companies. Free cash flow may not be indicative of cash flows available for discretionary expenditures, and we do not mean it to be predictive of future cash flows.

Free cash flow reconciled to cash provided by operating activities is as follows:

	Years ended December 31,			Three months ended March 31,		Twelve months ended March 31,
	2011	2012	2013	2013	2014	2014
	(dollars rounded to nearest millions)					
Cash provided by operating activities	$ 1,180	$ 1,101	$ 1,773	$ 379	$ 419	$ 1,813
Less: Income distributions to noncontrolling interests	(101)	(114)	(139)	(35)	(33)	(138)
Cash provided by operating activities attributable to DaVita HealthCare Partners Inc.	1,079	987	1,634	344	386	1,675
Less: Expenditures for routine maintenance and information technology	(224)	(272)	(268)	(45)	(49)	(272)
Free cash flow	$ 855	$ 715	$ 1,366	$ 299	$ 337	$ 1,403

(4) Adjusted EBITDA is defined as net income attributable to DaVita HealthCare Partners Inc. before income taxes, debt expense, depreciation and amortization, noncontrolling interests and equity investment income, net, and we further adjust for non-cash charges, pro forma amounts for acquisitions and assets sales as if they had been consummated on the first day of each period, and non-cash gains and credits. We believe Adjusted EBITDA provides information useful for evaluating our businesses and understanding our operation performance in a manner similar to management. In addition, we present Adjusted EBITDA because it is one of the components used in the calculations under the covenants contained in our current senior secured credit facilities, and we expect similar covenants to be included in our proposed amended and restated senior secured credit facilities. Adjusted EBITDA is not a measure of operating performance computed in accordance with GAAP and should not be considered as a substitute for operating income, net income, cash flows from operations, or other statement of operations or cash flow data prepared in conformity with GAAP, or as measures of profitability or liquidity. In addition, Adjusted EBITDA may not be comparable to similarly titled measures of other companies. Adjusted EBITDA may not be indicative of historical operating results, and we do not mean for it to be predictive of future results of operations or cash flows.

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Adjusted EBITDA reconciled to net income attributable to DaVita HealthCare Partners Inc. is as follows:

	Years ended December 31,			Three months ended March 31,		Twelve months ended March 31,
	2011[a]	2012[a]	2013	2013	2014	2014
	(dollars rounded to nearest millions)					
Net income attributable to DaVita HealthCare Partners Inc.	$ 478	$ 536	$ 633	$ 30	$ 183	$ 787
Income tax expense	316	360	381	15	125	491
Debt expense [b]	240	298	427	105	105	427
Depreciation and amortization	267	344	529	126	142	545
Noncontrolling interests and equity investment income, net	96	109	126	28	29	126
Non-cash and other unusual charges [c]	81	172	482	316	17	183
Pro-forma amounts for acquisitions and assets sales	88	563	29	4	2	30
Non-cash gains and credits [d]	(32)	(45)	(96)	(28)	(16)	(85)
Adjusted EBITDA	$ 1,534	$ 2,337	$ 2,511	$ 596	$ 587	$ 2,504

(a) Represents the original amounts and have not been recast for certain divestitures that are reported as discontinued operations.

(b) Debt expense is defined as interest expense plus the amortization of deferred financing costs, the amortization of debt discounts, the amortization of interest rate cap agreements and debt refinancing costs.

(c) Includes stock-based compensation expense, impairments and valuation adjustments, other non-cash charges and losses, a loss contingency reserve, other legal settlements and transaction expenses associated with the acquisition of HCP.

(d) Includes a contingent earn-out adjustment, EBITDA related to HCP s non-guarantors entities and other non-cash gains and credits.

(5) As adjusted to give effect to the issuance of the notes offered hereby and the application of the proceeds therefrom to the repayment of a portion of the term loans under our current senior secured credit facilities and to pay fees and expenses related to this offering. None of the adjusted data appearing in the foregoing table gives effect to the proposed purchase of 2018 Notes in the Offer, entry into our proposed amended and

restated senior secured credit facility or any borrowings thereunder, or any of the other transactions described under Summary-Recent Developments-Tender Offer and Consent Solicitation for our 2018 Notes and Proposed Amended and Restated Senior Secured Credit Facilities.

(6) Interest expense is defined as debt expense minus amortization of deferred financing costs, the amortization of interest rate cap agreements, the amortization of debt discounts, and debt refinancing costs less interest income.

(7) Total debt refers to total funded debt outstanding plus outstanding letters of credit.

(8) As used in this prospectus supplement, net debt refers to total debt less cash and cash equivalents and excluding HCP s non-guarantors cash and cash equivalents.

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(9) The ratio of earnings to fixed charges is computed by dividing earnings by fixed charges. Earnings for this purpose are defined as pre-tax income from continuing operations adjusted by adding back fixed charges expensed during the period less pre-tax net income attributable to noncontrolling interests. Fixed charges include debt expense (interest expense, the amortization of deferred financing costs, the amortization of debt discounts, the amortization of the interest rate cap agreements and excludes interest income), the estimated interest component of rent expense on operating leases, and capitalized interest.

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RISK FACTORS

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

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

Risks Relating to Our Business

Risk factors related to our U.S. dialysis and related lab services, ancillary services and strategic initiatives:

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 33% of our dialysis and related lab services revenues for the quarter ended March 31, 2014, were generated from patients who have commercial payors as their 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 as a result of general conditions in the market, recent and future consolidations among commercial payors, increased focus on dialysis services and other factors. There is no guarantee that commercial payment rates will not be materially lower in the future.

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

individual and small group health plans in the risk factor below under the heading Health care reform could substantially reduce our revenues, earnings and cash flows.

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

Changes in the structure of and payment rates under the Medicare ESRD program, including the American Taxpayer Relief Act of 2012, the Budget Control Act of 2011 and other healthcare reform initiatives, could substantially reduce our revenues, earnings and cash flows.

Approximately 47% of our dialysis and related lab services revenues for the quarter ended March 31, 2014 was generated from patients who have Medicare as their primary payor. For patients with Medicare coverage, all ESRD payments for dialysis treatments are made under a single bundled payment rate which provides a fixed payment rate to encompass all goods and services provided during the dialysis treatment, including pharmaceuticals that were historically separately reimbursed to the dialysis providers, such as EPO, vitamin D analogs and iron supplements, irrespective of the level of pharmaceuticals administered or additional services performed. Most lab services that used to be paid directly to laboratories are also included in the bundled payment. The bundled payment rate is also adjusted for certain patient characteristics, a geographic usage index and certain other factors.

The current bundled payment system presents certain operating, clinical and financial risks, which include:

Risk that our rates are reduced by CMS. CMS issued the 2014 final rule for the ESRD PPS, which phases in over three to four years the 12% cut mandated by ATRA. Although no reimbursement reduction is expected in 2014 or 2015 under the final ESRD PPS rule, it is anticipated that future reductions will occur no later than 2017. However, the recent Protecting Access to Medicare Act that was passed on March 31, 2014 further modified the reduction to only 1.25% in 2016 and 2017, and 1% in 2018. While this modification eases reimbursement pressure, future legislative actions could have the opposite effect.

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

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Risk of federal budget sequestration cuts. As a result of the Budget Control Act of 2011 (BCA) and subsequent activity in Congress, a $1.2 trillion sequester (across-the-board spending cuts) in discretionary programs took effect on March 1, 2013. In particular, a 2% reduction to Medicare payments took effect on April 1, 2013, which was recently extended through 2014 and 2015 by a two-year funding bill signed into law on December 26, 2013. The across-the-board spending cuts pursuant to the sequester have affected and will continue to adversely affect our revenues, earnings and cash flows.

Risk that we may not be able to comply with the CMS ESRD Quality Incentive Program requirements. Beginning in payment year 2016, CMS proposed to adopt two new clinical and reporting measures, continue using six existing clinical and reporting measures, revise two existing clinical and reporting measures, and expand one existing reporting measure. The final rule establishes calendar year 2014 as the performance period for all of the quality measures. To the extent we are not able to meet CMS s quality measures, it could have a material adverse effect on our revenues, earnings and cash flows.

For additional details regarding the risks we face for failing to adhere to our Medicare and Medicaid regulatory compliance obligations, see the risk factor below under the heading If we fail to adhere to all of the complex government regulations that apply to our business, we could suffer severe consequences that would substantially reduce our revenues, earnings, cash flows and stock price.

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

We cannot predict how employers, private payors or persons buying insurance might react to the changes brought on by broad U.S. health care reform legislation.

The health care reform legislation introduced health care insurance exchanges which provide a marketplace for eligible individuals and small employers to purchase health care insurance. Although we cannot predict the short or long term effects of these measures, we believe the health care insurance exchanges could result in a reduction in patients covered by commercial insurance or an increase of patients covered through the exchanges under more restrictive commercial plans with lower reimbursement rates. To the extent that the implementation of such exchanges results in a reduction in patients covered by commercial insurance or a reduction in reimbursement rates for our services from commercial and/or government payors, our revenues, earnings and cash flows could be adversely affected.

In addition, the health care reform legislation introduced severe penalties for the knowing and improper retention of overpayments collected from government payors and reduced the timeline to file Medicare claims. As a result, we made significant initial investments in new resources to accelerate the time it takes us to identify and process overpayments and we deployed significant resources to reduce our timeline and improve our claims processing methods to ensure that our Medicare claims are filed in a timely fashion. We may be required to make additional investments in the future. Failure to timely identify and return overpayments may result in significant additional penalties, which may have a negative impact on our revenues, earnings and cash flows. Failure to file a claim within the one year window could result in payment denials, adversely affecting our revenues, earnings and cash flows.

The health care reform legislation also added several new tax provisions that, among other things, impose various fees and excise taxes, and limit compensation deductions for health insurance providers and their affiliates. These rules could negatively impact our cash flow and tax liabilities.

The CMS Center for Medicare & Medicaid Innovation (Innovation Center) is currently working with various healthcare providers to develop and implement ACOs and other innovative models of care for Medicare and Medicaid

beneficiaries. We are currently uncertain of the extent to which these models of care, including ACOs, Bundled Payments for Care Improvement Initiative, Comprehensive ESRD Care Model (which includes the

development of ESCOs), the Comprehensive Primary Care Initiative, the Duals Demonstration, or other models, will impact the health care market. Our U.S. dialysis business may choose to participate in one or several of these models either as a partner with other providers or independently. We are currently seeking to participate in the Comprehensive ESRD Care Model with the Innovation Center. Even if we do not participate in this or other programs, some of our patients may be assigned to a program, in which case the quality and cost of care that we furnish will be included in an ACO s or other programs calculations. As new models of care emerge, we may be at risk for losing our Medicare patient base, which would have a materially adverse effect on our revenues, earnings and cash flow. Other initiatives in the government or private sector may arise, including the development of models similar to ACOs, IPAs and integrated delivery systems or evolutions of those concepts which could adversely impact our business.

CMS instituted new screening procedures which we expect will delay the Medicare contractor approval process, potentially causing a delay in reimbursement. We anticipate the new screening and enrollment requirements will require additional personnel and financial resources and will potentially delay the enrollment and revalidation of our centers which in turn will delay payment. These delays may negatively impact our revenues, earnings and cash flows.

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

There is also a considerable amount of uncertainty as to the prospective implementation of the federal healthcare reform legislation and what similar measures might be enacted at the state level. The enacted reforms as well as future legislative changes could have a material adverse effect on our results of operations, including lowering our reimbursement rates and increasing our expenses.

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

Approximately 20% of our dialysis and related lab services revenues for the quarter ended March 31, 2014 was generated from patients who have state Medicaid or other non-Medicare government-based programs, such as coverage through the Department of Veterans Affairs (VA), as their primary coverage. As state governments and other governmental organizations face increasing budgetary pressure, we may in turn face reductions in payment rates, delays in the receipt of payments, limitations on enrollee eligibility or other changes to the applicable programs. For example, certain state Medicaid programs and the VA have recently considered, proposed or implemented payment rate reductions.

The VA recently adopted Medicare s bundled PPS pricing methodology for any veterans receiving treatment from non-VA providers under a new national contracting initiative. Since we are a non-VA provider, these reimbursements are now tied to a percentage of Medicare reimbursement, and we have additional exposure to any dialysis reimbursement changes made by CMS. Approximately 2% of our dialysis and related lab services revenues for the quarter ended March 31, 2014 was generated by the VA. On October 1, 2013, we entered into a five-year Nationwide Dialysis Services contract with the VA which is subject to one-year renewal periods, consistent with all provider agreements with the VA under this contract. These agreements provide for the right of the VA to terminate the agreements without cause on short notice. Should the VA not renew or cancel these agreements for any reason, we may cease accepting patients under this program and may be forced to close centers, which could adversely affect our revenues, earnings and cash flows.

State Medicaid programs are increasingly adopting Medicare-like bundled payment systems, but sometimes these payment systems are poorly defined and are implemented without any claims processing infrastructure, or patient or facility adjusters. If these payment systems are implemented without any adjusters and claims processing changes, Medicaid payments will be substantially reduced and the costs to submit such claims may increase,

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which will have a negative impact 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, resulting in decreased patient volumes and revenue. These Medicaid payment and enrollment changes, along with similar changes to other non-Medicare government programs could reduce the rates paid by these programs for dialysis and related services, delay the receipt of payment for services provided, and further limit eligibility for coverage which could adversely affect our revenues, earnings and cash flows.

