DAVITA INC.
Form 10-K
February 22, 2019
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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-K

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

For the Fiscal Year Ended December 31, 2018
Commission File Number: 1-14106

DAVITA INC.

(Exact name of registrant as specified in charter)

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

2000 16th Street
Denver, CO 80202
Telephone number (720) 631-2100
Securities registered pursuant to Section 12(b) of the Act:

Title of each class:	**Name of each exchange on which registered:**
Common Stock, $0.001 par value	**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 No
Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Exchange Act. Yes No
Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports) and (2) has been subject to such filing requirements for the past 90 days. Yes No
Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). Yes No
Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant’s knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K.
Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or an emerging growth company. See the definitions of “large accelerated filer,” “accelerated filer,” “smaller reporting company” and “emerging growth company” in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer	Accelerated filer
Non-accelerated filer	Smaller reporting company
	Emerging growth company

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act.
Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes No
As of June 29, 2018, the aggregate market value of the Registrant's common stock outstanding held by non-affiliates based upon the closing price on the New York Stock Exchange was approximately $11.9 billion.

As of January 31, 2019, the number of shares of the Registrant’s common stock outstanding was approximately166.4 million shares.

Documents incorporated by reference

Portions of the Registrant’s proxy statement for its 2019 annual meeting of stockholders are incorporated by reference in Part III of this Form 10-K.

PART I

Item 1. Business

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

Overview of DaVita Inc.

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

In December 2017, we entered into an equity purchase agreement to sell our DMG division to Collaborative Care Holdings, LLC (Optum), a subsidiary of UnitedHealth Group Inc., subject to receipt of required regulatory approvals and other customary closing conditions. As a result, the DMG business has been classified as held for sale and its results of operations are reported as discontinued operations for all periods presented in the consolidated financial statements included in this report.

For financial information about our DMG business see Note 22 to the consolidated financial statements included in this report.

Kidney Care Division

U.S. dialysis and related lab services business overview

Our U.S. dialysis and related lab services business is a leading provider of kidney dialysis services for patients suffering from ESRD. As of December 31, 2018, we provided dialysis and administrative services in the U.S. through a network of 2,664 outpatient dialysis centers in 46 states and the District of Columbia, serving a total of approximately 202,700 patients. We also provide acute inpatient dialysis services in approximately 900 hospitals and related laboratory services throughout the U.S.

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

According to the United States Renal Data System (USRDS), there were over 511,000 ESRD dialysis patients in the U.S. in 2016. Based on the most recent 2018 annual data report from the USRDS, the underlying ESRD dialysis patient population has grown at an approximate compound rate of 3.8% from 2000 to 2016. However, more recent preliminary data from the USRDS suggest that the rate of growth of the ESRD patient population may be declining. A number of factors may impact ESRD growth rates, including the aging of the U.S. population, increasing transplant rates, incidence rates for diseases that cause kidney failure such as diabetes and hypertension, mortality rates for dialysis patients and growth rates of minority populations with higher than average incidence rates of ESRD.

Since 1972, the federal government has provided healthcare coverage for ESRD patients under the Medicare ESRD program regardless of age or financial circumstances. ESRD is the first and only disease state eligible for Medicare coverage both for dialysis and dialysis-related services and for all benefits available under the Medicare program. For patients with Medicare coverage, all ESRD payments for dialysis treatments are made under a single bundled payment rate. See page 6 for further details.

Although Medicare reimbursement limits the allowable charge per treatment, it provides industry participants with a relatively predictable and recurring revenue stream for dialysis services provided to patients without commercial insurance. For the year ended December 31, 2018, approximately 89.6% of our total dialysis patients were covered under some form of

government-based program, with approximately 74.8% of our dialysis patients covered under Medicare and Medicare-assigned plans.

Treatment options for ESRD

Treatment options for ESRD are dialysis and kidney transplantation.

Dialysis options

- *Hemodialysis*

Hemodialysis, the most common form of ESRD treatment, is usually performed at a freestanding outpatient dialysis center, at a hospital-based outpatient center, or at the patient's home. The hemodialysis machine uses an artificial kidney, called a dialyzer, to remove toxins, fluids and salt from the patient's blood. The dialysis process occurs across a semi-permeable membrane that divides the dialyzer into two distinct chambers. While blood is circulated through one chamber, a pre-mixed fluid is circulated through the other chamber. The toxins, salt and excess fluids from the blood cross the membrane into the fluid, allowing cleansed blood to return back into the patient's body. Each hemodialysis treatment that occurs in the outpatient dialysis centers typically lasts approximately three and one-half hours and is usually performed three times per week.

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

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

- *Peritoneal dialysis*

Peritoneal dialysis uses the patient's peritoneal or abdominal cavity to eliminate fluid and toxins and is typically performed at home. The most common methods of peritoneal dialysis are continuous ambulatory peritoneal dialysis (CAPD) and continuous cycling peritoneal dialysis (CCPD). Because it does not involve going to an outpatient dialysis center three times a week for treatment, peritoneal dialysis is an alternative to hemodialysis for patients who are healthier, more independent and desire more flexibility in their lifestyle.

CAPD introduces dialysis solution into the patient's peritoneal cavity through a surgically placed catheter. Toxins in the blood continuously cross the peritoneal membrane into the dialysis solution. After several hours, the patient drains the used dialysis solution and replaces it with fresh solution. This procedure is usually repeated four times per day. CCPD is performed in a manner similar to CAPD, but uses a mechanical device to cycle dialysis solution through the patient's peritoneal cavity while the patient is sleeping or at rest.

Kidney transplantation

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

U.S. Dialysis and related lab services we provide

Outpatient hemodialysis services

As of December 31, 2018, we operated or provided administrative services through a network of 2,664 outpatient dialysis centers in the U.S. that are designed specifically for outpatient hemodialysis. In 2018, our overall network of U.S. outpatient dialysis centers increased by 154 primarily as a result of the opening of new dialysis centers and acquisitions, net of center closures and divestitures, representing a total increase of approximately 6.1% from 2017.

As a condition of our enrollment in Medicare for the provision of dialysis services, we contract with a nephrologist or a group of associated nephrologists to provide medical director services at each of our dialysis centers. In addition, other

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

Under Medicare regulations, we cannot promote, develop or maintain any kind of contractual relationship with our patients that would directly or indirectly obligate a patient to use or continue to use our dialysis services, or that would give us any preferential rights other than those related to collecting payments for our dialysis services. Our total patient turnover, which is based upon all causes, averaged approximately 24% in 2018 and 26% in 2017. However, in 2018, the overall number of patients to whom we provided services in the U.S. increased by approximately 2.5% from 2017, primarily from the opening of new dialysis centers and acquisitions, and continued growth within the industry.

Hospital inpatient hemodialysis services

As of December 31, 2018, we provided hospital inpatient hemodialysis services, excluding physician services, to patients in approximately 900 hospitals throughout the U.S. We render these services based on a contracted per-treatment fee that is individually negotiated with each hospital. When a hospital requests our services, we typically administer the dialysis treatment at the patient's bedside or in a dedicated treatment room in the hospital, as needed. In 2018, hospital inpatient hemodialysis services accounted for approximately 5.4% of our U.S. dialysis and related lab services revenues and 4.2% of our total U.S. dialysis treatments.

Home-based dialysis services

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

ESRD laboratory services

Our ESRD laboratory services have consisted of two separately licensed, clinical laboratories which specialize in ESRD patient testing. These specialized laboratories provide routine laboratory tests for dialysis and other physician-prescribed laboratory tests for ESRD patients which are integral components of the overall dialysis services that we provide. Our laboratories provide these tests predominantly for our network of ESRD patients throughout the U.S. These tests are performed to monitor a patient's ESRD condition, including the adequacy of dialysis, as well as other medical conditions of the patient. Our laboratories utilize information systems which provide information to certain members of the dialysis centers' staff and medical directors regarding critical outcome indicators. In 2018, we ceased operations at our prior laboratory locations, and consolidated our laboratory services operations into a single, new geographic location.

Management services

We currently operate or provide management and administrative services pursuant to management and administrative services agreements to 34 outpatient dialysis centers located in the U.S. in which we either own a noncontrolling interest or which are wholly-owned by third parties. Management fees are established by contract and are recognized as earned typically based on a percentage of revenues or cash collections generated by the outpatient dialysis centers.

Quality care

Centers for Medicare and Medicaid Services (CMS) promotes high quality services in outpatient dialysis facilities treating patients with ESRD through its Quality Incentive Program (QIP). QIP associates a portion of Medicare reimbursement directly with a facility's performance on quality of care measures. Reductions in Medicare reimbursement result when a facility's overall score on applicable measures does not meet established standards. For the sixth year in a row, we are an industry leader in QIP, including the industry leader for catheter rates and the total number of our patients in home-based hemodialysis services.

In addition, CMS' Five-Star Quality Rating system, is a rating system that assigns one to five stars to rate the quality of outcomes for dialysis facilities. The rating system provides patients reported information about any given dialysis facility and identifies differences in quality between facilities so that patients can make more informed decisions about where to receive treatment. For the last five years, we have been an industry leader under the CMS Five-Star Quality

Rating system.

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Our facilities employ registered nurses, licensed practical or vocational nurses, patient care technicians, social workers, registered dieticians, biomedical technicians and other administrative and support teammates who aim to achieve superior clinical outcomes at our centers.

As of December 31, 2018, our physician leadership in the Office of the Chief Medical Officer (OCMO) for our U.S. dialysis and related lab services business included 16 senior nephrologists, led by our Chief Medical Officer, with a variety of academic, clinical practice, and clinical research backgrounds. Our Physician Council is an advisory body to senior management composed of ten physicians with extensive experience in clinical practice. In addition, we also had eight Group Medical Directors as of December 31, 2018.

Sources of revenue—concentrations and risks

Our U.S. dialysis and related lab services business net revenues represent approximately 90% of our consolidated net revenues for the year ended December 31, 2018. Our U.S. dialysis and related lab services revenues are derived primarily from our core business of providing dialysis services and related laboratory services and, to a lesser extent, the administration of pharmaceuticals and management fees generated from providing management and administrative services to certain outpatient dialysis centers, as discussed above.

The sources of our U.S. dialysis and related lab services revenues are principally from government-based programs, including Medicare and Medicare-assigned plans, Medicaid and managed Medicaid plans and commercial insurance plans. The following graphs summarize our U.S. dialysis and related lab patient services revenues by source and our U.S dialysis patient services revenues by modality for the year ended December 31, 2018.

Revenues by source:

Revenues by modality:

Medicare revenue

Government dialysis related payment rates in the U.S. are principally determined by federal Medicare and state Medicaid policy. For patients with Medicare coverage, all ESRD payments for dialysis treatments are made under a single

bundled payment rate which provides a fixed payment rate to encompass all goods and services provided during the dialysis treatment that are related to the dialysis treatment, including certain pharmaceuticals, such as Epogen® (EPO), vitamin D analogs and iron supplements, irrespective of the level of pharmaceuticals administered to the patient or additional services performed except for calcimimetics, which are subject to a transitional drug add-on payment adjustment for the Medicare Part B ESRD payment. Most lab services are also included in the bundled payment. Under the ESRD Prospective Payment System (PPS), the bundled payments to a dialysis facility may be reduced by as much as 2% based on the facility's performance in specified quality measures set annually by CMS through QIP, which was established by the Medicare Improvements for Patients and Providers Act of 2008. The bundled payment rate is also adjusted for certain patient characteristics, a geographic usage index and certain other factors.

Uncertainty about future payment rates remains a material risk to our business, as well as the potential implementation of or changes in coverage determinations or other rules or regulations by CMS or Medicare Administrative Contractors (MACs) that may impact reimbursement. An important provision in the Medicare ESRD statute is an annual adjustment, or market basket update, to the ESRD PPS base rate. Absent action by Congress, the ESRD PPS base rate is automatically updated annually by a formulaic inflation adjustment.

In November 2018, CMS issued a final rule to update the Medicare ESRD PPS payment rate and policies. Among other things, the final rule expands the transitional drug add-on payment to certain new renal dialysis drugs and biological products and amends the reporting measures in the ESRD QIP. We estimate that the overall impact of the final rule will increase Medicare reimbursement to our ESRD facilities by 1.2% in 2019.

As a result of the Budget Control Act of 2011 (BCA) and subsequent activity in Congress, a $1.2 trillion sequester (across-the-board spending cuts) in discretionary programs took effect in 2013 reducing Medicare payments by 2%, which was subsequently extended through fiscal year 2027. These across-the-board spending cuts have affected and will continue to adversely affect our business, results of operations, financial condition and cash flows. Although the Bipartisan Budget Act (BBA) of 2018 passed in February 2018 enacted a two-year federal spending agreement and raised the federal spending cap on non-defense spending for fiscal years 2018 and 2019, the Medicare program is frequently mentioned as a target for spending cuts.

