RENAL CARE GROUP INC
Form 10-K
March 15, 2006

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

FORM 10-K
FOR ANNUAL AND TRANSITION REPORTS
PURSUANT TO SECTIONS 13 OR 15(D) OF THE
SECURITIES EXCHANGE ACT OF 1934

þ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(D) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the fiscal year ended December 31, 2005
or

o **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(D) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the transition period from_____to_____
Commission file number 0-27640
RENAL CARE GROUP, INC.
(Exact Name of Company as Specified in its Charter)

Delaware	**62-1622383**
(State or other Jurisdiction of Incorporation or Organization)	(I.R.S. Employer Identification No.)

2525 West End Avenue, Suite 600
Nashville, Tennessee 37203
(Address, Including Zip Code, of Principal Executive Offices)
Registrant s Telephone Number, Including Area Code: (615) 345-5500
Securities Registered Pursuant to Section 12(b) of the Act:

Title of Each Class	Name of Exchange on Which Registered
Common Stock, $0.01 par value	New York Stock Exchange
Series A Junior Participating Preferred Stock Purchase Rights	New York Stock Exchange

Securities Registered Pursuant to Section 12(g) of the Act: None

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

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

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

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

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

Large accelerated filer þ Accelerated filer o Non-accelerated filer o

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

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The aggregate market value of the voting stock held by non-affiliates of the Company was $3,103,391,332 as of June 30, 2005, based upon the closing price of such stock as reported on the New York Stock Exchange on that day (assuming for purposes of this calculation, without conceding, that all executive officers and directors are affiliates).

There were 68,742,244 shares of common stock, $0.01 par value, issued and outstanding at March 9, 2006.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Registrant s Proxy Statement for its 2006 Annual Meeting of Stockholders are incorporated by reference in Part III of this annual report on Form 10-K.

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FORWARD LOOKING STATEMENTS

This report contains forward-looking statements. Forward-looking statements relate to our expectations, beliefs, future plans and strategies, anticipated events or trends and similar expressions concerning matters that are not historical facts or that necessarily depend upon future events. In some cases, you can identify forward-looking statements by words like may, will, should, could, would, expect, plan, anticipate, believe, estimate potential and similar expressions. Specifically, this report contains, among others, forward-looking statements about:

- our expectations regarding financial condition or results of operations for periods after December 31, 2005;
- the agreement by Fresenius Medical Care to acquire Renal Care Group;
- our critical accounting policies;
- our business strategies and our ability to grow our business;
- the reimbursement levels of third-party payors; and
- our future sources of and needs for liquidity and capital resources.

The forward-looking statements included in this report reflect our current views about future events. They are based on assumptions and are subject to known and unknown risks and uncertainties. Many factors could cause actual results or achievements to differ materially from future results or achievements that may be expressed in or implied by our forward-looking statements. Many of the factors that will determine future events or achievements are beyond our ability to control or predict. Important factors that could cause actual results or achievements to differ materially from the results or achievements reflected in our forward-looking statements include, among other things, the factors discussed on pages 18 to 27 of this report under the heading Risk Factors.

You should read this report, the information incorporated by reference into this report and the documents filed as exhibits to this report completely and with the understanding that our actual future results or achievements may be materially different from what we expect or anticipate.

The forward-looking statements contained in this report reflect our views and assumptions only as of the date this report is filed with the Securities and Exchange Commission. Except as required by law, we assume no responsibility to update any forward-looking statements.

Before you invest in our common stock, you should understand that the occurrence of any of the events described in the Risk Factors section, located elsewhere in this annual report on Form 10-K or incorporated by reference into this annual report on Form 10-K and other events that we have not predicted or assessed could have a material adverse effect on our earnings, financial condition and business. If the events described in the Risk Factors or other unpredicted events occur, then the trading price of our common stock could decline, and you may lose all or part of your investment.

We qualify all of our forward-looking statements by these cautionary statements. In addition, with respect to all of our forward-looking statements, we claim the protection of the safe harbor for forward-looking statements contained in the Private Securities Litigation Reform Act of 1995.

Unless otherwise indicated, Renal Care Group, we, us, our, and the Company refer to Renal Care Group, Inc. our consolidated subsidiaries.

PART I

Item 1. *Business*

ACQUISITION BY FRESENIUS MEDICAL CARE

On May 3, 2005 we entered into a definitive merger agreement with Fresenius Medical Care AG in which Fresenius Medical Care agreed to acquire all of Renal Care Group s outstanding stock. Fresenius Medical Care will pay $48.00 for each of our outstanding shares of common stock. Fresenius Medical Care will acquire Renal Care Group subject to its outstanding indebtedness.

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Our Board of Directors and the management and supervisory boards of Fresenius Medical Care have approved the transaction, and on August 24, 2005 our stockholders voted to approve the transaction. Completion of the transaction is subject to customary conditions to closing, including the termination or expiration of the waiting period under the Hart-Scott Rodino Antitrust Improvements Act of 1976, as amended. In June 2005, we received a request for additional information under the Hart-Scott Rodino Act from the Federal Trade Commission. Management believes the transaction will close by March 31, 2006.

GENERAL

Renal Care Group, Inc. provides dialysis services to patients with chronic kidney failure, also known as end-stage renal disease (ESRD). As of December 31, 2005, we provided dialysis and ancillary services to over 32,300 patients through 456 outpatient dialysis centers in 34 states, in addition to providing acute dialysis services to more than 200 hospitals. Renal Care Group was formed in 1996 by leading nephrologists with the objective of creating a company with the clinical and financial capability to manage the full range of care for ESRD patients on a cost-effective basis. As of December 31, 2005, there were 1,314 nephrologists with privileges to practice at one or more of our outpatient dialysis centers.

In our dialysis facilities, ESRD patients receive dialysis treatments, generally three times a week, in a technologically advanced outpatient setting. According to the Centers for Medicare & Medicaid Services (CMS), there were more than 4,500 facilities providing outpatient dialysis services in the United States at the end of 2003. Because of the critical role of dialysis in the treatment of patients with ESRD, many outpatient dialysis facilities were, in the 1980 s and 1990 s, owned by practicing nephrologists and comprised an integral component of their practice. The dialysis services industry has been consolidating since before we were formed. As a result, we believe that as of December 31, 2005, approximately 67% of outpatient dialysis centers are now owned by multi-center dialysis companies, approximately 15% are owned by independent physicians, small chains and other small operators, and approximately 18% are owned by hospitals.

Renal Care Group is a Delaware corporation; our principal executive offices are located at 2525 West End Avenue, Suite 600, Nashville, Tennessee 37203; and our telephone number is (615) 345-5500. Our website is www.renalcaregroup.com.

INDUSTRY OVERVIEW

End-Stage Renal Disease

ESRD is a state of advanced kidney failure. ESRD is irreversible and, without a kidney transplant, ultimately lethal. It is most commonly a result of complications associated with diabetes, hypertension, certain renal and hereditary diseases, aging and other factors. In order to sustain life, ESRD patients must receive either dialysis for the remainder of their lives or a successful kidney transplant. By the end of 2003, dialysis was the primary treatment for approximately 72% of all ESRD patients in the United States, and the remaining 28% of ESRD patients had a functioning kidney transplant.

According to United States Renal Data System estimates, direct medical payments for ESRD totaled $27.3 billion during 2003. Of the total direct medical payments for ESRD, approximately $18.1 billion was paid by the federal government through the Medicare program. As a result of legislation enacted in 1972, the federal government provides Medicare benefits to patients who are diagnosed with ESRD, if they are eligible for Social Security, regardless of their age or financial circumstances.