Changes in clinical practices, payment rates or regulations impacting EPO and other pharmaceuticals could adversely affect our operating results, reduce our revenues, earnings and cash flows and negatively impact our ability to care for patients.

Medicare bundles EPO into the prospective payment system such that dosing variations do not change the amount paid to a dialysis facility. Although some Medicaid programs and other payors suggest movement towards a bundled payment system inclusive of EPO, some non-Medicare payors continue to pay for EPO separately from the treatment rate. The administration of EPO and other pharmaceuticals that are separately billable accounted for approximately 5% of our dialysis and related lab services revenues for the quarter ended March 31, 2014, with EPO alone accounting for approximately 3% of our dialysis and related lab services revenues during that period. Changes in physician clinical practices that result in further decreased utilization of prescribed pharmaceuticals or changes in payment rates for those pharmaceuticals could reduce our revenues, earnings and cash flows.

Evaluations on the utilization and reimbursement for ESAs, which have occurred in the past and may occur in the future, and related actions by the U.S. Congress and federal agencies, could result in further restrictions on the utilization and reimbursement for ESAs. Additionally, commercial payors have increasingly examined their administration policies for EPO and, in some cases, have modified those policies. Changes in labeling of EPO and other pharmaceuticals in a manner that alters physician practice patterns or accepted clinical practices, changes in private and governmental payment criteria, including the introduction of EPO administration policies or the conversion to alternate types of administration of EPO or other pharmaceuticals that result in further decreases in utilization of EPO for patients covered by commercial payors could have a material adverse effect on our revenues, earnings and cash flows. Further increased utilization of EPO for patients for whom the cost of EPO is included in a bundled reimbursement rate, or further decreases in reimbursement for EPO and other pharmaceuticals that are not included in a bundled reimbursement rate, could also have a material adverse effect on our revenues, earnings and cash flows.

Additionally, as a result of the current high level of scrutiny and controversy, we may be subject to increased inquiries or audits from a variety of governmental bodies or claims by third parties. Although we believe our anemia management practices and other pharmaceutical administration practices have been compliant with existing laws and regulations, increased inquiries or audits from governmental bodies or claims by third parties would require management s attention, and could result in significant legal expense. Any negative findings could result in substantial financial penalties or repayment obligations, the imposition of certain obligations on and changes to our practices and procedures as well as the attendant financial burden on us to comply with the obligations, or exclusion from future participation in the Medicare and Medicaid programs, and could have a material adverse effect on our revenues, earnings and cash flows.

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

Future increases in the cost of EPO without corresponding increases in payment rates for EPO from commercial payors and without corresponding increases in the Medicare bundled rate could have a material adverse effect on our earnings and cash flows and ultimately reduce our income. In November 2011, we entered into a seven year Sourcing and Supply Agreement with Amgen USA Inc., pursuant to which we committed to purchase EPO in

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amounts necessary to meet no less than 90% of our requirements for ESAs. As long as we meet certain conditions, the agreement limits Amgen s ability to unilaterally increase the price for EPO during the term of the agreement. Our agreement with Amgen for EPO provides for discounted pricing and rebates for EPO. However, some of the rebates are subject to various conditions including, but not limited to, future pricing levels of EPO by Amgen and data submission by us. In addition, the rebates are subject to certain limitations. We cannot predict whether, over the seven year term of the agreement, we will continue to receive the rebates for EPO that we have received in the past, or whether we will continue to achieve the same levels of rebates within that structure as we have historically achieved. In the initial years of the agreement, the total rebate opportunity is less than what was provided in the agreement that expired at the end of 2011; however, the opportunity for us to earn discounts and rebates increases over the term of the agreement. Factors that could impact our ability to qualify for rebates provided for in our agreement with Amgen in the future include, but are not limited to, our ability to track certain data elements. We cannot predict whether we will be able to meet the applicable qualification requirements for receiving rebates. Failure to meet certain targets and earn the specified rebates could have a material adverse effect on our earnings and cash flows.

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

We are the subject of a number of investigations by the federal government. We have received subpoenas or other requests for documents from the federal government in connection with the Vainer private civil suit, the 2010 U.S. Attorney physician relationship investigation, the 2011 U.S. Attorney physician relationship investigation and the 2011 U.S. Attorney Medicaid investigation. Certain current and former members of our Board, as well as executives and other teammates have been subpoenaed to testify before a grand jury in Colorado related to the 2011 U.S. Attorney physician relationship investigation.

With respect to the Vainer private civil suit, after investigation, the federal government did not intervene and is not actively pursuing this private civil suit. With respect to the Swoben civil suit, the United States Department of Justice declined to intervene after its review of the allegations contained in the Third Amended Complaint and is not actively pursuing this private civil suit other than its partial intervention for the purpose of settlement with and dismissal of the initial defendant in this proceeding. In each of these private civil suits, a relator filed a complaint against us in federal court under the qui tam provisions of the False Claims Act (FCA) (and in the Swoben matter, provisions of the California False Claims Act, as well) and pursued the claims independently after the government declined to intervene. The parties are engaged in active litigation in the Vainer private civil suit. With regard to the Swoben private civil suit, in July 2013, the court granted HCP s motion and dismissed with prejudice all of the claims in the Third Amended Complaint, and in October 2013 the plaintiff filed an appeal of the dismissal, which is currently pending.

We are cooperating with HHS s OIG and those offices of the U.S. Attorney pursuing the matters mentioned above. In addition, we have agreed to a framework for a global resolution with the United States Attorney s Office for the District of Colorado, the Civil Division of the United States Department of Justice and the Office of the Inspector General for both the 2010 and the 2011 U.S. Attorney Physician Relationship Investigations. The settlement will include the payment of approximately $389 million, entry into a corporate integrity agreement, the appointment of an independent compliance monitor, and the imposition of certain other business restrictions related to a subset of our joint venture arrangements. We have agreed to unwind a limited subset of joint ventures that were created through partial divestiture to nephrologists, and agreed not to enter into this type of partial divestiture joint venture with nephrologists in the future. The final settlement remains subject to negotiation of specific terms, and we can make no assurances as to the final outcome.

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

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

We endeavor to comply with all legal requirements, however, there is no guarantee that we will be able to adhere to all of the complex government regulations that apply to our business. For example, we have experienced past security breaches with regard to patient health information and there can be no assurance that we will not suffer security breaches in the future. We further endeavor to structure all of our relationships with physicians to comply with state and federal anti-kickback and physician self-referral laws. We utilize considerable resources to monitor the laws and implement necessary changes. However, the laws and regulations in these areas are complex and often subject to varying interpretations. For example, if an enforcement agency were to challenge the level of compensation that we pay our medical directors or the number of medical directors whom we engage, we could be required to change our practices, face criminal or civil penalties, pay substantial fines or otherwise experience a material adverse effect as a result of a challenge to these arrangements. In addition, amendments to the FCA impose severe penalties for the knowing and improper retention of overpayments collected from government payors. These amendments could subject our procedures for identifying and processing overpayments to greater scrutiny. We have made significant investments in new resources to decrease the time it takes to identify and process overpayments and we may be required to make additional investments in the future. An acceleration in our ability to identify and process overpayments could result in us refunding overpayments to government and other payors more rapidly than we have in the past which could have a material adverse effect on our operating cash flows. Additionally, amendments to the federal anti-kickback statute in the health reform law make anti-kickback violations subject to FCA prosecution, including qui tam or whistleblower suits.

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

Suspension or termination of our participation in government payment programs;

Refunds of amounts received in violation of law or applicable payment program requirements;

Loss of required government certifications or exclusion from government payment programs;

Loss of licenses required to operate health care facilities or administer pharmaceuticals in some of the states in which we operate;

Reductions in payment rates or coverage for dialysis and ancillary services and related pharmaceuticals;

Fines, damages or monetary penalties for anti-kickback law violations, Stark Law violations, FCA violations, civil or criminal liability based on violations of law, or other failures to meet regulatory requirements;

Enforcement actions by governmental agencies and/or state claims for monetary damages by patients who believe their protected health information has been used, disclosed or not properly safeguarded in

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violation of federal or state patient privacy laws, including Health Insurance Portability and Accountability Act (HIPAA) of 1996;

Mandated changes to our practices or procedures that significantly increase operating expenses;

Imposition of and compliance with corporate integrity agreements that could subject us to ongoing audits and reporting requirements as well as increased scrutiny of our billing and business practices which could lead to potential fines;

Termination of relationships with medical directors; and

Harm to our reputation which could impact our business relationships, affect our ability to obtain financing and decrease access to new business opportunities.

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

Before we can begin billing for patients treated in our outpatient dialysis centers who are enrolled in government-based programs, we are required to obtain state and federal certification for participation in the Medicare and Medicaid programs. As state agencies responsible for surveying dialysis centers on behalf of the state and Medicare program face increasing budgetary pressure, certain states are having difficulty keeping up with certifying dialysis centers in the normal course resulting in significant delays in certification. If state governments continue to have difficulty keeping up with certifying new centers in the normal course and we continue to experience significant delays in our ability to treat and bill for services provided to patients covered under government programs, it could cause us to incur write-offs of investments or accelerate the recognition of lease obligations in the event we have to close centers or our centers operating performance deteriorates, and it could have an adverse effect on our revenues, earnings and cash flows.

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

As of March 31, 2014, we owned a controlling interest in numerous dialysis-related joint ventures, which represented approximately 21% of our U.S. dialysis and related lab services revenues for the quarter ended March 31, 2014. In addition, we also owned minority equity investments in several other dialysis related joint ventures. We may continue to increase the number of our joint ventures. Many of our joint ventures with physicians or physician groups also have certain physician owners providing medical director services to centers we own and operate. Because our relationships with physicians are governed by the federal and state anti-kickback statutes, we have sought to structure our joint venture arrangements to satisfy as many federal safe harbor requirements as we believe are commercially reasonable. However, our joint venture arrangements do not satisfy all of the elements of any safe harbor under the federal anti-kickback statute. Arrangements that do not meet all of the elements of a safe harbor are not automatically prohibited under the federal anti-kickback statute but are susceptible to government scrutiny. We have recently agreed to a framework for a global resolution with the United States Attorney s Office for the District of Colorado, the Civil Division of the United States Department of Justice and the Office of the Inspector General for both the 2010 and the 2011 U.S. Attorney Physician Relationship Investigations, including the payment of approximately $389 million, entry into a corporate integrity agreement, the appointment of an independent compliance monitor, and the imposition

of certain other business restrictions related to a subset of our joint venture arrangements. Under the terms of the framework for resolution, we have agreed to unwind a limited subset of joint ventures that were created through partial divestiture to nephrologists, and agreed not to enter into this type of partial divestiture joint venture with nephrologists in the future. The final settlement remains subject to negotiation of specific terms, and we can make no assurances as to the final outcome.

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

There are significant estimating risks associated with the amount of dialysis and related lab services revenues and related refund liabilities that we recognize in a reporting period. The billing and collection process is complex due to ongoing insurance coverage changes, geographic coverage differences, differing interpretations of contract coverage, and other payor issues. Determining applicable primary and secondary coverage for approximately 165,000 U.S. patients at any point in time, together with the changes in patient coverage that occur each month, requires complex, resource-intensive processes. Errors in determining the correct coordination of benefits may result in refunds to payors. Revenues associated with Medicare and Medicaid programs are also subject to estimating risk related to the amounts not paid by the primary government payor that will ultimately be collectible from other government programs paying secondary coverage, the patient s commercial health plan secondary coverage or the patient. Collections, refunds and payor retractions typically continue to occur for up to three years and longer after services are provided. We generally expect our range of U.S. dialysis and related lab services revenues estimating risk to be within 1% of net revenues for the segment, which represents approximately 5% of dialysis adjusted operating income. If our estimates of dialysis and related lab services revenues and related refund liabilities are materially inaccurate, it could impact the timing and the amount of our revenues recognition and have a significant impact on our operating results.

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

Our ancillary services and strategic initiatives currently include pharmacy services, disease management services, vascular access services, ESRD clinical research programs, physician services, direct primary care and our international dialysis operations. We expect to add additional service offerings and pursue additional strategic initiatives in the future as circumstances warrant, which could include healthcare services not related to dialysis. Many of these initiatives require or would require investments of both management and financial resources and can generate significant losses for a substantial period of time and may not become profitable. There can be no assurance that any such strategic initiative will ultimately be successful. Any significant change in market conditions, or business performance, or in the political, legislative or regulatory environment, may impact the economic viability of any of these strategic initiatives. If any of our ancillary services or strategic initiatives, including our international dialysis operations, do not perform as planned, we may incur a material write-off or an impairment of our investment, including goodwill, in one or more of these activities or we could incur significant termination costs if we were to exit a certain line of business.

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.

Our medical director contracts are for fixed periods, generally ten years, and at any given time a large number of them could be up for renewal at the same time. Medical directors have no obligation to extend their agreements with us and if we are unable to enforce noncompetition provisions contained in terminated medical director agreements, our former medical directors may choose to provide medical director services for competing providers or establish their

own dialysis centers in competition with ours. Neither our current nor former medical directors have an obligation to refer their patients to our centers.

