



DaVita HealthCare Partners (DVA)

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@find_me_value

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Overview of DaVita HealthCare Partners (DVA)

DaVita Dialysis

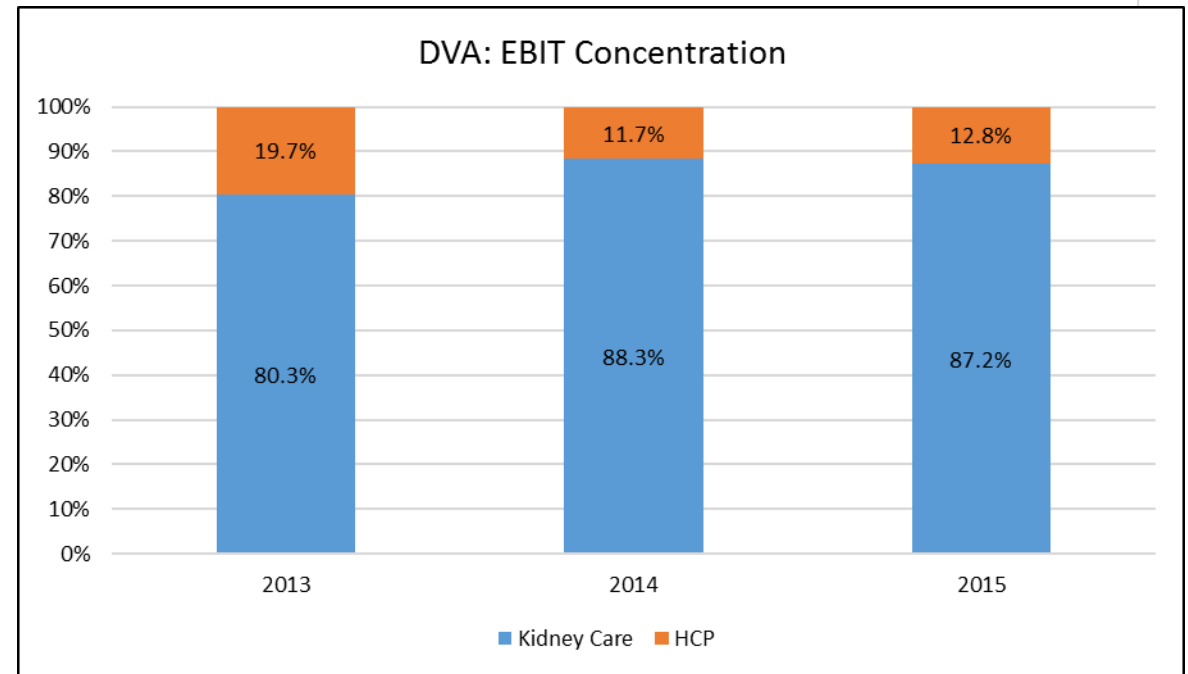
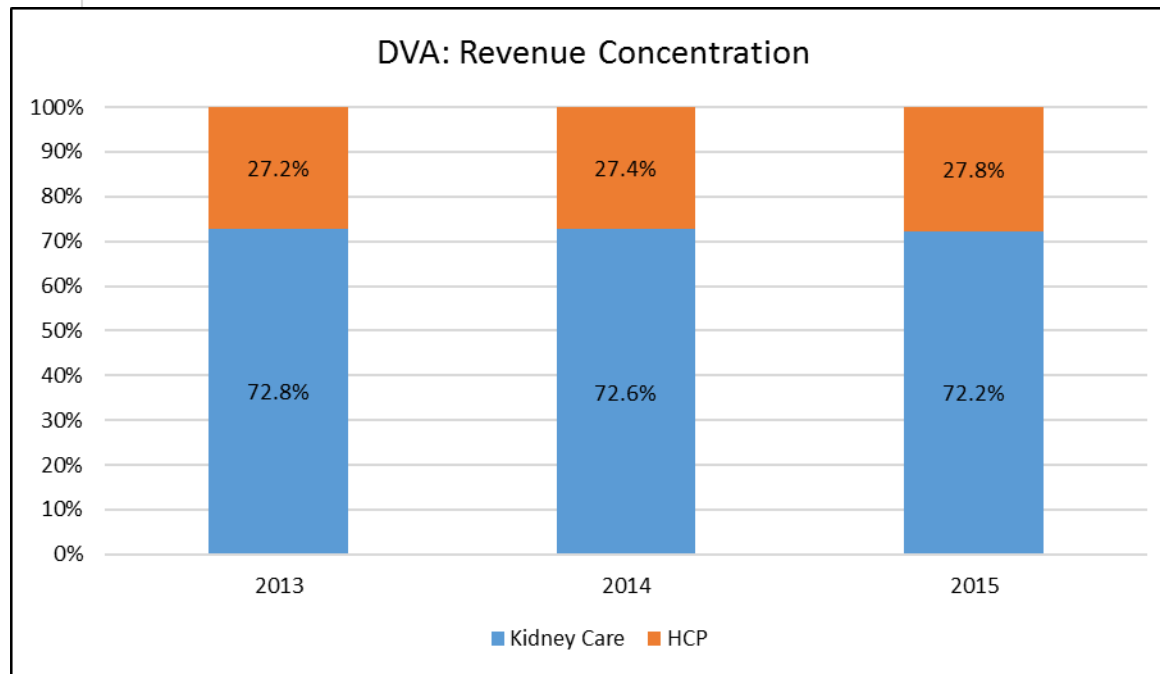
- 2,251 dialysis centers across 46 states in U.S.
- 180,000 patients in the U.S.
- 36% market share of dialysis patients in U.S. (tied with Fresenius FMC)
- \$8.6 billion dialysis revenues in 2015 and \$1.75 billion in operating income
- \$1.3 billion of ancillary services/international dialysis revenue losing about \$100m in 2015 (international has 118 centers, start-up phase)
- \$2.8 million cost for new dialysis center, profitable by year 2, mature in 3-5 years
- 89% of patients are government paying/ 11% commercial
- 11% patient mix of commercial = 110%+ of profitability

HealthCare Partners

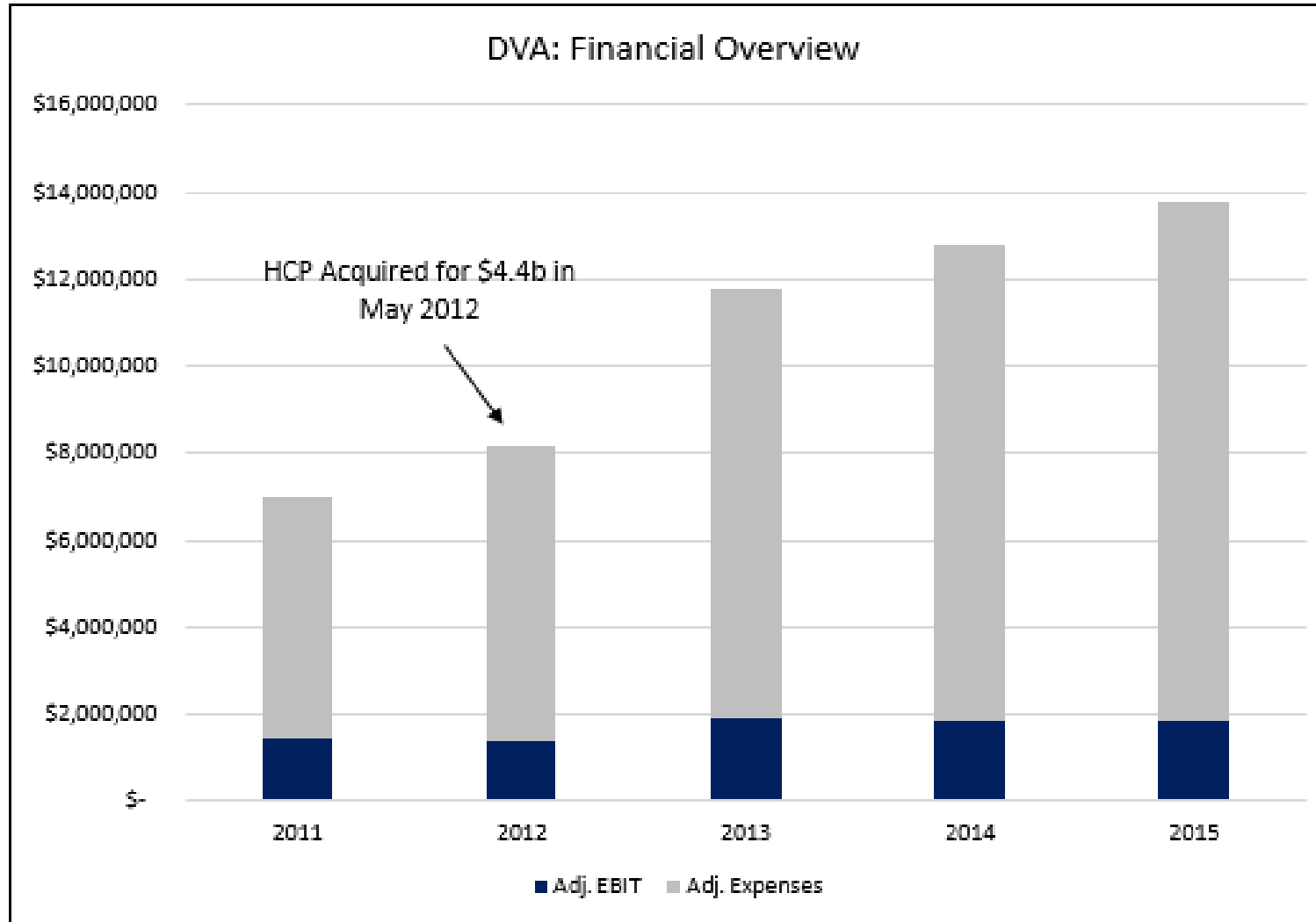
- Acquired in May 2012 for \$4.4 billion
- Different type of business than legacy dialysis services
- Groups of physicians working primarily under capitated models with Medicare Advantage patients
- \$3.84 billion revenues in 2015, only \$240m Adj. EBIT
- Has been really underperforming since 2012 acquisition, incurred \$206m goodwill impairment in 2015
- \$4.95 billion care dollars under manager
- 807,400 capitated “lives”
- In California, Florida, Nevada, Arizona, New Mexico, Washington (Everett Clinic acquisition in 2015)
- Mostly a “pay for performance” business model, aligned with legacy DaVita vision of “population health management”

Overview of DaVita HealthCare Partners (DVA)

- Revenue is split about 73% in legacy DaVita Dialysis, 27% in HealthCare Partners (HCP)
- Due to dialysis margins (~20%) being much higher than HCP (~6%), EBIT concentration is dominated by kidney care business
- The kidney care business is being understated due to investments in international center growth (118 centers, negative margin)



Overview of DaVita HealthCare Partners (DVA)



What Guides DVA Decisions?

- DVA's decisions (mostly) are tied to attempting to becoming a “population health management” company
- Due to the expense of dialysis on the government (~\$90,000/yr.) and the fact that ESRD is the only illness where anyone of age automatically qualifies for Medicare if they have ESRD, DVA likely trying to protect shareholder capital/margins by being very “value added”
- DVA generates substantial cash flow on dialysis services, earns very high returns on tangible capital once a center becomes mature (3-5 years)
- Like **all** regulated companies, DVA has to show they are “earning their keep”
 - Utility companies are very capital intensive, reinvest heavily, attempt to keep costs for customers low
 - Railroads are very capital intensive but are safer/better means of transporting goods, to earn solid ROIC they invest heavily, focus on safety
 - Cable companies can be capital intensive, to earn solid ROIC must be able to not discriminate against certain providers, provide services to lower income individuals
 - DaVita's largest customer is the U.S. Government. Although DVA is not capital intensive, they must **show** they are a business that works with the government and improves their patients lives (which they do).

How does DaVita maintain Government “approval”?

- DVA is not capital intensive, like many other regulated/monitored corporations (maintenance is around 2.5% of revenue/yr.)
- Instead, DVA looks to bring other value in other areas:
 - Improving mortality rates: patient percentages have decreased from 19.0% in 2001 to 13.7% in 2014
 - Operate a number of centers (due to patient mix) at an operating loss: ~200 centers are losing money (the scale that larger dialysis providers can afford, all others cannot)
 - Ancillary services such as DaVita RX, Village Health, Lifeline, DaVita Clinical Research (DCR), Nephrology Practice Solutions (NPS) that are meant to bring more value and attention to patients but operate at a loss/breakeven
- DaVita and Fresenius are considered LDO – Large Dialysis Organizations – and continue to operate at much higher clinical outcomes than the smaller dialysis operators
- DaVita is, by far, the highest quality of care provider in the dialysis industry, exceeding comparable Fresenius Medical (FMC) handsomely – For example, DaVita has 874 centers receiving 4 or 5 stars from CMS Star Rating, versus 318 for Fresenius Medical

What Matters the Most:

Dialysis Business:

- Strongest clinical outcomes (CMS needs to see DVA excelling versus peers, based on CMS 5-Star Ranking)
- The patient base for ESRD continues to grow at similar (or better) pace as historically (3.6% from 2000 to 2013)
- DaVita continues to reinvest and develop new centers to capture the underlying need for dialysis without adequate numbers of centers available
- Patient mix remains stable or improves (89% government, 11% commercial paying) as DaVita loses money on the government paying and any increase in government patient mix would/could cripple DVA margins (assuming CMS does not adequately reimburse DVA per treatment)
- Modality types remain somewhat constant (hemodialysis versus peritoneal)

HealthCare Partners (HCP):

- The business stabilizes, as it has strongly underperformed since the 2012 acquisition for \$4.4 billion
- Legacy markets maintain leadership
- Proves their value proposition through high quality of care (look at health metrics) to stay “partner of choice” for both government and commercial payers
- Any M&A must be done at a reasonable price, as the space has been “expensive” over last few years

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Dialysis:

Overview of the Treatment Service

What is Dialysis:

- The loss of kidney function is normally *irreversible*
- Kidney failure is caused by Type I and Type II diabetes, high blood pressure, polycystic kidney disease, long-term autoimmune attack on the kidney, and prolonged urinary tract obstruction
- ESRD is the stage of advanced kidney impairment, only have **two options to stay alive:**
 - Continued dialysis treatments
 - Kidney transplant
- Dialysis = removal of the toxins, fluids and salt from blood of patients by artificial means
- Most patients are older (~62-65 years of age) and are less mobile, thus require hemodialysis modality type, which is dialysis treatments at *least three times a week for the rest of their lives*
- According to US Renal Data System, approximately 468,000 ESRD patients in U.S. (2013, latest data, lags)
- ESRD patient growth of 3.6% from 2000 to 2013, very constant rate

Options for ESRD

1. Dialysis
2. Kidney Transplant

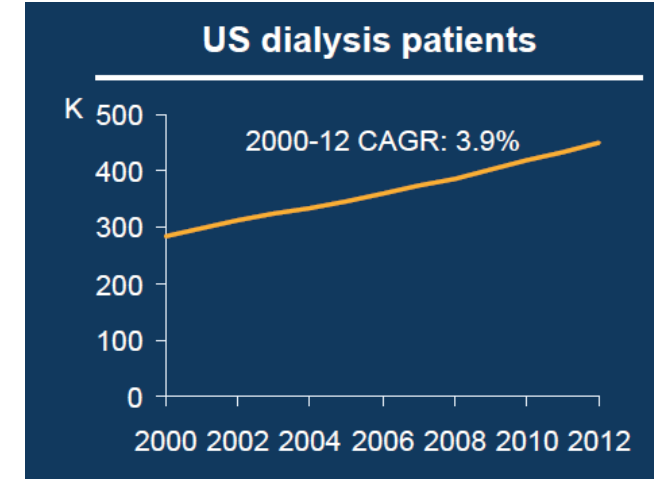
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3. Death with a couple weeks as your kidneys shut down altogether, cannot remove toxic waste from your body

There are ~100,000 people on the kidney transplant waiting list, yet only about 16,000 are done each year. There are not enough “alternatives” to dialysis for people with ESRD.