According to CMS data, the number of ESRD patients in the United States who need dialysis grew from approximately 66,000 in 1982 to approximately 325,000 as of December 31, 2003. Based on data from the United States Renal Data System, the rate of ESRD incidence among Medicare-eligible patients was approximately 341 patients per million in 2003 as compared to 111 patients per million in 1984.

Based on these trends, United States Renal Data System forecasts indicate that the total number of ESRD patients, including those with functioning transplants, will grow from approximately 453,000 in 2003 to 621,000 in 2012. The growth in the number of ESRD patients is expected to result principally from the aging of the population along with better treatment of, and better survival rates for, diabetes and other illnesses that lead to chronic kidney disease, reduced somewhat by declines in incidence of ESRD among patients with high blood pressure as a result of better treatments for high blood pressure. In addition, as a result of improved technology, older patients and patients who

could not previously tolerate dialysis due to other illnesses can now receive life-sustaining dialysis treatment.

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Treatment Options for End-Stage Renal Disease

Currently, there are three treatment options for patients with ESRD:

hemodialysis performed in a hospital setting, an outpatient facility or a patient s home,

peritoneal dialysis, which is generally performed in the patient s home, and

kidney transplant surgery.

According to CMS data, in 2003 approximately 92% of patients on dialysis in the United States received hemodialysis in an outpatient setting, and approximately 8% received hemodialysis or peritoneal dialysis in their homes.

Hemodialysis is the most common form of ESRD treatment. It is generally performed in either a freestanding center or a hospital. Hemodialysis uses a dialyzer, essentially an artificial kidney, to remove toxins, fluid and chemicals from the patient s blood, while the patient is connected to another device that controls external blood flow and monitors the patient s vital signs. The dialysis process occurs across a semi-permeable membrane that divides the dialyzer into two chambers. While the blood is circulated through one chamber, a pre-mixed dialysis fluid is circulated through the adjacent chamber. The toxins and excess fluid contained in the patient s blood cross the membrane into the dialysis fluid. Hemodialysis usually takes about four hours and is usually administered three times per week for the life of the patient or until the patient receives a transplant.

Peritoneal dialysis is typically performed by the patient at home and uses the patient s abdominal cavity to eliminate fluids and toxins in the patient s blood. There are several forms of peritoneal dialysis. Continuous ambulatory peritoneal dialysis and continuous cycling peritoneal dialysis are the most common. Under each method, the patient s blood is circulated across the peritoneal membrane into a dialysis solution that removes toxins and excess fluid from the patient s blood. Patients treated at home are monitored monthly through either a visit from a staff person from a designated outpatient dialysis center or a visit by the patient to a dialysis center or home dialysis support facility.

Kidney transplants, when successful, are the most desirable form of therapy for ESRD patients. There is a shortage of donors that severely limits the availability of this procedure as a treatment option. Only about 4% of ESRD patients received kidney transplants in 2003.

OPERATIONS

Location, Capacity and Use of Facilities

As of December 31, 2005, Renal Care Group operated 456 outpatient dialysis centers in 34 states with 7,894 certified dialysis stations and provided inpatient dialysis services to more than 200 acute care hospitals. During 2005, we provided approximately 4.8 million dialysis treatments. We estimate that on average our centers were operating at approximately 57% of capacity as of December 31, 2005, based on the assumption that a dialysis center is able to provide up to three treatments a day per station, six days a week.

Operation of Facilities

Our dialysis centers provide outpatient hemodialysis and related services to ESRD patients using technologically advanced dialysis equipment to provide effective and efficient dialysis. Our centers generally contain between 10 and 30 dialysis stations, one or more nurses stations, a patient waiting area, examination rooms, a supply room, a water treatment space to purify water used in hemodialysis treatments, a dialyzer reprocessing room, staff work areas, offices and a staff lounge. Many of our centers are adjacent to areas used for training patients in home dialysis.

In order for our dialysis centers to be eligible to participate in the Medicare ESRD program, a qualified physician or group of physicians must act as medical director for each center and must supervise medical aspects of the center s operations. An administrator or manager manages each center. The administrator or manager is typically a registered nurse who is responsible for the day-to-day operations of the center and oversight of the staff. The staff of each center typically includes registered nurses, licensed practical or vocational nurses, patient care technicians, social workers, registered dietitians, a unit clerk and biomedical equipment technicians. We work to staff each center in a manner that allows us to adjust to the scheduling of personnel according to the number of patients receiving treatments.

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Home Dialysis

All of our markets offer home dialysis, either home hemodialysis, peritoneal dialysis or both. As of December 31, 2005, about 10% of the patients we were treating received home dialysis. We provide equipment and supplies, training, patient monitoring and follow-up assistance to patients who receive dialysis treatments in their homes. Management believes that home dialysis is important to providing a full range of dialysis care, and we continue to work to expand our home dialysis program.

Inpatient Care

We also provide inpatient dialysis services to hospitals in most of our markets. We often refer to these services as acute dialysis services. As of December 31, 2005, we provided inpatient services to more than 200 hospitals. Under these arrangements, we typically provide equipment, supplies and personnel to perform hemodialysis and peritoneal dialysis in connection with a hospital s inpatient services. Patients with acute renal failure resulting from accidents, medical and surgical complications, patients in early stages of renal failure and ESRD patients who need to be in the hospital for other reasons often require inpatient dialysis services. Most of our hospital acute dialysis contracts specify predetermined fees per dialysis treatment. Management believes that these fees will be subject to re-negotiation in the future as competition increases among dialysis providers and as hospitals face increased cost pressures.

Nephrologists

Caring for ESRD patients is typically the primary clinical activity of a physician specializing in nephrology (a nephrologist). A nephrologist s other clinical activities include the post-surgical care of kidney transplant patients, the diagnosis and treatment of kidney diseases in patients who are at risk for developing ESRD, and the diagnosis, treatment and management of clinical disorders including hypertension, kidney stones and autoimmune diseases. While some nephrologists practice independently or are members of multi-specialty groups, most nephrologists practice in small single-specialty groups. A nephrology group s practice often covers a relatively large geographic service area. Outside metropolitan areas, a large geographic area may be served by only one nephrology group. Most nephrologists also have a significant office practice, consult on numerous hospitalized patients who are not on dialysis and follow the progress of kidney transplant patients.

A key factor in the success of a dialysis center is the local nephrologist. An ESRD patient generally seeks treatment at a center where his or her nephrologist has privileges to admit patients. Consequently, we rely on our ability to satisfy the needs of patients of local nephrologists in order to gain new patients and to retain existing patients. As of December 31, 2005, there were 1,314 nephrologists with privileges to practice at one or more of our outpatient dialysis centers.

Medical Directors

To satisfy the requirements of the Medicare ESRD program, we must engage a medical director for each of our facilities. We generally engage practicing, board-certified or board-eligible nephrologists to serve as medical directors for our centers. The medical director is usually an independent contractor who provides services under an agreement with Renal Care Group. Medical directors are responsible for administering and monitoring our patient care policies, including patient education, administration of dialysis treatment, staff development and training programs, and assessment of all patients. Medical directors play an important role in quality assurance activities in our facilities and in coordinating the delivery of care to maintain dialysis patients general level of health and to avoid medical complications that might require hospitalization.

Renal Care Group s typical medical director agreement has a term of between five and ten years with renewal options. We pay medical directors fees that management believes are consistent with the fair market value of the required services. These medical director fees are the result of arms-length negotiations. Most of our medical director agreements also include non-competition clauses with specific limitations on the medical director s ability to compete with us by owning, or providing medical director services for, another dialysis facility for certain specified periods of time and in specified geographic areas.