The CMS Innovation Center (Innovation Center) is currently working with various healthcare providers to develop, refine and implement Accountable Care Organizations (ACOs) and other innovative models of care for Medicare and Medicaid beneficiaries. We are uncertain of the extent to which the long-term operation and evolution of these models of care, including ACOs, the Comprehensive ESRD Care (CEC) Model (which includes the development of ESRD Seamless Care Organizations (ESCOs)), the Duals Demonstration, or other models, will impact the healthcare market over time. Our U.S. dialysis business may choose to participate in one or several of these models either as a partner with other providers or independently. We currently participate in the CEC Model with the Innovation Center, including the ESCO organizations in the Phoenix-Tucson, Arizona, South Florida, Philadelphia, Pennsylvania-Camden, and New Jersey markets. In areas where our U.S. dialysis business is not directly participating in this or other Innovation Center models, some of our patients may be assigned to an ACO, another ESRD Care Model, or another program, in which case the quality and cost of care that we furnish will be included in an ACO's, another ESRD Care Model's or other program's calculations. In addition to the aforementioned new models of care, federal bipartisan legislation in the form of the Dialysis Patient Access to Integrated-care, Empowerment, Nephrologists, Treatment and Services Demonstration Act of 2017 (PATIENTS Act) has been proposed. The PATIENTS Act builds on prior coordinated care models, such as the CEC Model, and would establish a demonstration program for the provision of integrated care to Medicare ESRD patients. We have made and continue to make investments in building our integrated care capabilities to prepare for integrated care initiatives such as the PATIENTS Act, but there can be no assurances that the PATIENTS Act or similar legislation will be passed. If such legislation is passed, there can be no assurances that we will be able to successfully provide integrated care on the broader scale contemplated by this legislation, and our costs of care could exceed our associated reimbursement rates. In general, if we are unable to efficiently adjust to these and other new models of care, it may erode our patient base or reimbursement rates, which could have a material adverse impact on our business.

The Department of Health and Human Services (HHS) targeted to tie 40% and 50% of Medicare Fee-for-Service (FFS) payments to quality or alternate payment models by the end of 2017 and 2018, respectively. The Health Care

Payment Learning & Action Network reported Medicare FFS had 38.3% of health care dollars tied to alternate payment models for 2017 and results of this target are still pending for 2018. As new models of care emerge and evolve, we may be at risk for losing our Medicare patient base, which would have a material adverse effect on our business, results of operations, financial condition and cash flows. Other initiatives in the government or private sector may also arise, including the development of models similar to ACOs, independent practice associations (IPAs) and integrated delivery systems or evolutions of those concepts which could adversely impact our business.

ESRD patients receiving dialysis services become eligible for primary Medicare coverage at various times, depending on their age or disability status, as well as whether they are covered by a commercial insurance plan. Generally, for a patient not covered by a commercial insurance plan, Medicare becomes the primary payor for ESRD patients receiving dialysis services either immediately or after a three-month waiting period. For a patient covered by a commercial insurance plan, Medicare generally becomes the primary payor after 33 months, which includes the three-month waiting period, or earlier if the patient's commercial insurance plan coverage terminates. When Medicare becomes the primary payor, the payment rates we receive for that patient shift from the commercial insurance plan rates to Medicare payment rates, which are on average significantly lower than commercial insurance rates.

Medicare pays 80% of the amount set by the Medicare system for each covered dialysis treatment. The patient is responsible for the remaining 20%. In most cases, a secondary payor, such as Medicare supplemental insurance, a state Medicaid program or a commercial health plan, covers all or part of these balances. Some patients who do not qualify for Medicaid, but otherwise cannot afford secondary insurance in the form of a Medicare Supplement Plan, can apply for premium payment assistance from charitable organizations to obtain secondary coverage. If a patient does not have secondary insurance coverage, we are generally unsuccessful in our efforts to collect from the patient the remaining 20% portion of the ESRD composite rate that Medicare does not pay. However, we are able to recover some portion of this unpaid patient balance from Medicare through an established cost reporting process by identifying these Medicare bad debts on each center's Medicare cost report.

The 21st Century Cures Act, enacted in December 2016, includes a provision that will allow Medicare beneficiaries with ESRD to choose to obtain coverage under a Medicare Advantage plan, which could broaden access to certain enhanced benefits offered by Medicare Advantage plans. Until the effective date of this law, this choice is available only to Medicare beneficiaries without ESRD. The ESRD related provisions of the 21st Century Cures Act are scheduled to take effect in 2021.

Medicaid revenue

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

Commercial revenue

Before a patient becomes eligible to elect to have Medicare as their primary payor for dialysis services, a patient's commercial insurance plan, if any, is generally responsible for payment of such dialysis services for up to the first 33 months, as discussed above. Although commercial payment rates vary, average commercial payment rates established under commercial contracts are generally significantly higher than Medicare rates. The payments we receive from commercial payors generate nearly all of our profits. Payment methods from commercial payors can include a single lump-sum per treatment, referred to as bundled rates, or in other cases separate payments for dialysis treatments and pharmaceuticals, if used as part of the treatment, referred to as FFS rates. Commercial payment rates are the result of negotiations between us and insurers or third-party administrators. Our out-of-network payment rates are on average higher than in-network commercial contract payment rates. Some of our commercial contracts pay us under a single bundled payment rate for all dialysis services provided to covered patients. However, some of our commercial contracts also pay us for certain other services and pharmaceuticals in addition to the bundled payment. Our commercial contracts typically contain annual price escalator provisions. We are continuously in the process of negotiating agreements with our commercial payors and if our negotiations result in overall commercial contract payment rate reductions in excess of our commercial contract payment rate increases, or if commercial payors implement plans that restrict access to coverage or the duration or breadth of benefits or impose restrictions or limitations on patient access to non-contracted or out-of-network providers, it could have a material adverse effect on our business, results of operations, financial condition and cash flows. In addition, if there is an increase in job losses in the U.S., or depending upon changes to the healthcare regulatory system by CMS and/or the impact of healthcare insurance exchanges, we could experience a decrease in the number of patients covered under commercial insurance

plans and/or an increase in uninsured or underinsured patients. Patients with commercial insurance who cannot otherwise maintain coverage frequently rely on financial assistance from charitable organizations, such as the American Kidney Fund. If these patients are unable to obtain or continue to receive or receive for a limited duration such financial assistance, or if our assumptions about how patients will respond to any change in such financial assistance are incorrect, it could have a material adverse effect on our business, results of operations, financial condition and cash flows.

Approximately 25% of our U.S. dialysis and related lab patient services revenues and approximately 10.4% of our U.S. dialysis patients are associated with non-acute commercial payors for the year ended December 31, 2018. Non-acute commercial patients as a percentage of our total U.S. dialysis patients for 2018 were relatively flat as compared to 2017. Less than 1% of our U.S. dialysis and related lab services revenues are due directly from patients. There is no single commercial payor that accounted for more than 10% of total U.S. dialysis and related lab services revenues for the year ended December 31, 2018. See Note 2 to the consolidated financial statements included in this report for disclosure on our concentration related to our commercial payors on a total consolidated net revenue basis.

The healthcare reform legislation enacted in 2010 introduced healthcare insurance exchanges which provide a marketplace for eligible individuals and small employers to purchase healthcare insurance. The business and regulatory environment continues to evolve as the exchanges mature, and statutes and regulations are challenged, changed and enforced. Commercial payor participation in the exchanges has decreased and may continue to decrease. If commercial payor participation in the exchanges continues to decrease, it could have a material adverse effect on our business, results of operations, financial condition and cash flows. Although we cannot predict the short- or long-term effects of these factors, we believe future market changes could result in a reduction in ESRD patients covered by traditional commercial insurance policies and an increase in the number of patients covered through the exchanges under more restrictive commercial plans with lower reimbursement rates or higher deductibles and co-payments that patients may not be able to pay. To the extent that changes in statutes, regulations or related guidance or changes in other market conditions result in a reduction in reimbursement rates for our services from commercial and/or government payors, it could have a material adverse effect on our business, results of operations, financial condition and cash flows.

In December 2016, CMS published an interim final rule that questioned the use of charitable premium assistance for ESRD patients and would have established new conditions for coverage standards for dialysis facilities. In January 2017, a federal court issued a preliminary injunction on CMS' interim final rule and in June 2017, at the request of CMS, the court stayed the proceedings while CMS pursues new rulemaking options. CMS has not issued any new rulemaking related to charitable premium assistance yet, but that does not preclude CMS or another regulatory agency or legislative authority from issuing a new rule or guidance that challenges charitable premium assistance. Additionally, any other law, rule, or guidance, proposed or issued by CMS or other federal or state regulatory or legislative authorities, including any ballot or other initiatives, restricting or prohibiting the ability of patients with access to alternative coverage from selecting a marketplace plan on or off exchange, limiting the amount of revenue dialysis providers can retain for caring for patients with commercial insurance by, among other things, requiring rebates to insurers and taking into account only a portion of the costs incurred by dialysis providers, affecting payments made to providers for services provided to patients who receive charitable premium assistance, and/or otherwise restricting or prohibiting the use of charitable premium assistance, could cause us to incur substantial costs to oppose any such proposed measures, impact our dialysis center development plans, and if passed and/or implemented, could adversely impact dialysis centers across the U.S. making certain centers economically unviable, lead to the closure of certain centers, restrict the ability of dialysis patients to obtain and maintain optimal insurance coverage, and in some cases have a material adverse effect on our business, results of operations, financial condition and cash flows. For a discussion of recent state legislative and ballot initiatives and related risks, see our Risk Factor in Item 1A Risk Factors under the heading "Changes in federal and state healthcare legislation or regulations could have a material adverse effect on our business, results of operations, financial condition and cash flows."

Revenue from other pharmaceuticals

The impact of physician-prescribed pharmaceuticals on our overall revenues that are separately billable has significantly decreased since Medicare's single bundled payment system went into effect beginning in January 2011, and as a result of commercial contracts that pay us a single bundled payment rate. Effective January 1, 2018, both oral and IV forms of calcimimetics, a drug class taken by many patients with ESRD to treat mineral bone disorder, became the financial responsibility of our U.S. dialysis and lab services business for our Medicare patients and are now reimbursed under Medicare Part B. During an initial pass-through period, Medicare payment for calcimimetics will be based on a pass-through rate of the average sales price plus approximately 4%. CMS has stated intentions to enter calcimimetics into the ESRD bundle two years after transitioning to Part B. Previously, calcimimetics were

reimbursed for Medicare patients through Part D once dispensed from traditional pharmacies.

Approximately 7% and 2% of our total U.S. dialysis and related lab services net patient services revenues for the years ended December 31, 2018 and 2017, are associated with the administration of separately-billable physician-prescribed pharmaceuticals of which the administration of calcimimetics and EPO accounted for approximately 5% and 1% of our total U.S. dialysis and related lab services net revenues, respectively, for the year ended December 31, 2018. The administration of EPO accounted for approximately 1% of our total U.S. dialysis and related lab services net revenues for the year ended December 31, 2017.

Currently, EPO and both the oral and IV forms of calcimimetics are produced by a single manufacturer, Amgen USA Inc. (Amgen). In 2017, we entered into a Sourcing and Supply Agreement with Amgen for both the oral and IV versions of calcimimetics that expires on December 31, 2022. Our business, results of operations, financial condition and cash flows could be materially impacted by certain factors relating to calcimimetics, including physician prescribing patterns, vendor contracts with Amgen and other suppliers, the availability in the market of a generic oral equivalent, whether the drug becomes part of the ESRD PPS bundled payment and, if so, at what rate, and how commercial payors will treat reimbursement of the drug. If payors do not pay as anticipated, if we are not adequately reimbursed for the cost of the drug, or the processes we have implemented to provide the drug do not perform as anticipated, then we could be subject to both financial and operational risk, among other things. In addition, in 2017, we also entered into a separate Sourcing and Supply Agreement with Amgen for EPO that expires on December 31, 2022. Under the terms of the agreement, we will purchase EPO in amounts necessary to meet no less than 90% of our requirements for erythropoiesis-stimulating agents (ESAs) through the expiration of the contract. The actual amount of EPO that we will purchase from Amgen will depend upon the amount of EPO administered during dialysis treatments as prescribed by physicians and the overall number of patients that we serve. Any interruption in the supply of EPO, calcimimetics, or product cost increases for which we are not appropriately reimbursed or that we are unable to mitigate could materially impact our operations, among other things.

Physician relationships

Community Physicians

An ESRD patient generally seeks treatment at an outpatient dialysis center near his or her home where his or her treating nephrologist has practice privileges. Our relationships with local nephrologists and our ability to provide quality dialysis services and to meet the needs of their patients are key factors in the success of our dialysis operations. Over 5,300 nephrologists currently refer patients to our outpatient dialysis centers. As is typical in the dialysis industry, one or a few physicians, usually account for all or a significant portion of an outpatient dialysis center's patient base. If a significant number of physicians cease referring patients to our outpatient dialysis centers, it would have a material adverse effect on our business, results of operations, financial condition and cash flows.

Medical Directors

Participation in the Medicare ESRD program requires that dialysis services at an outpatient dialysis center be under the general supervision of a medical director. Per these requirements, this individual is usually a board certified nephrologist. We have engaged physicians or groups of physicians to serve as medical directors for each of our outpatient dialysis centers. At some outpatient dialysis centers, we also separately contract with one or more other physicians or groups to serve as assistant or associate medical directors over other modalities such as home dialysis. We have over 1,000 individual physicians and physician groups under contract to provide medical director services.

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

Our medical director contracts, joint venture operating agreements and dialysis center purchase agreements generally include covenants not to compete or own interests in other competing outpatient dialysis centers within a defined geographic area for various time periods, as applicable. These non-compete agreements do not prohibit the physicians from referring patients to any outpatient dialysis center, including competing centers.

As part of our Corporate Integrity Agreement (CIA), as described below, we have agreed not to enforce investment non-compete restrictions relating to dialysis clinics or programs that were established pursuant to a partial divestiture joint venture transaction. Therefore, to the extent a joint venture partner or medical director has a contract(s) with us covering dialysis clinics or programs that were established pursuant to a partial divestiture, we will not enforce the

investment non-compete provision relating to those clinics and/or programs.