Growth Rate of Dialysis Patients:

- 3.6% from 2000 to 2013 (USRDS data, 2013)
- Attributable to:
 - Aging population
 - Increased incidence rates for disease that causes kidney failure such as diabetes and hypertension
 - Lower mortality rates for dialysis patients (living longer)
 - Higher growth rates for minority populations with higher incidence rate of ESRD
- From an investment standpoint, the demand is very stable
- Dialysis demand is not cyclical or seasonal, patients typically need it 3x per week or they die, for the rest of their lives
- The only alternative to dialysis is: kidney transplant
- Strong center loyalty due to nephrologist being medical director, familiarity of nurses, and close location to home



Source: DaVita 2015 Investor Day Presentation



ESRD prevalence per USRSD government data

How DaVita *Captures* Dialysis Patients

- As a condition for enrolling in Medicare, DaVita contracts with a nephrologist or a group of nephrologists to provide medical director services at each dialysis center
- Approx. 4,900 nephrologists currently refer patients to DaVita's outpatient centers, where one of them is typically the center's medical director
- Other nephrologists may apply for practice privileges to treat patients at dialysis centers
- Nephrologist = kidney doctor/specialist
- Each center is staffed with registered nurses, licensed practical/vocational nurses, patient care techs, a social worker, a registered dietitian, and other support personnel
- Under Medicare regulations, there can be no contract with the patients to obligate them to continue to use DaVita as a provider
- Medical director contracts include covenants for non-compete clauses
- DVA owns controlling interest in numerous centers that are joint ventures with nephrologists, within guidelines of Anti-Kickback Statute (~23% of revenues are from JVs)

Other DVA notes:

- Patient turnover is ~25%, mostly due to death, less so due to kidney transplant or moving to another provider
- DVA also provides dialysis to patients in approx. 900 hospitals on a contracted per-treatment fee negotiated with each hospital (= ~4.2% of total U.S. dialysis treatments)
- DVA operates or provides management to 31 dialysis centers in U.S. in which they own a minority equity investment or are wholly owned by third parties and thus earn only a management fee
- Employs 240 clinical service teammates, focusing on superior clinical outcomes at the centers

Partnering with CMS

How DVA works with Medicare
5 Star Rating
“Quality Incentive Program”

DaVita and CMS

- As of end of 2015, 89% of DVA's dialysis patients were covered under some form of government-based programs
- 76% were covered specifically under Medicare and Medicare-assigned plans
- CMS ranks dialysis providers in a 5-star-rating
- CMS can reduce payments to each dialysis center under the QIP program based on performance (or lack of)

ESRD: A Special Place in CMS's 'Heart'

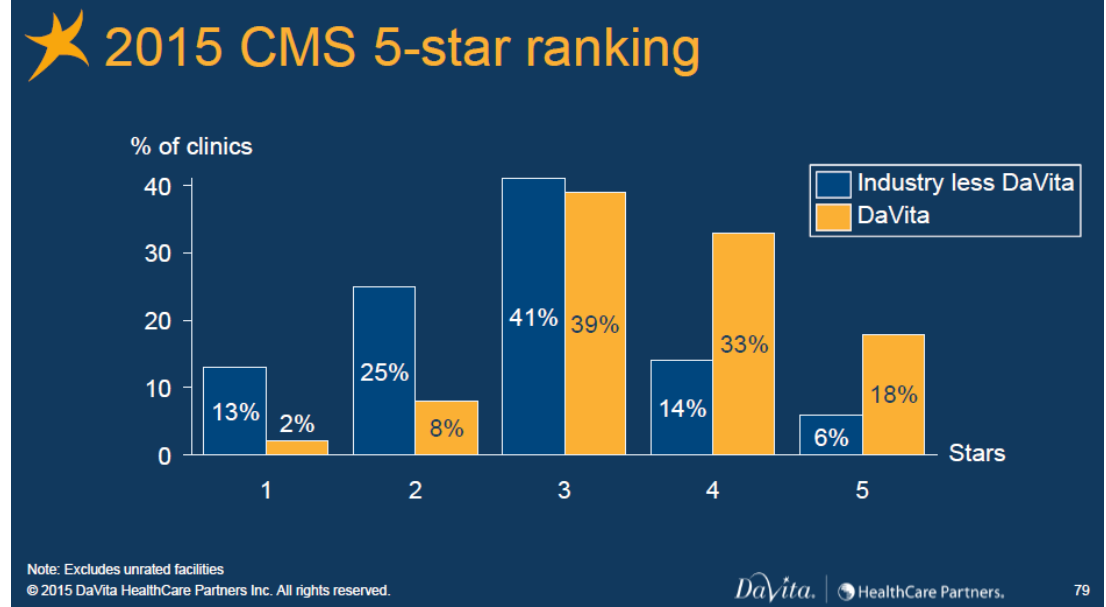
- Since 1972, federal government has provided healthcare coverage for ESRD patients under the Medicare ESRD program *regardless* of age or financial circumstances
- ESRD is the **only** disease state eligible for Medicare coverage both for dialysis and dialysis-related services and for all benefits available under the Medicare program
- Historically payments to dialysis providers were on a separate basis, whereby the pharmaceuticals and the service received different payment
- Effective January 2011, CMS moved to a “bundled payment”

CMS 5-Star Ranking

- CMS adopted “Five Star Ratings” across all Medicare facilities to help consumers understand the standards and quality of each
- Instituted October 2014
- Created due to Affordable Care Act desire for easily understood formats for consumers and CMS
- Facilities with the top 10% final scores based on numerous factors receive a rating of 5 stars
- DaVita = 51% of centers rank in the top 30% of all dialysis centers, with 18% in the top 10%

Star Rating on DFC

- Star Rating is based on Quality Measures (QMs) currently reported on DFC that assess patient health outcomes and processes of care
- Each facility is given a rating between one and five stars



CMS “Quality Incentive Program” Payment

- CMS administers the ESRD “Quality Incentive Program (QIP)” to promote high-quality services in outpatient dialysis centers
- This is the *first of its kind* in Medicare
- Changes the way CMS pays for the treatment of patients with ESRD by linking a portion of payment directly to center’s performance on quality of care measures
- Known as “pay for performance”
- If ESRD centers have below average performance, there will be reduced payments, a maximum of 2.0%

CMS “Quality Incentive Program” Payment

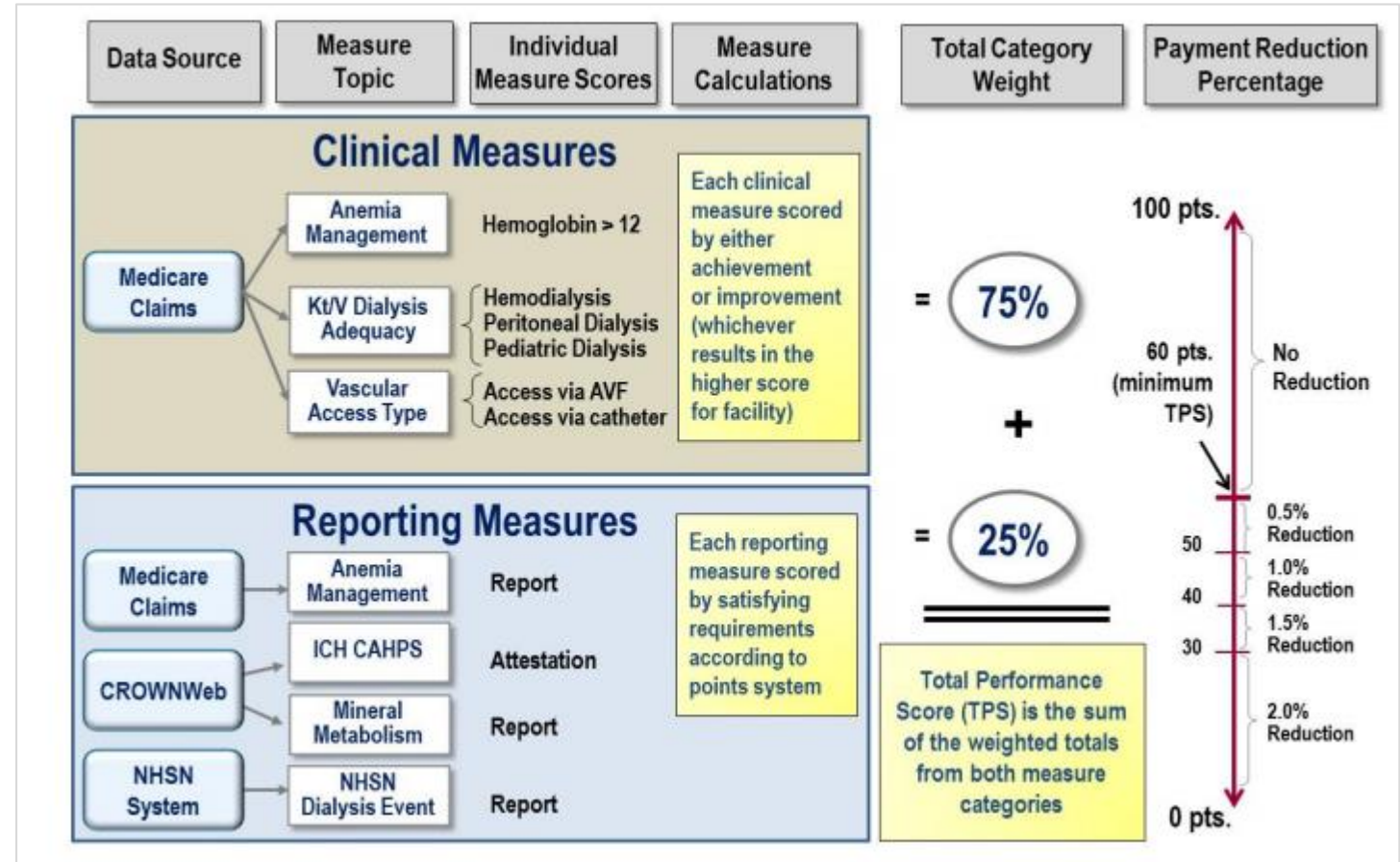
Scale for Payment Reductions

PY 2015 payment reductions will apply to a facility according to the following chart:

Total Performance Score	Payment Reduction
60 to 100	No reduction
50 to 59	0.5%
40 to 49	1.0%
30 to 39	1.5%
0 to 29	2.0%

QIP will be beneficial to DVA by:

- Showing the substantial difference in quality of care between DVA and all other providers
- DVA has the scale and technology to better handle patients health
- DVA has large investments in programs beyond just dialysis, can integrate these to improve patient health, whereas most other providers does not have this breadth (FMC does)
- Reinforce the need for market share leaders – FMC and DVA – to get adequate reimbursement rates as they are exemplary compared to other providers



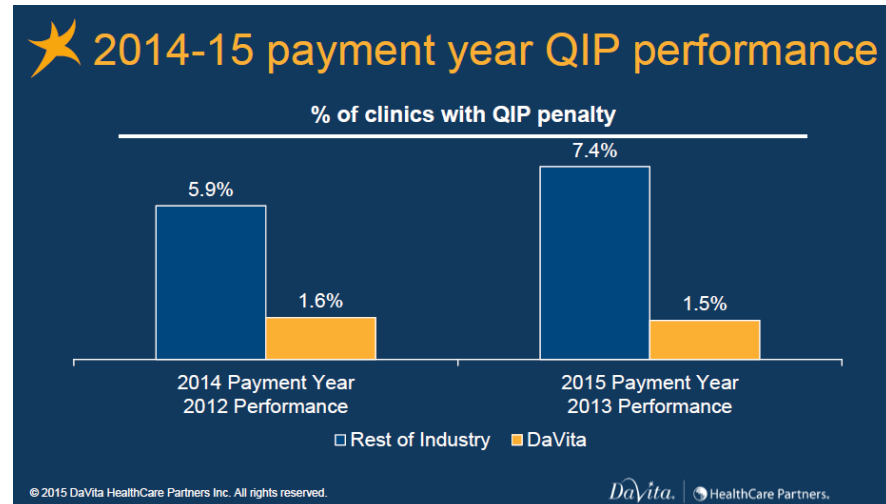
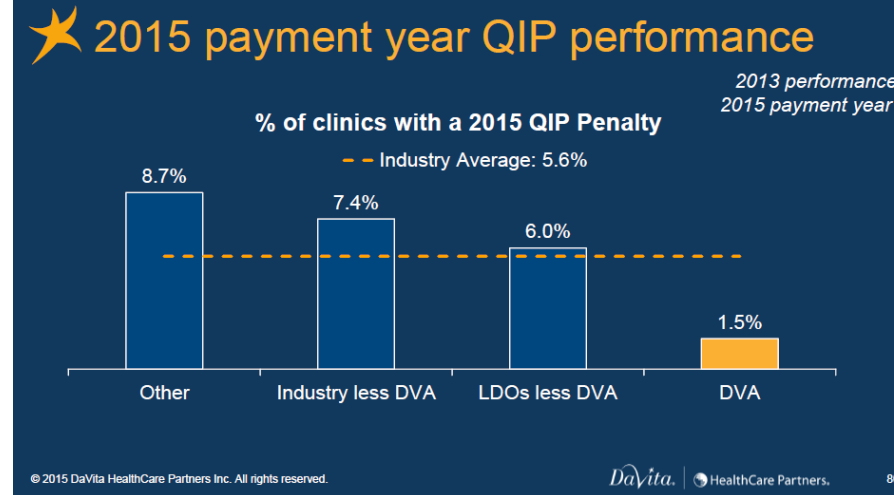
CMS QIP Program: DaVita Outperforms

DVA is clearly the “quality of care” leader:

- Only 1.5% of centers (~33 est.) had a penalty based on 2013 performance (DVA has improved since then)
- Fresenius had 6.0% of centers have a QIP penalty
- The industry excluding DVA averaged 7.4% of centers with a QIP penalty

2012 to 2013 Performance Year:

- DaVita improved from 1.6% of centers with a QIP penalty to 1.5%
- The Industry excluding DVA worsened, from 5.9% to 7.4%

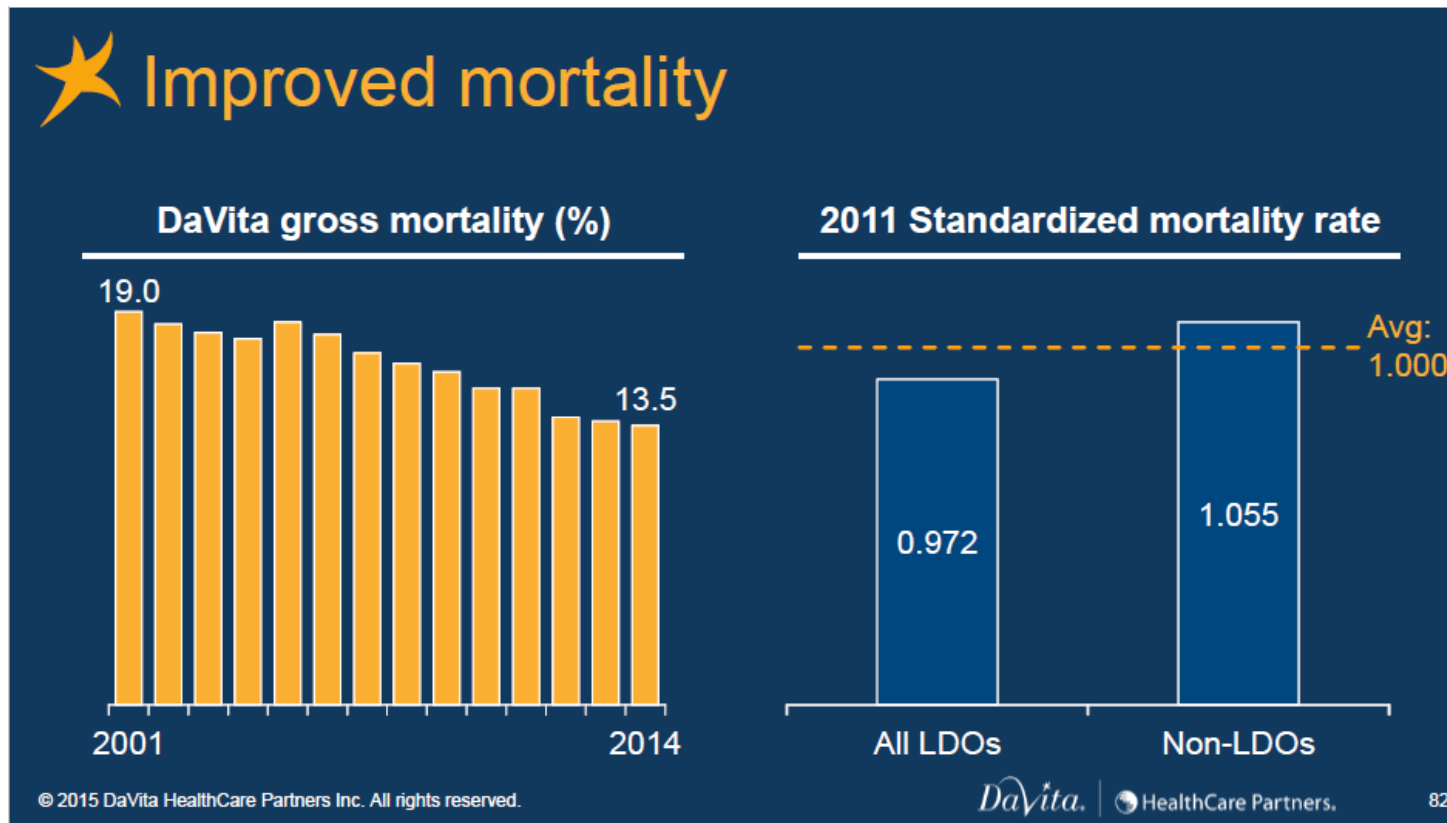


CMS QIP Program: DaVita Outperforms

- Results from the 2014 Performance Year (2016 Payment Year) showed a continuation of outperformance by DaVita
- Performance Year percentage of centers having QIP penalty:
 - 2012: 1.6% of DVA centers
 - 2013: 1.5% of DVA centers
 - 2014: 1.4% of DVA centers
- Industry performance – QIP penalty:
 - 2012: 5.9% of industry centers
 - 2013: 7.4% of industry centers
 - 2014: 5.6% of industry centers

DaVita: Mortality Rate Improvements

- DaVita's ancillary businesses, scale, and quality of care has helped improve mortality rates over the years
- Their mortality levels are exceptional compared to the industry



Dialysis Industry

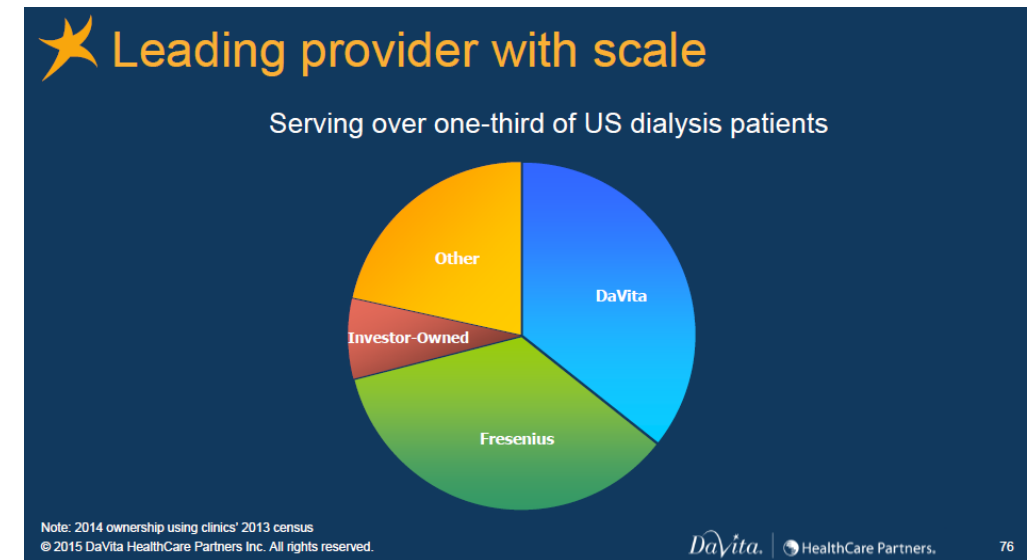
DaVita ~ tied #1 in U.S. for Dialysis

The Dialysis Industry in the U.S.