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Ancillary Services

Renal Care Group provides a variety of ancillary services to treat ESRD patients in its dialysis operations. The most significant ancillary service is the administration of erythropoietin (also known as Epogen® or EPO). EPO is a bio-engineered protein that stimulates the production of red blood cells. EPO is used in connection with all forms of dialysis to treat anemia, a complication experienced by almost all ESRD patients. EPO is manufactured by a single supplier, Amgen Inc. Through our RenaLab subsidiary, we also provide clinical laboratory services for our dialysis operations. We also offer some other ancillary services ordered by patients physicians, including the administration of other drugs, tests for bone deterioration, electrocardiograms, nerve conduction studies to test for deterioration of a patient s nerves, Doppler flow testing to measure the effectiveness of the patient s vascular access for dialysis, and blood transfusions.

QUALITY ASSURANCE

Integral to our operating philosophy is the belief that providing high quality care is in the best interest not only of patients but also of our shareholders. Better patient care results in improved mortality and morbidity and a greater number of treatments, as patients life spans increase and the number of days patients spend in hospitals declines. In order to optimize therapy and improve outcomes, we maintain a vigorous quality assurance program. We establish, maintain and monitor quality criteria for clinical operations and monitor patient outcomes in all of our centers.

Medical Advisory Board

Our Medical Advisory Board oversees the review of patient outcomes and the development and communication of clinical protocols. The Medical Advisory Board is chaired by Raymond Hakim, M.D., Ph.D., our Chief Medical Officer, and is composed of 12 nephrologists, each of whom is the medical director of one or more of our centers. The Medical Advisory Board is responsible for establishing, implementing and monitoring our quality assurance policies and procedures and for reviewing and recommending protocols, policies and procedures for clinical treatment. The Medical Advisory Board also works to identify deficiencies in treatment practices and to evaluate technological changes. The Medical Advisory Board s ultimate objective is to assist Renal Care Group in developing and communicating a protocol-driven clinical care model that will assist us in continuously improving the care we provide to patients, with the goal of providing optimal care to all patients.

Quality Criteria

Continuous quality improvement is our primary clinical objective. We work to achieve this objective by regularly evaluating dialysis treatments and patients key physiological parameters. Our Quality Assurance Coordinator is a registered nurse who oversees our quality assurance program. In addition, each of our dialysis centers has a quality assurance committee that monitors the quality of care in the center and oversees compliance with applicable regulations. These committees typically include the medical director, the center administrator, nurses and other technical personnel.

CORPORATE COMPLIANCE PROGRAM

We have developed and maintain a company-wide compliance program as part of our commitment to comply fully with all laws and regulations applicable to our business and to maintain high standards of ethical conduct by our associates. The primary purposes of the program are to heighten associates and affiliated professionals awareness of the importance of complying with all laws and regulations that apply to our business and to take steps to identify and resolve promptly instances of non-compliance.

The compliance program has been approved by our Board of Directors. The program addresses general compliance issues and areas of particular sensitivity. Among the areas of particular sensitivity covered by the compliance program are health care fraud and abuse issues, financial reporting, conflicts of interest and antitrust. As part of the program we have published a code of conduct setting forth standards of conduct and principles of business ethics that we will follow and that we expect each employee and affiliated professional to follow. We review and update the code of conduct regularly. An internal compliance committee comprised of some of our officers and senior managers and our full-time Compliance Officer administer our corporate compliance program. The internal compliance committee and our Compliance Officer are authorized to report compliance issues directly to the Compliance Committee of our Board of Directors or, if appropriate, to the Audit Committee of our Board of Directors.

We also maintain a compliance program specific to RenaLab, our laboratory subsidiary. This program mandates laboratory-specific compliance standards, policies and procedures. The laboratory compliance program is administered by an internal laboratory

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compliance committee, composed of officers and senior managers of Renal Care Group and RenaLab. This committee includes our Compliance Officer and a part-time RenaLab Compliance Officer. This committee and the RenaLab Compliance Officer are authorized to report compliance issues directly to the RenaLab Board of Directors and to the Compliance Committee and the Audit Committee of Renal Care Group s Board of Directors.

REIMBURSEMENT

Sources of Net Revenue

The following table sets forth information regarding the sources of our net revenue:

	Year Ended December 31,		
	2003	**2004**	**2005**
Medicare	49%	49%	52%
Medicaid	6	4	4
Commercial and other payors	40	42	39
Acute dialysis services	5	5	5
Total	100%	100%	100%

Medicare

The Social Security Act provides that most U.S. citizens and resident aliens with ESRD are entitled to Medicare coverage. If a physician diagnoses an eligible person with ESRD, then the patient will be entitled to Medicare coverage (1) beginning the third month after the month in which a regular course of dialysis is initiated, or (2) as early as the month in which a kidney transplant candidate is hospitalized for the transplant if certain conditions are met.

For Medicare purposes, ESRD is defined as kidney impairment that appears irreversible and permanent and that requires a regular course of dialysis or a kidney transplant to maintain life. For a period of 30 months, Medicare coverage is secondary for patients who have qualifying employer-based health insurance. After this 30-month period, Medicare becomes the primary coverage for patients, and the patient s other health insurance generally pays applicable Medicare coinsurance payments and deductibles.

Congress mandated a change in the way we were paid beginning in 2005 for most of the drugs, including EPO, that we bill for outside of the flat composite rate. This change resulted in lower reimbursement for these drugs and a higher composite rate. In 2006 we will be reimbursed for separately billable ESRD drugs at average sales price plus 6.0%. In addition, the composite rate was increased by 14.7% for 2006 to account for the reduction in drug payments. These regulations also include a case-mix adjustment that became effective in April 2005, a geographic adjustment to the composite rate and a budget-neutrality adjustment. Management believes these changes coupled with the 1.6% increase in the Medicare composite rate in 2006 will be positive to Renal Care Group s revenue per treatment and earnings in 2006.

According to the Medicare Payment Advisory Commission, also known as MedPAC, the Medicare ESRD composite rate for outpatient dialysis services averaged $140 per treatment in freestanding facilities during 2005. The Medicare ESRD composite rate is subject to regional differences based on a number of factors, including labor costs. CMS or Congress may periodically adjust Medicare reimbursement rates, including the ESRD composite rate, based on many factors, including legislation, executive and congressional budget reduction and control processes, inflation and costs incurred in rendering the services. Historically, adjustments in the Medicare ESRD composite rate have had little relationship to the cost of providing dialysis care.

The Medicare ESRD composite rate applies to a designated group of outpatient dialysis services, including dialysis treatment, supplies used for treatment, certain laboratory tests and some medications, and most of the home dialysis services we provide. Some other services, laboratory tests and drugs are eligible for separate reimbursement under Medicare and are not part of the composite rate. These separately reimbursed items include specific drugs such as EPO, some physician-ordered tests provided to dialysis patients and some home dialysis services.