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Opportunities presented by our competitors or different affiliation models in the changing healthcare environment, such as an increase in the number of physicians becoming employed by hospitals or a perceived decrease in the quality of service levels at our centers may negatively impact a medical director s decision to enter into or extend his or her agreement with us, refer patients to our centers or otherwise negatively impact treatment volumes.

In addition, we may take actions to restructure existing relationships or take positions in negotiating extensions of relationships to assure compliance with the anti-kickback statute, Stark Law and other similar laws. 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. These actions in an effort to comply with applicable laws and regulations could negatively impact the decision of physicians to extend their medical director agreements with us or to refer their patients to us. If a significant number of physicians were to cease referring patients to our dialysis centers, our revenues, earnings and cash flows would be substantially reduced.

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

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

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

We are experiencing increased labor costs and difficulties in hiring nurses due to a nationwide shortage of skilled clinical personnel. We compete for nurses with hospitals and other health care providers. This nursing shortage may limit our ability to expand our operations. In addition, changes in certification requirements or increases in the required staffing levels for skilled clinical personnel can impact our ability to maintain sufficient staff levels to the extent our teammates are not able to meet new requirements or we experience a higher than normal turnover rate due to increased competition for qualified clinical personnel. 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 are unable to maintain satisfactory relations with our employees or if union organizing activities result in significant increases in our operating costs or decreases in productivity.

Our business is labor intensive, and our results are subject to variations in labor-related costs, productivity and the number of pending or potential claims against us related to labor and employment practices. If political

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efforts at the national and local level result in actions or proposals that increase the likelihood of union organizing activities at our facilities or if union organizing activities increase for other reasons, or if labor and employment claims, including the filing of class action suits, trend upwards, our operating costs could increase and our employee relations, productivity, earnings and cash flows could be adversely affected.

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

We are continuously performing upgrades to our billing systems and expect to continue to do so in the near term. In addition, we continuously work to improve our billing and collections performance through process upgrades, organizational changes and other improvements. We may experience difficulties in our ability to successfully bill and collect for services rendered as a result of these changes, including a slow-down of collections, a reduction in the amounts we expect to collect, increased risk of retractions from and refunds to commercial and government payors, an increase in our provision for uncollectible accounts receivable and noncompliance with reimbursement regulations. The failure to successfully implement 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, Baxter Healthcare Corporation, NxStage Medical, Inc. and others or to which we have committed obligations to make purchases including Gambro and FMC. If any of these suppliers are unable to meet our needs for the products they supply, including in the event of a product recall or shortage, and we are not able to find adequate alternative sources, or if some of the drugs that we purchase are not reimbursed or not adequately reimbursed by commercial payors or through the bundled payment rate by Medicare, our revenues, earnings and cash flows could be substantially reduced. In addition, the technology related to the products critical to the services we provide is subject to new developments and may result in superior products. If we are not able to access superior products on a cost-effective basis or if suppliers are not able to fulfill our requirements for such products, we could face patient attrition which could substantially reduce our revenues, earnings and cash flows.

Risk factors related to HCP:

HCP is subject to many of the same risks to which our dialysis business is subject.

As a participant in the healthcare industry, HCP is subject to many of the same risks to which our dialysis business is subject to as described in the risk factors set forth above, any of which could materially and adversely affect HCP s revenues, earnings or cash flows. Among these risks are the following:

- The healthcare business is heavily regulated and changes in laws, regulations, or government programs could have a material impact on HCP;

Failure to comply with complex governmental regulations could have severe consequences to HCP, including, without limitation, exclusion from governmental payor programs like Medicare and Medicaid;

HCP could become the subject of governmental investigations, claims, and litigation;

HCP may be unable to continue to explore potential acquisition candidates, make acquisitions or successfully integrate such acquisitions into its business, and such acquisitions may include liabilities of which HCP was not aware; and

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As a result of the broad scope of HCP s medical practice, HCP is exposed to medical malpractice claims, as well as claims for damages and other expenses, that may not be covered by insurance or for which adequate limits of insurance coverage may not be available.

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

Substantially all of HCP s revenue is derived from fixed Per Member Per Month (PMPM) fees paid by health plans under capitation agreements with HCP or its associated physician groups. While there are variations specific to each arrangement, HealthCare Partners Affiliates Medical Group and HealthCare Partners Associates Medical Group, Inc. (collectively HCPAMG) generally contract with health plans to receive a PMPM fee for professional services and assumes the financial responsibility for professional services only. In some cases, the health plans separately enter into capitation contracts with third parties (typically hospitals) who receive directly a PMPM fee and assume contractual financial responsibility for hospital services. In other cases, the health plan does not pay any portion of the PMPM fee to the hospital, but rather administers claims for hospital expenses itself. In both scenarios, HCP enters into managed care-related administrative services agreements or similar arrangements with those third parties (hospitals) under which HCP agrees to be responsible for utilization review, quality assurance, and other managed care-related administrative functions and claim payments. As compensation for such administrative services, HCP is entitled to receive a percentage of the amount by which the institutional capitation revenue received from health plans exceeds institutional expenses; any such risk-share amount to which HCP is entitled is recorded as medical revenues and HCP is also responsible for any short-fall in the event that institutional expenses exceed institutional revenues. To the extent that members require more care than is anticipated, aggregate fixed PMPM amounts, or capitation payments, may be insufficient to cover the costs associated with treatment. If medical expenses exceed estimates, except in very limited circumstances, HCP will not be able to increase the PMPM fee received under these risk agreements during their then-current terms and could, directly or indirectly through its contracts with its associated physician groups, suffer losses with respect to such agreements.

Changes in HCP s or its associated physician groups anticipated ratio of medical expense to revenue can significantly impact HCP s financial results. Accordingly, the failure to adequately predict and control medical expenses and to make reasonable estimates and maintain adequate accruals for incurred but not reported claims, may have a material adverse effect on HCP s financial condition, results of operations or cash flows.

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

the health status of members;

higher than expected utilization of new or existing healthcare services or technologies;

an increase in the cost of healthcare services and supplies, including pharmaceuticals, whether as a result of inflation or otherwise;

changes to mandated benefits or other changes in healthcare laws, regulations, and practices;

periodic renegotiation of provider contracts with specialist physicians, hospitals, and ancillary providers;

periodic renegotiation of contracts with HCP s associated primary care physicians;

changes in the demographics of the participating members and medical trends;

contractual or claims disputes with providers, hospitals, or other service providers within a health plan s network;

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the occurrence of catastrophes, major epidemics, or acts of terrorism; and

plans with declining premiums.

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

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

Although HCP seeks to contractually reduce or eliminate its liability for risk-sharing deficits, risk-sharing deficits could significantly impact HCP s profitability.

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

Under most of HCP s and its associated physician groups capitation agreements with health plans, the health plan is generally permitted to modify the benefit and risk obligations and compensation rights from time to time during the terms of the agreements. If a health plan exercises its right to amend its benefit and risk obligations and compensation rights, HCP and its associated physician groups are generally allowed a period of time to object to such amendment. If HCP or its associated physician group so objects, under some of the risk agreements, the relevant health plan may terminate the applicable agreement upon 90 to 180 days written notice. If HCP or its associated physician groups enter into capitation contracts or other risk sharing arrangements with unfavorable economic terms, or a capitation contract is amended to include unfavorable terms, HCP could, directly or indirectly through its contracts with its associated physician groups, suffer losses with respect to such contract. Since HCP does not negotiate with CMS or any health plan regarding the benefits to be provided under their Medicare Advantage plans, HCP often has just a few months to familiarize itself with each new annual package of benefits it is expected to offer. Depending on the health plan at issue and the amount of revenue associated with the health plan s risk agreement, the renegotiated terms or termination may have a material adverse effect on HCP s and DaVita s future revenues and profitability.

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

Some states have laws that prohibit business entities, such as HCP, from practicing medicine, employing physicians to practice medicine, exercising control over medical decisions by physicians (also known collectively as the corporate practice of medicine) or engaging in certain arrangements, such as fee-splitting, with physicians.

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In some states these prohibitions are expressly stated in a statute or regulation, while in other states the prohibition is a matter of judicial or regulatory interpretation. Of the states in which HCP currently operates, California and Nevada prohibit the corporate practice of medicine.

In California and Nevada, HCP operates by maintaining long-term contracts with its associated physician groups which are each owned and operated by physicians and which employ or contract with additional physicians to provide physician services. Under these arrangements, HCP provides management services, receives a management fee for providing non-medical management services, does not represent that it offers medical services, and does not exercise influence or control over the practice of medicine by the physicians or the associated physician groups.

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

It is possible that a state regulatory agency or a court could determine that HCP s agreements with physician equity holders of certain managed California and Nevada associated physician groups as described above, either independently or coupled with the management services agreements with such associated physician groups are in violation of the corporate practice of medicine doctrine. As a result, these arrangements could be deemed invalid, potentially resulting in a loss of revenues and an adverse effect on results of operations derived from such associated physician groups. Such a determination could force a restructuring of HCP s management arrangements with associated physician groups in California and/or Nevada, which might include revisions of the management services agreements, including a modification of the management fee and/or establishing an alternative structure, which would permit HCP to contract with a physician network without violating the corporate practice of medicine prohibition. There can be no assurance that such a restructuring would be feasible, or that it could be accomplished within a reasonable time frame without a material adverse effect on HCP s operations and financial results. In December 2013, HCP obtained a restricted Knox-Keene license in California pursuant to the California Knox-Keene Health Care Service Plan Act of 1975 (the Knox-Keene Act), which permits HCP to contract with a physician network in California without violating the corporate practice of medicine prohibition. However, HCP s Nevada associated physician groups and HCP, as well as those physician equity holders of associated physician groups who are subject to succession agreements with HCP, could be subject to criminal or civil penalties or an injunction for practicing medicine without a license or aiding and abetting the unlicensed practice of medicine.

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

HCP s financial statements are consolidated and include the accounts of its majority-owned subsidiaries and certain non-owned HCP-associated and managed physician groups, which consolidation is effectuated in accordance with applicable accounting standards. Such consolidation for accounting and/or tax purposes does not, is not intended to, and should not be deemed to, imply or provide to HCP any control over the medical or clinical affairs of such

physician groups. In the event of a change in accounting standards promulgated by FASB or in interpretation of its standards, or if there were an adverse determination by a regulatory agency or a court,

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or a change in state or federal law relating to the ability to maintain present agreements or arrangements with such physician groups, HCP may not be permitted to continue to consolidate the total revenues of such organizations. A change in accounting for consolidation with respect to HCP s present agreement or arrangements would diminish HCP s reported revenues but would not be expected to materially adversely affect its reported results of operations, while regulatory or legal rulings or changes in law interfering with HCP s ability to maintain its present agreements or arrangements could materially diminish both revenues and results of operations.

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

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

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

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

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

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

A significant portion of HCP s revenue is directly or indirectly derived from the monthly premium payments paid by CMS to health plans for medical services provided to Medicare Advantage enrollees. As a result, HCP s results of operations are, in part, dependent on government funding levels for Medicare Advantage programs. Any changes that limit or reduce Medicare Advantage reimbursement levels, including those recently approved and effective in 2014, such as reductions in or limitations of reimbursement amounts or rates under programs, reductions in funding of programs, expansion of benefits without adequate funding, elimination of coverage for certain benefits, or elimination of coverage for certain individuals or treatments under programs, could have a material adverse effect on HCP s revenues, earnings and cash flows. We expect the Medicare provider reimbursement cuts that we currently face will reduce HCP s Medicare Advantage reimbursement levels by approximately 8% in 2014 as compared to 2013. On April 7, 2014 CMS issued final guidance for 2015 Medicare Advantage rates, which incorporated a re-blending of the

risk adjustment models which CMS utilizes to determine risk acuity scores of Medicare Advantage patients. We estimate that the final cumulative impact of the 2015 rate structure represents an increase of up to approximately 0.5% of HCP s average revenues it manages on behalf of its senior capitated population as compared to 2014.

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The Health Reform Acts contain a number of provisions that negatively impact Medicare Advantage plans, which may each have an adverse effect on HCP s revenues, earnings, and cash flows. These provisions include the following:

Medicare Advantage benchmarks for 2011 were frozen at 2010 levels. Beginning in 2012, Medicare Advantage benchmark rates are being phased down from prior levels to levels that are between 95% and 115% of the Medicare FFS costs, depending on a plan s geographic area. Failure to meet these revised benchmarks may have a significant negative impact on HCP s revenues, earnings and cash flows.

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

The Secretary of the HHS has been granted the explicit authority to deny Medicare Advantage plan bids that propose significant increases in cost sharing or decreases in benefits. If the bids submitted by plans contracted with HCP are denied, this would have a significant negative impact on HCP s revenues, earnings and cash flows.

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

Since January 1, 2011, cost-sharing for certain services (such as chemotherapy and skilled nursing care) has been limited to the cost-sharing permitted under the original FFS Medicare program, which could reduce HCP s revenues, earnings and cash flows by reducing the amount that enrollees are permitted to pay for such services.