- Essentially an “oligopoly” structure that will not change
- DaVita and Fresenius Medical Care (FMC) account for ~ 72% of outpatient dialysis patients in U.S., split about even at 36% each
- Industry has consolidated significantly over the last 20 years
- Of the centers not owned by FMC or DVA, 45% are owned/controlled by hospitals or non-profits (*and are more difficult to acquire than physician-owned centers*)
- Stable demand growth (patient demand in U.S. grew 3.6% from 2000 – 2013)
- Steady cash flows
- Significant government engagement (Medicare/ CMS)
- High transparency on clinical outcomes and cost structure due to CMS oversight and CMS being largest payer

The Dialysis Industry in the U.S.

- Two dominant players in the U.S. dialysis space service 72% patients – Fresenius (FMC) and DaVita (DVA)
- DVA consistently lagged behind FMC in terms of patients, centers, and market share but have caught up (2015)
- Based on dialysis centers, DVA has 32.8% share versus FMC with 29.9%
- Remaining market share ~28%
 - 45% are hospital or non-profit owned, very difficult to acquire
 - 55% are small chains, or centers that are “unwanted” due to patient mix (more government patients, thus lower margins or are barely profitable)
 - 883 of 6,491 centers are “non-profit”



The Dialysis Industry in the U.S.

Provider	Clinics	Market Share
DaVita	2,129	32.8%
Fresenius Medical	1,940	29.9%
Gambro Healthcare	112	1.7%
Renal Advantage	65	1.0%
Independent	881	13.6%
American Renal Ass.	184	2.8%
Dialysis Clinic, Inc.	229	3.5%
US Renal Care	119	1.8%
DSI	65	1.0%
Renal Care Group	179	2.8%
National Renal Inst.	23	0.4%
Northwest Kidney Centers	15	0.2%
Reliant Renal	9	0.1%
Purity Dialysis	10	0.2%
Renal Care Partners	13	0.2%
Renal Ventures Management	32	0.5%
Satellite Dialysis/Healthcare	68	1.0%
Sankar Nephrology Group	15	0.2%
University of Utah	18	0.3%
Wake Forest University	15	0.2%
Other	370	5.7%
	6,491	100.0%

Provider	Clinics	Market Share	CMS Star Rating (2014 Performance Year)				
			5	4	3	2	1
DaVita	2,129	32.8%	307	567	800	197	38
Fresenius Medical	1,940	29.9%	68	250	693	521	278
All Others	2,422	37.3%	209	352	834	446	257
	6,491		584	1,169	2,327	1,164	573

Dialysis Centers Ranked by CMS under “Star Rating” System:

- DaVita has 31% of centers in 4 or 5 stars, versus 16.4% for Fresenius and 23.1% for all others
- DaVita has 78.6% of centers in 3/4/5 star ratings, versus 52.1% for Fresenius and 57.6% for all other

Conclusion: DaVita is the top dialysis provider, far exceeding comparable-in-size Fresenius (FMC) and far better than the industry excluding FMC and DVA

Why is this important: Dialysis is expensive but a necessary service or people die. As DVA has strong returns on capital invested, and steady cash flow, it is important they “protect” their business model by providing the top service in the industry.

Suppliers

- Fresenius (FMC)
 - Entered into contract January 2010 to purchase dialysis equipment, parts, and supplies
 - Ends February 29, 2016 (already passed)
 - Expenditures for FMC products = 2% of total U.S. operating expenses (~\$250 million)
- Amgen
 - Entered into agreement November 2011
 - 7 Year Sourcing and Supply Agreement
 - Expires December 31, 2018
 - Will purchase EPO in amounts necessary to meet no less than 90% of requirements for ESAs
- Baxter HealthCare
 - Purchase hemodialysis non-equipment product supplies (dialyzers) from Baxter
 - Fixed prices
 - Through Dec. 31, 2018

Business Drivers

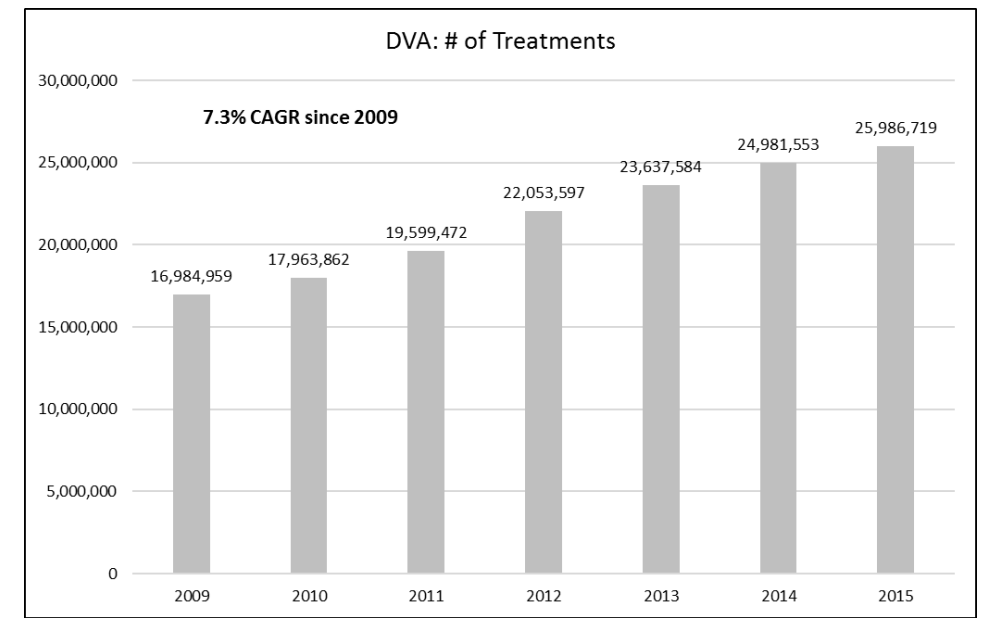
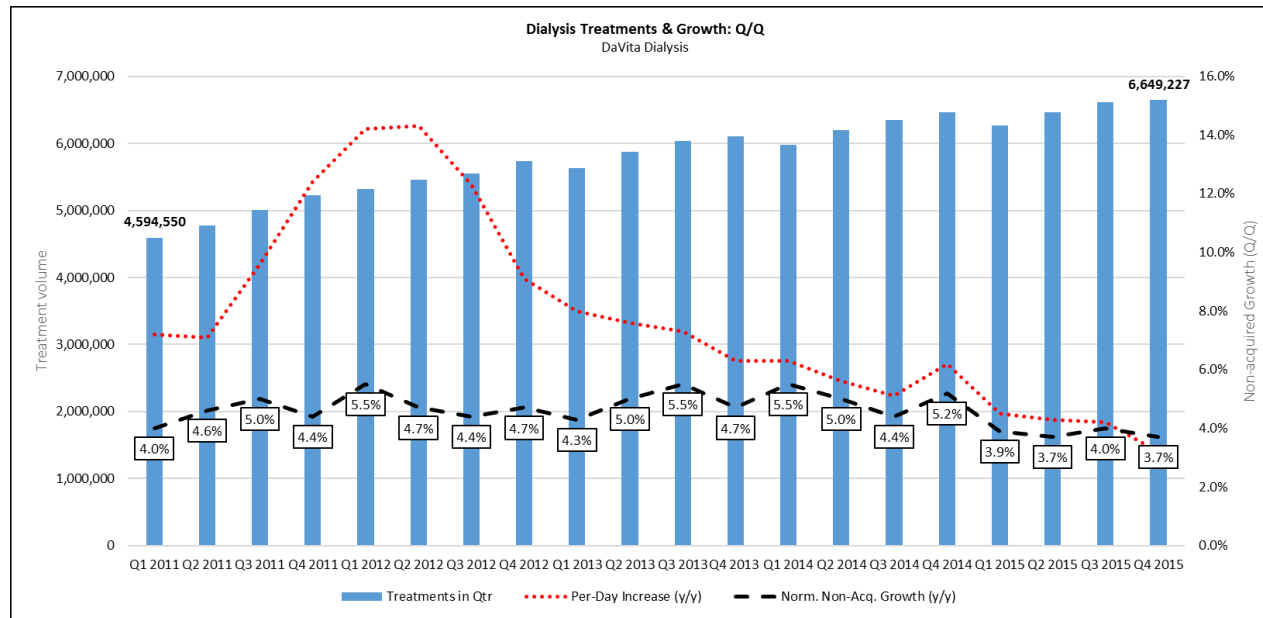
What to expect from DVA going forward....

The Business Driver Formula

- Demand: # of Treatments (Volume)
 - Based on # patients
 - # of Centers (assuming patients per center remain stable, which it has)
 - Patients receiving hemodialysis treatment (3-4x per week) versus peritoneal
 - Based on the underlying ESRD patient growth rate in the U.S.
- Revenue per Treatment (Price)
 - Based on patient mix: government (89%) versus commercial (11%)
 - Government reimbursement rate is inadequate to earn any cost of capital, a bundle payment
 - Commercial rates, often 2-3x that of the government reimbursement rate
 - Based on fragmentation of insurance providers
 - In network provider versus out-of-network provider (pays more)
 - Recovery of the 20% CMS doesn't cover, as well as the commercial payer paying their portion (bad debt expense, contra to revenue)
- Expense per Treatment
 - Patient care costs
 - Pharmaceuticals and supplies – based on contracts with FMC, Amgen which expire in 2016-2018
 - G&A, growing in line with treatment growth

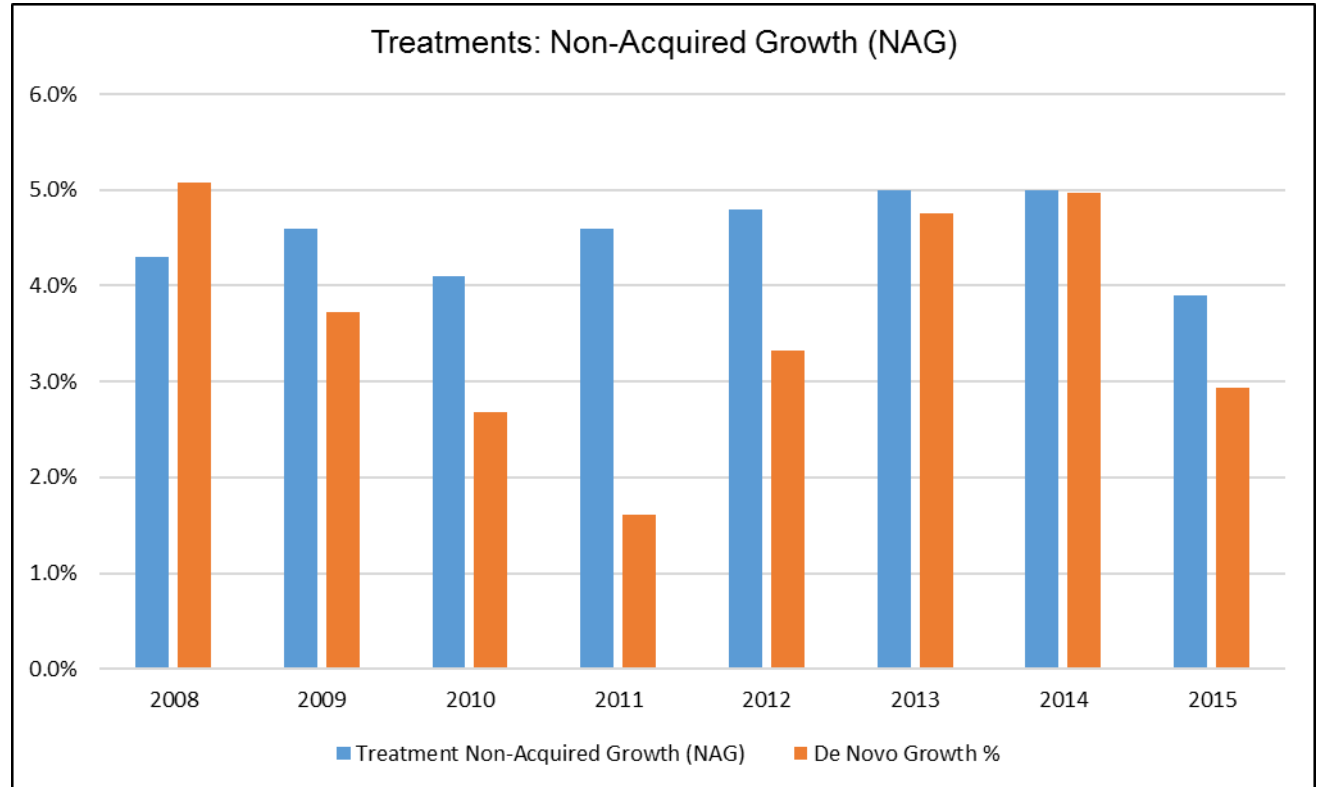
The Business Driver Formula: *# of Treatments*

- Non-acquired growth (NAG):
 - Based on non-acquisition growth
 - Mostly from developing new centers to meet the consistent demand for ESRD patient growth
- Per Treatment growth ranges from high-3% to mid-5% dependent on the year, which is constant with the ESRD patient growth rates in the U.S.