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Changes in the Medicare ESRD Composite Rate

Congress approved a 1.6% increase in the Medicare ESRD composite rate for 2006, following increases of 1.6% in 2005, 2.4% in 2001 and 1.2% in 2000. Under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, or MMA, in 2006, Medicare will reimburse dialysis providers for ESRD drugs (including EPO) at an amount equal to the drug s average sales price (as determined by the Inspector General of the Department of Health and Human Services) plus 6.0%, and the Medicare ESRD composite rate will be increased by an amount estimated by HHS to be dialysis provider s average profit on these drugs before the change in drug reimbursement. To account for the changes in drug reimbursement, CMS has determined that in 2006 the composite rate will be increased from 2005 levels by approximately 14.7%, or approximately $19, per treatment, while payments for most separately billable drugs will be reduced. In addition, Medicare has revised the geographic adjustments in the composite rate beginning in 2006. Management believes that the net effect of all of these changes in Medicare payments (including the 1.6% increase in the composite rate, the increase in the composite rate intended to offset reductions in drug reimbursements, the reductions in drug reimbursements and the change in the geographic adjustments) will be positive to the Company in 2006 in terms of average Medicare revenue per treatment.

Before 2000, the Medicare ESRD composite rate was unchanged from commencement of the program in 1972 until 1983. From 1983 through December 1990, a series of congressional actions resulted in net reductions of the average Medicare ESRD composite rate from approximately $138 per treatment in 1983 to approximately $125 per treatment in 1986. Our average Medicare rate per dialysis treatment was $140 during 2005.

The Medicare ESRD composite rate has been the subject of a number of reports and studies. During 2000, Congress directed a study of the ESRD composite rate structure, which was delivered in 2003. The study reviewed items included in the composite rate and items that are currently separately billable (such as EPO and certain laboratory services) and analyzed whether the composite rate should be subject to an annual inflationary update. The study made preliminary recommendations to expand the services covered by the Medicare ESRD composite rate. The study made no final recommendations, and Congress has not acted on it.

During recent congressional sessions, there have been proposals to change numerous aspects of Medicare, not all of which were included in the MMA. We are unable to predict what, if any, future changes may occur in the Medicare ESRD composite rate. Any reductions in the Medicare ESRD composite rate or change in the items covered by the composite rate (such as EPO or certain laboratory services) could have a material adverse effect on our earnings, financial condition and business.

Medicare Reimbursement for EPO

We derive a significant portion of our revenue and earnings from the administration of EPO. Medicare reimbursement for EPO was fixed at $10 per 1,000 units from 1994 through 2004. The Secretary of HHS has the authority to determine the Medicare reimbursement rate for EPO, which will equal its average sales price plus 6.0% for 2006. Medicare reimbursement for EPO was reduced in 2005 to $9.76 as a result of the MMA, and it will be further reduced to $9.57 in the first quarter of 2006 and will be adjusted quarterly in the future based on changes in the average sales price. Approximately 24% of our revenue in 2005 was generated from the administration of EPO; therefore, any further reduction in Medicare reimbursement for EPO could have a material adverse effect on our earnings, financial condition and business.

In the past CMS has placed limits on EPO reimbursement based on patients hematocrit levels. Hematocrit is a measure of a patient s anemia. In 2005, CMS issued a national medical review policy to limit EPO reimbursement based on hematocrit levels and EPO dosage levels, which is scheduled to take effect in April 2006. Medicare s contractors often conduct medical necessity reviews of claims involving high doses of EPO for patients with relatively high hematocrits. We are unable to predict what any changes in EPO reimbursement will occur based on this new policy. Any reduction in Medicare reimbursement for EPO could have a material adverse effect on our earnings, financial condition and business.

Medicaid Reimbursement

Medicaid programs are health care programs that are partially funded by the federal government and are administered by the states. These programs generally provide coverage for uninsured patients whose income and assets are below levels determined by the states. The programs also serve as supplemental insurance programs for the

Medicare co-insurance portion and provide coverage for some items (for example, oral medications) that are not covered by Medicare. State regulations generally follow Medicare reimbursement levels and coverage without any coinsurance amounts. Some states, however, require beneficiaries to pay a share of the cost based upon their income or assets. We are a licensed ESRD Medicaid provider in all of the states in which we do business.

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Some of the states in which we do business have dialysis reimbursement rates for Medicaid patients that are higher than Medicare rates. Representatives of CMS and some of these states have indicated that the states should consider reducing these higher reimbursement levels, and, as a result, several states have implemented reductions in Medicaid reimbursement. We currently do business in two states in which Medicaid reimbursement remains substantially higher than Medicare rates Alaska and New Mexico. Reductions in Medicaid reimbursement in these states could have an adverse effect on our earnings, financial condition and business.

In addition, under the Balanced Budget Act of 1997, state Medicaid programs are not required to pay the patient s Medicare cost-sharing amounts for dialysis treatment if the state Medicaid dialysis payment rates are at or below the Medicare composite rate. In such cases, the patient is not liable for the cost-sharing amounts. Since the effect of the MMA has increased the Medicare composite rate by dialysis providers average profit on separately billable drugs, nearly all state dialysis payment rates are now below the new Medicare composite rate. Thus, if states exercise their option not to pay applicable patient cost-sharing amounts, Medicaid reimbursement in these states could be further reduced.

Non-governmental Reimbursement

Before Medicare becomes a patient s primary payor, if a patient has private health insurance coverage, then the patient s own insurance plan or other health care coverage pays for his or her ESRD treatments. We estimate that Medicare and Medicaid are the primary payors for approximately 80% of the patients to whom we provide care. Therefore, reimbursement from private payors, including acute dialysis payors, cover the other 20% of the patients to whom we provide care; however, that private reimbursement usually represents more than 40% of our net revenue. Reimbursement rates from these private payors are generally significantly higher than the rates paid by Medicare. We have negotiated contracts with most managed care payors in our markets at rates that are higher than the Medicare ESRD composite rate. Rates under these managed care contracts are, however, generally lower than those we charge other private payors. After Medicare becomes a patient s primary payor, private secondary payors generally reimburse us for the patient s copayment which is 20% of the applicable Medicare rate.

We also receive payments from hospitals under acute care contracts. Rates under these contracts for dialysis treatments are generally higher than the Medicare ESRD composite rate. Rates under these acute care contracts are the result of arms-length negotiations between the hospital and us, and management believes they approximate fair market value of the services we provide.

GOVERNMENT REGULATION

General

Federal, state, and local governments extensively regulate Renal Care Group s operations, including the dialysis centers and laboratory we own. Applicable federal and state statutes and regulations require us to meet various standards relating, among other things, to licensure, billing and reimbursement, management of dialysis centers, patient care personnel, maintenance of proper records, confidentiality of medical records, equipment and quality assurance programs, and the treatment and disposal of biomedical waste. In addition, our laboratory is subject, among other laws, to the federal Clinical Laboratory Improvement Amendments of 1988, also known as CLIA. Our dialysis centers and laboratory are subject to periodic inspection by state and federal agencies to determine if they meet applicable requirements. In addition, through certificate of need or permit programs, some states regulate the development or expansion of health care facilities and services, including dialysis centers. Our operations also are subject to regulations of the Occupational Safety and Health Administration, also known as OSHA, concerning workplace safety and employee exposure to blood and other potentially infectious materials.

We are subject to federal and state laws governing, among other things, our relationships with physicians and other health care providers, patient referrals, and false claims. See Government Regulation Anti-Kickback Statute, Government Regulation Stark Law and Government Regulation Civil Monetary Penalties. The federal government, many states and some private third-party payors have made combating fraud and abuse in the health care industry a high priority. As a result, scrutiny and investigation of health care providers and their relationships with physicians and other referral sources has increased significantly.