Government regulation

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

If any of our operations are found to violate applicable laws or regulations, we could suffer severe consequences that would have a material adverse effect on our business, results of operations, financial condition, cash flows, reputation and stock price, including:

- Suspension or termination of our participation in government payment programs;
- Refunds of amounts received in violation of law or applicable payment program requirements dating back to the applicable statute of limitation periods;
- Loss of required government certifications or exclusion from government payment programs;
- Loss of licenses required to operate healthcare facilities or administer pharmaceuticals in the states in which we operate;
- Reductions in payment rates or coverage for dialysis and ancillary services and pharmaceuticals;
- Civil or criminal liability, fines, damages or monetary penalties for violations of healthcare fraud and abuse laws, including the federal Anti-Kickback Statute contained in the Social Security Act of 1935, as amended (Anti-Kickback Statute), Civil Monetary Penalties Statute, Stark Law and False Claims Act (FCA), or other failures to meet regulatory requirements;
- Enforcement actions by governmental agencies and/or state law claims for monetary damages from patients who believe their protected health information (PHI) has been used, disclosed or not properly safeguarded in violation of federal or state patient privacy laws including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Privacy Act of 1974;
- Mandated changes to our practices or procedures that significantly increase operating expenses;
- Imposition of and compliance with corporate integrity agreements that could subject us to ongoing audits and reporting requirements as well as increased scrutiny of our billing and business practices;
- Termination of various relationships and/or contracts related to our business, including joint venture arrangements, medical director agreements, real estate leases and consulting agreements with physicians; and
- Harm to our reputation which could negatively impact our business relationships, affect our ability to attract and retain patients and physicians, affect our ability to obtain financing and decrease access to new business opportunities, among other things.

We expect that our industry will continue to be subject to substantial regulation, the scope and effect of which are difficult to predict. We are currently subject to ongoing investigations, audits and inquiries by various government and regulatory agencies as further described in Note 17 to the consolidated financial statements. Our activities could be reviewed or challenged by regulatory authorities at any time in the future, as further described in Item 1A. Risk Factors under the heading, "We are, and may in the future be, a party to various lawsuits, demands, claims, qui tam suits, governmental investigations and audits (including investigations or other actions resulting from our obligation to self-report suspected violations of law) and other legal matters, any of which could result in, among other things, substantial financial penalties or awards against us, mandated refunds, substantial payments made by us, required changes to our business practices, exclusion from future participation in Medicare, Medicaid and other healthcare programs and possible criminal penalties, any of which could have a material adverse effect on our business, results of operations, financial condition, cash flows and materially harm our reputation". This regulation and scrutiny could have a material adverse impact on us.

Licensure and certification

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

We have experienced some delays in obtaining Medicare certifications from CMS. However, recent changes in the prioritizing of dialysis providers as well as recent legislation allowing private entities to perform initial dialysis facilities certifications may help to decrease or limit delays. The number of companies who will enter the market and the cost of surveys they might perform is unclear.

Federal Anti-Kickback Statute

The federal Anti-Kickback Statute prohibits, among other things, knowingly and willfully offering, paying, soliciting or receiving remuneration, directly or indirectly, in cash or kind, to induce or reward either the referral of an individual for, or the purchase, or order or recommendation of, any good or service, for which payment may be made under federal and state healthcare programs such as Medicare and Medicaid.

Federal criminal penalties for the violation of the federal Anti-Kickback Statute include imprisonment, fines and exclusion of the provider from future participation in the federal healthcare programs, including Medicare and Medicaid. Violations of the federal Anti-Kickback Statute are punishable by imprisonment for up to ten years and fines of up to $100,000 or both. Larger fines can be imposed upon corporations under the provisions of the U.S. Sentencing Guidelines and the Alternate Fines Statute. Individuals and entities convicted of violating the federal Anti-Kickback Statute are subject to mandatory exclusion from participation in Medicare, Medicaid and other federal healthcare programs for a minimum of five years. Civil penalties for violation of this law include up to $100,000 in monetary penalties per violation, repayments of up to three times the total payments between the parties to the arrangement and suspension from future participation in Medicare and Medicaid. Court decisions have held that the statute may be violated even if only one purpose of remuneration is to induce referrals. The Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 (Affordable Care Act (ACA)), amended the federal Anti-Kickback Statute to clarify the intent that is required to prove a violation. Under the statute as amended, the defendant does not need to have actual knowledge of the federal Anti-Kickback Statute or have the specific intent to violate it. In addition, the ACA amended the federal Anti-Kickback Statute to provide that any claims for items or services resulting from a violation of the federal Anti-Kickback Statute are considered false or fraudulent for purposes of the FCA.

The federal Anti-Kickback Statute includes statutory exceptions and regulatory safe harbors that protect certain arrangements. Business transactions and arrangements that are structured to comply fully with an applicable safe harbor do not violate the federal Anti-Kickback Statute. However, transactions and arrangements that do not satisfy all elements of a relevant safe harbor do not necessarily violate the law. When an arrangement does not satisfy a safe harbor, the arrangement must be evaluated on a case-by-case basis in light of the parties' intent and the arrangement's potential for abuse. Arrangements that do not satisfy a safe harbor may be subject to greater scrutiny by enforcement agencies.

We enter into several arrangements with physicians that potentially implicate the Anti-Kickback Statute, such as:

Medical Director Agreements. Because our medical directors refer patients to our dialysis centers, our arrangements with these physicians are designed to substantially comply with the safe harbor for personal service arrangements. Although we endeavor to structure the Medical Director Agreements we enter into with physicians to substantially comply with the safe harbor for personal service arrangements, including the requirement that compensation be consistent with fair market value, the safe harbor requires that when services are provided on a part-time basis, the agreement must specify the schedule of intervals of services, and their precise length and the exact charge for such services. Because of the nature of our medical directors' duties, it is impossible to fully satisfy this technical element of the safe harbor. As a result, these arrangements could be subject to scrutiny since they do not expressly describe the schedule of part-time services to be provided under the arrangement.

Joint Ventures. We own a controlling interest in numerous U.S. dialysis related joint ventures. For the year ended December 31, 2018, these joint ventures represented approximately 25% of our net U.S. dialysis and related lab services revenues. We expect to continue to enter into new U.S. dialysis related joint ventures in the ordinary course of business while maintaining over time most of our existing joint ventures, which would increase the total number of our Kidney Care joint ventures. Our relationships with physicians and other referral sources relating to these joint ventures do not fully satisfy the safe harbor for investments in small entities. Although failure to comply with a safe harbor does not render an arrangement illegal under the federal Anti-Kickback Statute, an arrangement that does not operate within a safe harbor may be subject to scrutiny and the Department of Health and Human Services' Office of Inspector General (OIG) has warned in the past that certain joint venture relationships have a potential for abuse. Physician joint ventures that fall outside the safe harbors are evaluated on a case-by-case basis under the federal Anti-Kickback Statute.

In this regard, we have endeavored to structure our joint ventures to satisfy as many elements of the safe harbor for investments in small entities as we believe are commercially reasonable. For example, we believe that these investments are offered and made by us on a fair market value basis and provide returns to the investors in proportion to their actual investment in the venture. However, since the arrangements do not satisfy all of the requirements of an applicable safe harbor, these arrangements could be subject to scrutiny on the ground that they are intended to induce patient referrals.

We were subject to investigation by the United States Attorney's Office for the District of Colorado, the Civil Division of the United States Department of Justice (DOJ) and the OIG related to our then-existing relationships with physicians,

including our joint ventures, and whether those relationships and joint ventures comply with the federal Anti-Kickback Statute and the FCA. In October 2014, we entered into a Settlement Agreement with the United States and relator David Barbetta to resolve the then pending 2010 and 2011 U.S. Attorney physician relationship investigations. In connection with the resolution of this matter, and in exchange for the OIG's agreement not to exclude us from participating in the federal healthcare programs, we entered into a five-year CIA with the OIG. The CIA (i) requires that we maintain certain elements of our compliance programs; (ii) imposes certain expanded compliance-related requirements during the term of the CIA; (iii) requires ongoing monitoring and reporting by an independent monitor, imposes certain reporting, certification, records retention and training obligations, allocates certain oversight responsibility to the Board's Compliance Committee, and necessitates the creation of a Management Compliance Committee and the retention of an independent compliance advisor to the Board; and (iv) contains certain business restrictions related to a subset of our joint venture arrangements. For additional information regarding our CIA, see Item 1 Business under the heading "Corporate Compliance Program."

Lease Arrangements. We lease space for numerous dialysis centers from entities in which physicians, hospitals or medical groups hold ownership interests, and we sublease space to referring physicians at approximately 240 of our dialysis centers as of December 31, 2018. We endeavor to structure these arrangements to comply with the federal Anti-Kickback Statute safe harbor for space rentals in all material respects.

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

Discounts. Our dialysis centers sometimes acquire certain items and services at a discount that may be reimbursed by a federal healthcare program. We endeavor to structure our vendor contracts that include discount or rebate provisions to comply with the federal Anti-Kickback Statute safe harbor for discounts.

If any of our business transactions or arrangements, including those described above, were found to violate the federal Anti-Kickback Statute, we, among other things, could face criminal, civil or administrative sanctions, including possible exclusion from participation in Medicare, Medicaid and other state and federal healthcare programs. Any findings that we have violated these laws could have a material adverse impact on our business, results of operations, financial condition, cash flows, reputation and stock price.

As part of HHS's Regulatory Sprint to Coordinated Care (Regulatory Sprint), OIG issued a request for information (RFI) in August 2018 seeking input on regulatory provisions that may act as barriers to coordinated care or value-based care. Specifically, OIG sought to identify ways in which it might modify or add new safe harbors to the Anti-Kickback Statute (as well as exceptions to the definition of "remuneration" in the beneficiary inducements provision of the Civil Monetary Penalty statute) in order to foster arrangements that promote care coordination and advance the delivery of value-based care, while also protecting against harms caused by fraud and abuse. Comments were due in October 2018, but OIG has yet to issue any proposed rules or take other regulatory action related to the RFI.

Stark Law

The Stark Law prohibits a physician who has a financial relationship, or who has an immediate family member who has a financial relationship, with entities providing Designated Health Services (DHS), from referring Medicare and Medicaid patients to such entities for the furnishing of DHS, unless an exception applies. DHS is defined to mean any of the following enumerated items or services; clinical laboratory services; physical therapy services; occupational therapy services; radiology services, including magnetic resonance imaging, computerized axial tomography 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; inpatient and outpatient hospital services; and outpatient speech-language pathology services. The types of financial arrangements between a physician and a DHS entity that trigger the self-referral prohibitions of the Stark Law are broad and include direct and indirect ownership and investment interests and compensation arrangements. The Stark Law also prohibits the DHS entity receiving a prohibited referral from presenting, or causing to be presented, a claim or billing for the services arising out of the prohibited referral. The prohibition applies regardless of the reasons for the financial relationship and the referral; unlike the federal

Anti-Kickback Statute, intent to induce referrals is not required. If the Stark Law is implicated, the financial relationship must fully satisfy a Stark Law exception. If an exception is not satisfied, then the parties to the arrangement could be subject to sanctions. Sanctions for violation of the Stark Law include denial of payment for claims for services provided in violation of the prohibition, refunds of amounts collected in violation of the prohibition, a civil penalty of up to $15,000 for each service arising out of the prohibited referral, a civil penalty of up to $100,000 against parties that enter into a scheme to circumvent the Stark Law prohibition, civil assessment of up to three times the amount claimed, and potential exclusion from the federal healthcare programs, including Medicare and Medicaid. Amounts collected for prohibited claims

must be reported and refunded generally within 60 days after the date on which the overpayment was identified. Furthermore, Stark Law violations and failure to return overpayments timely can form the basis for FCA liability as discussed below.

The definition of DHS under the Stark Law excludes services paid under a composite rate, even if some of the components bundled in the composite rate are DHS. Although the ESRD bundled payment system is no longer titled a composite rate, we believe that the former composite rate payment system and the current bundled system are both composite systems excluded from the Stark Law. Since most services furnished to Medicare beneficiaries provided in our dialysis centers are reimbursed through a bundled rate, the services performed in our facilities generally are not DHS, and the Stark Law referral prohibition does not apply to those services. Certain separately billable drugs (drugs furnished to an ESRD patient that are not for the treatment of ESRD that CMS allows our centers to bill for using the so-called AY modifier) may be considered DHS. However, we have implemented certain billing controls designed to limit DHS being billed out of our dialysis clinics. Likewise, the definition of inpatient hospital services, for purposes of the Stark Law, also excludes inpatient dialysis performed in hospitals that are not certified to provide ESRD services. Consequently, our arrangements with such hospitals for the provision of dialysis services to hospital inpatients do not trigger the Stark Law referral prohibition.

In addition, although prescription drugs are DHS, there is an exception in the Stark Law for calcimimetics, EPO and other specifically enumerated dialysis drugs when furnished in or by an ESRD facility such that the arrangement for the furnishing of the drugs does not violate the Stark Law. The exception is available only for drugs included on a list of Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) codes published by CMS, and for calcimimetics, EPO, Aranesp® and equivalent drugs dispensed by the ESRD facility for use at home. While we believe that most drugs furnished by our dialysis centers are covered by the exception, dialysis centers may administer drugs that are not on the list of CPT/HCPCS codes and therefore do not meet this exception. In order for a physician who has a financial relationship with a dialysis center to order one of these drugs from the center and for the center to obtain Medicare reimbursement, another exception must apply.

We have entered into several types of financial relationships with referring physicians, including compensation arrangements. If our dialysis centers were to bill for a non-exempted drug and the financial relationships with the referring physician did not satisfy an exception, we could be required to change our practices, face civil penalties, pay substantial fines, return certain payments received from Medicare and beneficiaries or otherwise experience a material adverse effect as a result of a challenge to payments made pursuant to referrals from these physicians under the Stark Law.