Prescription drug plans are now required to cover all drugs on a list developed by the Secretary of HHS, which could increase the cost of providing care to Medicare Advantage enrollees, and thereby reduce HCP s revenues. The Medicare part D premium subsidy for high-income beneficiaries has been reduced by 25%, which could lower the number of Medicare Advantage enrollees, which would have a negative impact on HCP s revenues, earnings and cash flows.

Beginning in 2014, CMS is required to increase coding intensity adjustments for Medicare Advantage plans, which is expected to reduce CMS payments to Medicare Advantage plans, which in turn will likely reduce the amounts payable to HCP and its associated physicians, physician groups, and IPAs under its capitation agreements. The government s budget for Fiscal Year 2014 further increases the coding intensity adjustments starting in 2015, which may further

reduce HCP s revenues, earnings and cash flows.

The President s proposed 2015 budget proposes nearly $400 million in cuts to Medicare over the next decade. Although the majority of the cuts are not targeted at Medicare Advantage plans, the broad cuts could signal further downward pressure on reimbursement to Medicare providers and Medicare Advantage plans, which would have a negative impact on HCP s revenues, earnings and cash flows.

On April 1, 2013, CMS published its final 2014 Call Letter CMS s annual notice to health plans regarding the Medicare Advantage payment methodology and estimated rates for 2014. In a reversal of its previous estimates, which called for a 2.2% reduction in the 2014 Medicare Advantage rates, CMS included in its final

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2014 Call Letter an estimated 3.3% increase in the 2014 Medicare Advantage rates. This reversal was the result of CMS s new assumption that Congressional action would prospectively fix the Medicare physician fee schedule s SGR formula. By assuming an imminent solution to the SGR formula s automatic rate reductions, CMS was able to base its 2014 Medicare Advantage estimates on an assumed 0% change in the Medicare physician fee schedule rates for 2014. As noted above, this change in CMS s assumption has a dramatic positive impact on the estimated Medicare Advantage rates for 2014. However, a resolution of the SGR formula has yet to be passed by Congress, it recently passed its 17th delay to the implementation of the SGR formula, which would have led to a 24% reduction in Medicare payments to physicians. This delay extends implementation for a further 12 months, during which time we believe that Congress intends to be able to pass a more permanent solution to the SGR formula. Although a congressionally mandated change to the SGR formula, as described above, would potentially have a significant positive impact on HCP s Medicare Advantage revenues and net income, the likelihood of increasing medical costs and the uncertainty of Congressional action mitigate against the positive impact of CMS s recent Medicare Advantage estimates.

In addition to the uncertainty surrounding whether Congress will be able to resolve the SGR formula s automatic rate reductions, there is uncertainty regarding both Medicare Advantage payment rates and beneficiary enrollment, which, if reduced as a result of the implementation of the Health Reform Acts, would reduce HCP s overall revenues and net income. For example, although the Congressional Budget Office (CBO) predicted in 2012 that Medicare Advantage participation would drop precipitously by 2020, in 2013 the CBO reversed its prediction and instead predicted that enrollment in Medicare Advantage could increase by up to 50% in the next decade. Uncertainty over Medicare Advantage enrollment and payment rates present a continuing risk to HCP s business.

Finally, although the Health Reform Acts provide for reductions in payments to Medicare Advantage plans, the Health Reform Acts also provide for bonus payments to Medicare Advantage plans with four or five star quality ratings. In November 2011, CMS announced a three-year demonstration project with an alternative bonus structure that awards bonuses to plans with three or more stars. Now in the final year of the demonstration, it is unclear what payment structure will be proposed after the demonstration project, which could impact HCP s Medicare Advantage and other revenues and net income.

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

For the quarter ended March 31, 2014, 66% of HCP s consolidated capitated medical revenues were earned through contracts with three health plans.

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

Notwithstanding each health plan s and HCP s current shared interest in providing service to HCP s members who are enrolled in the subject health plans, the health plans may have different and, at times, opposing economic interests from those of HCP. The health plans provide a wide range of health insurance services across a wide range of geographic regions, utilizing a vast network of providers. As a result, they and HCP may have different views regarding the proper pricing of services and/or the proper pricing of the various service providers in their provider networks, the cost of which HCP bears to the extent that the services of such service providers are utilized. These health plans may also have different views than HCP regarding the efforts and expenditures that they, HCP, and/or

other service providers should make to achieve and/or maintain various quality ratings. In addition, several health plans have purchased or announced their intent to purchase provider organizations. If health plans with which HCP contracts make significant purchases, they may not continue to contract with HCP

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or contract on less favorable terms or seek to prevent HCP from acquiring or entering into arrangements with certain providers. Similarly, as a result of changes in laws, regulations, consumer preferences, or other factors, the health plans may find it in their best interest to provide health insurance services pursuant to another payment or reimbursement structure. In the event HCP s interests diverge from the interests of the health plans, HCP may have limited recourse or alternative options in light of its dependence on these health plans. There can be no assurances that HCP will continue to find it mutually beneficial to work with the health plans. As a result of various restrictive provisions that appear in some of the managed care agreements with health plans, HCP may at times have limitations on its ability to cancel an agreement with a particular health plan and immediately thereafter contract with a competing health plan with respect to the same service area.

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

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

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

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

To expand the operations of its network outside of the Existing Geographic Regions, HCP must devote resources to identifying and exploring such perceived opportunities. Thereafter, HCP must, among other things, recruit and retain qualified personnel, develop new offices, establish potentially new relationships with one or more health plans, and establish new relationships with physicians and other healthcare providers. The ability to establish such new relationships may be significantly inhibited by competition for such relationships and personnel in the health care marketplace in the targeted new geographic regions. Additionally, HCP may face the risk that a substantial portion of the patients served in a new geographic area may be enrolled in a Medicare FFS program and will not desire to transition to a Medicare Advantage program, such as those offered through the health plans that HCP serves, or they may enroll with other health plans with whom HCP does not contract to provide services, which could reduce substantially HCP s perceived opportunity in such geographic area. In addition, if HCP were to seek expansion outside of the Existing Geographic Regions, HCP would be required to comply with laws and regulations of states that may differ from the ones in which it currently operates, and could face competitors with greater knowledge of such local markets. HCP anticipates that any geographic expansion may require it to make a substantial investment of management time, capital, and/or other resources. There can be no assurance that HCP will be able to establish profitable operations or relationships in any new geographic markets.

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

As a result of the Health Reform Acts, HCP anticipates that the level of reimbursement each health plan receives from CMS will be dependent, in part, upon the quality rating of the Medicare plan that such health plan serves. Such ratings are expected to impact the percentage of any cost savings rebate and any bonuses earned by such health plan. Since a significant portion of HCP s revenue is expected to be calculated as a percentage of CMS reimbursements received by these health plans with respect to HCP members, reductions in the quality ratings of a health plan that HCP serves could have an adverse effect on its results of operations, financial condition, and/or cash flows. In addition, CMS has announced its intention to terminate any plan that has a rating of less than three stars for three consecutive years. Medicare Advantage plans with five stars are permitted to conduct enrollment throughout the year and enrollees in plans with 4.5 or fewer stars are permitted to change plans during the year. Currently, HCP does not contract with any five star plans. Given each health plan s control of its plans and the many other providers that serve such plans, HCP believes that it will have limited ability to influence the overall quality rating of any such plan. Accordingly, since low quality ratings can potentially lead to the termination of a plan that HCP serves, HCP may not be able to prevent the potential termination of a contracting plan or a shift of patients to other plans based upon quality issues which could, in turn, have an adverse effect on HCP s results of operations, financial condition, and/or cash flows.

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

HCP, on behalf of itself and its associated physicians, physician groups and IPAs, submits to health plans claims and encounter data that support the risk adjustment factor, or RAF, scores attributable to members. These RAF scores determine, in part, the revenue to which the health plans and, in turn, HCP is entitled for the provision of medical care to such members. The data submitted to CMS by each health plan is based on medical charts and diagnosis codes prepared and submitted by HCP. Each health plan generally relies on HCP to appropriately document and support such RAF data in HCP s medical records. Each health plan also relies on HCP to appropriately code claims for medical services provided to members. HCP may periodically review medical records and may find inaccurate or unsupportable coding or otherwise inaccurate records. Erroneous claims and erroneous encounter records and submissions could result in inaccurate PMPM fee revenue and risk adjustment payments, which may be subject to correction or retroactive adjustment in later periods. This corrected or adjusted information may be reflected in financial statements for periods subsequent to the period in which the revenue was recorded. HCP might also need to refund a portion of the revenue that it received, which refund, depending on its magnitude, could damage its relationship with the applicable health plan and could have a material adverse effect on HCP s results of operations, financial condition or cash flows.

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

CMS has indicated that, starting with payment year 2011, payment adjustments will not be limited to RAF scores for the specific Medicare Advantage enrollees for which errors are found but may also be extrapolated to the entire Medicare Advantage plan subject to a particular CMS contract. CMS has described its audit process as plan-year

specific and stated that it will not extrapolate audit results for plan years prior to 2011.

CMS has not specifically stated that payment adjustments as a result of one plan year s audit will not be extrapolated to prior plan years. There can be no assurance that a health plan will not be randomly selected or

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targeted for review by CMS or that the outcome of such a review will not result in a material adjustment in HCP s revenue and profitability, even if the information HCP submitted to the plan is accurate and supportable. Since the CMS rules, regulations, and statements regarding this audit program are still not well defined and, in some cases, have not been published in final form, there is also a risk that CMS may adopt new rules and regulations that are inconsistent with their existing rules, regulations, and statements.

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

Patient care costs include estimates of future medical claims that have been incurred by the patient but for which the provider has not yet billed HCP. These claim estimates are made utilizing actuarial methods and are continually evaluated and adjusted by management, based upon HCP s historical claims experience and other factors, including an independent assessment by a nationally recognized actuarial firm. Adjustments, if necessary, are made to medical claims expense and capitated revenues when the assumptions used to determine HCP s claims liability changes and when actual claim costs are ultimately determined.

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

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

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

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

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

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

benefits offered.

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

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CMS allows Medicare beneficiaries who are enrolled in a Medicare Advantage plan with a quality rating of 4.5 stars or less to enroll in a 5-star rated Medicare Advantage plan at any time during the benefit year. None of the plans HCP serves are 5-star rated. Therefore, HCP may face a competitive disadvantage in recruiting and retaining Medicare beneficiaries.

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

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

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

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

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

Key primary care physicians with large patient enrollment could retire, become disabled, terminate their provider contracts, get lured away by a competing independent physician association or medical group, or otherwise become unable or unwilling to continue practicing medicine or contracting with HCP or its associated physicians, physician groups, or IPAs. In addition, HCP s associated physicians, physician groups and IPAs could view the business model as unfavorable or unattractive to such providers, which could cause such associated physicians, physician groups or IPAs to terminate their relationships with HCP. Moreover, given limitations relating to the enforcement of post-termination noncompetition covenants in California, it would be difficult to restrict a primary care physician from competing with HCP s associated physicians, physician groups, or IPAs. As a result, members who have been served by such physicians could choose to enroll with competitors physician organizations or could seek medical care elsewhere, which could reduce HCP s revenues and profits. Moreover, HCP may not be able to attract new physicians to replace the services of terminating physicians or to service its growing membership.

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

The Health Reform Acts establish Medicare Shared Savings Program (MSSP) for ACOs, which took effect in January 2012. Under the MSSP, eligible organizations are accountable for the quality, cost and overall care of Medicare beneficiaries assigned to an ACO and may be eligible to share in any savings below a specified benchmark amount. The Secretary of HHS is also authorized, but not required, to use capitation payment models with ACOs. HCP is evaluating ACOs in which it might participate through one or more of its subsidiaries and expects to participate in one or more ACOs in the future. The continued development and expansion of ACOs will have an uncertain impact on HCP s revenue and profitability.

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

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

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

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

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

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

Any negative changes in governmental capitation or FFS rates or methods of reimbursement for the services HCP provides could have a significant adverse impact on HCP s revenue and financial results. Since

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

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

HCP depends on a complex, specialized, and integrated management information system and standardized procedures for operational and financial information, as well as for HCP s billing operations. HCP may experience unanticipated delays, complications, or expenses in implementing, integrating, and operating these integrated systems. Moreover, HCP may be unable to enhance its existing management information system or implement new management information systems where necessary. HCP s management information system may require modifications, improvements, or replacements that may require both substantial expenditures as well as interruptions in operations. HCP s ability to implement and operate its integrated systems is subject to the availability of information technology and skilled personnel to assist HCP in creating and maintaining these systems.

HCP s failure to successfully implement and maintain all of its systems could have a material adverse effect on its business, financial condition, and results of operations. For example, HCP s failure to successfully operate its billing systems could lead to potential violations of healthcare laws and regulations. If HCP is unable to handle its claims volume, or if HCP is unable to pay claims timely, HCP may become subject to a health plan s corrective action plan or de-delegation until the problem is corrected, and/or termination of the health plan s agreement with HCP. This could have a material adverse effect on HCP s operations and profitability. In addition, if HCP s claims processing system is unable to process claims accurately, the data HCP uses for its incurred but not received (IBNR) estimates could be incomplete and HCP s ability to accurately estimate claims liabilities and establish adequate reserves could be adversely affected. Finally, if HCP s management information systems are unable to function in compliance with applicable state or federal rules and regulations, including, without limitation, medical information confidentiality laws such as HIPAA, possible penalties and fines due to this lack of compliance could have a material adverse effect on HCP s financial condition, and results of operations.