We believe our operations substantially comply with applicable federal and state laws. However, if a state or the federal government finds that we have not complied with these laws, then we could be required to change our

operations. We are currently under investigation by two United States Attorneys offices (See Government Regulation Government Investigations). Any changes we are required to make as a result of a determination we have not complied with law or to settle an investigation could have a negative impact on us. To date, our dialysis centers have maintained their licenses and their Medicare and Medicaid certifications, but if there is a determination that we have not complied with law, our certifications could be revoked. Any loss of certification to participate in the Medicare and Medicaid programs or loss of any required state or federal licenses or certifications would have a negative effect on us. Management believes that the health care services industry will continue

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to be subject to extensive regulation at the federal, state and local levels. We cannot predict the scope and effect of future regulation of our business and cannot predict whether health care reform will require us to change our operations or whether such reform will have a negative impact on us.

We cannot predict whether we will be held responsible for actions previously taken by acquired companies or facilities before we purchased them. We also cannot predict whether our operations, or the previous operations of acquired companies or facilities, will be reviewed or challenged by the government. Any review or challenge of our operations could have a negative impact on us.

Government Investigations

Last year the federal government continued to investigate the practices of health care providers, including providers of dialysis. In March 2005, the office of the United States Attorney for the Eastern District of Missouri served a subpoena on one of our competitors, DaVita, Inc., requiring the production of a broad range of documents. In April 2005, the office of the United States Attorney for the Eastern District of Missouri served a similar subpoena on another of our competitors, Fresenius Medical Care. In December 2004, another of our competitors, Gambro Healthcare, settled an investigation conducted by the office of the United States Attorney for the Eastern District of Missouri and paid more than $350 million in connection with the settlement.

On August 9, 2005, we received a subpoena from the office of the United States Attorney for the Eastern District of Missouri. The subpoena requires us to produce documents related to numerous aspects of our business and operations. The subpoena includes specific requests for documents related to our supply company, pharmaceutical and other ancillary services we provide to patients (including the administration of EPO), our relationships with pharmaceutical companies, our relationships with physicians, medical director compensation, joint ventures with physicians and our purchases of dialysis equipment from Fresenius Medical Care. The subpoena was issued in connection with a joint civil and criminal investigation. We are cooperating with the government s investigation; we have produced numerous documents to the government in response to this subpoena. We have incurred significant legal and other expenses responding to the subpoena and have experienced distraction of management attention. Compliance with the subpoena will require us to incur substantial additional legal and other expenses and will require further management attention. To our knowledge, no proceedings have been initiated against Renal Care Group at this time, but we cannot predict whether or when proceedings might be initiated. In addition, we cannot predict the outcome of any proceedings that may be initiated against us as a result of this investigation. Any such proceedings could have a material adverse effect on our business, financial condition and results of operations.

On October 25, 2004, we received a subpoena from the office of the United States Attorney for the Eastern District of New York. This subpoena requires the production of documents related to numerous aspects of our business and operations, including those of our laboratory, RenaLab, Inc. The subpoena includes specific requests for documents related to testing for parathyroid hormone (PTH) levels and vitamin D therapies. Our competitors DaVita, Inc., Fresenius Medical Care, and Gambro Healthcare, as well as other participants in the dialysis industry, have announced that they have received similar subpoenas. We are cooperating with the government s investigation. We have produced numerous documents to the government in response to this subpoena. We have incurred significant legal and other expenses responding to the subpoena. Compliance with this subpoena will require us to incur additional legal expenses and could distract management attention. To our knowledge, no proceedings have been initiated against Renal Care Group at this time, but we cannot predict whether or when proceedings might be initiated. We cannot predict the outcome of any proceedings that may be initiated against us a result of this investigation. Any such proceedings could have a material adverse effect on our business, financial condition and results of operations.

If any aspect of our operations is found to violate applicable laws, then we may be subject to severe sanctions and we could be required to alter or discontinue the challenged conduct or both. If sanctions are imposed on us, then there could be a material adverse effect on our business, financial condition and results of operations. If we are required to alter or discontinue practices, then we may not be able to do so successfully, which could have a material adverse effect on our business, financial condition and results of operations.

The federal government also continues to investigate practices of laboratories. Each of the laboratories owned and operated by the major dialysis providers, including our laboratory, has been the subject of a government investigation in addition to the one in the Eastern District of New York described above. These laboratories, including our

laboratory, could be the subject of future investigations.

Medicare and Medicaid Certification and Reimbursement

To receive reimbursement from federal health care programs for dialysis and laboratory services, our dialysis centers and laboratory must be certified by one or more government agencies. For example, to receive Medicare reimbursement, our dialysis centers and laboratory must be certified by CMS. All of our dialysis centers and our laboratory operations are certified under the Medicare program and applicable state Medicaid programs. In connection with our participation in Medicare, we must comply with conditions for coverage, including requirements concerning personnel, management, patient care, patient rights, medical records and physical environment. We must also comply with extensive billing rules governing, among other things, medical necessity and documentation. See Government Regulation False Claims Act and Government Regulation Civil Monetary Penalties.

HHS has recently issued proposed regulations to adopt new Medicare conditions for coverage for ESRD services. The proposed changes to the Medicare conditions for coverage for ESRD facilities could require us to change our operations and may have a negative effect on our business and profitability.

The HHS Office of Inspector General, also known as the OIG, issued reports in the summer of 2000 recommending greater oversight of the quality of care in dialysis facilities. In January of 2003, the United States General Accounting Office (now the Government Accountability Office), known as the GAO, issued a report finding that efforts by CMS to ensure quality care at certain facilities including kidney dialysis facilities continue to be jeopardized by problems in the performance of state inspections, complaint investigations and enforcement of federal standards. Any increased oversight could lead to increased requirements and greater scrutiny of dialysis facilities, including those we own.

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The Anti-Kickback Statute

Under Medicare, Medicaid and other government-funded health care programs, such as the CHAMPUS/Tri-Care program, federal and state governments enforce provisions of the Social Security Act of 1965 that are commonly referred to as the Anti-Kickback Statute. The Anti-Kickback Statute prohibits any person from offering, paying, soliciting or receiving any type of benefit (1) in exchange for the referral of a patient covered by Medicare, Medicaid or other federal health care programs, or (2) for the leasing, purchasing, ordering or arranging for or recommending the lease, purchase or order of any item, good, facility or service covered by the programs. Remuneration prohibited by the Anti-Kickback Statute includes the payment or transfer of anything of value. Many states have similar anti-kickback statutes that are not necessarily limited to items or services paid for by a federal or state health care program.

Any person or entity that violates the Anti-Kickback Statute may be penalized. These penalties include criminal fines of up to $25,000 per violation and imprisonment. In addition, the government may impose civil penalties of up to $50,000 per violation, plus three times total remuneration offered, paid, solicited or received. Further, the Secretary of HHS has the authority to exclude or bar individuals or entities who violate the Anti-Kickback Statute from participating in Medicare and Medicaid.

The Anti-Kickback Statute is a broad law. Courts have stated that, under certain circumstances, the Anti-Kickback Statute is violated when just one purpose, as opposed to the primary purpose, of a payment is to induce referrals. To clarify what acts or arrangements will not be subject to prosecution by the OIG or the United States Attorney, HHS has adopted a set of safe harbor regulations and continues to publish clarifications to these safe harbors. If an arrangement meets all of the requirements of a safe harbor, it will not violate the Anti-Kickback Statute.

The types of arrangements covered by safe harbors include certain investments in companies whose stock is traded on a national exchange, certain small company investments in which physician ownership is limited, rentals of space, rentals of equipment, personal services and management contracts, sales of physician practices, physician referral services, warranties, discounts, payments to employees, group purchasing organizations, and waivers of beneficiary deductibles and co-payments. Each type of arrangement must meet specific requirements to enjoy the benefits of the applicable safe harbor. Meeting the requirements of a safe harbor will protect an arrangement from enforcement action by the government. However, the fact that an arrangement does not meet the requirements of a safe harbor does not mean that the arrangement is necessarily illegal or will be prosecuted under the Anti-Kickback Statute.