Medical Director Agreements. We endeavor to structure our medical director agreements to satisfy the personal services arrangement exception to the Stark Law. While we believe that the compensation provisions included in our medical director agreements are the result of arm’s length negotiations and result in fair market value payments for medical director services, an enforcement agency could nevertheless challenge the level of compensation that we pay our medical directors.

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

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

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

Ancillary Services. The operations of our ancillary and subsidiary businesses are also subject to compliance with the Stark Law, and any failure to comply with these requirements, particularly in light of the strict liability nature of the

Stark Law, could subject these operations to the Stark Law penalties and sanctions described above.

If CMS or other regulatory or enforcement authorities determined that we have submitted claims in violation of the Stark Law, or otherwise violated the Stark Law, we would be subject to the penalties described above. In addition, it might be necessary to restructure existing compensation agreements with our medical directors and to repurchase or to request the sale of ownership interests in subsidiaries and partnerships held by referring physicians or, alternatively, to refuse to accept referrals

for DHS from these physicians, or take other actions to modify our operations. Any such penalties and restructuring or other required actions could have a material adverse effect on our business, results of operations, financial condition and cash flows.

In June 2018, CMS issued an RFI seeking input on how to address any undue regulatory impact and burden of the Stark Law. CMS placed the RFI in the context of HHS's Regulatory Sprint and stated that it identified aspects of the Stark Law that pose potential barriers to coordinated care. CMS thus sought comments on the impact and burden of the Stark Law, including whether it prevents or inhibits care coordination. Comments closed on August 24, 2018 and CMS has not yet issued proposed or final regulations based on the RFI.

Fraud and abuse under state law

Some states in which we operate dialysis centers have laws prohibiting physicians from holding financial interests in various types of medical facilities to which they refer patients. Some of these laws could potentially be interpreted broadly as prohibiting physicians who hold shares of our publicly traded stock or are physician owners from referring patients to our dialysis centers if the centers use our laboratory subsidiary to perform laboratory services for their patients or do not otherwise satisfy an exception to the law. States also have laws similar to or stricter than the federal Anti-Kickback Statute that may affect our ability to receive referrals from physicians with whom we have financial relationships, such as our medical directors. Some state anti-kickback laws also include civil and criminal penalties. Some of these laws include exemptions that may be applicable to our medical directors and other physician relationships or for financial interests limited to shares of publicly traded stock. Some, however, may include no explicit exemption for certain types of agreements and/or relationships entered into with physicians. If these laws are interpreted to apply to referring physicians with whom we contract for medical director and similar services, to referring physicians with whom we hold joint ownership interests or to referring physicians who hold interests in DaVita Inc. limited solely to our publicly traded stock, and for which no applicable exception exists, we may be required to terminate or restructure our relationships with or refuse referrals from these referring physicians and could be subject to criminal, civil and administrative sanctions, refund requirements and exclusions from government healthcare programs, including Medicare and Medicaid, which could have a material adverse effect on our business, results of operations, financial condition, cash flows, reputation and stock price.

Corporate Practice of Medicine and Fee-Splitting

There are states in which we provide management services to nephrology physician practices that have laws that prohibit business entities, such as our Company and our subsidiaries, from practicing medicine, employing physicians to practice medicine or exercising control over medical decisions by physicians (known collectively as the corporate practice of medicine). These states also prohibit entities from engaging in certain financial arrangements, such as fee-splitting, with physicians. In some states these prohibitions are expressly stated in a statute or regulation, while in other states the prohibition is a matter of judicial or regulatory interpretation. Violations of the corporate practice of medicine vary by state and may result in physicians being subject to disciplinary action, as well as to forfeiture of revenues from payors for services rendered. For lay entities, violations may also bring both civil and, in more extreme cases, criminal liability for engaging in medical practice without a license. Some of the relevant laws, regulations, and agency interpretations in states with corporate practice of medicine restrictions have been subject to limited judicial and regulatory interpretation. Moreover, state laws are subject to change.

The False Claims Act

The federal FCA is a means of policing false bills or false requests for payment in the healthcare delivery system. In part, the FCA authorizes the imposition of up to three times the government’s damages and civil penalties on any person who, among other acts:

- Knowingly presents or causes to be presented to the federal government, a false or fraudulent claim for payment or approval;
- Knowingly makes, uses or causes to be made or used, a false record or statement material to a false or fraudulent claim;
- Knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay the government, or knowingly conceals or knowingly and improperly, avoids or decreases an obligation to pay or transmit

money or property to the federal government; or

- Conspires to commit the above acts.

In addition, amendments to the FCA impose severe penalties for the knowing and improper retention of overpayments collected from government payors. Under these provisions, within 60 days of identifying and quantifying an overpayment, a provider is required to notify CMS or the Medicare Administrative Contractor of the overpayment and the reason for it and return the overpayment. An overpayment impermissibly retained could subject us to liability under the FCA, exclusion from government healthcare programs, and penalties under the federal Civil Monetary Penalty statute. As a result of these provisions, our procedures for identifying and processing overpayments may be subject to greater scrutiny.

The penalties for a violation of the FCA range from $5,500 to $11,000 (adjusted for inflation) for each false claim, plus up to three times the amount of damages caused by each false claim, which can be as much as the amounts received directly or indirectly from the government for each such false claim. On January 29, 2018, the DOJ issued a final rule announcing adjustments to FCA penalties, under which the per claim penalty range increased to a range from $11,181 to $22,363 for penalties assessed after January 29, 2018, so long as the underlying conduct occurred after November 2, 2015. The federal government has used the FCA to prosecute a wide variety of alleged false claims and fraud allegedly perpetrated against Medicare and state healthcare programs, including coding errors, billing for services not rendered, the submission of false cost reports, billing for services at a higher payment rate than appropriate, billing under a comprehensive code as well as under one or more component codes included in the comprehensive code and billing for care that is not considered medically necessary. The ACA provides that claims tainted by a violation of the federal Anti-Kickback Statute are false for purposes of the FCA. Some courts have held that filing claims or failing to refund amounts collected in violation of the Stark Law can form the basis for liability under the FCA. In addition to the provisions of the FCA, which provide for civil enforcement, the federal government can use several criminal statutes to prosecute persons who are alleged to have submitted false or fraudulent claims for payment to the federal government.

Civil Monetary Penalties Statute

The Civil Monetary Penalties Statute, 42 U.S.C. § 1320a-7a, authorizes the imposition of civil money penalties, assessments, and exclusion against an individual or entity based on a variety of prohibited conduct, including, but not limited to:

- Presenting, or causing to be presented, claims for payment to Medicare, Medicaid, or other third-party payors that the individual or entity knows or should know are for an item or service that was not provided as claimed or is false or fraudulent;
- Offering remuneration to a Federal health care program beneficiary that the individual or entity knows or should know is likely to influence the beneficiary to order or receive health care items or services form a particular provider;
- Arranging contracts with an entity or individual excluded from participation in the Federal health care programs;
- Violating the federal Anti-Kickback Statute;
- Making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim for payment for items and services furnished under a Federal health care program;
- Making, using, or causing to be made any false statement, omission, or misrepresentation of a material fact in any application, bid, or contract to participate or enroll as a provider of services or a supplier under a Federal health care program; and
- Failing to report and return an overpayment owed to the federal government.

Substantial civil monetary penalties may be imposed under the federal Civil Monetary Penalty Statute and vary, depending on the underlying violation. In addition, an assessment of not more than three times the total amount claimed for each item or service may also apply, and a violator may be subject to exclusion from Federal and state health care programs.

Privacy and Security

The Health Insurance Portability and Accountability Act of 1996 and its implementing privacy and security regulations, as amended by the federal Health Information Technology for Economic and Clinical Health Act

(HITECH Act), (collectively referred to as HIPAA), require us to provide certain protections to patients and their health information. The HIPAA privacy and security regulations extensively regulate the use and disclosure of PHI and require covered entities, which include healthcare providers, to implement and maintain administrative, physical and technical safeguards to protect the security of such information. Additional security requirements apply to electronic PHI. These regulations also provide patients with substantive rights with respect to their health information.

The HIPAA privacy and security regulations also require us to enter into written agreements with certain contractors, known as business associates, to whom we disclose PHI. Covered entities may be subject to penalties for, among other activities, failing to enter into a business associate agreement where required by law or as a result of a business associate violating HIPAA if the business associate is found to be an agent of the covered entity and acting within the scope of the agency. Business associates are also directly subject to liability under the HIPAA privacy and security regulations. In instances where we act as a business associate to a covered entity, there is the potential for additional liability beyond our status as a covered entity.

Covered entities must report breaches of unsecured PHI to affected individuals without unreasonable delay but not to exceed 60 days of discovery of the breach by a covered entity or its agents. Notification must also be made to the HHS, and, for breaches of unsecured PHI involving more than 500 residents of a state or jurisdiction, to the media. All non-permitted uses or disclosures of unsecured PHI are presumed to be breaches unless the covered entity or business associate establishes that there is a low probability the information has been compromised. Various state laws and regulations may also require us to notify affected individuals in the event of a data breach involving individually identifiable information without regard to whether there is a low probability of the information being compromised.

Penalties for impermissible use or disclosure of PHI were increased by the HITECH Act by imposing tiered penalties of more than $50,000 per violation and up to $1.5 million per year for identical violations. In addition, HIPAA provides for criminal penalties of up to $250,000 and ten years in prison, with the severest penalties for obtaining and disclosing PHI with the intent to sell, transfer or use such information for commercial advantage, personal gain or malicious harm. Further, state attorneys general may bring civil actions seeking either injunction or damages in response to violations of the HIPAA privacy and security regulations that threaten the privacy of state residents.

Data protection laws are evolving globally, and may add additional compliance costs and legal risks to our international operations. In Europe, the General Data Protection Regulation (GDPR) became effective on May 25, 2018. The GDPR applies to entities that are established in the European Union (EU), as well as extends the scope of EU data protection laws to foreign companies processing data of individuals in the EU. The GDPR imposes a comprehensive data protection regime with the potential for regulatory fines as well as data breach litigation by impacted data subjects. Under GDPR, regulatory penalties may be passed by data protection authorities for up to the greater of 4% of worldwide turnover or €20 million. The costs of compliance with, and other burdens imposed by, the GDPR and other new laws, regulations and policies implementing the GDPR may impact our European operations and/or limit the ways in which we can provide services or use personal data collected while providing services. If we fail to comply with the requirements of GDPR, we could be subject to penalties that would have a material adverse impact on our business, results of operations, financial condition and cash flows.

Data protection laws are also evolving nationally, and may add additional compliance costs and legal risks to our U.S. operations. For example, the California legislature recently passed the California Consumer Protection Act (CCPA), which is scheduled to become effective January 1, 2020. The CCPA is a privacy bill that requires certain companies doing business in California to disclose information regarding the collection and use of a consumer's personal data and to delete a consumer's data upon request. The Act also permits the imposition of civil penalties and expands existing state security laws by providing a private right of action for consumers in certain circumstances where consumer data is subject to a breach. We are still evaluating whether and how this rule will impact our U.S. operations and /or limit the ways in which we can provide services or use personal data collected while providing services.

Healthcare reform

In March 2010, broad healthcare reform legislation was enacted in the U.S. through the ACA. Although many of the provisions of the ACA did not take effect immediately and continue to be implemented, and some have been and may be modified before or during their implementation, the reforms could continue to have an impact on our business in a number of ways. We cannot predict how employers, private payors or persons buying insurance might react to federal and state healthcare reform legislation or what form many of these regulations will take before implementation.

The ACA introduced healthcare insurance exchanges, which provide a marketplace for eligible individuals and small employers to purchase healthcare insurance. The business and regulatory environment continues to evolve as the exchanges mature, and statutes and regulations are challenged, changed and enforced.

The ACA also requires that all non-grandfathered individual and small group health plans sold in a state, including plans sold through the state-based exchanges created pursuant to the healthcare reform laws, cover essential health benefits (EHBs) in ten general categories. The scope of the benefits is intended to equal the scope of benefits under a typical employer plan.

On February 25, 2013, HHS issued the final rule governing the standards applicable to EHB benchmark plans, including new definitions and actuarial value requirements and methodology, and published a list of plan benchmark options that states can use to develop EHBs. The rule describes specific coverage requirements that (i) prohibit discrimination against individuals because of pre-existing or chronic conditions, (ii) ensure network adequacy of essential health providers, and (iii) prohibit benefit designs that limit enrollment and that prohibit access to care for enrollees. Subsequent regulations relevant to the EHB have continued the benchmark plan approach for 2016 and future years and have implemented clarifications and modifications to the existing EHB regulations, including the prohibition on discrimination, network adequacy standards and other requirements. In recent years, CMS has issued an annual Notice of Benefit and Payment Parameters rulemaking and related guidance setting forth standards for insurance plans provided through the exchanges.