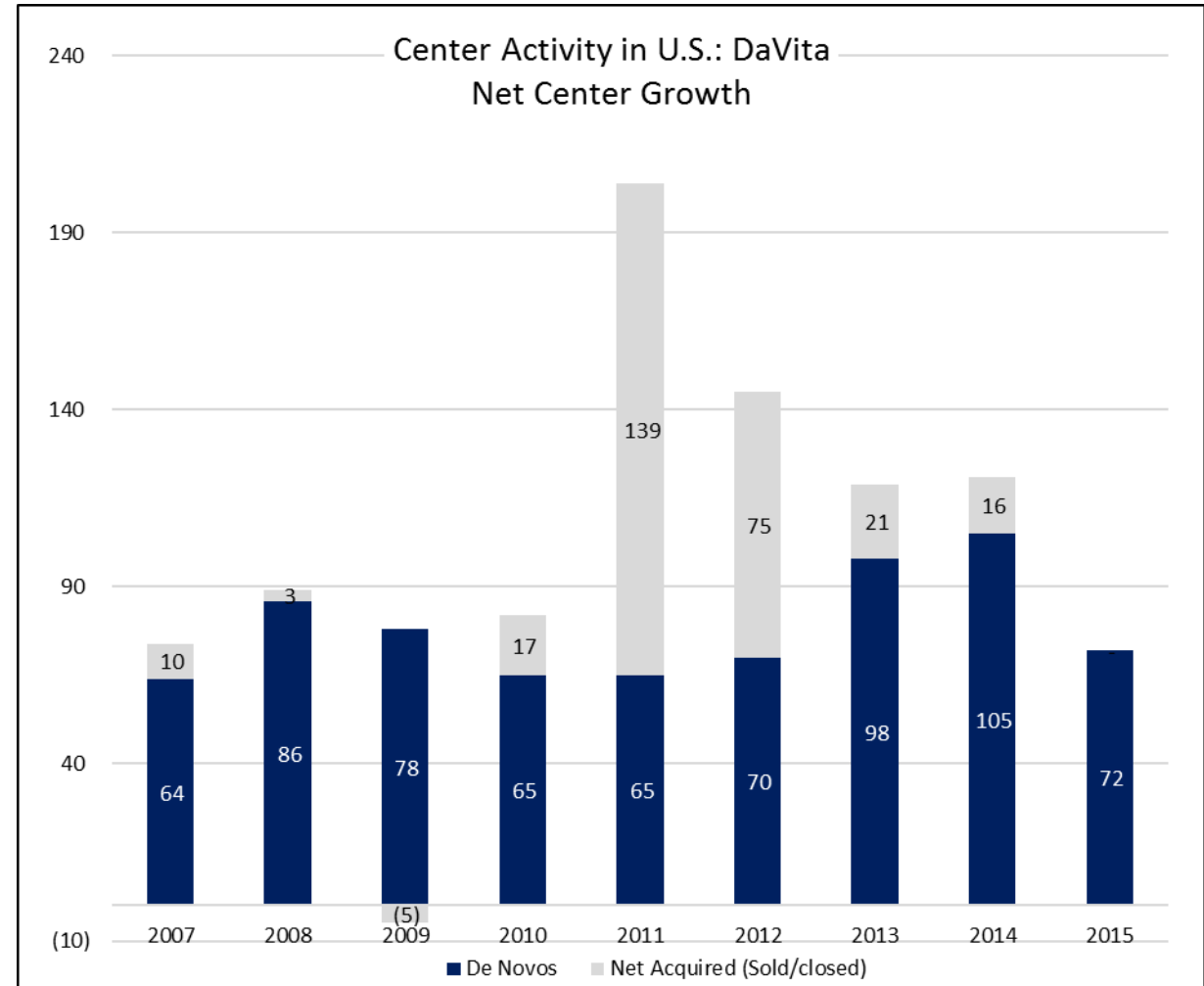
The Business Driver Formula: *# of Treatments*

- Non-acquired growth (NAG) tracks *net* newly developed center growth per year
- **Future growth in the U.S. is and will be largely dependent on DaVita continuing to open new centers**
- Treatment modality (hemodialysis versus peritoneal) unlikely to change much in near term due to typical patient health prevents peritoneal dialysis service (need to be healthier)



The Business Driver Formula: *# of Treatments*

- Newly developed centers per year, even with acquisitions, remain the *largest* driver of patient (and treatment) growth
- From 2007 – 2015 there were 703 new centers opened, versus 417 acquired (mostly in 2011 and 2012)
- From 2008 – 2014, there were 28,100 patients “acquired”, versus a total patient growth of 55,800
- **DaVita expects # of Treatments to grow 4.5% - 6.0% in the foreseeable future**



“De Novo” (New Center)

- Has been the predominant means of growing patients, treatments, revenues for dialysis business
- Development of typical outpatient center generally requires approx. \$2.8 million for leasehold improvements (fungible costs), equipment, and first-year working capital
- 61 centers were certified by CMS in 2015 for DaVita, and 105 for the remaining providers in the industry (Fresenius with 55)
- Timeline:
 - Within 1 year after property lease signed, new outpatient center opens
 - Second year after Medicare certification – center achieves operating profitability
 - 3-5 years – center reaches level of maturity
- Returns for new centers are ~ high (>40% on tangible invested capital)
- Returns for new centers should improve, due to:
 - Improved scale
 - Understanding of likely patient mix characteristics of new center prior to development
 - Initial costs are mostly fungible

“De Novo” (New Center)

- 2015: \$381 million spent for “new center developments and relocations”
 - No new centers were developed internationally and 72 were developed in U.S.
 - Based on those numbers, cost ~\$5.3m; number likely misleading because some of those expenditures could include new center developments for 2016, or improvements to centers open in 2014
-
- 2014: \$376 million spent for “new center developments and relocations”
 - No new centers were developed internationally, and 105 were developed in U.S.
 - Based on those numbers, cost \$3.6m

Dialysis Acquisitions

- 2015: \$415 million in cash to buy “Renal Ventures Limited LLC”
 - 36 dialysis clinics in 6 states
 - Approx. 2,400 patients
 - Needs approval by FTV and Hart-Scott-Rodino antitrust clearance
 - DVA expects there will be the need for some center divestitures to get approval

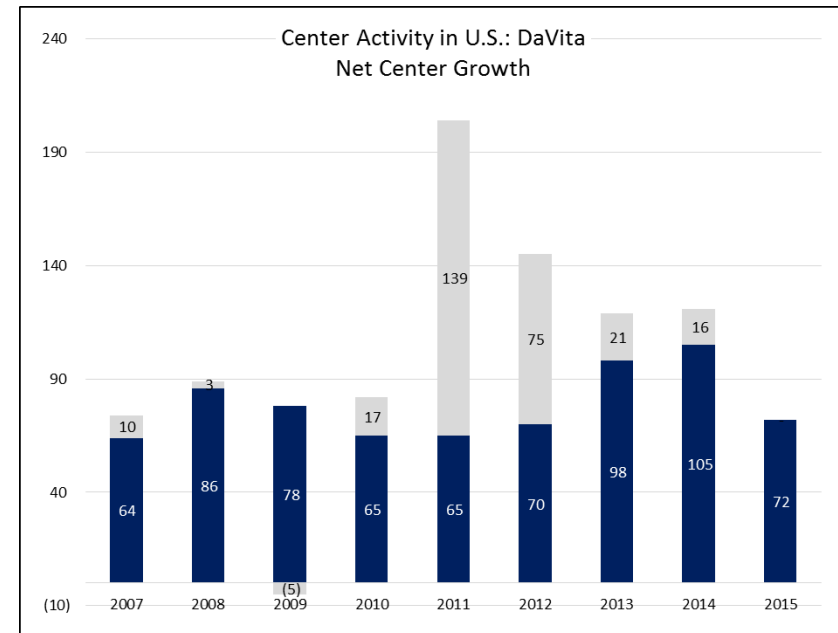
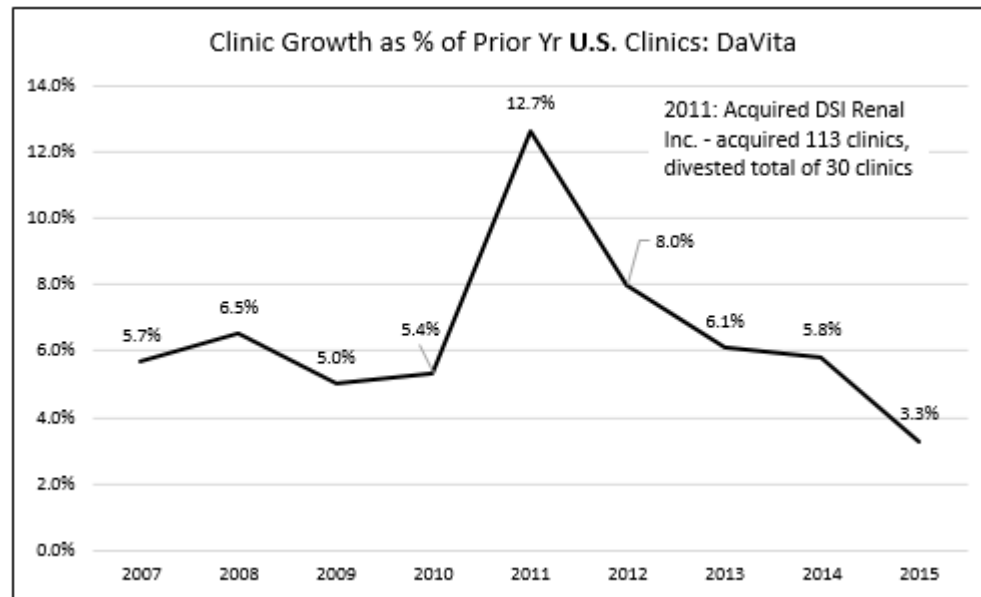
Clinics – 2,251 Outpatient Centers in U.S.

- 43.5% of centers are in the top 6 states: CA, TX, FLA, GA, OH, PA
- Only 2,220 are consolidated in financials; remaining 31:
 - 22 centers DVA owns minority stake
 - 9 centers DVA provides management services, owned by third parties
- 200 are operating at a loss due to patient mix (too many government patients)

State	Centers	State	Centers	State	Centers
California	259	Minnesota	50	Nebraska	15
Texas	199	New Jersey	50	Massachusetts	12
Florida	169	Wisconsin	40	Mississippi	11
Georgia	123	Colorado	37	District of Columbia	10
Ohio	115	Oklahoma	36	Idaho	9
Pennsylvania	102	Louisiana	35	West Virginia	8
Illinois	85	South Carolina	35	New Mexico	5
Michigan	77	Kentucky	34	New Hampshire	4
North Carolina	69	Washington	34	Utah	4
Virginia	65	Arkansas	33	Maine	3
Maryland	60	Arizona	26	South Dakota	3
Indiana	59	Iowa	26	North Dakota	2
Missouri	56	Kansas	26	Montana	1
Alabama	55	Connecticut	25	Rhode Island	1
New York	55	Oregon	24		
Tennessee	54	Nevada	19		

Clinic Growth – United States

- Since 2007, 703 clinics have been opened in the U.S. by DaVita (“de novo”), 71 have been sold (30 in 2011 due to DSI Renal Inc. acquisition), and 65 have been closed
- Since 2007, 417 clinics (gross) have been acquired, with 113 coming from DSI Renal Inc. in 2011
- Since 2007, an increase of >950 clinics in the U.S., largely through “de novos”



Center Growth – United States

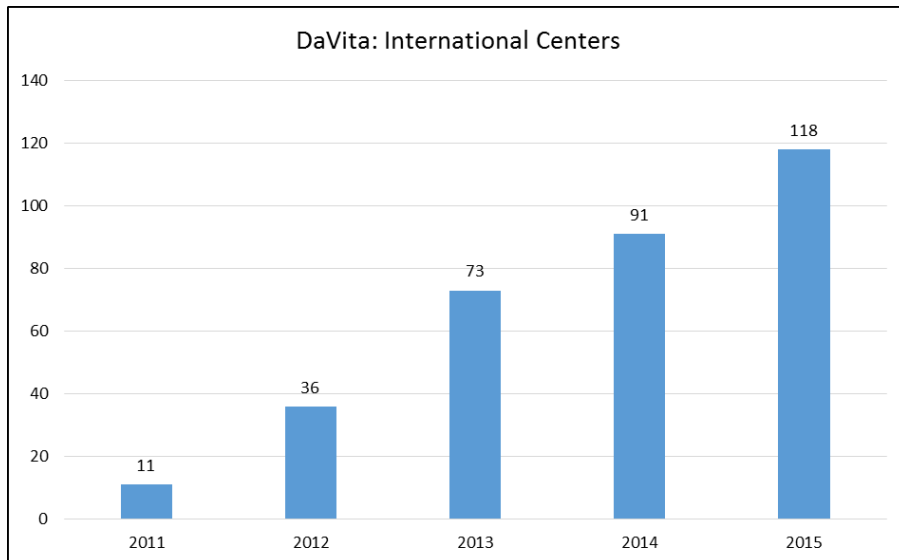
- “De Novo” (developed) center activity remains robust, with developed center activity increasing each year except for 2015 (Management stated some delays in CMS certification of some new centers in pipeline)
- 2015 was the lowest level of “acquired centers” (6) in 10+ years
- Acquisition growth getting more difficult – industry is oligopoly, most remaining centers to acquire have less than desired patient mix characteristics, likely sold off in recent years by DVA

The table below shows the growth of our U.S. dialysis operations by number of dialysis centers.

	2015	2014	2013	2012	2011
Number of centers at beginning of year	2,179	2,074	1,954	1,809	1,612
Acquired centers	6	18	26	93	170 (1)
Developed centers	72	105	98	70	65
Net change in centers with management and administrative services agreements*	2	—	4	(8)	1
Sold and closed centers**	(3)	(2)	(5)	(1)	(32) (1)
Closed centers***	(5)	(16)	(3)	(9)	(7)
Number of centers at end of year	<u>2,251</u>	<u>2,179</u>	<u>2,074</u>	<u>1,954</u>	<u>1,809</u>

Dialysis Centers – 118 Internationally

- 118 international clinics
- Long growth runway, as the story is in the “first inning”
- “International” is not something ‘new’ to DaVita Dialysis, as rapid expansion internationally almost bankrupted the company in the mid-late 1990s
- Taking a more deliberate and careful approach to international, as the regulations, payers, and cost structures differ than in U.S.



	2015	2014	2013	2012
Number of centers at beginning of year	91	73	36	11
Acquired centers	21	9	38	13
Developed and hospital operated centers	7	11	2	9
Managed centers, net	(1)	—	—	3
Closed centers	—	(2)	(3)	—
Number of centers at end of year	118	91	73	36

Growth has come from “acquisition”, a different approach than in the U.S.

International Centers

- About 50% of the current ~118 centers are in 2 countries:
 - Malaysia (38)
 - Germany (20)
- As imagined, dynamics internationally are very different than in U.S.

From 2015 10-K

Malaysia	38
Germany	20
Colombia	15
India	13
Saudi Arabia	10
Poland	8
Portugal	5
Taiwan	5
China	3
Singapore	1
	118

From 2015 Investor Day (#'s higher since presentation)



International Centers

- As expected, international dynamics are different
 - Rates, labor costs, growth rates, and so on – all different than in U.S.
- Although DVA is ~ #1 in the U.S. (followed closely by Fresenius Medical – “FMC”)
- Internationally = very large runway for growth for DVA
- DVA exited all international centers in late 1990s, began international dialysis strategy 4-5 years ago, currently have 118 centers
- U.S. only has about ~20% of the global dialysis population; DVA is essentially non-existent in the remaining 80%
- Long runway enhanced by DVA’s “quality of care” leadership, and thus requested internationally to partner with governments as a dialysis provider

T. 2.8 DIALYSIS PATIENTS: REGIONAL DEVELOPMENT		
	2014	Change
North America	596,000	~ 4 %
Europe/Middle East/Africa	666,000	~ 4 %
Asia-Pacific	1,138,000	~ 8 %
Latin America	265,000	~ 5 %
► WORLDWIDE	2,665,000	~ 6 %

Source: Company data and estimates

International Opportunity

- International modality is similar to U.S., with most treatments being hemodialysis and in-center (versus home)
- Worldwide = 89% of treatments are in-center, versus 81% for North America
- Estimated 3.371 million patients with chronic kidney failure, only 706,000 have kidney transplants = 2.665 million on dialysis globally
- Largest dialysis population is in Asia-Pacific with 1.138 million
- Outside U.S., much more **fragmented**
- Still, **DaVita is the #2 provider globally despite** having minimal international presence; this illustrates the fragmented marketplace outside of the U.S.
- Growth rates outside of U.S. much **faster** than in U.S.