The OIG has issued a Special Fraud Alert concerning the pricing of laboratory testing at ESRD centers. Medicare pays for laboratory tests provided to ESRD patients in two different ways. Some laboratory tests are considered routine, and Medicare includes payment for those tests in the Medicare ESRD composite rate paid to the dialysis center. Some laboratory testing is not included in the composite rate, and these tests are billed by the laboratory directly to Medicare. In the Special Fraud Alert, the OIG stated it is aware of cases where a laboratory offers to perform tests included in the composite rate at a price below fair market value. In exchange, the dialysis facility agrees to refer all or most of its non-composite rate tests to the laboratory. The OIG identified such an arrangement as raising issues under the Anti-Kickback Statute. Management believes that our arrangements with laboratories reflect fair market value and comply with the Anti-Kickback Statute.

We seek to satisfy as many safe harbor requirements as possible when we are structuring business arrangements. However, not all of our arrangements satisfy all elements of a safe harbor. Management believes that we have a reasonable basis for concluding we substantially comply with the Anti-Kickback Statute and other applicable related federal and state laws and regulations. Management believes that our current arrangements with physicians including nephrologists owning our common stock, medical directors, laboratories, suppliers, hospitals, and other sources of referrals to our dialysis centers and our arrangements with hospitals to provide acute dialysis materially comply with the Anti-Kickback Statute. However, a government agency might take a position contrary to our interpretations or may require us to change our practices. If an agency were to take such a position, it could materially and adversely affect Renal Care Group.

The Stark Law

Congress has also passed significant prohibitions against some physician referrals of patients for health care services. These prohibitions are commonly known as the Stark Law. The Stark Law prohibits a physician from

making referrals for particular health care services (called designated health services) to entities with which the physician, or an immediate family member of the physician, has a financial relationship. If an arrangement is covered by the Stark Law, the requirements of a Stark Law exception must be met for the physician to be able to make referrals to the entity for designated health services.

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Under the Stark Law, the term financial relationship is defined very broadly to include most ownership and compensation relationships. The Stark Law also prohibits the entity receiving the referral from seeking payment under the Medicare and Medicaid programs for services rendered pursuant to a prohibited referral. If an entity is paid for services rendered pursuant to a prohibited referral, it may incur civil penalties or could be excluded from participating in Medicare or Medicaid.

The Stark Law restricts referrals for clinical laboratory services; physical therapy services; occupational therapy services; radiology services, including magnetic resonance imaging (MRI), computerized axial tomography (CAT) scans, and ultrasound services; radiation therapy services and supplies; durable medical equipment and supplies; parenteral and enteral nutrients, equipment, and supplies; prosthetics, orthotics, and prosthetic devices and supplies; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services.

The Stark Law defines a financial relationship to include (1) a physician s ownership or investment interest in an entity and (2) a compensation relationship between a physician and an entity. Under the Stark Law, financial relationships include both direct and indirect relationships. We have compensation arrangements with medical directors or the professional practices of the medical directors. The medical directors or their practices may also own shares, and options to purchase shares, of our common stock. In addition, other physicians who refer patients to our centers may own our stock. If so, the medical directors and other physicians would have a financial relationship with us. Accordingly, these physicians would not be able to refer patients to our dialysis centers for designated health services unless a Stark Law exception applies.

Dialysis is not listed as a designated health service under the Stark Law. However, the definition of designated health services includes some items and services that are components of dialysis or that we may provide to patients in connection with dialysis services. On March 26, 2004, CMS issued Phase II of its regulations under the Stark Law (referred to as the Stark II Regulations). The Stark II Regulations exclude from the definition of covered designated health services those services that are reimbursed by Medicare as part of a composite rate. They also contain an exception under the Stark Law for clinical laboratory services that are included in the Medicare ESRD composite rate. Therefore, services that are included in the Medicare ESRD composite rate are not covered by the Stark Law.

Further, the Stark II Regulations exclude from the referral prohibition EPO and certain other dialysis-related drugs if certain requirements are met. The list of drugs eligible for this exception is published and updated from time to time by CMS. If the requirements are met, this exception applies whether or not these drugs are included in the Medicare ESRD composite rate.

The final regulations also exclude from the definition of inpatient hospital services any dialysis services provided by a hospital that is not certified by CMS to provide outpatient dialysis services. This rule would have the effect of excluding from the Stark Law prohibition, any dialysis services we provide under an acute dialysis contract with a hospital, if that hospital is not certified to provide outpatient dialysis. The Stark II Regulations exclude from the definition of durable medical equipment all equipment and supplies used in connection with home dialysis that are reimbursable under a composite rate. These Stark II Regulations exclude most of the items and services connected with dialysis from the Stark Law prohibitions.

If the Stark Law were found to apply to our relationships with referring physicians, there are exceptions to the Stark Law, which would permit such physicians to refer patients to us for designated health services if we meet certain requirements. The Stark Law contains exceptions for certain physician ownership or investment interests in entities and certain physician compensation arrangements with entities. The exceptions for compensation arrangements include employment relationships, personal services contracts, and space and equipment leases. If a compensation arrangement between a physician, or immediate family member of a physician, and an entity satisfies all requirements for a Stark Law exception, then the Stark Law will not prohibit the physician from referring patients to the entity for designated health services. The Stark II Regulations establish a safe harbor for compensation to physicians providing that hourly payments set under either of two methodologies will constitute fair market value, qualifying the arrangement for the fair market value exception under the Stark Law. The preamble to the Stark II Regulations contains a discussion indicating CMS s view that the hourly rate methodologies could be applicable to compensation under an ESRD facility medical director agreement. Our medical director agreements do not provide for compensation to our medical directors based on an hourly rate. However, we believe that our agreements with medical directors or

their professional practices provide for fair market value compensation and materially satisfy the Stark Law exception for personal service arrangements.

The Stark Law also includes an exception for a physician s ownership or investment interest in certain entities through the ownership of stock. If a physician owns stock in an entity, and the stock is listed on a national exchange or is quoted on the Nasdaq Stock Market and the ownership meets certain other requirements, then the Stark Law will not apply to prohibit the physician from referring to the entity for designated health services. The requirements for this Stark Law exception include a requirement that the

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entity issuing the stock have at least $75.0 million in stockholders equity at the end of its most recent fiscal year or on average during the previous three fiscal years. As of December 31, 2005, we had stockholders equity of more than $739.0 million. Management believes that physician ownership of our stock satisfies this Stark Law exception.

If an entity violates the Stark Law, it could be subject to civil penalties of up to $15,000 per prohibited claim and may be excluded from Medicare and Medicaid. If the Stark Law applies to our relationships with referring physicians and no exceptions under the Stark Law are available, then we would be required to restructure these relationships or refuse to accept referrals for designated health services from these physicians. If we were found to have submitted claims to Medicare for services provided pursuant to a referral prohibited by the Stark Law, then we would be required to repay amounts we received from Medicare for those services and could be subject to civil monetary penalties. If we were required to repay amounts to Medicare or were subject to fines, our business and profits could be harmed.

Many states have physician relationship and referral statutes that are similar to the Stark Law. Management believes we are in substantial compliance with applicable state laws with respect to physician relationships and referrals. However, any finding that we are not in compliance with these state laws could require us to change our operations and could have a negative impact on us.