Other aspects of the 2010 healthcare reform laws may affect our business as well, including provisions that impact the Medicare and Medicaid programs. These and other provisions of the ACA remain subject to ongoing uncertainty due to developing regulations and clarifications, including those described above, as well as continuing political and legal challenges at both the federal and state levels. Republicans control the Executive branch and Senate, and since 2016 have implemented both administrative and legislative initiatives that have had adverse impacts on the ACA and its programs. For example, in October 2017, the federal government announced that cost-sharing reduction payments to insurers would end, effective immediately, unless Congress appropriated the funds, and, in December 2017, Congress passed the Tax Cuts and Jobs Act, which includes a provision that eliminates the penalty under the ACA's individual mandate for individuals who fail to obtain a qualifying health insurance plan and could impact the future state of the exchanges. Moreover, in February 2018, Congress passed the BBA which, among other things, repealed the Independent Payment Advisory Board that was established by the ACA and intended to reduce the rate of growth in Medicare spending by extending sequestration cuts to Medicare payments through fiscal year 2027. While certain provisions of the BBA may increase the scope of benefits available for certain chronically ill federal health care program beneficiaries beginning in 2020, the ultimate impact of such changes cannot be predicted. While there may be significant changes to the healthcare environment in the future, the specific changes and their timing are not yet apparent. As a result, there is considerable uncertainty regarding the future with respect to the exchanges, and, indeed, many core aspects of the current health care marketplace. While specific changes and their timing are not yet apparent, such changes could lower our reimbursement rates or increase our expenses. Any failure to successfully implement strategic initiatives that respond to future legislative, regulatory, and executive changes could have a material adverse effect on our business, results of operations, financial condition and cash flows.

Other regulations

Our U.S. dialysis and related lab services operations are subject to various state hazardous waste and non-hazardous medical waste disposal laws. These laws do not classify as hazardous most of the waste produced from dialysis services. Occupational Safety and Health Administration regulations require employers to provide workers who are occupationally subject to blood or other potentially infectious materials with prescribed protections. These regulatory requirements apply to all healthcare facilities, including dialysis centers, and require employers to make a determination as to which employees may be exposed to blood or other potentially infectious materials and to have in effect a written exposure control plan. In addition, employers are required to provide or employ hepatitis B vaccinations, personal protective equipment and other safety devices, infection control training, post-exposure evaluation and follow-up, waste disposal techniques and procedures and work practice controls. Employers are also required to comply with various record-keeping requirements.

In addition, a few states in which we do business have certificate of need programs regulating the establishment or expansion of healthcare facilities, including dialysis centers.

Capacity and location of our U.S. dialysis centers

Typically we are able to increase our capacity by extending hours at our existing dialysis centers, expanding our existing dialysis centers, relocating our dialysis centers, developing new dialysis centers and by acquiring dialysis centers. The development of a typical outpatient dialysis center by us generally requires approximately $2.2 million for leasehold improvements and other capital expenditures. Based on our experience, a new outpatient dialysis center typically opens within a year after the property lease is signed, normally achieves operating profitability in the second

year after Medicare certification and normally reaches maturity within three to five years. Acquiring an existing outpatient dialysis center requires a substantially greater initial investment, but profitability and cash flows are generally accelerated and more predictable. To a limited extent, we enter into agreements to provide management and administrative services to outpatient dialysis centers in which we own a noncontrolling equity investment or which are wholly-owned by third parties in return for management fees, which are typically based on a percentage of revenues or cash collections of the managed center’s operations.

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

	2018	2017	2016	2015	2014
Number of centers at beginning of year	2,510	2,350	2,251	2,179	2,074
Acquired centers	18	66	8	6	18
Developed centers	152	121	100	72	105
Net change in centers with management and administrative services agreements[1]	(5)	(2)	—	2	—
Sold and closed centers[2][3]	(9)	(15)	(4)	(3)	(2)
Closed centers[4]	(2)	(10)	(5)	(5)	(16)
Number of centers at end of year	2,664	2,510	2,350	2,251	2,179

(1) Represents dialysis centers in which we own a noncontrolling equity investment or which are wholly-owned by third parties, and also includes dialysis centers we deconsolidated and transferred to management services agreements.

(2) Includes centers that were divested as a part of our Renal Ventures acquisition in 2017.

(3) Represents dialysis centers that were sold and/or closed for which patients were not retained.

(4) Represents dialysis centers that were closed for which the majority of patients were retained and transferred to one of our other existing outpatient dialysis centers.

As of December 31, 2018, we operated or provided administrative services to a total of 2,664 U.S. outpatient dialysis centers. A total of 2,630 of such centers are consolidated in our financial statements. Of the remaining 34 unconsolidated U.S. outpatient dialysis centers, we own a noncontrolling interest in 30 centers and provide management and administrative services to four centers that are wholly-owned by third parties. The locations of the 2,630 U.S. outpatient dialysis centers consolidated in our financial statements at December 31, 2018 were as follows:

Ancillary services and strategic initiatives businesses, including our international operations

As of December 31, 2018, our ancillary services and strategic initiatives consisted primarily of disease management services, vascular access services, clinical research programs, physician services, ESRD seamless care organizations, comprehensive care, and our international operations and relate primarily to our core business of providing kidney care services.

Ancillary services and strategic initiatives consist primarily of the following:

- *Disease management services.* VillageHealth DM, LLC doing business as DaVita Integrated Kidney Care (DaVita IKC) provides advanced integrated care management services to health plans and government programs for members/beneficiaries diagnosed with ESRD, chronic kidney failure, and/or poly-comorbid conditions. Through a combination of clinical coordination, innovative interventions, medical claims analysis and information technology, we endeavor to assist our customers and patients in obtaining superior renal healthcare and improved clinical outcomes, as well as helping to reduce overall medical costs. Integrated kidney care management revenues from commercial and Medicare Advantage insurers can be based upon either an established contract fee recognized as earned over the contract period, or related to the operation of value-based programs, including pay for performance, shared savings, and capitation contracts. DaVita IKC also operates Medicare Advantage ESRD Special Needs Plans in partnership with payors that work with CMS to provide ESRD patients full service healthcare. We are at risk for all medical costs of the program in excess of the capitation payments. Furthermore, in October 2015, DaVita IKC entered into management service agreements to support three ESCO joint ventures in which we are an investor through certain wholly- or majority-owned dialysis clinics.
- *Vascular access services.* Lifeline provides management and administrative services to physician-owned vascular access clinics that provide vascular services for dialysis and other patients. Lifeline is also the majority-owner of three vascular access clinics. Management fees generated from providing management and administrative services are recognized as earned typically based on a percentage of revenues or cash collections generated by the clinics. Revenues associated with the vascular access clinics that are majority-owned are recognized in the period when the services are provided.
- *Clinical research programs.* DaVita Clinical Research (DCR) is a provider-based specialty clinical research organization with a full spectrum of services for clinical drug research and device development. DCR uses its extensive, applied database and real-world healthcare experience to assist in the design, recruitment and completion of retrospective and prospective pragmatic and clinical trials. Revenues are based upon an established fee per study, as determined by contract with drug companies and other sponsors and are recognized as earned according to the contract terms.
- *Physician services.* Nephrology Practice Solutions (NPS) is an independent business that partners with physicians committed to providing outstanding clinical and integrated care to patients. NPS provides nephrologist recruitment and staffing services in select markets which are billed on a per search basis. NPS also offers physician practice management services to nephrologists under administrative services agreements. These services include physician practice management, billing and collections, credentialing, coding, and other support services that enable physician practices to increase efficiency and manage their administrative needs. Additionally, NPS owns and operates nephrology practices in multiple states. Fees generated from these services are recognized as earned typically based upon flat fees or cash collections generated by the physician practice.
- *ESRD Seamless Care Organization joint ventures (ESCO JVs).* In October 2015, certain of our dialysis clinics entered into partnerships with various nephrology practices, health systems, and other providers to establish three ESCO JVs in Phoenix-Tucson Arizona, South Florida, and Philadelphia Pennsylvania-Camden, New Jersey. The ESCO JVs were formed under the CMS Innovation Center's Comprehensive ESRD Care (CEC) Model, a demonstration to assess the impact of care coordination for ESRD patients in a dialysis-center oriented ACO setting. Each ESCO JV has a shared risk arrangement with CMS and the programs are evaluated on a performance year basis. The delivery of improved quality outcomes for patients and program savings depend on the contributions of the dialysis center teammates, nephrologists, health system and hospital partners, pharmacy providers, other primary care and specialty care providers and facilities, and integrated care management support from DaVita IKC, which is also the manager of the ESCO JVs. In October 2017, CMS published the results for the first performance year, covering the period from

October 2015 to December 2016, and all three ESCO JVs earned shared savings payments. Results for 2017 and 2018 performance years are anticipated to be released in 2019.

- *Comprehensive care.* DaVita Health Solutions was created to provide comprehensive care through house calls and post-acute care programs to help chronically ill patients through use of community based, physician- and nurse practitioner-led care teams to deliver medical, behavioral, social and palliative care within the patient's home or skilled nursing facility.

During 2018, we transitioned the customer service and fulfillment functions of our pharmacy business, DaVita Rx, to third parties and ceased our related distribution operations. DaVita Rx was a pharmacy that specialized in providing oral medications and medication management services to patients with ESRD. In addition, effective June 1, 2018, we sold 100% of the stock of Paladina Health, our direct primary care business. For additional discussion of our ancillary services and strategic initiatives businesses, see Item 7 Management's Discussion and Analysis of Financial Condition and Results of Operations.

International dialysis operations

As of December 31, 2018, we operated or provided administrative services to a total of 241 outpatient dialysis centers, which includes consolidated and nonconsolidated centers located in nine countries outside of the U.S., serving approximately 25,000 patients. Our international dialysis operations have continued to grow steadily and expand as a result of developing and acquiring outpatient dialysis centers in various strategic markets. Our international operations are included as part of our ancillary services and strategic initiatives. The table below summarizes the number of locations of our international outpatient dialysis centers.

	2018	2017	2016	2015	2014
Number of centers at beginning of year	237	154	118	91	73
Acquired centers	28	68	21	21	9
Developed and hospital operated centers	3	8	12	7	11
Managed centers, net	—	—	—	(1)	—
Closed centers	(2)	(1)	—	—	(2)
Net change in Asia Pacific Joint Venture (APAC JV) operated centers[1]	(25)	8	3	—	—
Number of centers at end of year	241	237	154	118	91

(1) In 2016 we deconsolidated the APAC JV.

The locations of our international outpatient dialysis centers are as follows:

Germany	56
Poland	51
Malaysia[1]	40
Brazil	33
Saudi Arabia	23
Colombia	20
Portugal	9
Taiwan[1]	7
China[1]	2
	241

(1) Includes centers that are operated or managed by our APAC JV.

Corporate Administrative Support

Corporate administrative support consists primarily of labor, benefits and long-term incentive compensation costs for departments which provide support to all of our different operating lines of business. These expenses are included in our consolidated general and administrative expenses and are partially offset by the allocation of management fees.

DaVita Medical Group (DMG) Division

In December 2017, we entered into an agreement to sell our DMG division to Optum, a subsidiary of UnitedHealth Group Inc., subject to receipt of required regulatory approvals and other customary closing conditions. As a result, the DMG business has been classified as held for sale and its results of operations are reported as discontinued operations.

DMG business overview

DMG is a patient- and physician-focused integrated healthcare delivery and management company with over two decades of experience providing coordinated, outcomes-based medical care in a cost-effective manner. As of December 31, 2018, DMG served approximately 753,800 members under its care in southern California, central and south Florida, southern Nevada and central New Mexico through capitation contracts with some of the nation's leading health plans. Of these members, approximately 321,500 individuals were patients enrolled in Medicare and Medicare Advantage, and the remaining approximately 432,300 individuals were managed care members whose health coverage is provided through their employer or who have individually acquired health coverage directly from a health plan or as a result of their eligibility for Medicaid benefits. In addition to its managed care business, during the year ended December 31, 2018, DMG provided care across all markets to approximately 932,700 patients whose health coverage is structured on a FFS basis, including patients enrolled through traditional Medicare and Medicaid programs, preferred provider organizations and other third party payors.

DMG patients as well as the patients of DMG's associated physicians, physician groups and IPAs benefit from an integrated approach to medical care that places the physician at the center of patient care. As of December 31, 2018, DMG delivered services to its members via a network of approximately 750 primary care physicians, over 3,200 associated group and other network primary care physicians, approximately 185 network hospitals, and several thousand associated group and network specialists. Together with hundreds of case managers, registered nurses and other care coordinators, these medical professionals utilize a comprehensive information technology system, sophisticated risk management techniques and clinical protocols to provide high-quality, cost-effective care to DMG's members.

U.S. healthcare spending has increased steadily over the past twenty years. These increases have been driven, in part, by the aging of the baby boomer generation, unhealthy behavioral and lifestyle choices in terms of exercise and diet, rapidly increasing costs in medical technology and pharmaceutical research, and provider reimbursement structures that may promote volume over quality in a FFS environment. These factors, as well as the steady growth of the U.S. population, have made the healthcare industry a growing market. CMS reported that in 2017 healthcare accounted for 17.9% of the U.S. gross domestic product and that healthcare spending increased 3.9% to reach $3.5 trillion. Medicare spending grew 4.2% to $706 billion in 2017 or 20% of National Health Expenditures, according to CMS. Medicare's share of the federal budget was approximately 17.1% in 2018 according to the Congressional Budget Office (CBO). Medicare is frequently the focus of discussions on how to moderate the growth of both federal spending and healthcare spending in the U.S.

Growth in Medicare spending is expected to continue due to demographic changes. According to the U.S. Census Bureau, the U.S. population aged 65 and over is expected to be 83.7 million in 2050 — almost double its estimated population of 43.1 million in 2012.

Medicare Advantage is an alternative to the traditional FFS Medicare program, which permits Medicare beneficiaries to receive benefits from a managed care health plan. Medicare Advantage plans contract with CMS to provide benefits that are at least comparable to those offered under the traditional FFS Medicare program in exchange for a fixed per-member monthly premium payment from CMS. The monthly premium varies based on the county in which the member resides, further adjusted to reflect the plan members' expected medical cost risk. Individuals who elect to participate in the Medicare Advantage program typically receive greater benefits than traditional FFS Medicare Part B beneficiaries, including additional preventive services, vision, dental and prescription drug benefits, and often have lower deductibles and co-payments than traditional FFS Medicare.