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

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

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

Due to potential decreased availability of healthcare through private employers, the number of patients who are uninsured or participate in governmental programs may increase. The Health Reform Acts will increase the

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

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

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

- requiring HCP to change its products and services;
- increasing the regulatory, including compliance, burdens under which HCP operates, which, in turn, may negatively impact the manner in which HCP provides services and increase HCP s costs of providing services;
- adversely affecting HCP s ability to market its products or services through the imposition of further regulatory restrictions regarding the manner in which plans and providers market to Medicare Advantage enrollees; or
- adversely affecting HCP s ability to attract and retain members.

Risk factors related to our overall business:

Disruptions in federal government operations and funding create uncertainty in our industry and could have a material adverse effect on our revenues, earnings and cash flows and otherwise adversely affect our financial condition.

A substantial portion of our revenues is dependent on federal healthcare program reimbursement, and any disruptions in federal government operations could have a material adverse effect on our revenues, earnings and cash flows. Although the government passed a budget for fiscal year 2014, there is no guarantee that the U.S. government will be able to pass the federal budget for subsequent fiscal years. In addition, if the U.S. government defaults on its debt, there could be broad macroeconomic effects that could raise our cost of borrowing funds, and delay or prevent our future growth and expansion. Any future federal government shutdown, U.S. government default on its debt and/or failure of the U.S. government to enact annual appropriations could have a material adverse effect on our revenues, earnings and cash flows. Additionally, disruptions in federal government operations may negatively impact regulatory

approvals and guidance that are important to our operations, and create uncertainty about the pace of upcoming health care regulatory developments.

Changes in CMS diagnosis and inpatient procedure coding require us to make modifications to processes and information systems, which could result in significant development costs and which if unsuccessful could adversely affect our revenues, earnings and cash flows.

CMS has mandated the use of new patient codes for reporting medical diagnosis and inpatient procedures, referred to as ICD-10. CMS is requiring all providers, payors, clearinghouses, and billing services to utilize

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ICD-10 when submitting claims for payment. ICD-10 will affect diagnosis and inpatient procedure coding for everyone covered by HIPAA, not just those who submit Medicare or Medicaid claims. Claims for services provided on or after the date that CMS sets must use ICD-10 for medical diagnosis and inpatient procedures or they will not be paid. In a bill passed on March 31, 2014, Congress voted to delay the ICD-10 implementation deadline until no earlier than October 1, 2015. Although CMS is expected to delay the deadline only until October 1, 2015, it has the authority to delay implementation even further. Uncertainty about when ICD-10 will be mandated could lead to additional costs of running ICD-9 and ICD-10 systems, which could negatively impact our revenues, earnings and cash flows.

We anticipate that if our services, processes or information systems or those of our payors do not comply with ICD-10 requirements at any future date, it could potentially delay or even reduce reimbursement payments to us. These delays or reductions could negatively impact our revenues, earnings and cash flows.

We may engage in acquisitions, mergers or dispositions, which may affect our results of operations, debt-to-capital ratio, capital expenditures or other aspects of our business, and if businesses we acquire have liabilities we are not aware of, we could suffer severe consequences that would materially and adversely affect our business.

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

Businesses we acquire may have unknown or contingent liabilities or liabilities that are in excess of the amounts that we originally estimated, and may have other issues, including those related to internal controls over financial reporting or issues that could affect our ability to comply with healthcare laws and regulations and other laws applicable to our expanded business. As a result, we cannot make any assurances that the acquisitions we consummate will be successful. 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, the amounts held in escrow for our benefit (if any), 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 or alternative remedies that might be available to us, or any applicable insurance, we could suffer severe consequences that would substantially reduce our earnings and cash flows or otherwise materially and adversely affect our business.

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

Acquisitions, patient retention and medical director and physician retention are an important part of our growth strategy. We face intense competition from other companies for acquisition targets. In our U.S. dialysis business, we continue to face increased competition from large and medium-sized providers which compete directly with us for acquisition targets as well as for individual patients and medical directors. In addition, as we continue our

international dialysis expansion into various international markets, we will face competition from large and medium-sized providers for these acquisition targets as well. Because of the ease of entry into the dialysis

business and the ability of physicians to be medical directors for their own centers, competition for growth in existing and expanding markets is not limited to large competitors with substantial financial resources. Occasionally, we have experienced competition from former medical directors or referring physicians who have opened their own dialysis centers. In addition, Fresenius, our largest competitor, manufactures a full line of dialysis supplies and equipment in addition to owning and operating dialysis centers. This may give it cost advantages over us because of its ability to manufacture its own products. If we are not able to continue to make acquisitions, continue to maintain acceptable levels of non-acquired growth, or if we face significant patient attrition to our competitors or a reduction in the number of our medical directors or associated physicians, it could adversely affect our business.

HCP operates in a different line of business from our historical business. We may face challenges managing HCP as a new business and may not realize anticipated benefits.

As a result of the HCP transaction, we are now significantly engaged in a new line of business. We may not have the expertise, experience, and resources to pursue all of our businesses at once, and we may be unable to successfully operate all businesses in the combined Company. The administration of HCP will require implementation of appropriate operations, management, and financial reporting systems and controls. We may experience difficulties in effectively implementing these and other systems. The management of HCP will require the focused attention of our management team, including a significant commitment of its time and resources. The need for management to focus on these matters could have a material and adverse impact on our revenues and operating results. If the HCP operations are less profitable than we currently anticipate or we do not have the experience, the appropriate expertise, or the resources to pursue all businesses in the combined company, the results of operations and financial condition may be materially and adversely affected.

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

The integration of HCP into our internal control over financial reporting has required and will continue to require significant time and resources from our management and other personnel and will increase our compliance costs. Failure to maintain an effective internal control environment could have a material adverse effect on our ability to accurately report our financial results and the market s perception of our business and our stock price.

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

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

- changes in the local economic environment;
- political instability, armed conflicts or terrorism;

social changes;

intellectual property legal protections and remedies;

trade regulations;

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

foreign currency;

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

export controls;

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

changes in local laws or regulations;

potentially longer ramp-up times for starting up new operations and for payment and collection cycles;

financial and operational, and information technology systems integration; and

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

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

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

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

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

Our operations and how we manage the Company may subject the Company, as well as its officers and directors to whom the Company owes certain defense and indemnity obligations, 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 or limits of coverage of any applicable insurance coverage, including claims related to adverse patient events, contractual disputes, professional and general liability, and directors and officers duties. 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 insurance coverage for those risks we deem are appropriate to insure against and make determinations about whether to self-insure as to other risks or layers of coverage. However, a successful claim, including a professional liability, malpractice or negligence claim which is in excess of any applicable insurance coverage, or that is subject to our self-insurance retentions, could have a material adverse effect on our earnings and cash flows.

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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; or
- an inability to obtain one or more types of insurance on acceptable terms, if at all.

Risks Relating to Investment in the Notes

The notes will be unsecured.

The notes will not be secured by any of our or our subsidiaries assets. The indenture governing the notes will permit us and our subsidiaries to incur secured debt, including pursuant to our senior secured credit facilities and other forms of secured debt. As a result, the notes and the guarantees will be effectively subordinated to all of our and the guarantors secured obligations to the extent of the value of the assets securing such obligations.

As of March 31, 2014, after giving effect to the issuance of the notes offered hereby and the application of the proceeds therefrom to the repayment of a portion of the term loans under our current senior secured credit facilities and to pay related fees and expenses as if they had occurred on that date, the Company and the guarantors would have had total secured debt of approximately $3,678 million, excluding the debt discounts associated with our term loans, and approximately $267 million of additional secured debt available to be borrowed under our current senior secured credit facilities, after giving effect to outstanding letters of credit of approximately $83 million, and the notes and the guarantees of the notes would have been structurally subordinated to approximately $319 million of indebtedness and other liabilities (including trade payables, but excluding liabilities owed to the Company or a guarantor of the notes) of the Company s non-guarantor subsidiaries, and the total assets of our non-guarantor subsidiaries would have accounted for approximately 14% of our consolidated total assets at that date**.**

If, after the issuance of the notes offered hereby and the application of the proceeds therefrom on the terms described below under Use of Proceeds, we were able to enter into our proposed amended and restated senior secured credit facilities, make the initial borrowings thereunder and apply the proceeds thereof to the payment of all remaining borrowings and other amounts payable under our current senior secured credit facilities and to repurchase all of the 2018 Notes in the Offer, all as contemplated under Summary Recent Developments , then, after giving effect to all of the foregoing transactions as if they had occurred on March 31, 2014, as of that date the Company and the guarantors would have had total secured debt of approximately $4,553 million, excluding the debt discounts associated with our term loans, and approximately $917 million of additional secured debt available to be borrowed under our proposed amended and restated senior secured credit facilities, after giving effect to outstanding letters of credit of approximately $83 million**.** Our current senior secured credit facilities are, and we expect that our proposed amended and restated secured credit facilities will be, secured by substantially all of the assets of our subsidiary guarantors.

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

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The indentures governing our outstanding senior notes and the agreement governing our current senior secured credit facilities contain, and the indenture governing the notes offered hereby and the agreement that is expected to govern our proposed amended and restated senior secured credit facilities will contain, various covenants which limit our management s discretion in the operation of our business.

The indentures governing our outstanding senior notes restrict, and the indenture governing the notes offered hereby restrict, among other things, our ability and the ability of our Restricted Subsidiaries (as defined) to:

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

In addition, the agreement governing our current senior secured credit facilities includes similar restrictions and requires us to maintain certain financial ratios and contains negative covenants. The agreement governing our proposed amended and restated senior secured credit facilities is expected to include similar provisions. Our ability to comply with these ratios and covenants may be affected by events beyond our control.

Any failure to comply with the restrictions of the indentures related to outstanding senior notes or the notes offered hereby, the agreements governing our current senior secured credit facilities or our proposed amended and restated senior secured credit facilities or any other subsequent financing agreements may result in an event of default under those agreements. Such a default may allow the creditors, if the agreements so provide, to declare the related debt immediately due and payable as well as any other debt to which a cross-acceleration or cross-default provision applies. In addition, lenders may have the right in these circumstances to terminate any commitments they have to provide further borrowings. Our assets and cash flow may not be sufficient to fully repay borrowings under our outstanding debt agreements if accelerated upon an event of default.

Most of the covenants in the indenture that will govern the notes will terminate if the notes are rated investment grade by both Moody s and Standard & Poor s.

Most of the covenants in the indenture that will govern the notes will terminate if on any date the notes are rated investment grade by both Moody s and Standard & Poor s, provided that no default or event of default under the

indenture has occurred and is continuing on that date. If that occurs, those covenants will not be reinstated even if the notes thereafter lose their investment grade rating. The covenants that will terminate include those restricting, among other things, our ability to incur debt, pay dividends or make distributions on or repurchase our capital stock, make certain loans and investments, sell certain assets, enter into certain transactions with affiliates, and alter the types of business we conduct. There can be no assurance that the notes will ever be rated investment grade or, if they are rated investment grade, that the notes will maintain those ratings. However, termination of those covenants would allow us to engage in certain transactions that would not be permitted while those covenants were in force, including the incurrence of additional indebtedness. See Description of Notes Certain Covenants Covenant Termination.

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

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

- was insolvent on the date that it gave the guarantee or became insolvent as a result of giving the guarantee, or
- was engaged in a business or transaction, or was about to engage in a business or transaction, for which the property remaining with the guarantor was an unreasonably small capital, or
- intended to incur, or believed that it would incur, debts that would be beyond the guarantor s ability to pay as those debts matured.

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

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

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

We cannot predict:

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

The indenture will contain a savings clause intended to limit each subsidiary guarantor s liability under its guarantee to the maximum amount that it could incur without causing the guarantee to be a fraudulent transfer under applicable law. There can be no assurance that this provision will be upheld as intended to protect such guarantees from fraudulent transfer challenges or, if it were to be upheld, that the remaining amount collectible under such guarantee would suffice to pay the notes when due, or that the guarantor s obligations under its guarantee would not be reduced to an amount that effectively makes its guarantee worthless. In at least one case, a court has concluded that such a savings clause is unenforceable and ineffective to permit even the partial enforcement of a subsidiary guarantee.

If a guarantee is deemed to be a fraudulent transfer, it could be voided altogether. In addition, as a court of equity, a bankruptcy court could subordinate the guarantee to all other debts of the guarantor. In such case, any payment by the guarantor pursuant to its guarantee could be required to be returned to the guarantor or to a fund

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for the benefit of the creditors of the guarantor. If a guarantee is voided or held unenforceable for any other reason, holders of the notes offered hereby would cease to have a claim against the subsidiary guarantor based on the guarantee and would be creditors only of the Company and any guarantor whose guarantee was not similarly voided or otherwise held unenforceable.

In addition, any payment by us pursuant to the notes or by a guarantor under a guarantee made at a time when we or such guarantor were subsequently found to be insolvent could be voided and required to be returned to us or to a fund for the benefit of our creditors if such payment was made to an insider within a one-year period prior to a bankruptcy filing or within 90 days prior to such filing for any outside party.