The Health Insurance Portability and Accountability Act of 1996

In an effort to combat health care fraud, Congress included several anti-fraud measures in the Health Insurance Portability and Accountability Act of 1996, also called HIPAA. Among other things, HIPAA broadened the scope of certain fraud and abuse laws, extended criminal penalties for Medicare and Medicaid fraud to other federal health care programs. HIPAA also expanded the authority of the OIG to exclude persons and entities from participating in the Medicare and Medicaid programs. HIPAA extended the Medicare and Medicaid civil monetary penalty provisions to other federal health care programs, increased the amounts of civil monetary penalties, and established a criminal health care fraud statute.

Federal health care offenses under HIPAA include health care fraud and making false statements relating to health care matters. Under HIPAA, among other things, any person or entity that knowingly and willfully defrauds or attempts to defraud a health care benefit program is subject to a fine, imprisonment or both. Also under HIPAA, any person or entity that knowingly and willfully falsifies, conceals or covers up a material fact, or makes any materially false or fraudulent statements in connection with the delivery of or payment for health care services by a health care benefit plan is subject to a fine, imprisonment or both.

HIPAA also required the OIG to issue advisory opinions to outside parties regarding the interpretation and applicability of the Anti-Kickback Statute and other OIG health care fraud and abuse sanctions. An OIG advisory opinion only applies to the people or entities that requested it. However, advisory opinions are published and made available to the public, and they provide guidance on practices the OIG believes may violate federal law. We have not requested any advisory opinions from the OIG. However, the OIG has issued several advisory opinions addressing practices of companies owning ESRD centers.

In advisory opinions addressing practices of companies owning ESRD centers, the OIG has advised ESRD companies that they may not pay policy premiums for Medicare supplemental insurance for patients, even patients with proven financial hardship. Prior to the adoption of HIPAA and the issuance of these OIG opinions, we had paid premiums for Medicare supplemental insurance for some patients with demonstrated financial need. We stopped making such payments following the adoption of HIPAA. Consistent with the OIG s advisory opinions, we have made donations to charitable foundations that may, but are not required to, make premium payments on behalf of ESRD patients. We believe, but cannot make assurances, that our current practices regarding supplemental insurance substantially comply with the general principles expressed by the OIG in these advisory opinions.

HHS has adopted regulations governing electronic transactions by certain entities involving health information. These regulations are part of the administrative simplification provisions of HIPAA. These regulations are commonly referred to as the Transaction Standards rule. The rule establishes standards for eight of the most common health care transactions by reference to technical standards promulgated by recognized standards publishing organizations. Under the new standards, any party transmitting or receiving health transactions electronically must send and receive data in a prescribed format, rather than the large number of different data formats previously used. This rule applies to Renal

Care Group as we submit and process health claims. The Transaction Standards rule also applies to many of our payors and to our relationships with those payors.

HHS has also adopted regulations implementing HIPAA that adopted standards for privacy of individually identifiable health information. These regulations cover health care providers, health care clearinghouses and health plans. The privacy regulations, among other things, require companies covered by the regulations:

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to obtain patient authorization prior to certain uses or disclosures of protected health information,

to provide notice of privacy practices to patients and obtain an acknowledgement that the patient has received the notice,

to respond to requests from patients for access to or to obtain a copy of their information,

to respond to patient requests for amendments of their information,

to designate a privacy officer,

to use and disclose only the minimum necessary information to accomplish a particular purpose, and

to establish policies and procedures with respect to uses and disclosures of protected health information.

These regulatory requirements impose significant administrative and financial obligations on companies that use or disclose individually identifiable information relating to the health of a patient. We have implemented policies and procedures to maintain patient privacy and comply with HIPAA s privacy requirements. The privacy regulations are extensive, and we may need to change some of our practices to comply with them as they are interpreted and as we deal with issues that arise.

HHS has also published regulations implementing HIPAA that govern the security of health information that is maintained or transmitted electronically. The regulations generally require the implementation of administrative, physical and technical safe guards to ensure the confidentiality, integrity and availability of electronic health information. Management believes we are in substantial compliance with these regulations.

The False Claims Act

The federal False Claims Act gives the federal government an additional way to police false bills or requests for payment for health care services. Under the False Claims Act, the government may fine any person who knowingly submits, or participates in submitting, claims for payment to the federal government that are false or fraudulent, or that contain false or misleading information. Any person who knowingly makes or uses a false record or statement to avoid paying the federal government may also be subject to fines under the False Claims Act. Under the False Claims Act, the term person means an individual, company or corporation. The federal government has used the False Claims Act widely to prosecute fraud against Medicare and other governmental programs in areas such as coding errors, billing for services not provided and submitting false cost reports. The False Claims Act has also been used to prosecute people or entities that bill services at a higher reimbursement rate than is allowed and billing for care that is not medically necessary.

The penalty for violation of the False Claims Act ranges from $5,500 to $11,000 for each fraudulent claim plus up to three times the amount of damages caused to the government as a result of each fraudulent claim. In addition to the False Claims Act, the federal government may use several criminal statutes to prosecute the submission of false or fraudulent claims for payment to the federal government. Many states have similar false claims statutes that impose liability for the types of acts prohibited by the False Claims Act.

Civil Monetary Penalties

The Secretary of HHS may impose civil monetary penalties on any person or entity that presents or causes to be presented certain ineligible claims for medical items or services. The amount of penalties varies, depending on the offense, from $2,000 to $50,000 per violation. HHS can impose penalties for false or fraudulent claims and those that include services not provided as claimed. In addition, HHS may impose penalties on claims:

for physician services the person or entity knew or should have known were rendered by a person who was unlicensed, or misrepresented either (1) his or her qualifications in obtaining his or her license or (2) his or her certification in a medical specialty;

that were furnished by a person who was, at the time the claim was made, excluded from the program to which the claim was made; or

that show a pattern of medically unnecessary items or services.

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Penalties also may be imposed on a person or entity that violates rules regarding the assignment of payments, that knowingly gives false or misleading information that could reasonably influence the discharge of patients from a hospital, or that offers inducements to beneficiaries for program services. Persons who have been excluded from the program and who retain ownership in a participating entity, or who contract with excluded persons, may be penalized. Penalties also are applicable in certain other cases, including violations of the federal Anti-Kickback Statute, payments to limit certain patient services and improper execution of statements of medical necessity.

Health Care Legislation and Regulatory Developments

Congress may enact legislation and/or CMS may promulgate regulations in the future that may significantly change the Medicare ESRD program or reduce the amount that Medicare and Medicaid will pay for our services. In addition, federal and state statutes or regulations may be enacted to impose additional requirements on us to continue to provide services to ESRD patients, to provide new services, or to maintain eligibility to participate in federal and state payment programs. Any new legislation or regulations, or new interpretations of existing statutes and regulations, governing reimbursement of dialysis providers or the manner in which dialysis companies provide services to patients could have a material impact on us and could adversely affect our profitability.

Joint Ventures

A number of the dialysis centers we operate are owned by joint ventures in which we own a controlling interest and one or more physicians or physician practice groups own a minority interest. The physician owners may also provide medical director services to those centers and/or to other centers we own and operate. Because our relationships with physicians are governed by the Anti-Kickback Statute, we have sought to satisfy as many safe harbor requirements as possible in structuring these joint venture arrangements. However, our joint venture arrangements do not satisfy all elements of a safe harbor. Management believes that we have a reasonable basis for concluding that we substantially comply with the Anti-Kickback Statute. We also believe we have structured the physician relationships in these joint ventures in a way that substantially complies with the Stark Law or meets applicable exceptions under the Stark Law. If the joint ventures were found to be in violation of the Anti-Kickback Statute or the Stark Law, we could be required to restructure them or refuse to accept referrals for designated health services from the physicians with whom the joint venture centers have a financial relationship. We also could be required to repay to Medicare amounts received by the joint ventures pursuant to prohibited referrals, and we could be subject to monetary penalties. If the joint venture centers are subject to any of these penalties, our business and profits could be damaged.