CMS pays Medicare Advantage health plans under a bidding process. Plans bid against county-level benchmarks. If a plan's bid is higher than the benchmark, enrollees pay the difference in the form of a monthly premium. If the bid is lower than the benchmark, the plan receives the difference between its payment amount and its bid as a rebate, which must be returned to enrollees in the form of additional benefits, reduced premiums, or lower cost sharing.

Managed care health plans were developed, primarily during the 1980s, in an attempt to mitigate the rising cost of providing healthcare benefits to populations covered by traditional health insurance. These managed care health plans often enroll members through their employers. As a result of the prevalence of these health plans, many seniors now becoming eligible for Medicare have been interacting with managed care companies through their employers for the last 30 years. Individuals turning 65 now are likely to be far more familiar with the managed care setting than previous Medicare

populations. According to Kaiser Family Foundation, in 2018, Medicare Advantage represented 34% of total Medicare members, creating a significant opportunity for additional Medicare Advantage penetration of newly eligible seniors.

In an effort to reduce the number of uninsured and to begin to control healthcare expenditures, President Obama signed the ACA into law in March 2010, which was affirmed, in substantial part, by the U.S. Supreme Court in June 2012. As of the end of 2017, the number of uninsured nonelderly Americans was 28.5 million, a decrease of over 13 million since 2013. These previously uninsured Americans and potentially newly eligible Medicaid beneficiaries represent a significant new market opportunity for health plans. We believe that health plans looking to cover these newly eligible individuals under fixed premium arrangements will seek provider arrangements that can effectively manage the cost and quality of the care being provided to these newly eligible individuals, although the 2016 Presidential and Congressional elections and subsequent developments, including recent federal tax reform legislation and legal challenges to the law, have caused the future state of the ACA to become less clear.

One of the primary ways in which the ACA funded expanded health insurance coverage is through cuts in Medicare Advantage reimbursement. County benchmarks have transitioned to a system in which each county's benchmark is a certain percentage (ranging from 95% to 115%) of FFS Medicare. In a March 2018 report to Congress, the Medicare Payment Advisory Commission (MedPAC) estimated that 2018 Medicare Advantage benchmarks (including quality bonuses), bids, and payments would average 107%, 90%, and 101% of FFS spending, respectively.

Despite the fact that the plan bids average less than FFS spending, payments for enrollees in these plans usually exceed FFS spending because the benchmarks are high relative to FFS spending. For example, health maintenance organizations (HMOs) as a group bid an average of 88% of FFS spending, yet 2018 payments for HMO enrollees are estimated to average 100% of FFS spending (including the quality bonuses).

Nonetheless, changes in benchmarks and/or bids that lower payments to Medicare Advantage plans could adversely affect DMG's business, results of operations, financial condition and cash flows.

Many health plans recognize both the opportunity for growth from senior members as well as the potential risks and costs associated with managing additional senior members. In regions operated by DMG and numerous other markets, many health plans subcontract a significant portion of the responsibility for managing patient care to integrated medical networks such as DMG. These integrated healthcare networks, whether medical groups or IPAs, offer a comprehensive medical delivery system and sophisticated care management knowledge and infrastructure to more efficiently provide for the healthcare needs of the population enrolled with that health plan. While reimbursement models for these arrangements vary around the country, health plans in California, Florida, Nevada and New Mexico often prospectively pay the integrated healthcare network a fixed Per Member Per Month (PMPM) amount, or capitation payment, which is often based on a percentage of the amount received by the health plan. The capitation payment is for much-and sometimes virtually all-of the care needs of the applicable membership. Capitation payments to integrated healthcare networks, in aggregate, represent a prospective budget from which the network manages care-related expenses on behalf of the population enrolled with that network. To the extent that these networks manage care-related expenses below the capitated levels, the network realizes an operating profit. On the other hand, if care-related expenses exceed projected levels, the network will realize an operating deficit. Since premiums paid represent a significant amount per person, there is a significant revenue opportunity for an integrated medical network like DMG that is able to effectively manage its costs under a capitated arrangement.

Integrated medical networks, such as DMG, that have scale are positioned to spread an individual member's cost exposure across a wider population and realize the benefits of pooling medical risk among large numbers of patients. In addition, integrated medical networks with years of managed care experience can utilize their sizeable medical experience data to identify specific medical care and quality management strategies and interventions for potential high cost cases and aggressively manage them to improve the health of its population base and, thus, lower cost. Many integrated medical networks, like DMG, also have established physician performance metrics that allow them to monitor quality and service outcomes achieved by participating physicians in order to reward efficient, high quality care delivered to members and initiate improvement efforts for physicians whose results can be enhanced.

Healthcare reform

The U.S. healthcare system, including the Medicare Advantage program, is subject to a broad array of new laws and regulations as a result of the ACA. This legislation made significant changes to the Medicare program and to the health insurance market overall. The ACA is considered by some to be the most dramatic change to the U.S. healthcare system in decades. The U.S. Supreme Court found that the individual mandate to obtain health insurance coverage under this legislation is constitutional and also found that the expanded Medicaid benefit included in the legislation is constitutional if states can opt out of the expanded Medicaid benefit without losing their funding under the pre-reform Medicaid program. In a separate,

subsequent case, the U.S. Supreme Court also upheld the use of subsidies to individuals in federally-facilitated healthcare exchanges, rejecting an argument that such subsidies would apply only in the state-run healthcare exchanges.

The ACA reflects sweeping legislation that, if fully implemented, may have a significant impact on the U.S. healthcare system generally and the operations of DMG's business. There are numerous steps required to implement the ACA, and implementation remains ongoing and uncertain. Congress also has enacted, and may continue to seek, legislative changes that alter, delay, or eliminate some of the ACA's provisions. For example, under the 2016 omnibus budget agreement, Congress voted to delay certain new taxes that the ACA had enacted, including the excise tax on certain high-cost health plans, the medical device tax, and the tax on health insurers. In addition, the 2016 Presidential and Congressional elections and subsequent developments have caused the future state of the ACA to be unclear. In October 2017, the federal government announced that cost-sharing reduction payments to insurers would end, effective immediately, unless Congress appropriated the funds, and, in December 2017, Congress passed the Tax Cuts and Jobs Act, which includes a provision that eliminates the penalty under the ACA's individual mandate for individuals who fail to obtain a qualifying health insurance plan and could impact the future state of the exchanges. Further, in February 2018, Congress passed the BBA, which, among other things, repealed the Independent Payment Advisory Board that was established by the ACA and intended to reduce the rate of growth in Medicare spending by extending sequestration cuts to Medicare payments through fiscal year 2027. While certain provisions of the BBA may increase the scope of benefits available for certain chronically ill federal health care program beneficiaries beginning in 2020, the ultimate impact of such changes cannot be predicted. While specific changes and their timing are not yet apparent, the enacted reforms as well as future legislative, regulatory, judicial or executive changes could have a material adverse effect on our business, results of operations, financial condition and cash flows, including lowering our reimbursement rates and increasing our expenses.

One provision of the ACA required CMS to establish a Medicare Shared Savings Program (MSSP) that promotes accountability and coordination of care through the creation of ACOs. The program allows certain providers and suppliers (including hospitals, physicians and other designated professionals) to voluntarily form ACOs and work together along with other ACO participants to invest in infrastructure and redesign delivery processes to achieve high quality and efficient delivery of services. In 2017, HCP ACO California, LLC (formerly DaVita Medical ACO California, LLC) doing business as HealthCare Partners ACO participated in its first year of the CMS Innovation Center's Next Generation ACO model and achieved $11.8 million in savings. HealthCare Partners ACO will continue to participate in the Next Generation program for both 2018 and 2019. Results for 2018 participation will be available in 2019. In December 2018, CMS issued a final rule for the MSSP, which among other things, requires ACOs to accept a two-sided risk model (as opposed to a one-sided model), wherein ACOs need to share in the financial risk of their patients' healthcare spending (i.e., shared losses) in addition to shared savings. This rule could negatively impact the revenue and profitability of DMG's MSSP ACO.

Payor environment

Government programs

DMG derives a significant portion of its revenues from services rendered to beneficiaries of Medicare (including Medicare Advantage), Medicaid, and other governmental healthcare programs.

Medicare. The Medicare program was established in 1965 and became effective in 1967 as a federally funded U.S. health insurance program for persons aged 65 and older, and it was later expanded to include individuals with ESRD and certain disabled persons, regardless of income or age. Since its formation, Medicare has grown to an approximately $706 billion program in 2017, covering approximately 60 million Americans and, based on the growing number of eligible beneficiaries and increases in the cost of healthcare, CBO projects that net Medicare spending will increase from $585 billion in 2018 to $1.2 trillion in 2028.

Initially, Medicare was offered only on a FFS basis. Under the Medicare FFS payment system, an individual can choose any licensed physician enrolled in Medicare and use the services of any hospital, healthcare provider or facility certified by Medicare. CMS reimburses providers for covered services if CMS considers them medically necessary. FFS Medicare pays for physician services according to a physician fee schedule (PFS) set each year by CMS in accordance with formulas mandated by Congress. Historically, CMS annually adjusted the Medicare Physician Fee

Schedule (Medicare PFS) payment rates based on an updated formula that included application of the Sustainable Growth Rate (SGR). On April 16, 2015, President Obama signed and enacted into law H.R. 2, the Medicare Access and CHIP Reauthorization Act of 2015, which, among other things, repealed the SGR and instituted a 0% update to the single conversion factor under the Medicare PFS from January 1 through June 30, 2015, a 0.5% update for July 2015 through the end of 2019, and a 0% update for 2020 through 2025. For 2026 and subsequent years, the update will be either 0.75% or 0.25%, depending on the Alternate Payment Model (APM) in which the physician participates. On October 14, 2016, CMS released a final rule implementing,

among other changes, the Advanced APM incentive applicable to the physician fee schedule, under which physicians may receive bonus payments for participating in an Advanced APM. Among other things, the final rule identifies the criteria an APM must satisfy to be considered an Advanced APM, which could include some MSSP ACOs or providers participating in the CEC Model. Whether DMG's subsidiary ACO or dialysis providers participating in CEC are considered to be Advanced APMs could potentially affect physicians' willingness to participate in such entities, which may indirectly impact the operations of DMG's subsidiary ACO or its providers participating in the CEC Model. In addition, under the final rule, DMG's subsidiary ACO may also be required to submit certain quality data to CMS on behalf of its Merit-Based Incentive Payment System (MIPS) eligible clinicians, which could result in an increase in operational costs. Given that the payment updates for APMs have yet to take effect, we cannot determine the impact of such payment models on our business at this time.

In addition, in recent years, Congress has enacted various laws seeking to reduce the federal debt level and contain healthcare expenditures. For example, the BCA called for the establishment of a Joint Select Committee (the Committee) on Deficit Reduction, tasked with reducing the federal debt level. However, because the Committee did not draft a proposal by the BCA's deadline, President Obama issued an initial sequestration order that imposed automatic spending cuts on various federal programs. In particular, a 2% reduction to Medicare payments took effect on April 1, 2013, which was subsequently extended through 2027.

The instability of the federal budget may lead to legislation that could result in further cuts in Medicare and Medicaid payments to providers. In recent years, the government has enacted a patchwork of appropriations legislation to temporarily suspend the debt ceiling and continue government operations. Although the BBA passed in February 2018 enacted a two-year federal spending agreement and raised the federal spending cap on non-defense spending for fiscal years 2018 and 2019, the Medicare program is frequently mentioned as a target for spending cuts. Spending cuts to the Medicare program could adversely affect our business, results of operations, financial condition and cash flows.

Medicare Advantage. Medicare Advantage is a Medicare health plan program developed and administered by CMS as an alternative to the original FFS Medicare program. Under the Medicare Advantage program, Medicare beneficiaries may choose to receive benefits under a managed care health plan that provides benefits at least comparable to those offered under the original Medicare FFS payment system in exchange for which the health plan receives a monthly per patient premium payment from CMS. The Medicare Advantage monthly premium varies based on the county in which the member resides, and is adjusted to reflect the demographics and estimated risk profile of the members that enroll. Once a person is authorized by CMS to participate in Medicare Advantage, health plans compete for enrollment based on benefit design differences such as copayments or deductibles, availability of preventive care, attractiveness of and access to a network of hospitals, physicians and ancillary providers and enrollee premium contribution or, most often in Medicare Advantage plans, the absence of any monthly premium. In certain parts of the country, many health plans that provide Medicare Advantage benefits subcontract with integrated medical networks such as DMG to transfer the responsibility for managing patient care.

In 2004, CMS adopted a risk adjustment payment system for Medicare Advantage health plans in which the participating health plans' premiums are adjusted based on the actual illness burden of the members that enroll. The model bases a portion of the total CMS reimbursement payments on various clinical and demographic factors, including hospital inpatient diagnoses, additional diagnosis data from ambulatory treatment settings, hospital outpatient department and physician visits, gender, age and Medicaid eligibility. CMS requires that all managed care companies capture, collect and submit the necessary diagnosis code information to CMS twice a year for reconciliation with CMS's internal database. Medical providers, such as DMG, provide this diagnosis code information to health plan customers for submission to CMS. Under this system, the risk-adjusted portion of the total CMS payment to the Medicare Advantage plans will equal the local rate set forth in the traditional demographic rate book, adjusted to reflect the plan members' gender, age and morbidity.