We may not have sufficient funds to purchase notes upon a Change of Control.

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

We cannot assure you that we will have the financial ability to purchase outstanding notes upon the occurrence of a Change of Control. This risk is increased by the fact that the indentures governing our existing senior notes contain change of control provisions requiring us to offer to repurchase all of our outstanding senior notes upon the occurrence of change of control events substantially similar to those that would require us to offer to repurchase the notes offered hereby. In addition, our current senior secured credit facilities provide and the proposed amended and restated senior secured credit facilities are expected to provide that the occurrence of certain kinds of change of control events (including a Change of Control under the indenture that will govern the notes offered hereby or a similar change of control under the indentures governing our existing senior notes) will constitute an event of default under such senior secured credit facilities, which would allow the lenders under such senior secured credit facilities to terminate their commitments to lend thereunder, demand immediate repayment of all outstanding borrowings and seize and sell the pledged collateral in order to repay those borrowings. Any future agreements to which we become a party may contain similar provisions.

In the event a Change of Control occurs at a time when we are prohibited from purchasing notes pursuant to our senior secured credit facilities or any other debt agreement to which we may be a party and we do not obtain a consent or repay the borrowings, we will remain prohibited from purchasing notes. Our failure to purchase tendered notes would constitute an event of default under the indenture which may, in turn, constitute a default under our other debt agreements. See Description of Notes Change of control and - Events of default. Likewise, any failure or inability to repurchase our existing notes upon the occurrence of change of control events specified in the indentures governing those notes could have similar consequences.

Courts interpreting change of control provisions under New York law (which will be the governing law of the indenture governing the notes) have not provided clear and consistent meanings of such change of control provisions, leading to subjective judicial interpretation. In addition, a court case in Delaware has questioned whether a change of

control provision contained in an indenture could be unenforceable on public policy grounds. No assurances can be given that another court would enforce the change of control provisions in the indenture governing the notes as written for the benefit of the holders of the notes, or as to how these change of control provisions would be impacted were we to become a debtor in a bankruptcy case.

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

In addition, under clause (2) of the definition of Change of Control appearing below under Description of Notes Certain definitions, a Change of Control will occur when a majority of the members of our board of directors are not Continuing Directors (as defined). In a decision in connection with a proxy contest, the Court of Chancery of Delaware held that the occurrence of a change of control under a similar indenture provision may nevertheless be avoided if the existing directors were to approve the slate of new director nominees (who would constitute a majority of the new board of directors) as continuing directors solely for purposes of avoiding the triggering of such change of control clause, provided the incumbent directors give their approval in the good faith exercise of their fiduciary duties. Therefore, in certain circumstances involving a significant change in the composition of our board of directors, including in connection with a proxy contest where our board of directors does not endorse a dissident slate of directors but approves them as Continuing Directors, holders of the notes may not be entitled to require us to make an offer to purchase the notes as required by the indenture governing the notes.

Moreover, clause (3) of the definition of Change of Control includes a phrase relating to the sale, lease, transfer, conveyance or other disposition (other than by way of merger or consolidation) of all or substantially all of the assets of DaVita and its Restricted Subsidiaries (as defined), taken as a whole. Although there is a limited body of case law interpreting the phrase substantially all, there is no precise established definition of the phrase under applicable law. Accordingly, in certain circumstances there may be uncertainty as to whether a particular transaction would involve a disposition of substantially all of the property of the Company and its Restricted Subsidiaries. As a result, it may be unclear whether a Change of Control has occurred under the indenture governing the notes and whether a holder of notes offered hereby may require us to make an offer to repurchase the notes under those circumstances.

Investors may find it difficult to trade the notes.

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

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

- our operating performance, prospects and financial condition or the operating performance, prospects and financial condition of companies in our industry generally;
- prevailing interest rates and other economic conditions;

the interest of securities dealers in making a market for the notes; and

the market for similar securities.

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

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

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

Not all of our subsidiaries will guarantee our obligations under the notes, and the assets of the non-guarantor subsidiaries may not be available to make payments on the notes.

Certain of our domestic subsidiaries will not be guarantors of the notes. In addition, none of our existing or future Foreign Subsidiaries, Unrestricted Subsidiaries or Receivable Subsidiaries (as those terms are defined under Description of Notes Certain definitions) will guarantee the Notes. Likewise, our Restricted Subsidiaries (as defined) that do not guarantee Indebtedness of us or any other Restricted Subsidiaries will not guarantee the notes. Payments on the notes are only required to be made by the subsidiary guarantors and us. Our non-guarantor subsidiaries will have no obligation, contingent or otherwise, to pay amounts due under the notes or to make any funds available to pay those amounts, whether by dividend, distribution, loan or other payment. As a result, the notes and guarantees of the notes will be structurally subordinated to all indebtedness and other liabilities (including trade payables) of any non-guarantor subsidiary such that, in the event of insolvency, liquidation, reorganization, dissolution or other winding up of any non-guarantor subsidiary, all of that subsidiary s creditors (including trade creditors) would be entitled to payment in full out of that subsidiary s assets before any of those assets are made available for distribution to us. In addition, the indenture that will govern the notes, the agreement that governs our current senior secured credit facility and the agreement that we expect will govern our proposed amended and restated senior secured credit facilities permit, subject to some limitations, these non-guarantor subsidiaries to incur additional indebtedness and also provide that subsidiary guarantors will be automatically released from their guarantees of the notes upon the occurrence of certain events. As of March 31, 2014, after giving effect to the issuance of the notes offered hereby and the application of the proceeds therefrom to the repayment of a portion of the term loans under our current senior secured credit facilities and to pay fees and expenses related to the offering as if they had occurred on that date, the notes and the guarantees of the notes would have been structurally subordinated to approximately $319 million of indebtedness and other liabilities (including trade payables but excluding liabilities owed to the Company or a guarantor of the notes) of our non-guarantor subsidiaries and the total assets of our non-guarantor subsidiaries would have accounted for approximately 14% of our consolidated total assets at that date.

Our consolidated financial statements include the results of certain physician groups that are not owned by the Company and will not guarantee the notes.

The Company provides services to certain physician groups that, while consolidated in the Company s financial statements for financial reporting purposes, are not subsidiaries of or owned by the Company, do not constitute Subsidiaries , as defined in the indenture that will govern the notes offered hereby and the indentures governing the Company s outstanding senior notes, and will not guarantee the notes offered hereby and do not guarantee those outstanding senior notes. As of March 31, 2014, if these physician groups were not consolidated in the Company s financial statements, the Company s consolidated indebtedness would have been approximately $8,364 million, its consolidated other liabilities (excluding indebtedness) would have been approximately $3,214 million and its consolidated assets would have been approximately $16,913 million. In addition, the Company has entered into management agreements with these physician groups pursuant to which the Company receives management fees from

the physician groups. For the twelve months ended March 31, 2014, if these physician groups were not consolidated in the Company s financial statements but including approximately $700 million of such management fees payable to the Company, the Company s consolidated total net revenues, consolidated

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operating income and consolidated net income would be reduced (increased) by approximately $945 million, $16 million, and $(2) million, respectively. The Company may in the future provide services to additional physician groups that do not constitute Subsidiaries (as so defined) and do not guarantee the notes offered hereby even though those physician groups may also be consolidated in the Company s financial statements for financial reporting purposes.

In addition, the Company owns a 67% equity interest in California Medical Group Insurance (CMGI). CMGI is an Unrestricted Subsidiary , as defined in the indenture that will govern the notes offered hereby and the indentures governing the Company s outstanding senior notes, and will not guarantee the notes offered hereby and does not guarantee those outstanding senior notes. The Company s equity interest in CMGI is accounted for under the equity method of accounting, meaning that, although CMGI is not consolidated in the Company s financial statements for financial reporting purposes, the Company s consolidated income statement reflects its pro rata share of CMGI s net loss as equity investment loss . For the twelve months ended March 31, 2014, the Company s equity investment loss attributable to CMGI was a loss of approximately $0.7 million. For the twelve months ended March 31, 2014, excluding the Company s equity investment loss in CMGI, the Company s consolidated operating income and consolidated net income would be increased by approximately $0.7 million and $0.4 million, respectively.

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

As of March 31, 2014, after giving effect to the issuance of the notes offered hereby and the application of the proceeds therefrom to the repayment of a portion of the term loans under our current senior secured credit facilities and to pay fees and expenses related to this offering as if they had occurred on that date, we would have had approximately $8,405 million in outstanding debt, excluding the debt discounts associated with our term loans, on our consolidated balance sheet and approximately $267 million of available unused borrowing capacity under the revolving portion of our current senior secured credit facilities (after giving effect to outstanding letters of credit of approximately $83 million).

If, after the issuance of the notes offered hereby and the application of the proceeds therefrom on the terms described below under Use of Proceeds , we were able to enter into our proposed amended and restated senior secured credit facilities, make the initial borrowings thereunder and apply the proceeds thereof to the payment of all remaining borrowings and other amounts payable under our current senior secured credit facilities, and to repurchase all of the outstanding 2018 Notes in the Offer, all as contemplated under Summary - Recent Developments , then, after giving effect to all of the foregoing transactions as if they had occurred on March 31, 2014, as of that date we would have had approximately $8,505 million in outstanding debt, excluding the debt discounts associated with our term loans, on our consolidated balance sheet and approximately $917 million of available unused borrowing capacity under the revolving portion of our proposed amended and restated senior secured credit facilities, after giving effect to outstanding letters of credit of approximately $83 million.

Our substantial indebtedness could have important consequences to you. For example, it could

- make it more difficult for us to satisfy our obligations with respect to our debt securities, including the notes,
- increase our vulnerability to general adverse economic and industry conditions,

require us to dedicate a substantial portion of our cash flow from operations to payments on our indebtedness, thereby reducing the availability of our cash flow to fund working capital, capital expenditures, acquisitions and investments and other general corporate purposes,

expose us to interest rate fluctuations because the interest under our senior secured credit facilities is and in the future may be at variable rates,

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

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

limit our ability to borrow additional funds.

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

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

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

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

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USE OF PROCEEDS

We estimate the net proceeds from this offering, after deducting the underwriting discount and other estimated expenses payable by us, will be approximately $1,726 million. We intend to use net proceeds from this offering to repay, concurrently with the closing of this offering, a portion of our Term Loan B and Term Loan B-2 borrowings outstanding under our current senior secured credit facilities and to pay fees and expenses related to this offering. As of March 31, 2014, the Term Loan B was bearing interest at a rate of 4.50% per annum and the Term Loan B-2 was bearing interest at a rate of 4.00% per annum. The Term Loan B will mature on October 20, 2016, and the Term Loan B-2 will mature on August 2, 2018.

Certain of the underwriters or their respective affiliates may be lenders or agents under our current senior secured credit facilities and therefore would receive a portion of the proceeds from this offering through the repayment of borrowings under these facilities. See Underwriting .

Pending application of the net proceeds from the offering of the notes for the purposes described above, we may temporarily invest the net proceeds in short-term investments.

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CAPITALIZATION

The following table sets forth our cash and cash equivalents and our capitalization as of March 31, 2014:

- on an actual basis,
- on an as adjusted basis after giving effect to the issuance of the notes offered hereby and the application of the proceeds therefrom to the repayment of a portion of the term loans under our current senior secured credit facilities and to pay fees and expenses related to this offering as if they had occurred on that date.

The as adjusted information in the following table is based upon a number of assumptions and estimates and our actual cash and cash equivalents and capitalization, after giving effect to the issuance of the notes offered hereby and the application of the proceeds therefrom to the repayment of a portion of the term loans under our current senior secured credit facilities and to pay fees and expenses related to this offering will likely be different than that reflected below. You should read the following table in conjunction with the financial statements incorporated by reference in this prospectus supplement and the related notes thereto and Use of Proceeds above.

	As of March 31, 2014	
	Actual	As Adjusted[3]
	(unaudited, dollars in millions)	
Cash and cash equivalents	$ 1,108	$ 1,108
Total debt (including current maturities):		
Current senior secured credit facilities:		
Revolving credit facility	$	$
Term loans [1]	5,351	3,625
Notes offered hereby		1,750
Existing senior notes	2,800	2,800
Other debt	230	230
Total debt [2]	8,381	8,405
Total DaVita HealthCare Partners Inc. shareholders equity	4,660	4,660
Total capitalization	$ 13,041	$ 13,065

(1) Excludes $17 million unamortized balances of debt discounts associated with our Term Loan B and Term Loan B-2.

(2) Excludes the unamortized balance of debt discounts as described above in Footnote 1.

(3) The as adjusted data reflect the payment of underwriting discounts and other fees and expenses of this offering in an assumed total amount of $24.0 million and excluding any accrued and unpaid interest that will be paid from available cash. None of the as adjusted data appearing in the foregoing table gives effect to the proposed purchase of 2018 Notes in the Offer, entry into our proposed amended and restated senior secured credit facilities or any borrowings thereunder, or any of the other transactions described under Summary Recent Developments.