C. 2.15 DIALYSIS SERVICES BY REGION IN 2014
Number of patients treated

Total: 2.665 M

North America	
Fresenius Medical Care	176,203
DaVita	170,000
Dialysis Clinic Inc.	14,500
Europe	
Fresenius Medical Care	52,848
Diaverum	21,400
Kuratorium für Dialyse	18,700
Asia-Pacific	
Fresenius Medical Care	25,278
Showai-Kai	5,100
Tokushu-Kai	4,000
Latin America	
Fresenius Medical Care	31,983
Baxter	9,000
Diaverum	4,500

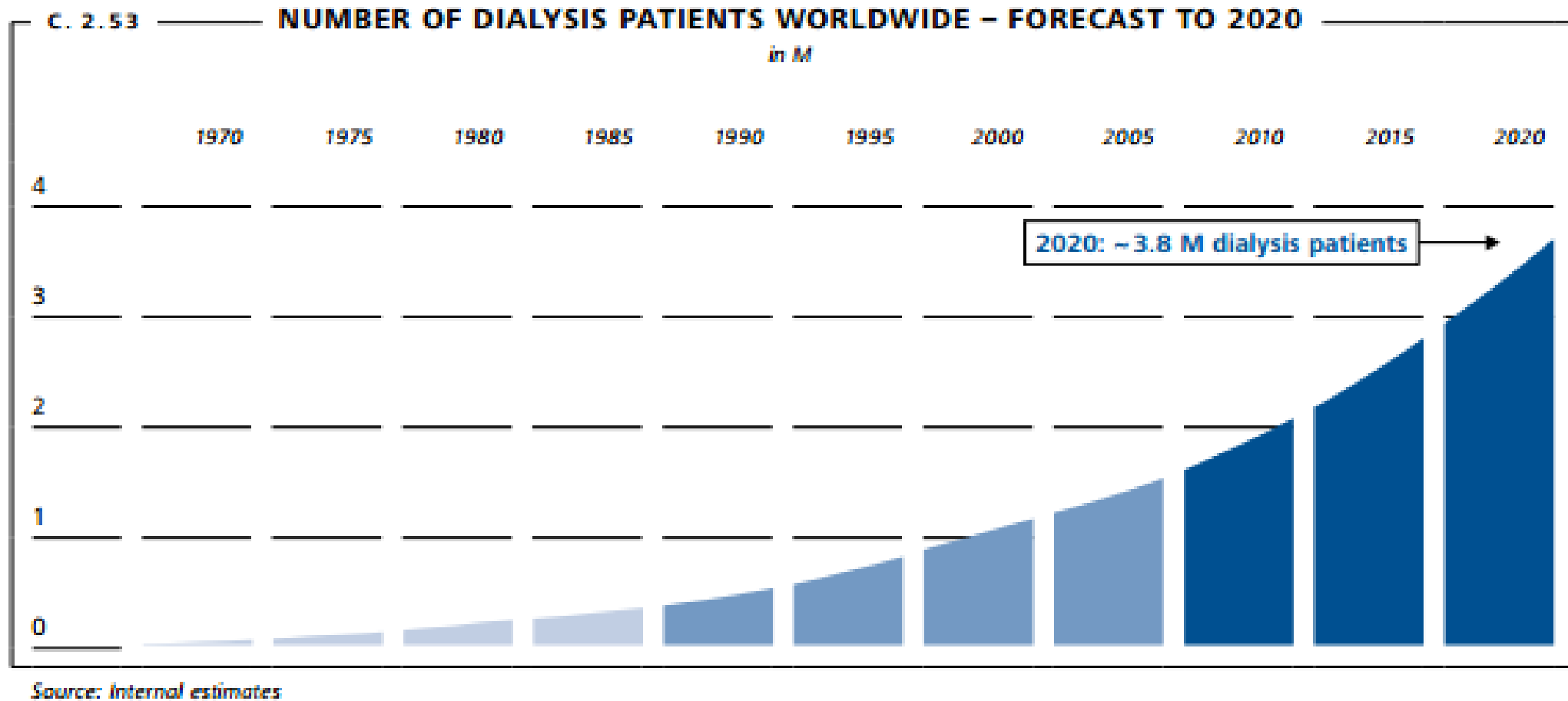
Source: Company data and estimates

T. 2.52 EXPECTED GROWTH IN PATIENT NUMBERS

	Growth 2015
North America	~4%
Europe/Middle East/Africa	~4%
Asia-Pacific	~7%
Latin America	~5%
► WORLDWIDE	~6%

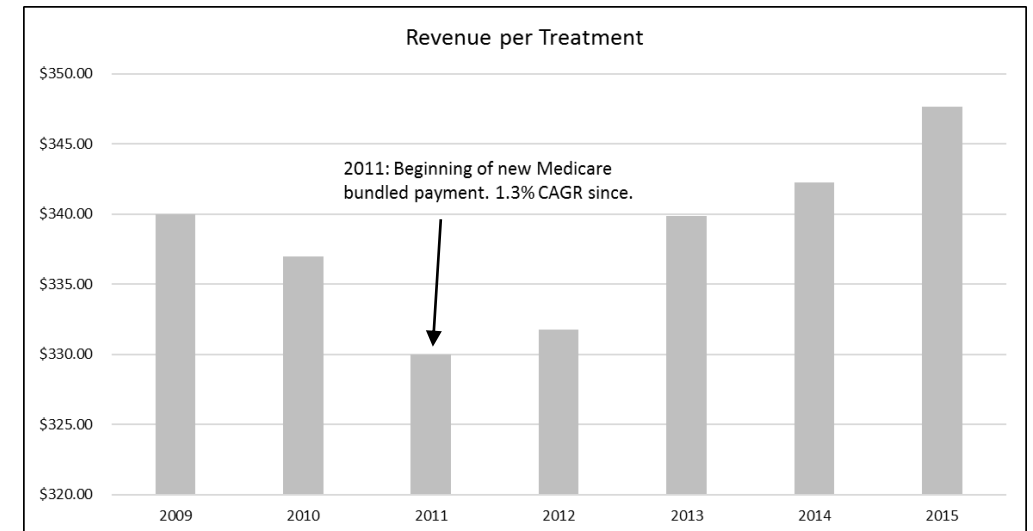
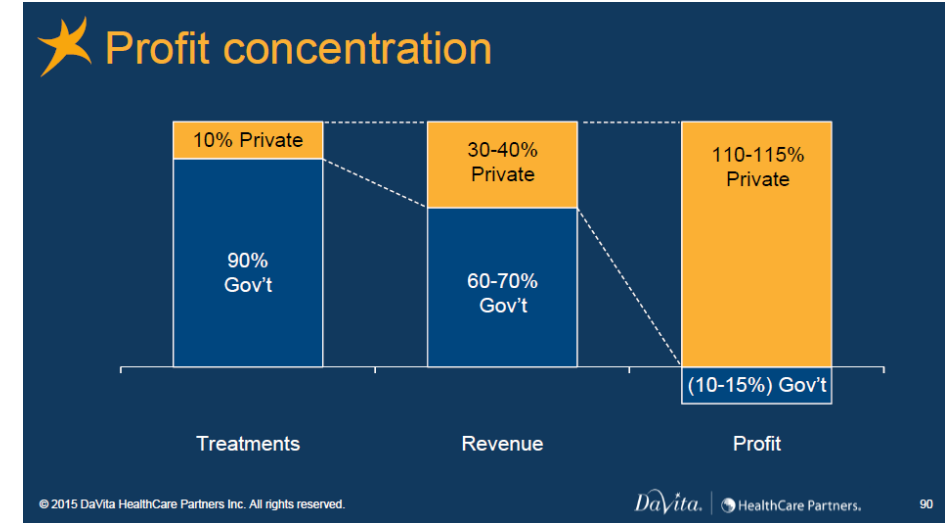
Source: Internal estimate

International Opportunity



The Business Driver Formula: *Revenue per Treatment*

- The single largest concern from most investors is the profit concentration is heavily unbalanced
- Government patients are 89% of the total mix, yet DaVita loses about 10-15% on these patients
- Thus, the 11% of patients provide 110-115% of the total profits for DaVita
- Concerns are obvious:
 - Any decrease in the government rates and it could cripple DVA's profits due to patient mix
 - Industry consolidation by insurance payers could increase their negotiating power over DVA
 - Patients living longer are actually a negative financially because they become Medicare-based after 33 months on dialysis



Revenue per Treatment: Medicare Bundled Payment

- CMS adjusted the payments based on an overpayment once the new bundled payment was created in 2011
- The bundled payment estimated reimbursement from prior year pharmaceutical costs which changed substantially once the new bundled payment went into effect
- Thus, CMS overpaid the industry
- To “recoup” the overpayment, CMS is adjusting the payment rate in 2014-2018
- As expected, this has put pressure on the commercial patient mix to make up for the reduction in these years

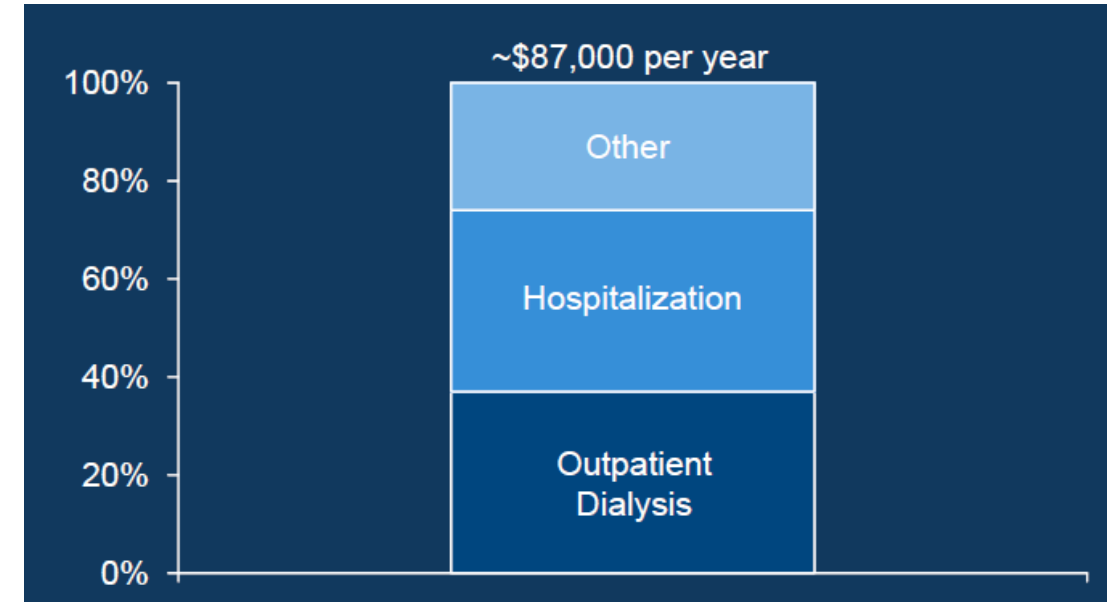
- 2014 & 2015: Flat despite increasing costs
- 2016: Market basket minus 1.25%
- 2017: Market basket minus 1.25%
- 2018: Market basket minus 1.00%

What Protects the Payment?

- ESRD has been the only illness that any individual, regardless of age or financial status, becomes eligible for Medicare after 33 months on dialysis
- CMS is careful, even in the case of the industry overpayment, to not reduce the bundled payment rate too much to the point where there are too many center closures (which impacts patient access to care)
- The commercial rate is protected by the highly fragmented payment network across the U.S., the small percentage of the population with ESRD, and the fact that patients move to Medicare after 33 months
- In addition, the largest “cost” of an ESRD patient is hospitalization. DVA is the lowest cost and highest quality provider by a long shot in the industry. Through DVA’s investments, they continue to work on lowering unnecessary hospitalizations and readmissions, in effect working to lower the annual cost of an ESRD patient on dialysis

What Protects the Payment?

- DaVita is making substantial investments to reduce the ‘hospitalization’ cost, the single *largest* cost for an ESRD patient per year
- Based on 2013 data, it costs Medicare about \$87,000 per year for a typical ESRD patient
- DaVita’s vision of “population health management” aligns with CMS and commercial payer interest of lowering unnecessary costs (certain hospitalizations are preventable)
- Outpatient dialysis (what DVA mostly does, earns revenue from) is *less* than 40% of the total cost of an ESRD patient



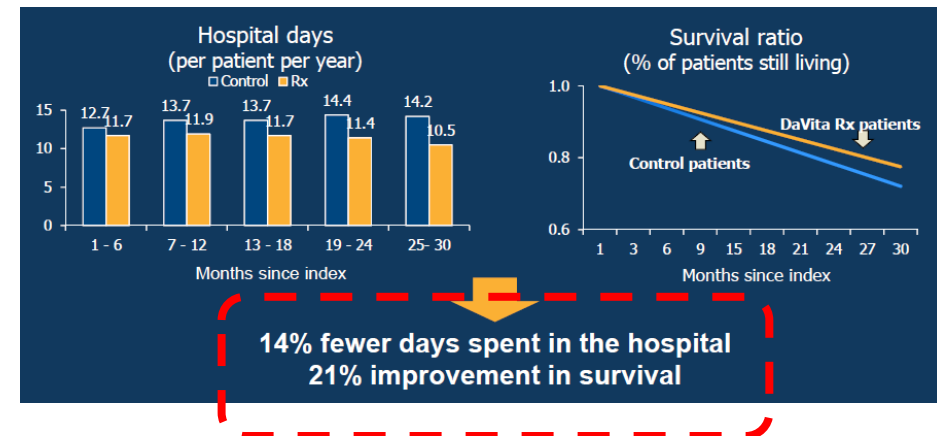
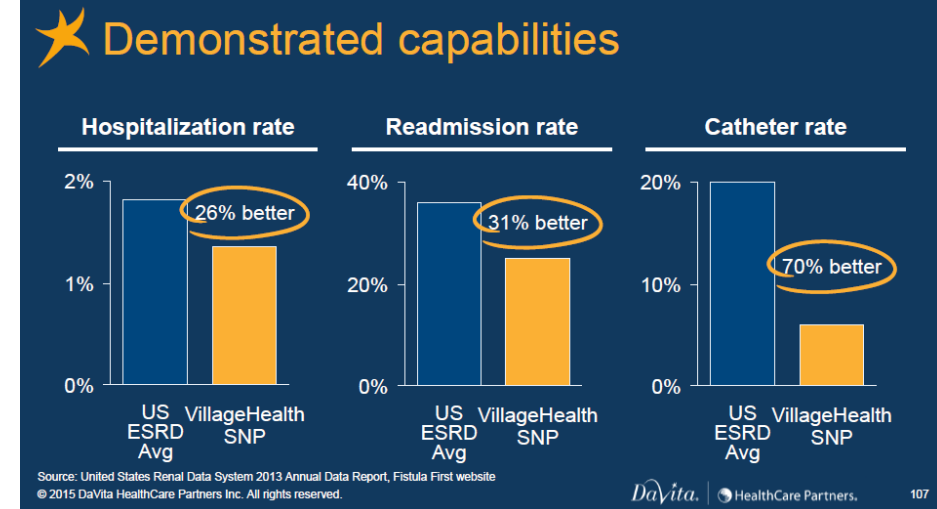
DaVita's Investments to Improve Quality of Care

- DaVita's investments may not yield direct returns on capital; rather they flow through to improving negotiations with commercial payers as well as protect their relationship as the leading dialysis provider in the industry with CMS
- Investments:
 - Lifeline Vascular Access
 - Kidney Smart ESRD Awareness Program
 - DaVita RX Prescription Management
 - Village Health Care Management
 - HCP Acquisition
- This ties into DaVita's vision for "population health management"



Demonstrating Improvements in Care

- As mentioned previously, a substantial portion of the ESRD patient care costs comes from hospitalizations
- Oftentimes, these hospitalizations are preventable:
 - Multiple doctors due to multiple co-morbidities
 - Patients are high risk/cost to healthcare system
 - Patients prescribed 8-9 medications, take ~21 pills per day, patient does not have single point of contact guidance and advice, as all are from specialists
 - VillageHealth steps in and provides guidance and oversight to the patients
- VillageHealth results are staggering versus the US ESRD average
- DVA has the negotiating capability of showing how they should be reimbursed adequately as they also help *lower* other portions of costs DVA isn't reimbursed on = "value add"

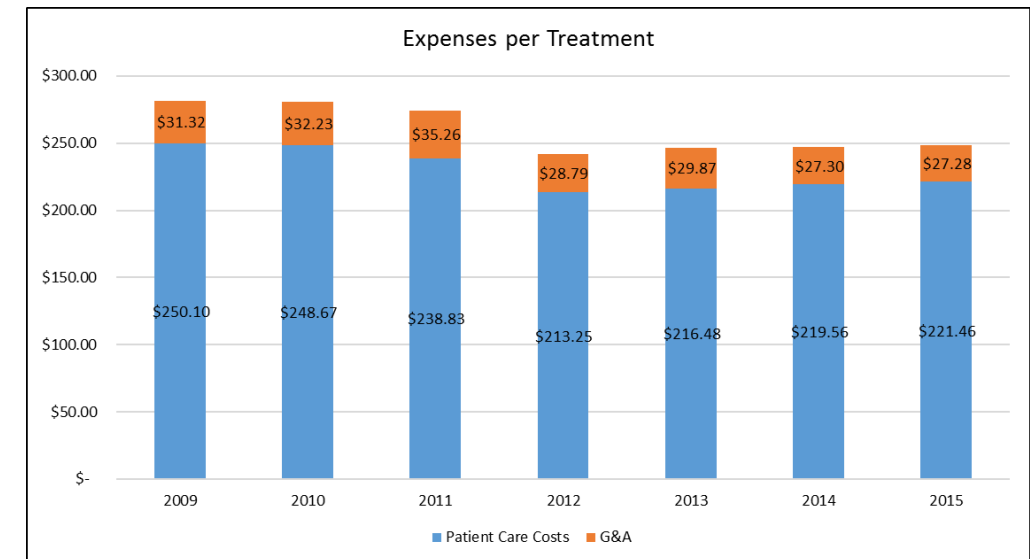
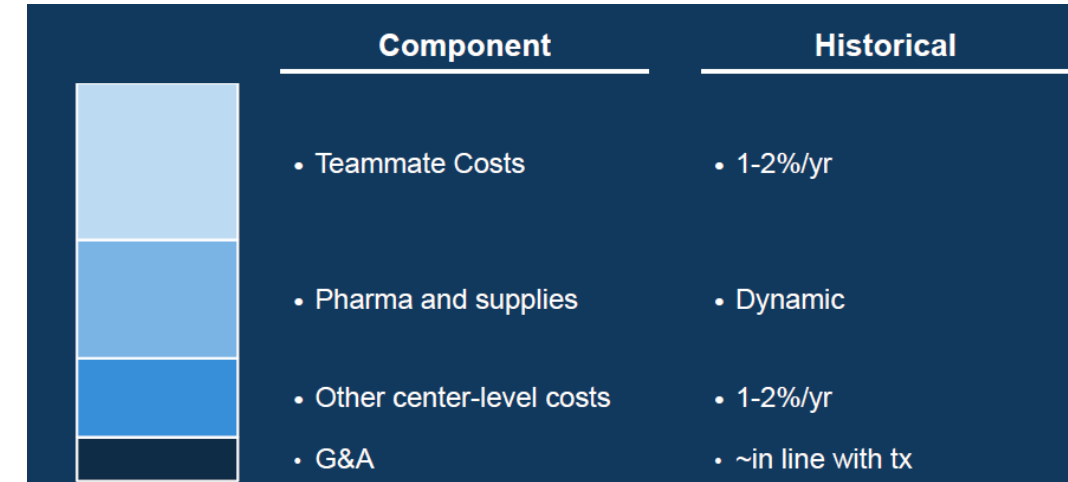