Most Medicare beneficiaries have the option to enroll in private health insurance plans that contract with Medicare under the Medicare Advantage program. According to the Kaiser Family Foundation, the share of Medicare beneficiaries in such plans has risen rapidly in recent years; it reached approximately 34% in 2018 from approximately 13% in 2004. Plan costs for the standard benefit package can be significantly lower or higher than the corresponding cost for beneficiaries in the traditional Medicare FFS payment program. Prior to the ACA, private plans

were generally paid a higher average amount, and they used the additional payments to reduce enrollee cost-sharing requirements, provide extra benefits, and/or reduce Medicare premiums. These enhancements were valuable to enrollees, but also resulted in higher Medicare costs overall and higher premiums for all Medicare Part B beneficiaries and not just those enrolled in Medicare Advantage plans. The ACA requires that future payments to plans be based on benchmarks in a range of 95% to 115% of local FFS Medicare costs, with bonus amounts payable to plans meeting high quality-of-care standards. In addition, health plans offering Medicare Advantage are required to spend at least 85% of their premium dollars on medical care, the so-called medical loss ratio (MLR). Since DMG is not a health plan, except for DaVita Health Plan of California, Inc. (DHPC), it is not subject to the 85% MLR requirement. See "DaVita Medical Group Division (DMG)—Knox-Keene" below. However, payments that health plans make to DMG will apply in full

towards the health plans' 85% MLR requirement. If a health plan does not meet the 85% MLR requirement, it must provide a rebate to its customers. Any such shortfalls would not impact amounts paid by health plans to DMG.

Medicaid. Medicaid is a federal entitlement program administered by the states that provides healthcare and long-term care services and support to low-income Americans. Medicaid is funded jointly by the states and the federal government. The federal government guarantees matching funds to states for qualifying Medicaid expenditures based on each state's federal medical assistance percentage, which is calculated annually and varies inversely with average personal income in the state. Subject to federal rules, each state establishes its own eligibility standards, benefit packages, payment rates and program administration within broad federal statutory and regulatory guidelines. Every state Medicaid program must balance a number of potentially competing demands, including the need for quality care, adequate provider access, and cost-effectiveness. In an effort to improve quality and provide more uniform and cost-effective care, many states have implemented Medicaid managed care programs to improve access to coordinated healthcare services, including preventative care, and to control healthcare costs. Under Medicaid managed care programs, a health plan receives capitation payments from the state. The health plan, in turn, arranges for the provision of healthcare services by contracting with a network of medical providers, such as DMG. DMG has entered into capitation agreements with health plans to manage approximately 90,800 Medicaid managed care members in its southern California market.

Commercial payors

According to the 2018 Annual Survey conducted by the Kaiser Family Foundation, approximately 152 million nonelderly people in the U.S. received their health insurance through their employers, which contracted with health plans to administer these healthcare benefits. Patients enrolled in health plans offered through an employment setting are generally referred to as commercial members. According to the survey, the percentage of workers covered was 53% in 2018 and 55% in 2017. Under the ACA, many uninsured individuals and many individuals who receive their health insurance benefits through small employers may purchase their healthcare benefits through insurance exchanges in which health plans compete directly for individual or small group members' enrollment. DMG derives a significant amount of its enrollment from commercial members; however, these members represent a disproportionately small share of DMG's operating profits.

Whether in the Medicare Advantage, commercial or Medicaid market, managed care health plans seek to provide a coordinated and efficient approach to managing the healthcare needs of their enrolled populations. By negotiating with providers, such as pharmacies, hospitals and physicians, and implementing various quality programs, managed care companies attempt to enhance their profitability by limiting their medical costs. These health plans have shown success in mitigating certain components of medical cost, but we believe the plans are limited by their indirect relationship with physicians, who in the aggregate direct most of their patients' healthcare costs. We believe that physician-led and professionally-managed integrated medical networks such as DMG's have a greater opportunity to influence cost and improve quality due to the close coordination of care at the most effective point of contact with the patient—the primary care physician.

Capitation and FFS revenue

There are a number of different models under which an integrated medical network receives payment for managing and providing healthcare services to its members.

Fee-for-service structure. Under traditional FFS reimbursement, physicians are paid a specified amount for each service or procedure that they provide during a patient visit. Under this structure, physician compensation is based on the volume of patient visits and procedures performed, thus offering limited financial incentive to focus on cost containment and preventative care. FFS revenues are derived primarily from DMG's physician services.

Capitation structure. Under capitation, payors pay a fixed amount per enrolled member, thereby subcontracting a significant portion of the responsibility and risks for managing patient care to physicians. Global capitation represents a prospective budget from which the provider network then manages care-related expenses including payments to associated providers outside the group, such as hospitals and specialists. Compared to traditional FFS models, we believe that capitation arrangements better align provider incentives with both quality and efficiency of care. We believe that this approach improves the quality of the experience for patients and the potential profitability for efficient care providers.

Since premiums paid represent a significant amount per person, the revenue and, when costs are effectively managed, profit opportunity available to an integrated medical network under a capitated arrangement can be significant. This is particularly the case for senior members and members with multiple diseases. We believe that the advantages, savings and efficiencies made possible by the capitated model are most pronounced when the care demands of the population are the most severe and require the most coordination, such as for the senior population or patients with chronic, complex and follow-on diseases. While organized coordination of care is central to the capitated model, it is also well suited to the implementation of

preventative care and disease management over the long-term since physicians have a financial incentive to improve the overall health of their patient population.

The inherent risk in assumption of global care risk relates to potential losses if a number of individual patients' medical costs exceed the expected amount. This risk is especially significant to individual practitioners or smaller physician groups who lack the scale required to spread the risk over a broad population. DMG has the scale, comprehensive medical delivery resources, significant infrastructure to support practicing physicians, and demonstrated care management knowledge to spread the risk of losses over a large patient population.

Global model. In Florida, DMG may contract directly with health plans under global capitation arrangements that include hospital services, because state law permits DMG to assume financial responsibility for both professional and institutional services. In New Mexico, DMG has assumed financial responsibility for professional services only.

In Nevada, DMG enters into global capitation arrangements to assume financial responsibility for both professional and institutional services. However, the Nevada Division of Insurance (NDI) has not opined on whether it is appropriate for an entity like DMG to enter into global capitation arrangements and assume financial responsibility for the provision of both professional and institutional services to either Medicare Advantage enrollees or enrollees of commercial health plans. In order to avoid an adverse finding by the NDI with respect to DMG's global capitation arrangements in Nevada, DMG applied for an insurance license from the NDI and obtained the license in 2015. DMG is currently evaluating its ability to assign any of its existing contracts to the NDI license holder. Because of the current global capitation to DMG, and DMG's assumption of nearly the entire professional and institutional risk in Nevada and Florida, DMG's health plan customers function primarily to support DMG in undertaking marketing and sales efforts to enroll members and processing claims in these states.

In California, entities that maintain full or restricted licenses under the California Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene) are permitted to assume financial responsibility for both professional and institutional services. As described below, in December 2013, DMG obtained a restricted Knox-Keene license and therefore may enter into global capitation arrangements with health plans through which DMG will assume financial responsibility for both professional and institutional services.

Risk-sharing model. In California, DMG currently utilizes a capitation model in several different forms. While there are variations specific to each arrangement, HealthCare Partners Affiliates Medical Group and HealthCare Partners Associates Medical Group, P.C. (collectively AMG), which are medical groups that have entered into management services agreements with DMG, have historically contracted with health plans to receive a PMPM or percentage of premium (POP) capitation payment for professional (such as physician) services and assumed the financial responsibility for professional services. In some cases, the health plans separately enter into capitation contracts with third parties (typically hospitals) who directly receive a capitation payment and assume contractual financial responsibility for institutional (such as hospital) services. In the case of institutional services and as a result of its managed care-related administrative services agreements with hospitals, AMG has recognized a percentage of the surplus of institutional revenues less institutional expense as AMG net revenues and has also been responsible for some percentage of any short-fall in the event that institutional expenses exceed institutional revenues. We refer to these arrangements as "dual risk arrangements." In other cases, the health plan does not pay a capitation payment to the hospital, but rather administers and pays fee-for-service claims for hospital expenses. We refer to these arrangements as "shared risk arrangements." In both cases, AMG has been responsible under its health plan agreements for managing the care dollars associated with both the professional and institutional services provided for in the AMG capitation payment. In total, approximately 29% of DMG's total membership was covered under dual risk arrangements as of December 31, 2018.

In connection with DMG's obtaining a restricted Knox-Keene license in California, substantially all of the California health plan contracts, along with the revenues received under such contracts, have been assigned from AMG to DHPC. In addition, DMG now has the legal authority to transition these health plan contracts to global capitation or "global risk" arrangements in which DMG is responsible for arranging professional and institutional services in exchange for capitation payments directly from the health plan. DMG evaluates its various payor arrangements on an ongoing basis, and based on this evaluation, may work with the California Department of Managed Health Care and certain selected health plans to convert to global risk arrangements. DMG converted two contracts to global risk in

2017 and one additional contract to global risk effective January 2019. In total, approximately 21% of DMG's total membership was covered under global risk arrangements as of December 31, 2018 and approximately 28% of its total membership is now covered under global risk arrangements as of January 2019.

Government regulation

In addition to the laws and regulations to which our U.S. dialysis and related lab services business are subject to, the internal operations of DMG and its contractual relationships with healthcare providers such as hospitals, other healthcare facilities, and healthcare professionals are subject to extensive and increasing regulation by numerous federal, state, and local government entities. These laws and regulations often are interpreted broadly and enforced aggressively by multiple government agencies, including the OIG, the DOJ, and various state authorities. Many of these laws and regulations are the same as those that impact our U.S. dialysis and related lab services business. For example:

- DMG's financial relationships with healthcare providers including physicians and hospitals could subject DMG to criminal and civil sanctions and penalties under the federal Anti-Kickback Statute;
- The referral of Medicare patients by DMG-associated physicians for the provision of DHS may subject the parties to sanctions and penalties under the Stark Law;
- DMG's financial relationships and those of its associated physicians may subject the parties to penalties and sanctions under state fraud and abuse laws;
- DMG's submission of claims to governmental payors such as the Medicare and Medicaid programs for services provided by its associated physicians and clinical personnel may subject DMG to sanction and penalties under the FCA; and
- DMG's handling of PHI may subject DMG to sanctions and penalties under HIPAA and its implementing privacy and security regulations, as amended by the HITECH Act, and state medical privacy laws which can include penalties and restrictions that are more severe than those which arise under HIPAA.

A finding that claims for services were not covered or not payable because services were not rendered or because claims otherwise were submitted in violation of the applicable healthcare laws and regulations, or the imposition of sanctions associated with a violation of any of these healthcare laws and regulations, could result in criminal and/or civil penalties and exclusion from participation in Medicare, Medicaid and other federal and state healthcare programs and could have a material adverse effect on DMG's business, results of operations, financial condition and cash flows. We cannot guarantee that the arrangements or business practices of DMG will not be subject to government scrutiny or be found to violate certain healthcare laws. Government audits, investigations and prosecutions, even if we are ultimately found to be without fault, can be costly and disruptive to DMG's business. Moreover, changes in healthcare legislation or government regulation may restrict DMG's existing operations, limit their expansion or impose additional compliance requirements and costs, any of which could have a material adverse effect on DMG's business, results of operations, financial condition and cash flows.

The following includes brief descriptions of some, but not all, of the laws and regulations that, in addition to those described in relation to our U.S. dialysis and related lab services business, affect DMG. DMG is also subject to the laws and regulations that apply to our U.S. dialysis and related lab services business. See "Kidney Care Division—Government regulation" above.

Licensing, certification, accreditation and related laws and guidelines. DMG clinical personnel are subject to numerous federal, state and local laws and regulations, relating to, among other things, licensing, professional credentialing and professional ethics. Since DMG clinical personnel perform services in medical office settings, hospitals and other types of healthcare facilities, DMG may indirectly be subject to laws applicable to those entities as well as ethical guidelines and operating standards of professional trade associations and private accreditation commissions, such as the American Medical Association and the Joint Commission. There are penalties for non-compliance with these laws, including discipline or loss of professional license, civil and/or criminal fines and penalties, loss of hospital admitting privileges, federal healthcare program disenrollment, loss of billing privileges, and exclusion from participation in various governmental and other third-party healthcare programs.

Professional licensing requirements. DMG's clinical personnel, including physicians, must satisfy and maintain their professional licensing in the states where they practice medicine. Activities that qualify as professional misconduct under state law may subject them to sanctions, including the loss of their licenses, and could subject DMG to sanctions as well. Many state boards of medicine impose reciprocal discipline, that is, if a physician is disciplined for having committed professional misconduct in one state where he or she is licensed, another state where he or she is

also licensed may impose the same discipline even though the conduct did not occur in that state. Therefore, if a DMG-associated physician is licensed in multiple states, sanctions or loss of licensure in one state may result in sanction or the loss of licensure in other states. Professional

licensing sanctions may also result in exclusion from participation in governmental healthcare programs, such as Medicare and Medicaid, as well as other third-party programs.

Corporate practice of medicine and fee splitting. California, Colorado, Nevada, and Washington are states in which DMG operates that have laws that prohibit business entities, such as our Company and our subsidiaries, from practicing medicine, employing physicians to practice medicine or exercising control over medical decisions by physicians (known collectively as the corporate practice of medicine). These states also prohibit entities from engaging in certain financial arrangements, such as fee-splitting, with physicians. In some states these prohibitions are expressly stated in a statute or regulation, while in other states the prohibition is a matter of judicial or regulatory interpretation.

Violations of the corporate practice of medicine vary by state and may result in physicians being subject to disciplinary action, as well as to forfeiture of revenues from payors for services rendered. For lay entities, violations may also bring both civil and, in more extreme cases, criminal liability for engaging in medical practice without a license.