COMPETITION

The dialysis industry is highly competitive. Competition for qualified physicians to act as medical directors is also intense. According to CMS, there were more than 4,500 outpatient facilities providing dialysis in the United States at the end of 2003. We believe that as of December 31, 2005, approximately 67% of these facilities were owned by the three largest multi-center dialysis companies, approximately 15% were owned by independent physicians, small chains and other small operators, and approximately 18% were owned by hospitals. The largest multi-center dialysis company is DaVita, Inc., which acquired the United States dialysis services business of Gambro Healthcare in October 2005. Fresenius Medical Care, Inc., which also manufactures and sells dialysis equipment and supplies, is our next largest competitor. As a vertically integrated provider, Fresenius may have some competitive advantages.

There are also a number of other health care providers that have entered or may decide to enter the dialysis business. Some of our competitors have substantially greater financial resources than ours, and they compete with us for acquisitions, development and/or management of dialysis centers and nephrology practices. We believe that competition for acquisitions has, over time, increased the cost of acquiring dialysis centers. We may also experience competition from centers established by former medical directors or other referring physicians. There can be no assurance that we will compete effectively with any of our competitors.

INSURANCE

We maintain professional liability insurance and general liability insurance policies for all of our operations. We also maintain insurance in amounts management deems adequate to cover property and casualty risks, workers compensation, and directors and officers liability. There can be no assurance that the aggregate amount and types of our insurance are adequate to cover all risks we may incur or that insurance will be available in the future.

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EMPLOYEES

At December 31, 2005, we employed 7,962 full-time employees and 1,454 part-time employees. Of the total employees, 76 were employed at our headquarters and 9,340 were employed at our dialysis facilities, laboratory or regional business offices. In management s opinion, employee relations are good.

INTERNET WEBSITE

Our internet website can be found at *www.renalcaregroup.com.* We make available free of charge on or through our internet website, access to our annual report on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, and amendments to those reports filed pursuant to the Exchange Act as soon as reasonably practicable after such material is filed with, or furnished to, the Securities and Exchange Commission. We will also provide a copy of these documents free of charge to shareholders upon request.

Item 1A. ***Risk Factors***

You should carefully consider the risks described below before investing in Renal Care Group. The risks and uncertainties described below are not the only ones facing Renal Care Group. Other risks and uncertainties that we have not predicted or assessed may also adversely affect us.

If any of the following risks occurs, our earnings, financial condition or business could be materially harmed, and the trading price of our common stock could decline, resulting in the loss of all or part of your investment.

Completion of the Fresenius Medical Care transaction is subject to various conditions; as a result we can not assure you that our transaction with Fresenius Medical Care will be completed.

The completion of the acquisition of Renal Care Group by Fresenius Medical Care is subject to various conditions, including the following:

- the termination or expiration of the waiting period under the Hart-Scott Rodino Antitrust Improvements Act of 1976, as amended, or the approval of the transaction under that act;
- the absence of a temporary restraining order, preliminary or permanent injunction or other order issued by any court or other legal restraint or prohibition preventing the consummation of the transaction;
- the accuracy of the representations and warranties of Renal Care Group and Fresenius Medical Care in the merger agreement;
- the performance in all material respects by Renal Care Group and Fresenius Medical Care of all obligations required to be performed by each of them under the merger agreement at or prior to the effective time of the transaction;
- the absence of an event, change, effect or development that, individually or in the aggregate, has had or would reasonably be expected to have, a material adverse effect on Renal Care Group as defined in the merger agreement; or
- the satisfaction or waiver by the lenders of the conditions precedent to the initial funding of Fresenius Medical Care s financing commitments that are related to the delivery of releases of liens encumbering the assets of Renal Care Group and the delivery of financial statements of Renal Care Group.

Because of these conditions, the transaction with Fresenius Medical Care may not be completed. If the transaction is not completed for any reason, then our current management, under the direction of our Board of Directors, will continue to manage Renal Care Group.

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Failure to complete the Fresenius Medical Care transaction could negatively impact the market price of our common stock and our ability to operate our business.

If the transaction with Fresenius Medical Care is not completed for any reason, we will be subject to a number of material risks, including:

- the market price of our common stock could decline;
- we must pay some of the costs related to the transaction, such as legal and accounting fees and a portion of the investment banking fees and, in specified circumstances, termination fees and expense reimbursement payments, even if the transaction is not completed, and those costs will be expensed in the fiscal period in which termination occurs;
- the diversion of management s attention from our day-to-day business and the unavoidable disruption to our associates and our relationships with patients, medical directors, attending physicians and suppliers, during the period before completion of the transaction, may make it difficult for us to regain our financial and market position if the transaction does not occur; and
- the loss of key management, clinical and technical personnel who may be uncertain about their future roles and relationships with Renal Care Group following the completion of the transaction with Fresenius Medical Care could make it difficult for us to operate our business effectively and profitably if we are unable to replace these employees if the transaction with Fresenius Medical Care is not completed.

If the merger agreement is terminated and our Board of Directors seeks another transaction or business combination, then our shareholders cannot be certain that we will be able to find an acquirer willing to pay an equivalent or better price than the price to be paid by Fresenius Medical Care under the merger agreement.

Our profits are dependent on the services we provide to a small portion of our patients who are covered by private insurance.

In recent reviews of dialysis reimbursement, the Medicare Payment Advisory Commission, also known as MedPAC, has noted that Medicare payments for dialysis services are less than the average costs that providers incur to provide the services. Since Medicaid rates are comparable to those of Medicare and because Medicare only pays us 80% of the Medicare allowable amount (the patient, Medicaid or secondary insurance being responsible for the remaining 20%), the amount we receive from Medicare and Medicaid is less than our average cost per treatment. As a result, the payments we receive from private payors both subsidize the losses we incur on services for Medicare and Medicaid patients and generate all the profits we report. In fact, much of our profit is generated from private-pay patients for whom we are paid at amounts equal to several times Medicare rates. We estimate that Medicare and Medicaid are the primary payors for approximately 80% of the patients to whom we provide care but that only 55% of our net revenue in 2003, 53% of our net revenue in 2004 and 56% of our net revenue in 2005 were derived from Medicare and Medicaid. Therefore, if the private payors who pay for the care of the other 20% of our patients reduce their payments for our services, or if we experience a shift in our revenue mix toward Medicare or Medicaid reimbursement, then our revenue, cash flow and earnings would decrease, and our cash flow and profits would be disproportionately impacted.

Over the last few years, we have generally been able to implement annual price increases of between 7% and 12% for private insurers and managed care organizations, but government reimbursement has remained flat or has been increased only modestly. Management believes that health insurance pricing is cyclical and that we may be at or near the top of the cycle. During 2005 we experienced pricing pressure from a number of private payors. As a result of the industry cycle and this pricing pressure, management believes that our ability to maintain or raise rates to private insurers and managed care companies may be more limited over the next several years than it has been in the recent past. Management believes that the reductions in reimbursement by commercial insurers, along with pricing pressure from other commercial insurers and managed care organizations, could adversely impact our revenue per treatment and earnings per share in 2006. Any of the following events could have a