Revenue per Treatment:

- **DaVita expects growth of 0.0% - 1.5% in revenue per treatment**
- Largely based around next couple of years receiving a rebased CMS payment
- Post-2018, the reimbursement rate has “upside”
 - Medicare payment “back to normal”
 - Recent commercial rates are strong, possibly due to DVA illustrating continued value-add in quality of care, lowering other unnecessary costs
- Since changed in Medicare reimbursement system in 2011, has grown 1.3% CAGR

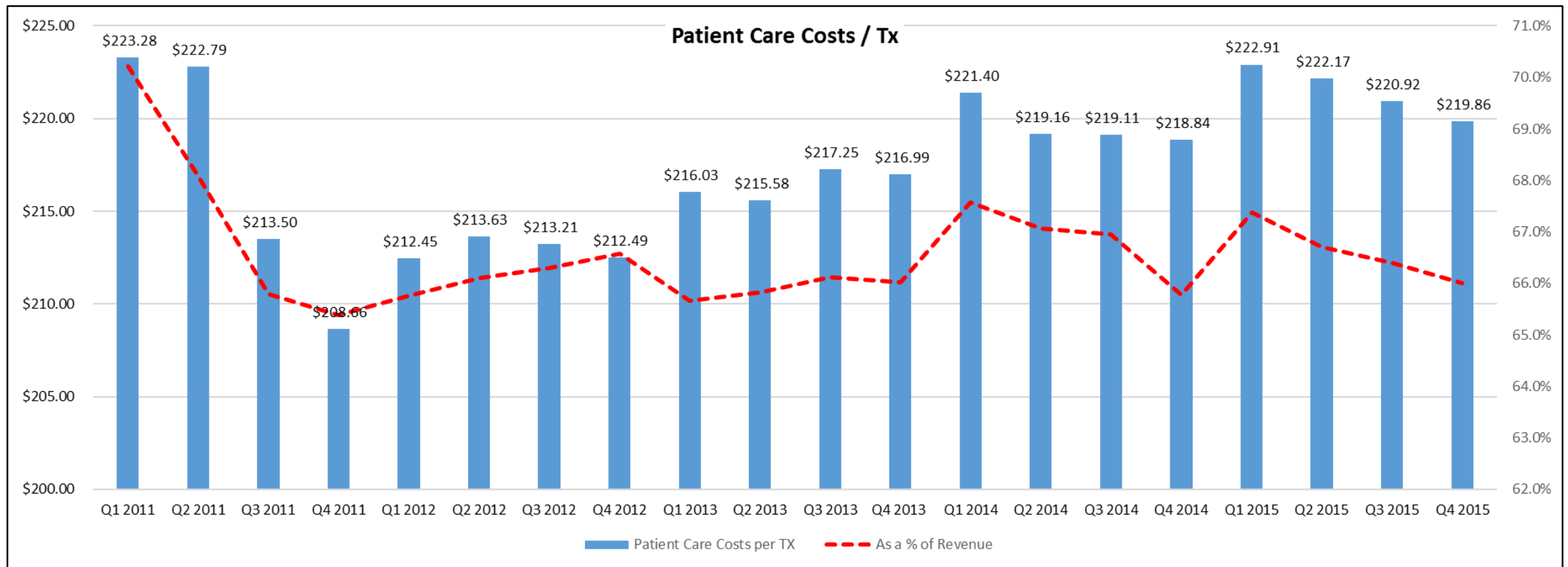
The Business Driver Formula: Expense per Treatment

- The largest expense for DaVita is “teammate costs”, which historically have grown 1-2% per year (*~40% of expense/treatment*)
- Pharma and supplies cost expense is slightly less than teammate costs, and those costs are dynamic, based on volume, contracts, and could change with the EPO contract expiring in a couple of years (*~30% of expense/treatment*)
- Other center level costs increase around 1% - 2% per year on average (*~20% of expense/treatment*)
- General and Administrative expenses are the smallest expense, grow in line with treatment growth (*~10% of expense/treatment*)



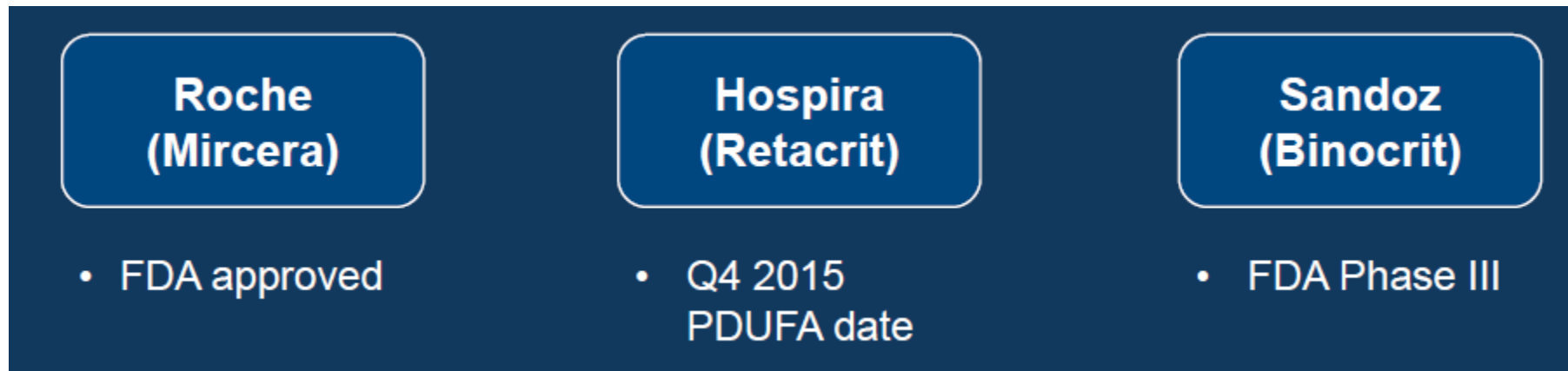
The Business Driver Formula: Expense per Treatment

- Patient care costs have been stable since 2011
- Increases since 2011 due to CMS reimbursement/payment method change



The Business Driver Formula: Expense per Treatment

- There is *upside* in the “pharma” costs
- Mircera is currently being sampled on Fresenius patients, is substantially less expensive than current ESAs
- There are other alternatives coming on-line as well
- Savings will likely begin in 2019+ as Amgen contract is through Dec. 2018

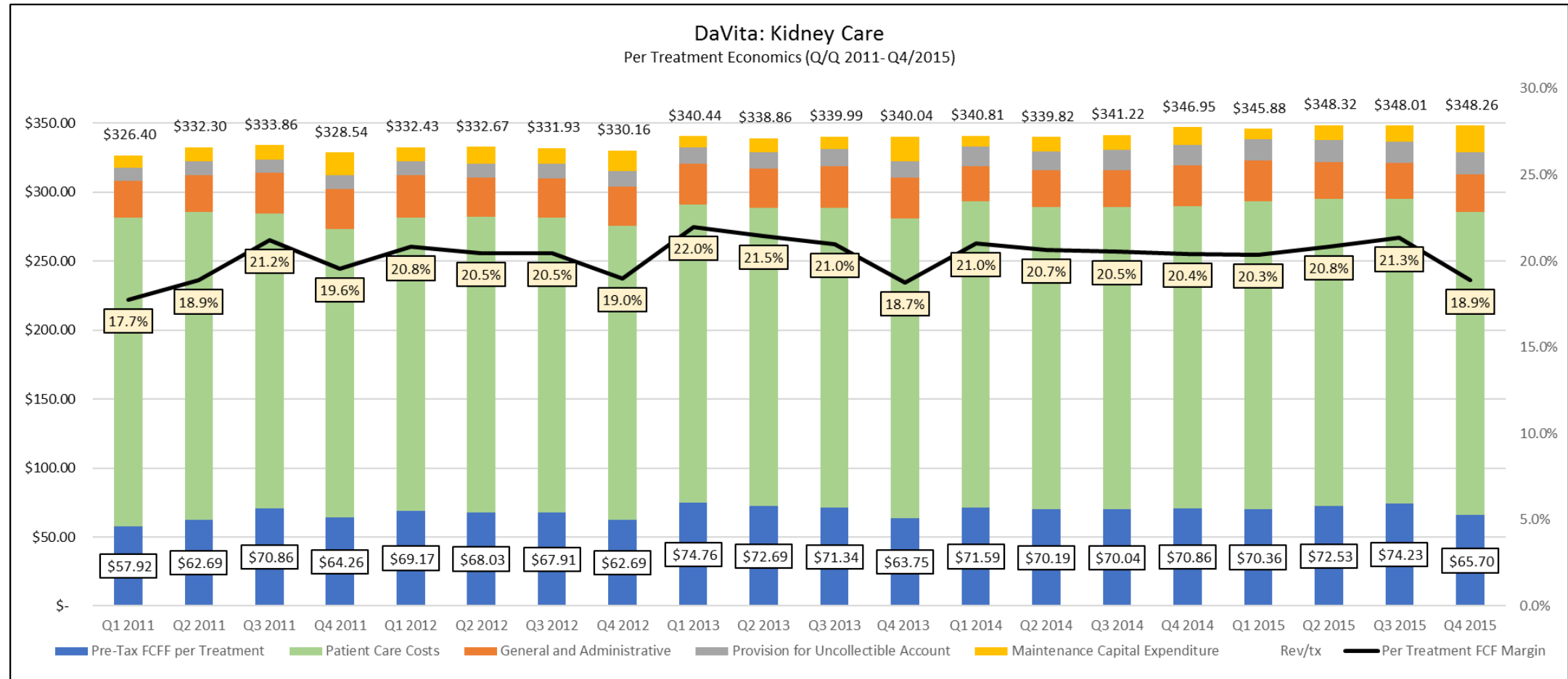


The Business Driver Formula

- In the near term, DaVita expects in the ballpark of 3% - 8% growth in kidney care Operating Income in the U.S.
- I would expect in the 4-5% range, excluding any further acquisitions, through 2017-2018
- Beyond 2018, there are substantial upside opportunities
 - Revenue per treatment: Medicare no longer “reduced” from overpayment recoupment
 - Expense per treatment: pharma costs could be substantially lower
 - Potentially mid-high single digit revenue growth in U.S. kidney care in the later part of the decade
 - Currently, there are 118 centers internationally that are in a start-up phase and are losing money because of start-up costs and working capital investments; huge upside here.
- Is making a “forecast” about revenue a few years from now even helpful?
 - Reminder that the demand is steady, non-cyclical, non-seasonal
 - Only current alternative to dialysis is kidney transplant
 - History is a good example, and the ability to have consistent historical growth coincides with the underlying demand drivers

Per Treatment Economics

- DVA makes about \$70 in pre-tax FCFF per treatment (~20% margin)



Patient Mix Impacts

- Patient mix is heavily concentrated towards government paying (~89%), mostly due to typical age of patient with ESRD, and the CMS automatic qualification for ESRD patients regardless of age/financial condition after 33 months on dialysis
- However, commercial rates are 3-4x that of Medicare, and thus the revenue is about 66% government, 34% commercial

	2014	2015
Lab Revenues by Source:		
Medicare and Medicare -assigned plans	58%	56%
Medicaid and Medicaid-assigned plans	6%	6%
Other Government-based programs	3%	4%
Total Government	67%	66%
Commercial (incl. hospital inpatient services)	33%	34%
Total Dialysis and Related Lab Revenues	100%	100%
Patient Mix		
Government Paying	90%	89%
Commercial Paying	10%	11%
Medicare patient mix		76%

Summary of Dialysis Business

- Stable and consistent underlying demand from ESRD patient growth
- Demand is non-cyclical
- Demand is not seasonal
- The only true alternative to dialysis is a kidney transplant, and there are not enough kidney transplants per year for the number of ESRD patients
- Without dialysis, an individual with ESRD will die within a couple of week, thus dialysis is a true necessity
- Since 1972, CMS has shown the importance of dialysis by qualifying any individual with ESRD to get Medicare regardless of age or financial condition, the only disease state to have this.
- DVA is the industry leader at ~34% in U.S., an industry essential is an oligopoly with Fresenius (FMC) as close #2
- DaVita is, by far, the highest quality of care provider, evidenced by the CMS Star Rating

HealthCare Partners

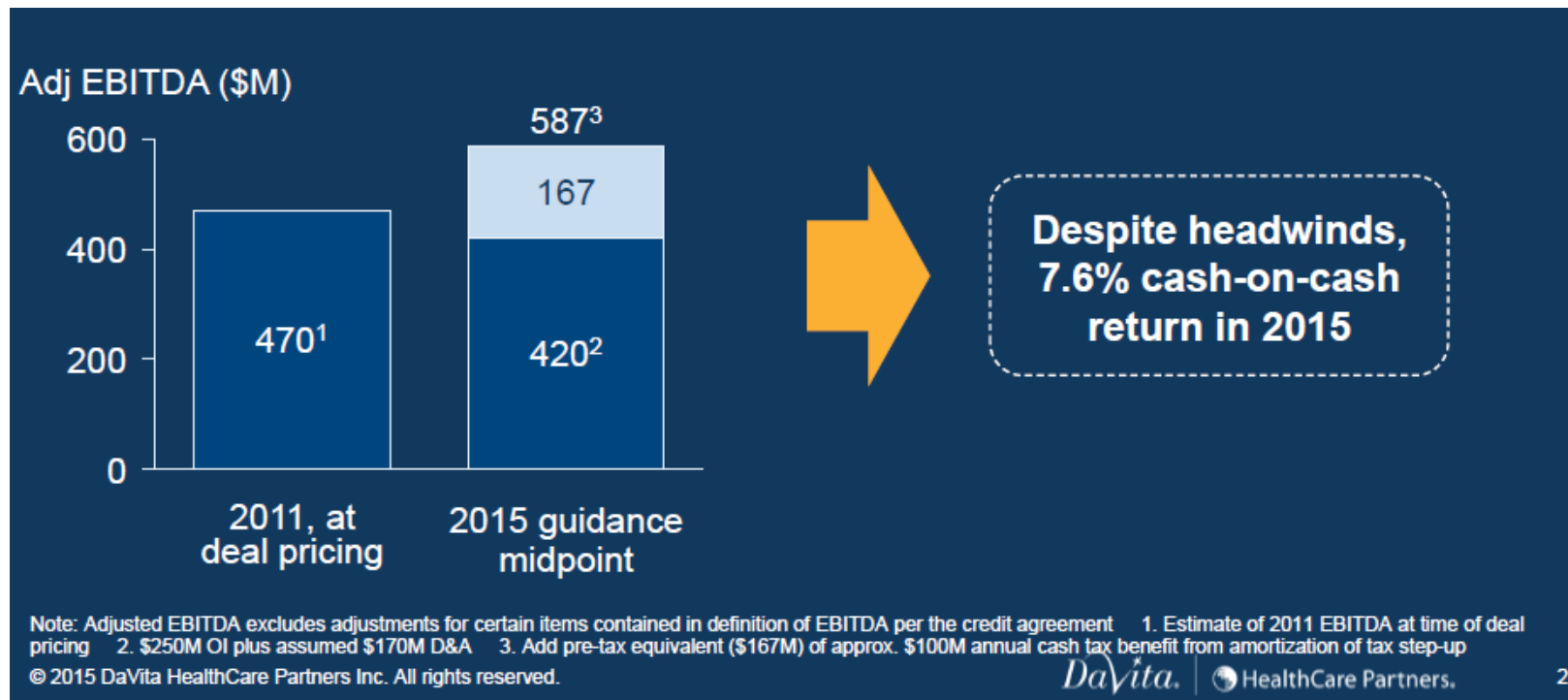
Healthcare Delivery and Management Company

About “HCP”