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DESCRIPTION OF OTHER INDEBTEDNESS

Current Senior Secured Credit Facility

We have an outstanding Senior Secured Credit Agreement, or Credit Agreement, which as of March 31, 2014, consisted of a $350,000,000 revolving line of credit, a $762,500,000 Term Loan A, a $1,265,625,000 Term Loan A-3, a $1,693,125,000 Term Loan B and a $1,629,375,000 Term Loan B-2. The Term Loan A and the Term Loan A-3 bear interest at a London Interbank Offered Rate (LIBOR) rate plus an interest rate margin, currently 2.50% for the Term Loan A and 2.25% for the Term Loan A-3. The Term Loan A interest rate margin can range from 2.25% to 2.75% and the Term Loan A-3 interest rate margin can range from 2.00% to 2.50% depending upon the Company s leverage ratio. The Term Loan B bears interest at LIBOR (floor of 1.50%) plus a margin of 3.00% subject to a ratings based step-down to 2.75% and the Term Loan B-2 bears interest at LIBOR (floor of 1.00%) plus a margin of 3.00%. The Company is subject to these LIBOR-based floors until such time as the LIBOR-based component of the interest rate exceeds 1.50% on the Term Loan B and 1.00% on the Term Loan B-2. At such time, the Company will then be subject to LIBOR-based interest rate volatility on the LIBOR variable component of its interest rate and the overall weighted average interest rate for the Term Loan B and Term Loan B-2 will then be determined based upon the LIBOR interest rates in effect for all individual tranches plus the interest rate margin. In each case, barring any extensions permitted pursuant to the Credit Agreement, the revolving loans and the Term Loan A will mature on October 20, 2015, the Term Loan A-3 will mature on July 21, 2016, the Term Loan B will mature on October 20, 2016, and the Term Loan B-2 will mature on August 2, 2018. The borrowings under the Credit Agreement are guaranteed by substantially all of our direct and indirect wholly-owned domestic subsidiaries and are secured by substantially all of DaVita s and our guarantors assets. The Credit Agreement contains customary affirmative and negative covenants such as various restrictions on investments, acquisitions, the payment of dividends, redemptions and acquisitions of capital stock, capital expenditures and other indebtedness, as well as limitations on the amount of tangible net assets in non-guarantor subsidiaries. However, many of these restrictions will not apply as long as our leverage ratio is below 3.50:1.00. In addition, the Credit Agreement requires compliance with financial covenants including an interest coverage ratio and a leverage ratio that determines the interest rate margins as described above.

Proposed Amended and Restated Senior Secured Credit Facilities

We have commenced a syndication process pursuant to which we are seeking to enter into proposed amended and restated senior secured credit facilities, which we are planning to enter into after the closing of this offering. We anticipate that the proposed amended and restated senior secured credit facilities will provide for an aggregate borrowing capacity of up to $5,500 million (with a right by the Company to request an increase in the borrowing capacity by up to $1,500 million or more, subject to lender participation and other specified conditions), comprised of: (i) a five-year $1,000 million revolving credit facility, (ii) a five-year $1,000 million term loan A, and (iii) a seven-year $3,500 million term loan B. We expect that our proposed amended and restated senior secured credit facilities will be guaranteed by subsidiaries holding most of our domestic assets and will be secured by substantially all of our and our subsidiary guarantors assets. In particular, we expect that these facilities will be secured by first priority pledges of 100% of the equity interests owned by us and our subsidiary guarantors in domestic subsidiaries and up to 65% of the equity interests of our direct wholly-owned foreign subsidiaries, if any. See Summary Recent Developments Proposed Amended and Restated Senior Secured Credit Facilities.

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

The proposed amended and restated senior secured credit facilities will be contingent upon the repayment of all borrowings and payment of other amounts payable under our current senior secured credit facilities, and certain other conditions, including final documentation, and we can give no assurance that our proposed amended and restated senior secured credit facilities will become effective as proposed or at all.

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Senior Notes Due 2018

On October 20, 2010, we issued $775 million aggregate principal amount of our 6 ⅜% Senior Notes due 2018, which we refer to as the 2018 Notes, all of which were outstanding as of March 31, 2014. The 2018 Notes require semi-annual interest payments in May and November of each year until maturity. The 2018 Notes are our general unsecured obligations and rank equally with all of our existing and future unsecured senior debt, including the notes. The 2018 Notes are guaranteed on an unsecured senior basis by our subsidiaries (subject to certain exceptions), including each subsidiary that guarantees our senior secured credit facilities. The 2018 Notes are subject to redemption at our option, in whole or in part, on or after November 1, 2013 at redemption prices starting at 104.781% of the principal amount plus accrued and unpaid interest, if any, to the applicable redemption date and declining annually to 100% of principal and accrued interest on November 1, 2016. We have commenced a cash tender offer concurrently with this offering for all of the outstanding 2018 Notes. We currently intend to redeem any 2018 Notes not tendered in the tender offer. See Summary Recent Developments Tender Offer and Consent Solicitation for Our 2018 Notes.

Senior Notes Due 2020

On October 20, 2010, we issued $775 million aggregate principal amount of our 6 ⅝% Senior Notes due 2020, which we refer to as the 2020 notes, all of which were outstanding as of March 31, 2014. The 2020 notes require semi-annual interest payments in May and November of each year until maturity. The 2020 notes are our general unsecured obligations and rank equally with all of our existing and future unsecured senior debt, including the notes. The 2020 notes are guaranteed on an unsecured senior basis by our subsidiaries (subject to certain exceptions), including each subsidiary that guarantees our senior secured credit facilities. The 2020 notes are subject to redemption at our option, in whole or in part, on or after November 1, 2014 at redemption prices starting at 104.969% of the principal amount plus accrued and unpaid interest, if any, to the applicable redemption date and declining annually to 100% of principal and accrued interest on November 1, 2017. The 2020 notes are subject to redemption at our option, in whole or in part, prior to November 1, 2014 at a make whole redemption price plus accrued and unpaid interest, if any, to the redemption date.

Senior Notes Due 2022

On August 28, 2012, we issued $1,250 million of 5.750% Senior Notes due 2022, which we refer to as the 2022 notes, all of which was outstanding as of March 31, 2014. The 2022 notes require semi-annual interest payments in February and August of each year until maturity. The 2022 notes are our general unsecured obligations and rank equally with all of our existing and future unsecured senior debt, including the notes. The 2022 notes are guaranteed on an unsecured senior basis by our subsidiaries (subject to certain exceptions), including each subsidiary that guarantees our senior secured credit facilities. The 2022 notes are subject to redemption at our option, in whole or in part, on or after August 15, 2017 at redemption prices starting at 102.875% of the principal amount plus accrued and unpaid interest, if any, to the applicable redemption date and declining annually to 100% of principal and accrued interest on August 15, 2020. The 2022 notes are subject to redemption at our option, in whole or in part, prior to August 15, 2017 at a make whole redemption price plus accrued and unpaid interest, if any, to the redemption date.

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DESCRIPTION OF NOTES

We will issue $1,750 million aggregate principal amount of 5.125% senior notes due 2024 (the **Notes**) under an Indenture dated as of the Issue Date (the **Indenture**) among us, as issuer, the Subsidiary Guarantors party thereto and The Bank of New York Mellon Trust Company, N.A., as trustee (the **Trustee**). The terms of the Notes include those expressly set forth in the Indenture and those made part of the Indenture by reference to the Trust Indenture Act of 1939, as amended. The Indenture does not limit the aggregate principal amount of Notes that may be issued thereunder, although the aggregate principal amount of Notes to be issued in this offering will be limited to $1,750 million. We may issue an unlimited principal amount of additional Notes under the Indenture having substantially identical terms and conditions as the Notes issued on the Issue Date (**Additional Notes**). We will only be permitted to issue Additional Notes if at the time of issuance we are in compliance with the covenants contained in the Indenture. Any Additional Notes will be part of the same series as the Notes that we are currently offering and will vote on all matters with the registered holders (the **Holders**) of the other Notes.

This Description of Notes is intended to be a useful overview of some of the provisions of the Notes and the Indenture. Since this description is only a summary, you should refer to the Indenture for a complete description of the obligations of the Company and the Subsidiary Guarantors and your rights.

You will find the definitions of capitalized terms used in this description under the heading Certain definitions. For purposes of this description, unless otherwise expressly stated or the context otherwise requires, references to the **Company**, **DaVita**, **we**, **our**, and **us** and similar references refer only to DaVita HealthCare Partners Inc. and no subsidiaries.

General

Maturity and interest. The Notes will mature on July 15, 2024; interest on the Notes will be payable semi-annually in arrears and will:

- accrue at the rate of 5.125% per annum,
- accrue from the most recent interest payment date or, if no interest has been paid on the Notes, from the Issue Date,
- be payable in cash semi-annually in arrears on January 15 and July 15 (commencing on January 15, 2015 with respect to the Notes issued in this offering) to the Holders of record on the January 1 and July 1, respectively, immediately preceding such interest payment dates, and
- be computed on the basis of a 360-day year comprised of twelve 30-day months.

Ranking. The Notes will be our unsecured senior obligations. The Notes:

will rank equally in right of payment with all of our other existing and future unsecured indebtedness that is not, by its terms, expressly subordinated in right of payment to the Notes (including our outstanding 6 ⅝% Senior Notes due 2020 and 5.750% Senior Notes due 2022),

will be senior in right of payment to all of our existing, if any, and future unsecured indebtedness that is, by its terms, expressly subordinated in right of payment to the Notes,

will be effectively subordinated to all of our existing and future secured indebtedness to the extent of the value of the assets securing such indebtedness, including indebtedness under our Senior Credit Agreement,

will be structurally subordinated to all existing and future indebtedness and other liabilities, including trade payables, of our Subsidiaries that do not guarantee the Notes, and

will not be guaranteed or otherwise supported, directly or indirectly, by the assets, profits or cash flow of certain affiliated physician groups that are consolidated with the Company for financial reporting purposes but are not Subsidiaries of the Company.

Similarly, a Subsidiary Guarantor s Note Guarantee of the Notes will be the unsecured senior obligation of such Subsidiary Guarantor and:

will rank equally in right of payment with all existing and future unsecured indebtedness of such Subsidiary Guarantor that is not, by its terms, expressly subordinated in right of payment to such Note Guarantee (including its guarantee of our outstanding 6 $\frac{5}{8}$% Senior Notes due 2020 and 5.750% Senior Notes due 2022),

will be senior in right of payment to all existing, if any, and future unsecured indebtedness of such Subsidiary Guarantor that is, by its terms, expressly subordinated in right of payment to such Note Guarantee, and

will be effectively subordinated to all of the existing and future secured indebtedness of such Subsidiary Guarantor (including its guarantee of our obligations under our Senior Credit Agreement) to the extent of the value of the assets securing such indebtedness.

As of March 31, 2014, after giving effect to the issuance of the Notes offered hereby and the application of the estimated proceeds therefrom to the repayment of a portion of the term loans outstanding under the Company s current senior secured credit facilities and to pay related fees and expenses as if they had occurred on that date, the Company and the Subsidiary Guarantors would have had total secured debt of approximately $3,678 million (excluding the debt discounts associated with the Company s term loans) and approximately $267 million of additional secured debt available to be borrowed under the Company s current senior secured credit facilities, after giving effect to outstanding letters of credit of approximately $83 million, and the Notes and the Note Guarantees would have been structurally subordinated to approximately $319 million of indebtedness and other liabilities (including trade payables but excluding liabilities owed to the Company or a Subsidiary Guarantor) of our Subsidiaries that are not Subsidiary Guarantors, and the total assets of our Subsidiaries that are not to Subsidiary Guarantors would have accounted for approximately 14% of our consolidated total assets at that date. For information on our debt as adjusted for this offering and the effectiveness of our proposed amended and restated senior secured credit facilities and the application of term loan borrowings thereunder to repay borrowings and other amounts payable under our current senior secured credit facilities and repurchase all of the outstanding 2018 Notes in the Offer as described above under Summary Recent Developments, see Risk Factors Risks Relating to Investment in the Notes The notes will be unsecured.

In addition, the Company provides services to certain physician groups that, while consolidated in the Company s financial statements for financial reporting purposes, are not subsidiaries of or owned by the Company, do not constitute Subsidiaries as defined in the Indenture that will govern the Notes offered hereby or the indentures governing the Company s outstanding senior notes, and will not guarantee the Notes offered hereby and do not guarantee those other senior notes. As of March 31, 2014, if these physician groups were not consolidated in the Company s financial statements, the Company s consolidated indebtedness would have been approximately $8,364 million, its consolidated other liabilities (excluding indebtedness) would have been approximately $3,214 million and its consolidated assets would have been approximately $16,913 million. In addition, the Company has entered into management agreements with these physician groups pursuant to which the Company receives management fees from the physician groups. For the twelve months ended March 31, 2014, if these physician groups were not consolidated in the Company s financial statements but including approximately $700 million of such management fees payable to the

Company, the Company s consolidated total net revenues, consolidated operating income and consolidated net income would be reduced (increased) by approximately $945 million, $16 million, and $(2) million, respectively. The Company may in the future provide services to additional physician groups that do not constitute Subsidiaries and do not guarantee the Notes even though those physician groups may also be consolidated in the Company s financial statements for financial reporting purposes.