- Patient and physician-focused “integrated healthcare delivery and management company”
- Over 20 years of experience
- Outcomes based model (focus on delivering care in cost-efficient manner)
- In 6 markets:
 - Southern California (Los Angeles)
 - Colorado
 - Florida
 - Southern Nevada
 - Central New Mexico
 - Central Arizona
- Based around “capitated” contracts with health plans
- 807,400 members under care as of end 2015, with 317,400 enrolled in Medicare Advantage, remaining 490,000 have ‘commercial’ health insurance

HCP: Underperforming Acquisition

- Purchased in 2012 for \$4.4 billion
- OI guidance at the beginning of 2013 was \$400m - \$450m, for 2016 its about half of that
- Impairment of \$200m in 2015 due to underperformance
- Things have worsened some since this chart below, by about \$50m OI (~20%)

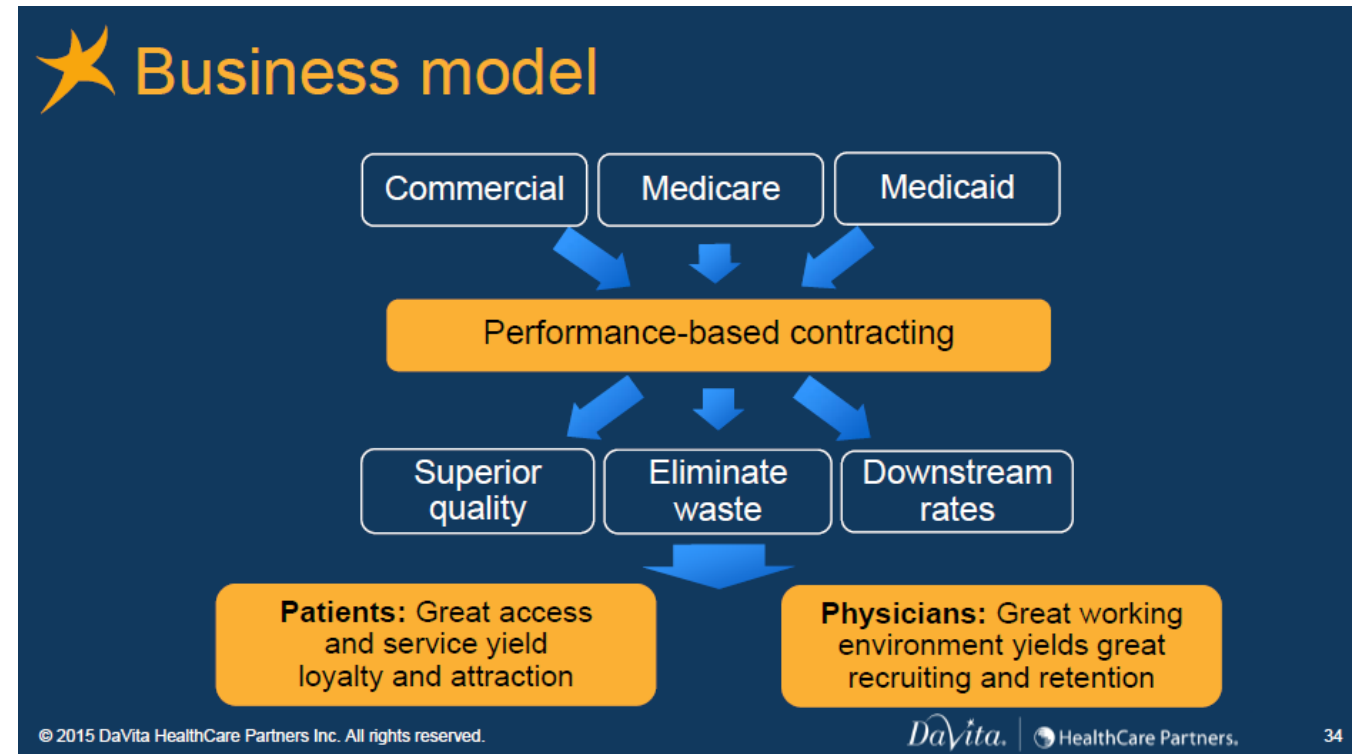


HCP Locations

- HCP managed a total of 226 medical clinics
 - 62 in California
 - 13 in Colorado
 - 79 in Florida
 - 55 in Nevada
 - 14 in New Mexico
 - 3 in Georgia
 - Arizona – members receive services at independent physician and medical group practices (does not directly manage these clinics)

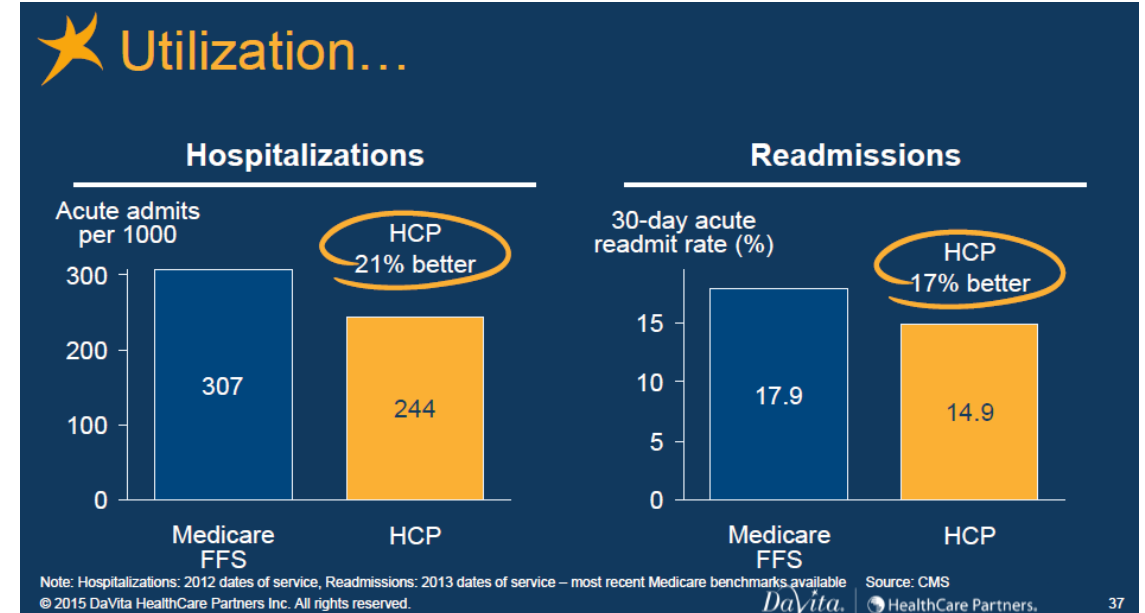
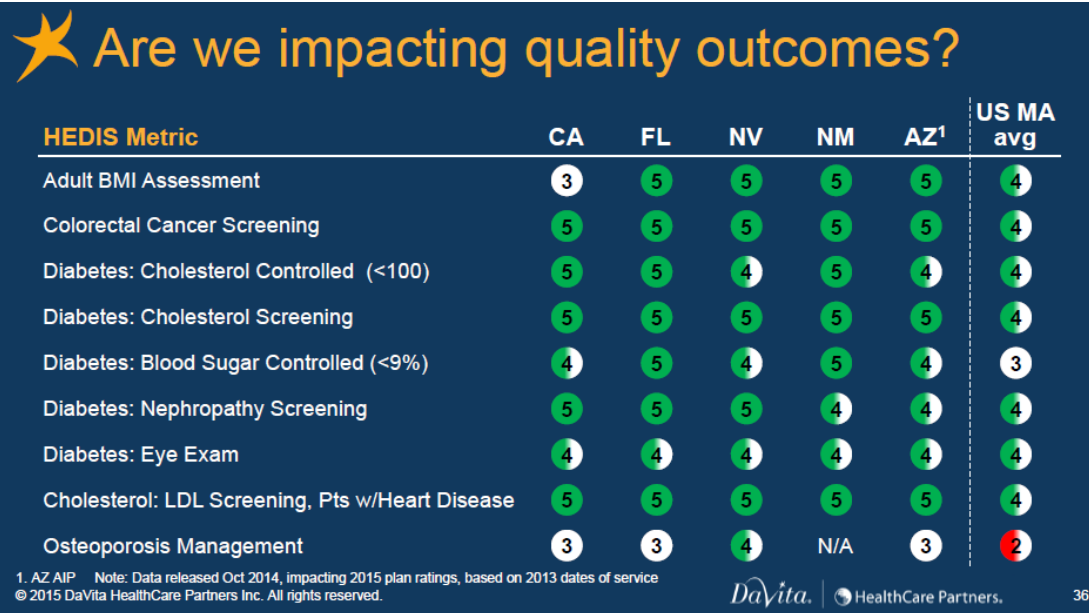
HCP Business Model

- To have “performance based” contracting with payers, whereby they receive a per-member/per-month rate and perform services on patient. Any “savings” becomes profit.
- At the forefront of the shift from traditional Medicare “Fee For Service” to “Fee for Performance”
- Use large database and technology to recognize common symptoms, issues with patients, can be more proactive than reactive
- Different than typical “Primary Care Physician” doctor visit, as HCP’s PCP’s see about 50% of the patients daily versus typical PCPs – this means more time to spend with the patient and diagnose issues, talk diet, etc.
- FFS encourages quick turnover of patient visits; FFP encourages highest quality and cost control.



HCP Leads US Medicare Advantage Averages: HEDIS

- In the primary 5 legacy markets, HCP has much strong performance than U.S. Medicare Advantage Averages
- Hard to overstate the importance of being a high quality of care provider currently, as things are shifting more and more and payers want improved margins, avoid unnecessary costs
- Similar to the dialysis business, HCP focuses heavily on avoiding unnecessary hospitalizations and readmissions



HCP Acquisitions

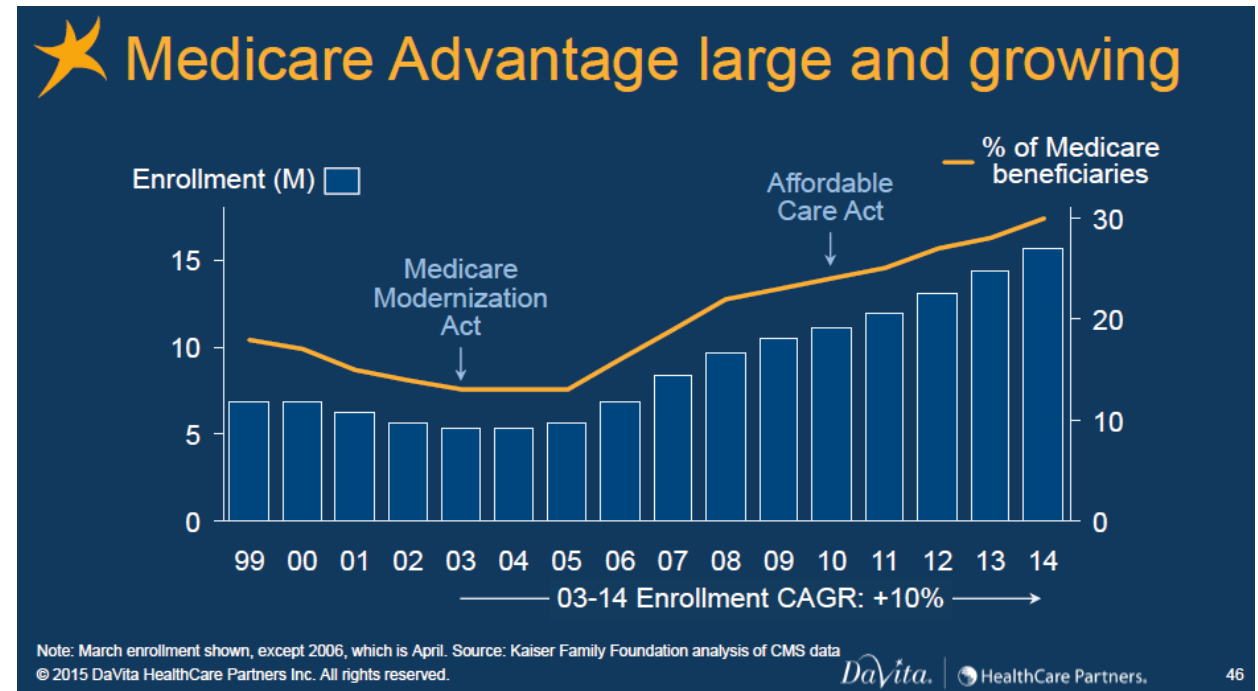
- 2015: \$385 million for “The Everett Clinic Medical Group” (TEC)
 - Washington state medical group
 - 500 providers in primary and specialty care locations in Snohomish County, Washington
 - Care for more than 315,000 patients

Business Driver Formula:

- Volume: Membership Numbers
 - MA patients: Growing
 - Commercial: Flat to lower
- Price: Reimbursement Rate
 - 2016 base rate better than expected
 - Star Ratings helps Plan get better reimbursement, which means better growth....

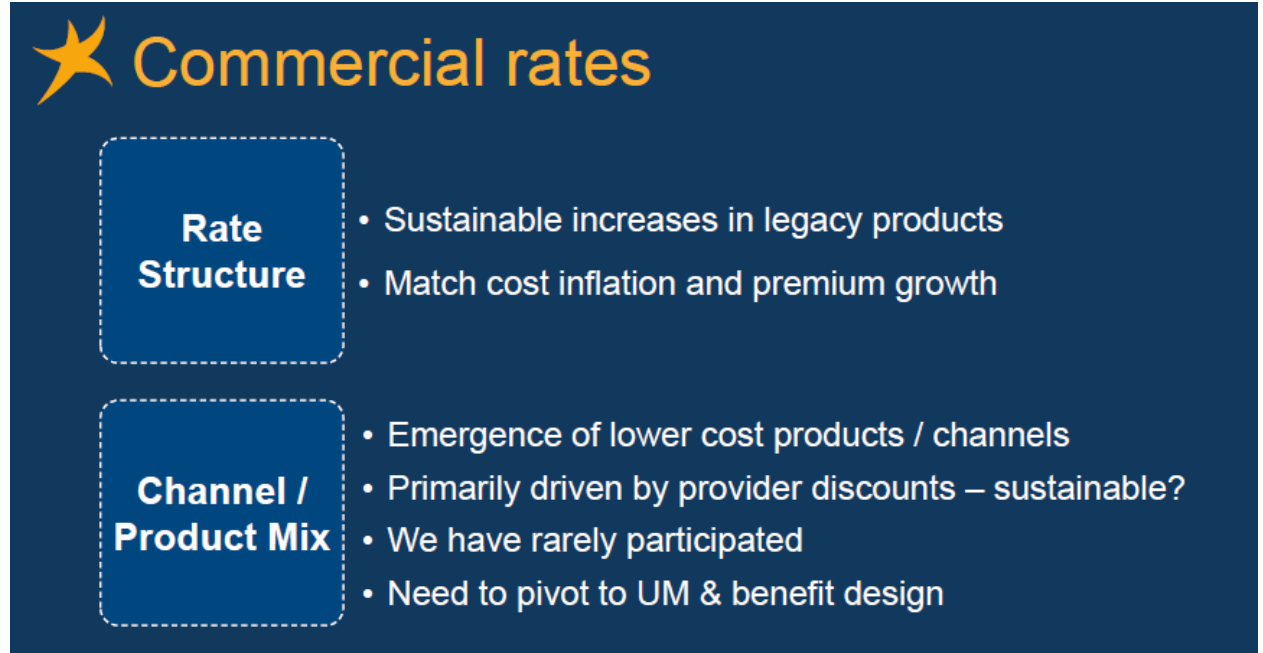
Volume: Growth from Medicare Advantage Success

- MA focuses on the capitated model, more fee-for-performance
- The growth of MA provides more patient opportunities for HCP
- HCP has faster in each legacy market than the growth rate in MA patients from 2012 – 2014
 - California: 9% versus 8% MA
 - Florida: 23% versus 9% MA
 - Nevada: 18% versus 8% MA
 - TOTAL: 16% versus 9% MA
- Penetration in these markets is around 40%



Rate: Star Ratings Get Bonuses

- Higher star ratings = higher funding
- For 2015:
 - 4 stars or 5 stars: 5% bonus
 - Less than 4 stars: 0% bonus
- 84% of HCP's MA patients were in 4+ Star plans for 2015
- Virtuous cycle: higher star ratings = better reimbursement = better growth
- Commercial Rates:
 - ~65% of contracts aligned, 35% not



Commercial rates

- Rate Structure**
 - Sustainable increases in legacy products
 - Match cost inflation and premium growth
- Channel / Product Mix**
 - Emergence of lower cost products / channels
 - Primarily driven by provider discounts – sustainable?
 - We have rarely participated
 - Need to pivot to UM & benefit design

Expenses:

- Expense breakdown typically:
 - 45% is institutional expenses
 - 35% are professional and ancillary network costs
 - 20% are group clinics
- Patient care costs make up ~75% of operating expenses for HCP
 - Largely related to medical ~60%
 - 20% is hospital costs
 - 20% is clinic support