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The Company currently has one Subsidiary that has been designated as an Unrestricted Subsidiary as defined in the indentures governing the Company s outstanding senior notes and that will be an Unrestricted Subsidiary as defined in the Indenture that will govern the Notes. Please see Risk Factors Risks Relating to Investment in the Notes Our consolidated financial statements include the results of certain physician groups that are not owned by the Company and will not guarantee the notes for certain consolidated financial information of the Company excluding such Unrestricted Subsidiary.

Payments on the Notes; paying agent and registrar. We will pay principal of, premium, if any, and interest on the Notes at the office or agency designated by the Company in the Borough of Manhattan, The City of New York, except that we may, at our option, pay interest on the Notes by check mailed to Holders of the Notes at their registered address as they appear in the registrar s books. We will designate the corporate trust office of the Trustee in New York, New York to act as our initial paying agent and registrar for the Notes. We may, however, change the paying agent or registrar or designate the Company or any of its Restricted Subsidiaries to act as paying agent or registrar for the Notes without prior notice to the Holders of Notes.

We will pay principal of, premium, if any, and interest on, Notes in global form (**Global Notes**) registered in the name of or held by The Depository Trust Company (**DTC**) or its nominee in immediately available funds to DTC or its nominee, as the case may be, as the Holder of such Global Notes.

Transfer and exchange. A Holder may transfer or exchange Notes in accordance with the Indenture. The registrar and the Trustee may require a Holder, among other things, to furnish appropriate endorsements and transfer documents. No service charge will be imposed by the Company, the Trustee or the registrar for any registration of transfer or exchange of Notes, but the Company may require a Holder to pay a sum sufficient to cover any transfer tax or other governmental taxes and fees required by law or permitted by the Indenture. The Company is not required to transfer or exchange any Note selected for redemption or tendered for repurchase and not withdrawn pursuant to a Change of Control Offer or Asset Disposition Offer. Also, the Company is not required to transfer or exchange any Note during a period beginning at the opening of business 15 days before the mailing of notice of redemption of Notes and ending at the close of business on the day of such mailing or register the transfer or exchange of any Note selected for redemption in whole or in part except the unredeemed portion of any Note redeemed in part.

The Holder of a Note will be treated as the owner of it for all purposes. Only Holders will have rights under the Indenture.

Defaulted interest. The Company will pay interest (including post-petition interest in any proceeding under any bankruptcy law) on overdue principal and, to the extent such payments are lawful, interest on overdue installments of interest, without regard to any applicable grace periods, at the rate of 2.0% per annum in excess of the interest rate applicable to the Notes.

Form of Notes; book-entry notes. The Notes will be issued in fully registered form, in minimum denominations of $2,000 in principal amount and multiples of $1,000 in principal amount in excess thereof and will be issued in the form of one or more Global Notes in book-entry form registered in the name of a depository (the **Depository**) or its nominee, which will be considered the Holder of those Global Notes for all purposes under the Indenture. The initial Depository will be DTC. Investors will not have the right to exchange beneficial interests in Global Notes for Notes in physical form. Notes in physical form will be issued in exchange for beneficial interests in the Global Notes only in the limited circumstances described elsewhere in this prospectus supplement under Book-entry, Delivery and Form.

Optional redemption

Except as described below, the Notes are not redeemable at our option until July 15, 2019. On and after July 15, 2019, we may at our option redeem the Notes, in whole or from time to time in part, upon not less than 15 nor more than 60 days notice, at the following redemption prices (expressed as a percentage of principal

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amount) plus accrued and unpaid interest, if any, on the Notes to be redeemed to the applicable redemption date, if redeemed during the twelve-month period beginning on July 15 of the years indicated below:

Year	Percentage
2019	102.563%
2020	101.708%
2021	100.854%
2022 and thereafter	100.000%

Prior to July 15, 2017, we may, at our option, on any one or more occasions, upon not less than 15 nor more than 60 days notice, redeem up to 35% of the original aggregate principal amount of Notes (including the original aggregate principal amount of any Additional Notes) issued under the Indenture with the Net Cash Proceeds of one or more Equity Offerings at a redemption price (expressed as a percentage of the principal amount thereof) of 105.125% *plus* accrued and unpaid interest, if any, to the redemption date; *provided* that

(1) at least 65% of the original aggregate principal amount of the Notes (including the original aggregate principal amount of any Additional Notes) issued under the Indenture remains outstanding after each such redemption; and

(2) the redemption date occurs within 90 days after the closing of such Equity Offering (for purposes of clarity, in the event that there are two or more closings for any Equity Offering, then each such closing shall be deemed a separate closing for purposes of the foregoing provisions of this clause (2) with respect to the securities issued at such closing).

In addition, the Notes may be redeemed, in whole or from time to time in part, at any time prior to July 15, 2019, at our option, upon not less than 15 nor more than 60 days notice, at a redemption price equal to 100% of the principal amount of the Notes redeemed plus the Applicable Premium on those Notes as of, and accrued and unpaid interest, if any, on those Notes to, the applicable redemption date.

Any redemption may, at our sole discretion, be subject to one or more conditions precedent, which shall be described in the related notice of redemption to Holders, which conditions may include, without limitation, completion of one or more Equity Offerings, other securities offerings or other financings, transactions or events. If such redemption is subject to satisfaction of one or more conditions precedent, such notice to Holders may (at the option of the Company) include a statement to the effect that the Redemption Date may be delayed, on one or more occasions and in the Company s sole discretion, either (at the Company s option) to a date specified by the Company in a subsequent notice to Holders (subject, if the Company shall so elect, to satisfaction of any or all such conditions or the Company s written waiver of any such conditions that are not satisfied) or until such time as any or all of such conditions have been satisfied or waived by the Company in writing, and that, if any such conditions shall not have been satisfied as and when required (as determined by the Company in its sole discretion and taking into account any election by the Company to delay such Redemption Date), then (unless the Company shall have waived in writing any such conditions that are not satisfied), the Company shall have no obligation to redeem the Notes called for redemption on such Redemption Date (as the same may have been delayed by the Company as aforesaid) and may cancel such proposed redemption and rescind any notice of such redemption. In order to delay any Redemption Date (or to further delay any delayed Redemption Date (as defined below)), the Company shall provide written notice to the Trustee, at least two Business Days before such Redemption Date (or such delayed Redemption Date, as the case may be), to the effect that the Company has elected to delay such Redemption Date (or such delayed Redemption Date, as the case may be) and specifying the new Redemption Date (a delayed Redemption Date) (which may, at the Company s option,

be specified as the date on which any or all conditions to such redemption are satisfied (as determined by the Company in its sole discretion) or waived by the Company), and the Trustee shall provide such notice to each Holder of the Notes that were to be redeemed in the same manner in which the notice of redemption was given. The Company may delay any Redemption Date on one or more occasions.

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If all conditions precedent (if any) to any redemption of the Notes shall not have been satisfied as and when required (as determined by the Company in its sole discretion and taking into account any election by the Company to delay such Redemption Date) or waived by the Company in writing and the Company has not elected to delay (or further delay) the applicable Redemption Date (or the applicable delayed Redemption Date, as the case may be), the Company shall provide written notice to the effect that the Company has elected to cancel such redemption to the Trustee prior to close of business two Business Days prior to such Redemption Date (or such delayed Redemption Date, as the case may be). Upon the Trustee s receipt of such notice, the notice of such redemption shall be automatically rescinded and such redemption shall be automatically cancelled and the Company shall have no obligation to redeem the Notes called for redemption. Upon receipt of such notice, the Trustee shall provide such notice to each Holder of the Notes that were to have been redeemed in the same manner in which the notice of redemption was given.

Selection and notice; conditions to redemption

If the optional redemption date for any Notes is on or after an interest payment record date and on or before the related interest payment date, the accrued and unpaid interest, if any, will be paid to the Person in whose name such Note is registered at the close of business on such record date, and no additional interest will be payable to Holders whose Notes are subject to redemption by the Company on such redemption date.

In the case of any partial redemption of the Notes, selection of those Notes for redemption will be made by the Trustee in compliance with the requirements of the principal national securities exchange, if any, on which the Notes are listed (provided that the Company shall have notified the Trustee of such requirements prior to the delivery of notice of redemption to the Holders of Notes called for redemption) or, if the Notes are not listed (or if the Company has not notified the Trustee of the applicable requirements of the principal national securities exchange on which the Notes are listed as aforesaid), then on a pro rata basis, by lot or by such other method as the Trustee in its sole discretion will deem to be appropriate or, in the case of Global Notes, by the Depository or, if applicable, in accordance with the procedures of the Depository; provided that, in the case of partial redemption of Notes pursuant to the second paragraph under the caption Optional Redemption above, the Notes will be selected for redemption on a pro rata basis (subject to the procedures of the Depository); and provided, further, that Notes may be redeemed in part in integral multiples of $1,000 only (provided that the remaining principal amount of any Note redeemed in part must not be less than $2,000). So long as the Notes are represented by one or more Global Notes registered in the name of the Depository, neither the Trustee nor any of its agents shall have any responsibility for any actions taken or not taken by the Depository. If any Note is to be redeemed in part only, the notice of redemption relating to such Note will state the portion of the principal amount thereof to be redeemed. A new Note in principal amount equal to the unredeemed portion thereof will be issued in the name of the Holder thereof upon cancellation of the original Note.

The Company is not required to make mandatory redemption payments or sinking fund payments with respect to the Notes.

Note guarantees

The Company s obligations under the Notes and the Indenture will be jointly and severally guaranteed by each Restricted Subsidiary (other than any Foreign Subsidiary or Receivables Subsidiary) that Guarantees any Indebtedness (including Indebtedness under the Senior Credit Agreement) of the Company or any other Restricted Subsidiary and each other Restricted Subsidiary that the Company may, at its option, otherwise cause to become a Subsidiary Guarantor of the Notes pursuant to the terms of the Indenture.

Not all of our Subsidiaries will be required to guarantee the Notes. Unrestricted Subsidiaries, Foreign Subsidiaries, our Receivables Subsidiaries and Restricted Subsidiaries that do not Guarantee Indebtedness of us or any Restricted Subsidiary will not be required to be Subsidiary Guarantors. In the event of a bankruptcy, liquidation or reorganization of any of these non-guarantor Subsidiaries, these non-guarantor Subsidiaries will generally be required to pay the holders of their debts and their trade creditors before they will be able to distribute any of their assets to us.

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As of March 31, 2014, after giving effect to the issuance of the Notes offered hereby and the application of the estimated proceeds therefrom to the repayment of a portion of the outstanding indebtedness under the Senior Credit Agreement and to pay fees and expenses related to this offering as if they had occurred on that date, our Subsidiaries that will not be Subsidiary Guarantors on the Issue Date would have had total indebtedness and other liabilities of approximately $319 million (including trade payables but excluding liabilities owed to the Company or a Subsidiary Guarantor) and their total assets would have accounted for approximately 14% of our consolidated total assets at that date.

In addition, the Company provides services to certain physician groups that, while consolidated in the Company s financial statements for financial reporting purposes, are not subsidiaries of or owned by the Company, do not constitute Subsidiaries as defined in the Indenture that will govern the Notes offered hereby or the indentures governing the Company s outstanding senior notes, and will not guarantee the Notes offered hereby and do not guarantee those other senior notes. As of March 31, 2014, if these physician groups were not consolidated in the Company s financial statements, the Company s consolidated indebtedness would have been approximately $8,364 million, its consolidated other liabilities (excluding indebtedness) would have been approximately $3,214 million and its consolidated assets would have been approximately $16,913 million. In addition, the Company has entered into management agreements with these physician groups pursuant to which the Company receives management fees from the physician groups. For the twelve months ended March 31, 2014, if these physician groups were not consolidated in the Company s financial statements but including approximately $700 million of such management fees payable to the Company, the Company s consolidated total net revenues, consolidated operating income and consolidated net income would be reduced (increased) by approximately $945 million, $16 million, and $(2) million, respectively. The Company may in the future provide services to additional physician groups that do not constitute Subsidiaries and do not guarantee the Notes even though those physician groups may also be consolidated in the Company s financial statements for financial reporting purposes.

The Indenture will permit the Incurrence of certain additional Indebtedness by our Subsidiaries that are not Subsidiary Guarantors.

The Indenture will provide that under certain circumstances, the Company will be permitted to designate any of its Subsidiaries as Unrestricted Subsidiaries under the Indenture. The effect of designating a Subsidiary as an Unrestricted Subsidiary will be that:

- an Unrestricted Subsidiary will not be subject to the restrictive covenants in the Indenture,
- a Subsidiary that is a Subsidiary Guarantor of the Notes issued under the Indenture and that is designated as an Unrestricted Subsidiary will be released from its Note Guarantee and its obligations under the Indenture, and
- the assets, income, cash flow and other financial results of an Unrestricted Subsidiary will not be consolidated with those of the Company for purposes of calculating compliance with the restrictive covenants contained in the Indenture.

The obligations of each Subsidiary Guarantor under its Note Guarantee and the Indenture will be limited to the maximum amount as will, after giving effect to all other contingent and fixed liabilities of such Subsidiary Guarantor (including, without limitation, its Guarantee of amounts payable under the Senior Credit Agreement and its Guarantees of the Existing Notes) that are relevant under federal or state bankruptcy, fraudulen