Risks

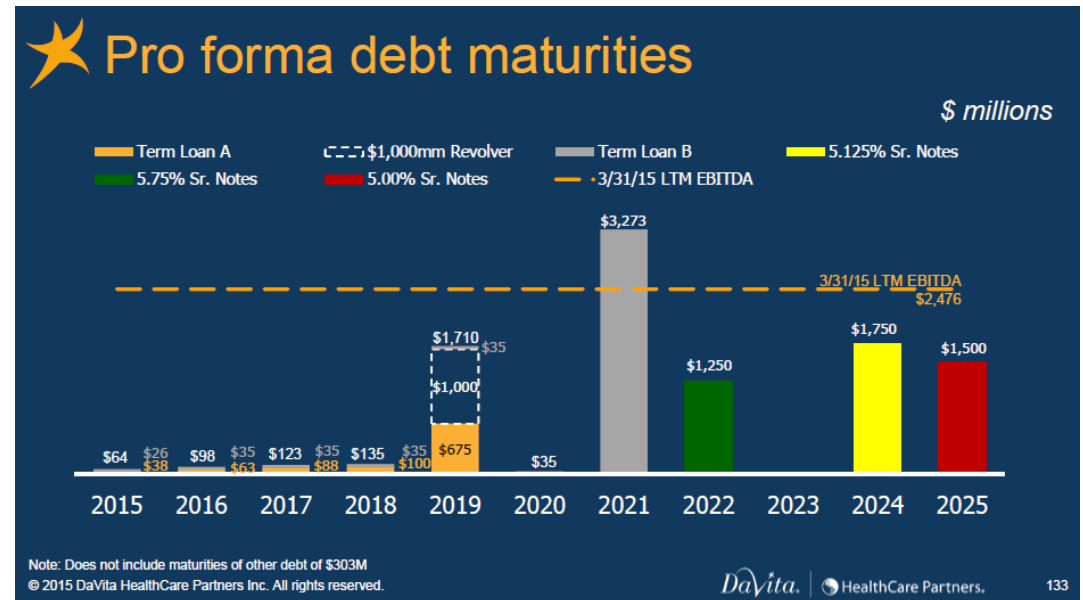
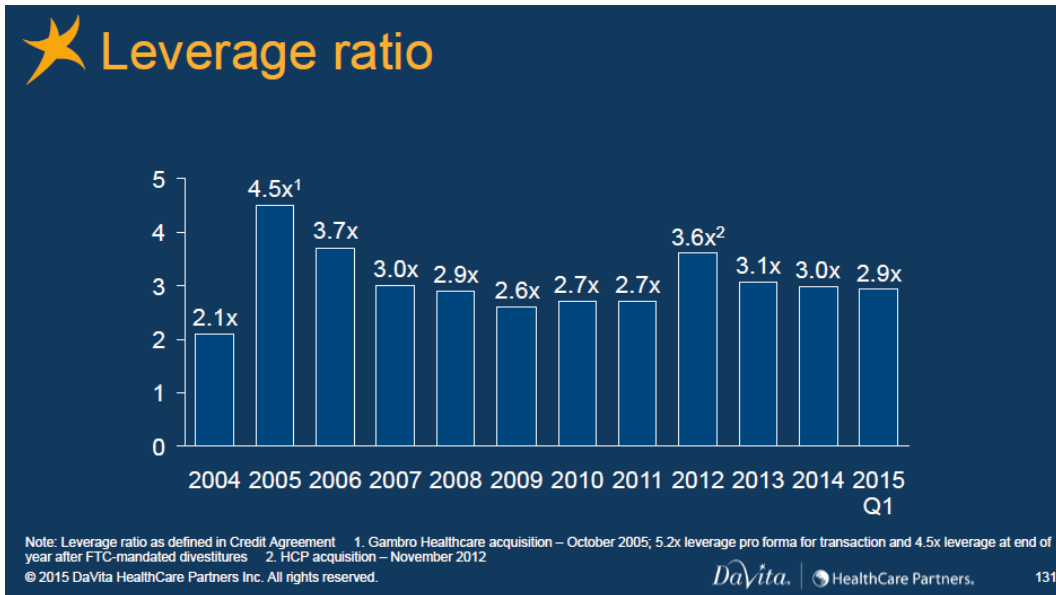
Concerns about DaVita...

Risks: Rate/Patient Mix

- Patient mix can be worrisome for dialysis segment, which produces substantial amount of DVA cash flow – 89% of patients are government paying, and DVA loses ~10%+ per patient
- Patient mix puts pressure on commercial contracting, where rates are 300-400% the Medicare reimbursement rate
- Higher unemployment rates = less commercial paying individuals, more government paying individuals
- Payer consolidation puts more negotiating leverage on the payer side
- Key man: Kent Thiry (CEO) is the dominant force behind the strength of the kidney care business
- HCP continues to underperform, creates additional goodwill impairment
- Technology finally catches up to created a suitable artificial kidney
- Population becomes healthier, ESRD growth rate slows

Risks: Debt

- About 90% of total debt outstanding is “fixed”
- Average fixed rates are 4.64%
- Average variable rates are 2.19% (matures <2019)
- Debt covenants state that Debt-EBITDA cannot be more than 5.0x, currently ~2.95x based on definitions
- No meaningful debt maturing until ~ 2019



Are “One-Time Charges” Really One-Time?

- The track record since 2012 hasn’t been stellar, with:
 - Multiple lawsuits – Vainer private civil suit and the U.S. Attorney physician relationship suit
 - Poor acquisition in “HCP”
 - Expenses associated with the acquisition of HCP
 - Goodwill and Intangible Asset Impairment of HCP in 2015
- From 2015 10-K: (are these really one-time expenses?)

related to simplification of debt issuance costs as well as ASU 2015-17 related to classification of deferred taxes (see “New Accounting Standards” below). All prior periods have been recast to conform to the current year presentation.

- (2) Operating expenses and charges in 2015 include a settlement charge of \$495,000 related to the Vainer private civil suit, estimated goodwill and intangible asset impairment charges of \$210,234, primarily related to certain HCP reporting units, and an estimated accrual for damages and liabilities of \$22,530 associated with our pharmacy business. Operating expenses and charges in 2014 and 2013 include an additional \$17,000 and \$397,000, loss contingency accrual related to the settlement of the 2010 and 2011 U.S. Attorney physician relationship investigations, respectively. Operating expenses and charges in 2013 also include a contingent earn-out obligation gain adjustment of \$56,977 related to a decrease in HCP’s 2013 contingent earn-out obligation and an adjustment to reduce a tax asset associated with the HCP acquisition escrow provisions of \$7,721. In addition, 2012 included \$85,837 for a legal settlement and related expenses, and \$30,753 of transaction expenses associated with the acquisition of HCP.

- (3) Income from operations of discontinued operations, net of tax includes the operations for all prior periods presented of HomeChoice Partners Inc. (HomeChoice) which was divested on February 1, 2013. The income from operations of discontinued operations in 2011 also includes a \$24,000 non-cash goodwill impairment charge related to

Management

Kent Thiry – an “Outsider”?

DaVita Dialysis: Almost Bankrupt in 1999

- The dialysis industry really expanded in mid-1990s through waves of new centers and consolidation
- DaVita was known as Total Renal Care (TRC)
- The massive expansion and push to international growth created a company with limited cash flow (due to upfront start-up costs), lack of investments in their systems and heavy in debt
- DVA was at risk of not meeting payroll, being forced into liquidation by banks, were being investigated by SEC, and sued by shareholders
- Kent Thiry became CEO in October 1999 and changed business model
 - Focus on paying down debt, becoming CF positive, selling all international centers, focusing on U.S. first

Kent Thiry

- Became CEO in October 1999 on the brink of bankruptcy
- Background:
 - Stanford (undergrad) 1978
 - Harvard Business School (MBA) 1981-83
 - Bain & Company Partner 1987-1991
 - Vivra Specialty Partners (Chairman and CEO) 1991 – 1999
 - DaVita (1999 – current)
- Vivra Specialty Partners – a dialysis business, sold to a Swedish firm in 1997 for \$1.6 billion, was the 2nd largest dialysis provider in the U.S. in 1997

Stock Performance Since “KT” became CEO

- DaVita (DVA) is up 2,875% since October 1, 1999, compared to 49.72% for S&P 500
- Compounded returns of 21% since he became CEO over 15 years ago



Stock Performance Since “KT” became CEO

- Since Kent Thiry became CEO:
 - **DaVita up 2,870%+**
 - Fresenius Medical (FMS) – top comp: up 267%
 - Berkshire Hathaway: up 234%
 - S&P 500: up 49%
 - AutoZone (AZO): 2,854%
 - Amazon (AMZN): 692%
 - Google (GOOG): 1,340%+
 - **Apple (AAPL): 3,600%**
- Truly, since he became CEO, DaVita is one of the best performing companies, outperforming some of the true great companies since 1999

Management Has Strong Track Record

- Typically, management commonly meeting guidance is a negative, as it can create pressure on management to continue to perform and “fudge” numbers to continue to show strong track record of meeting guidance
- In DaVita’s case, it is less of a concern.
Why?
 - The business is very stable, with steady cash flows and steady demand
 - The industry has not changed much in terms of demand, and demand is not cyclical or seasonal
 - Guidance for the kidney care business is easier to meet versus HCP, and thus they provide wider ranges for HCP guidance



Strong operating track record

OI	Guidance Provided ¹	Results Realized ^{2,3,6}	In or Above Range
2003	\$292-312M	\$355M	✓
2004	\$356-380M	\$402M	✓
2005	\$410-435M ⁴	\$462M	✓
2006	\$575-645M ⁵	\$701M	✓
2007	\$680-750M	\$800M	✓
2008	\$790-850M	\$822M	✓
2009	\$870-930M ⁶	\$940M	✓
2010	\$950-1,020M	\$997M	✓
2011	\$1,040-1,100M	\$1,155M	✓
2012 ⁷	\$1,100-1,200M	\$1,347M	✓
2013	\$1,750-1,900M	\$1,898M	✓
2014	\$1,675-1,850M	\$1,832M	✓

1. First guidance

2. Non-GAAP measure; excludes one-time charges and reported prior period recoveries.

3. 2010 and prior represents the original amounts as reported; OI has not been adjusted for the required divestitures that occurred in connection with the Gambro and DSI acquisitions. In addition, 2010 and prior amounts presented have not been adjusted for the divestiture of HomeChoice Partners.

4. Gambro acquisition completed October 2005.

5. Includes stock compensation expense; Original guidance excluded stock compensation.

6. Effective January 1, 2009, we were required to change the presentation of minority interests (noncontrolling interests) in our consolidated statement of income, which changed the presentation of operating income as well. All prior amounts have not been adjusted to reflect the application of this requirement.

7. Kidney Care only, since first guidance was provided prior to announcement of HealthCare Partners acquisition.

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Management Seems to Be Honest on Mistakes

- With a few larger lawsuits in the past few years (Vainer, Government), DVA's management takes full blame for mistakes
- Admits bad start and underperformance on HCP acquisition
- Open about challenges of both businesses, such as rate cuts, potential risk of payer consolidation

Vainer (2003-2010)

- Humbled
- Disappointed
- We made mistakes
- Not representative
- Must earn government's trust

Value and Expected Future Returns

~10%+ Expected Future Returns at Current Prices

Valuation

- Valuation must be based on **both** maintenance and growth capital expenditures, as DVA is dominated by the kidney care business, which needs to open new centers (growth capital) to get more patients, which increased the number of treatments they provide (volume)

Financials updated as of:

Q4 2015

Current Stock Price	\$ 70.00	
Shares Outstanding (Diluted)	205,073	* includes January 2016 repurchase
Market Capitalization	\$ 14,355,109	
(minus) Cash & Equiv.	\$ 1,499,116	
(minus) Investments in Aff.	\$ 167,490	
(add) Long Term Debt	\$ 9,001,308	
(add) Commercial Borrowing	\$ 129,037	
(add) Loss Contingency	\$ -	
Enterprise Value	\$ 21,818,848	

Leverage (EBITDA):	
Gross Debt	3.84
Net Debt	3.14

Adj. Debt (Op Lease)	
\$	11,563,420

Thru- Q4/2015		EV-to:	Market Cap-to:	Yield
FCF - Firm (ttm, post-tax)	\$ 1,628,822	13.40		7.5%
FCF - Firm (post tax) Actual CPX	\$ 1,151,322	18.95		5.3%
FCFE (ttm, maintenance Cpx)	\$ 1,220,442		11.76	8.5%
FCFE (ttm, Actual CPX)	\$ 722,816		19.86	5.0%
OCF (EBDA)	\$ 1,459,407		9.84	10.2%
EBIT (ttm, Adj.) (Includes NCI)	\$ 1,736,716	12.56		8.0%
EBIT (ttm) (Op Lease = Debt)	\$ 1,864,520	13.01		7.7%
Net Income (ttm)	\$ 823,722		17.43	5.7%
Net Income (per DVA, proxy FCF)	\$ 930,325		15.43	6.5%
EPS (ttm, adjusted)	\$ 4.02		17.43	5.7%
FCFFPS	\$ 7.94	13.40		7.5%
Operating Cash Flow (2016 est.)	\$ 1,700,000	12.83		7.8%
OCF - Capex (Mcx + de novo)	\$ 1,699,335	12.84		7.8%
EBITDA	\$ 2,374,740	9.19		10.9%
Est. NTM EBIT	\$ 1,900,000	11.48		8.7%

Best numbers to focus on, and cash flow amounts include *full* capex

Future Growth Rate:

- Based on consistent U.S. kidney care growth with appropriate leverage and operating efficiency, DaVita targets 5% - 12% EPS growth
- To obtain this 5% - 12% EPS growth, there is a necessity for “growth capital expenditures”, as there isn’t much pricing power and capital is needed to be deployed into new centers in order to obtain more patients, have more treatments, and so on.
- About ~3.5% of current kidney care service revenues are needed for “maintenance capital needs/IT”; remaining businesses (and HCP) don’t really need any capital/inventory, etc.
- Assuming DVA kidney care will grow ~4% in revenues, and 15% ROIC, they will need to reinvest ~1/4 of their operating income (*rough math*) or about \$450m in 2016
- Add another ~\$300m in “routine maintenance/IT/other” expenditures
- Total capex for 2016 = ~\$750m
- EBITDA ~ \$2.4 billion – noncontrolling interests \$160m = \$2.24b EBITDA
- **Post-Tax FCF for 2016 = ~\$1.19b (~18.3x current EV)**
- **Post-Tax FCFE for 2016 = ~\$750m (19x current equity price)**

Valuation:

- **Post-Tax FCF for 2016 = ~\$1.19b (~18.3x current EV)**
- **Post-Tax FCFE for 2016 = ~\$750m (19x current equity price)**
- These numbers are based on (1) maintenance capital expenditures, and (2) the likely capital expenditures to fund new center development to achieve the ~4% growth rate in revenues
- In other words, a 5.25% yield + 4% revenue growth rate + ~1-2% operating efficiencies = **~11%+ expected return at current pricing of ~\$70 per share**
- The more capital reinvested for growth in new centers, the lower the FCF yield but the higher the growth rate, which is preferable as ROIC is greater than cost of capital
- If DaVita does not see the underlying growth, they will not invest in new dialysis centers. Assuming *no* future center developments:
 - FCFE = \$1.2 billion with ~0% growth (growth in pricing offset by growth in expenses), or 12x current market cap, similar to a bond with a 8.3% coupon rate

~10% + Expected Return: Worth It?

- Many investors prefer higher return investments, thus DaVita not enticing, does not attract GARP or growth investors
- At ~19x free cash flow (after full capex), it does not really attract value investors, as it's not "cheap on paper" and never really trades cheaply
- Personally, we own DaVita for a few reasons:
 - Underlying demand is consistent, non-cyclical, not seasonal
 - The other alternative - kidney transplant – lacks "supply" to be a true substitute for the entire ESRD population each year
 - My concern about the high involvement of government is negated by the fact that the government has been highly supportive of accommodating the ESRD population by providing Medicare coverage at any age/financial status (the only disease state Medicare does this for), DaVita's investments in ancillary services to lower unnecessary hospitalization costs, and the fact DVA is (by far) the highest quality provider of dialysis services
 - To me, ~10%+ is still attractive, especially with concerns over "lower for longer interest rates", a fully valued stock market, worries over commodity fallout and China, and so on. **These "concerns" have no bearing on the demand for dialysis for those with ESRD.**
 - Underlying demand drivers in the U.S. should bode well for future dialysis needs
 - A true alternative to dialysis is still years away

Notes:

- I wrote about DaVita HealthCare Partners (DVA) in December 2015, at similar prices as current
- For additional information, some of which was not included in this slide deck, visit: valueseekerinvestments.blogspot.com
- Some updates from then include:
 - Full year 2015 #s
 - Update on CMS QIP information
 - 2016 Guidance numbers from DVA
 - DVA did an accelerated share repurchase in January 2016

Thank You

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