In California, a violation of the corporate practice of medicine prohibition constitutes the unlawful practice of medicine, which is a public offense punishable by fines and other criminal penalties. In addition, any person who conspires with or aids and abets another in the unlawful practice of medicine is similarly guilty of a public offense and may be subject to comparable fines and criminal penalties. In Nevada, engaging in the corporate practice of medicine where not provided by a specific statute may also constitute the unlawful practice of medicine. This violation is a felony punishable by fines and other civil and criminal penalties. Physicians in Nevada can similarly be punished for aiding or assisting in the unlicensed practice of medicine.

In Colorado, any physician found to have abetted or assisted or conspired to engage in unprofessional conduct with respect to the practice of medicine is subject to disciplinary action, including the loss of licensure. Corporate entities or lay persons who are found to have engaged in the unauthorized practice of medicine may be subject to injunctive action and other criminal penalties. In Washington, the Secretary of Health is responsible for investigating complaints concerning the unlicensed practice of medicine and violations may be subject to a cease and desist order, civil fines, injunctive action, and other criminal penalties.

In our markets where the corporate practice of medicine is prohibited, DMG has historically operated by maintaining long-term management contracts with multiple associated professional organizations which, in turn, employ or contract with physicians to provide those professional medical services required by the enrollees of the payors with which the professional organizations contract. Under these management agreements, DMG performs only non-medical administrative services, does not represent that it offers medical services, and does not exercise influence or control over the practice of medicine by the physicians or the associated physician groups with which it contracts. For example, in California, DMG has full-service management contracts with AMG. The AMG entities are owned by California-licensed physicians and professional medical corporations and contract with physicians to provide professional medical services. In Nevada and Washington, DMG’s Nevada and Washington subsidiaries have similar management agreements with Nevada and Washington professional corporations, as applicable, that employ and contract with physicians to provide professional medical services. In Colorado, the physician groups contract through a provider network to include a pharmacy and ambulatory surgery center.

Some of the relevant laws, regulations, and agency interpretations in states with corporate practice of medicine restrictions have been subject to limited judicial and regulatory interpretation. Moreover, state laws are subject to change. Regulatory authorities and other parties, including DMG’s associated physicians, may assert that, despite the management agreements and other arrangements through which DMG operates, we are engaged in the prohibited corporate practice of medicine or that DMG’s arrangements constitute unlawful fee-splitting. If this were to occur, we could be subject to civil and/or criminal penalties, DMG’s agreements could be found legally invalid and unenforceable (in whole or in part), or we could be required to restructure DMG's contractual arrangements.

If we were required to restructure DMG’s operating structures in our markets due to determination that a corporate practice of medicine violation existed, such a restructuring might include revisions of the California, Colorado, Nevada or Washington management services agreements, which might include a modification of the management fee, and/or establishing an alternative structure. For example, our subsidiaries in those states might have to obtain the

equivalent of a California Knox-Keene license in such state in order to comply with the corporate practice of medicine rules while contracting directly with payors and, in turn, physicians, to provide physician services to the payors' enrollees. In California, DMG's restricted Knox-Keene license has created potential flexibility for DMG in the event regulatory authorities seek to enforce corporate practice of medicine or fee splitting laws based upon current management services relationships with AMG. DMG's restricted Knox-Keene license allows DHPC to contract with or employ physicians as a result of an exemption from California's corporate practice of medicine laws applicable to Knox-Keene licensees.

Knox-Keene. The California Department of Managed Health Care (DMHC) licenses and regulates Health Care Service Plans (HCSPs) pursuant to Knox-Keene, as amended. In addition to regulating Knox-Keene's various patient's rights protections for HCSP-enrolled individuals, the DMHC is responsible for ensuring the financial sustainability over time of licensed HCSPs and other regulated entities. As such, the DMHC is charged with continually monitoring the financial health of regulated entities. The DMHC's Division of Financial Oversight monitors and evaluates the financial viability of health plans to ensure continued access to health care services. Financial examination reviews include examinations of financial statements and financial arrangements, both by routine and non-routine examinations. The examination also ensures that there is adequate tangible net equity (TNE), as determined according to calculations included in Knox-Keene. The TNE regulations for organizations holding a Knox-Keene license, like DHPC, vary depending on circumstances, but generally require any licensee to have on hand in cash or cash equivalents a minimum of the greater of (i) $1 million, (ii) the sum of 2% of the first $150 million of annualized premium revenues plus 1% of annualized premium revenues in excess of $150 million, or (iii) the sum of 8% of the first $150 million of annualized healthcare expenditures (except those paid on a capitated basis or managed hospital payment basis) plus 4% of the annualized healthcare expenditures (except those paid on a capitated basis or managed hospital payment basis) which are in excess of $150 million; plus 4% of annualized hospital expenditures paid on a managed hospital payment basis. In its sole discretion, the DMHC may require, as a condition to obtaining or maintaining an HCSP license, that a licensee accept certain contractual undertakings such that the licensee is obligated to maintain TNE in amounts greater than the minimum amount described above. Additionally, a licensed HCSP is subject to additional DMHC reporting requirements and financial oversight if the HCSP fails to maintain at least 130% of its required minimum TNE. During the 2016 financial examination, DHPC was required to provide evidence of exclusive fidelity bond coverage in the amount of at least $2 million, with a deductible amount not in excess of $100,000 with a requirement to notify the Director of DMHC 30 days prior to cancellation.

The DMHC interprets Knox-Keene HCSP licensing requirements to apply to both full-service HCSPs and downstream restricted HCSP contracting entities, including provider groups that enter into global risk contracts with licensed HCSPs. A global risk contract is a healthcare services contract in which a downstream contracting entity agrees to provide both professional (physician) services and institutional (hospital) services subject to an at-risk or capitated reimbursement methodology. According to the DMHC, entities that accept global risk must obtain a restricted Knox-Keene license. Under a restricted Knox-Keene license, entities may enter into global risk contracts with other licensed HCSPs. Holders of restricted Knox-Keene licenses must comply with the same financial requirements as HCSPs with full licenses, including demonstrating specific levels of TNE, but are not required to meet Knox-Keene requirements for functions they are not delegated such as marketing. The consequences of operating without a license include civil penalties, criminal penalties and the issuance of cease and desist orders. DHPC holds a restricted Knox-Keene license, which allows DHPC to contract directly with full service HCSPs to simplify DMG's historic contractual and financial structure and to facilitate expansion into new markets in California. However, this also subjects DMG and DHPC to additional regulatory obligations, including (i) regulatory oversight of operations, (ii) the need to seek approval for all material business changes, (iii) significant requirements to maintain certain TNE levels, and (iv) other operating limitations imposed by Knox-Keene and its regulations. Under its restricted Knox-Keene license, DHPC is prohibited from declaring or paying any dividends or making any distribution of cash or property to its parent, affiliates, or shareholders, if such a distribution would cause it to fail to maintain the minimum applicable TNE, have insufficient working capital or cash flow as required by DMHC regulation or otherwise be unable to provide or arrange healthcare services. In addition, DHPC is subject to DMHC oversight and must seek approval before incurring any debt or guaranteeing any debt relating to its parent, affiliates, or shareholders. DHPC must also submit proposed global capitation contracts to the DMHC for approval.

DMG services

Approximately 84% of DMG's operating revenues for the year ended December 31, 2018 were derived from capitation contracts with health plans. Under these contracts, DMG's health plan customers delegate full responsibility for member care to physicians and healthcare facilities that are part of DMG's provider network. In return, DMG receives a PMPM fee for each DMG member. As a result, DMG has financial and clinical accountability for a population of members. In California, DMG does not assume direct financial risk for institutional (hospital) services in some cases,

but is responsible for managing the care dollars associated with both the professional (physician) and institutional services being provided for the PMPM fee attributable to both professional and institutional services. In those cases and as a result of its managed care-related administrative services agreements with hospitals, DMG recognizes the surplus of institutional revenues less institutional expense as DMG net revenues and is also responsible for any short-fall in the event that institutional expenses exceed institutional revenues.

DMG provides comprehensive and quality medical care through a network of participating physicians and other healthcare professionals. Through its group model, DMG employs, directly (where permitted by state law) and through its associated physician groups, approximately 750 primary care physicians. Through its IPA model, DMG contracts with a network of approximately 3,200 associated groups and other network primary care physicians who provide care for DMG's members in an independent office setting. These physicians are complemented by several thousand network specialists and approximately 185 network hospitals that provide specialty or institutional care to the patients of DMG's associated physicians, physician groups and IPAs.

In order to comply with local regulations prohibiting the corporate practice of medicine, many of DMG's group physicians are employed by associated medical groups with which DMG has entered into long-term management agreements. The largest of these DMG managed medical groups is AMG, which employs, directly or indirectly, approximately 750 primary care physicians, specialists and hospitalists. See "Government Regulation—Corporate practice of medicine and fee splitting" above.

DMG does not own hospitals, although hospitals are an essential part of its provider network. In most cases, DMG contracts or otherwise aligns with hospitals to manage the utilization, readmission and cost of hospital services. Most DMG patients receive specialty care through DMG's network based on referrals made by their primary care physician. These specialists may be reimbursed based on capitation, case rates or on a discounted FFS rate.

DMG group physicians typically see 18 to 22 patients per day, which we believe is an appropriate benchmark to ensure there is sufficient time to understand all of the patients' clinical needs. DMG care teams, including nurses, engage in outreach to patients in order to help monitor fragile and high risk patients, and help improve adherence to physicians' care plans. During these visits, DMG's physicians, nurses and educators use the time to educate patients and manage their healthcare needs. The goal of this preventative care delivery model is to keep patients healthy. Education improves self-management and compliance which allows the patient to recognize early signs of their disease and seek appropriate care. We believe this translates into earlier intervention, which in turn leads to fewer emergency room visits, fewer hospital admissions and fewer hospital bed days (the most expensive location for healthcare). This clinical model seeks to provide early diagnosis of disease or deterioration in a chronic and complex condition and provide preventive care to maintain optimal health and avert unnecessary hospitalization. Clinic-based case managers and hospitalists coordinate with the primary care physicians to ensure that patients are receiving proper care whether they are in the clinic, in the hospital or are not regularly accessing healthcare. Physicians and case managers encourage patients to regularly visit the clinics in order to enhance their day-to-day health and diagnose any illness or deterioration in condition as early as possible.

DMG's information technology system, including DMG's electronic health record and data warehouse, is designed to support the DMG delivery model with data-driven opportunities to improve the quality and cost effectiveness of the care received by its members. Using informatics technology, DMG has created disease registries that track large numbers of patients with defined medical conditions. DMG applies the data from these registries to manage the care for patients with similar medical conditions which we believe leads to a better medical outcome. We believe this approach to using data is effective because the information is communicated by the patient's physician rather than the health plan or disease management companies.

DMG employs a wide variety of other information applications to service IPA and network providers using web connectivity. The HCP Connect! on-line portal provides web-based eligibility, referrals, electronic claims submission and explanation of benefits, and other communication vehicles for individual physician offices. The success of this suite of applications has enhanced DMG's ability to manage its IPA networks, and has resulted in significant back-office efficiencies for DMG and its associated physician groups. DMG has further expanded its ability to share key utilization and clinical data with its internal and contracted physicians and specialists through the Physician Information Portal and the Clinical Viewer. Through these secure web portals, a physician is able to obtain web-based, point of care information regarding a patient, including diagnosis history, quality indicators, historical risk-adjustment coding information, pharmacy medication history, and other key information. In addition to its web-portals geared towards physicians, DMG has recently introduced a patient on-line portal to enable DMG's patients to securely view their own clinical information, schedule physician appointments and interact electronically with their physicians. DMG believes these tools help lead to high quality clinical outcomes, create internal efficiencies, and

enhance the satisfaction of its associated physicians and patients.

In addition, DMG uses its data to carefully track high utilizing patients through robust data warehousing and data mining technologies. DMG filters the data warehouse to identify and reach out to patients with high-utilization patterns who are inefficiently using resources, such as visiting an emergency room when either a same-day appointment or urgent care center would be more appropriate and satisfactory for the member. High utilizing patients are identified and tracked as part of DMG's electronic health record by their physician and DMG's care management staff. Specific care plans are attached to each of these patients and tracked carefully for full compliance. The objective is to proactively manage their care at times when these patients

are either not compliant with the care plan or when changing circumstances require care managers to develop new and more suitable care plans. By using these resources, DMG has achieved improvements in quality of care, satisfaction and cost.

We believe DMG is well positioned to effectively leverage marketplace demands for greater provider accountability, measurable quality results and cost efficient medical care. We believe that DMG's business model is likely to continue to be an attractive alternative for health plans looking for high quality, cost effective delivery networks, physicians seeking an attractive practice environment and patients interested in a highly integrated approach to managing their medical care. Additionally, we believe that the scale of DMG's business allows it to spread capitation risk over a large population of members, invest in comprehensive analytic and healthcare information tools as well as clinical and quality measurement infrastructure, and recognize administrative and operating efficiencies. For these reasons, we believe that DMG offers patients, physicians and health plans a proven platform for addressing many of the most pressing challenges facing the U.S. healthcare system, including rising medical costs.

We also believe DMG has the ability to demonstrably improve medical outcomes and patient satisfaction while effectively managing costs through the following unique competitive strategies and internal progress and systems:

- DMG's clinical leadership and associated group and network physicians devote significant efforts to ensure that DMG's members receive the most appropriate care in the most appropriate manner.
- DMG is committed to maximizing its patients' satisfaction levels.
- DMG has the scale which, combined with its strong reputation and high quality patient care, makes it an attractive partner for health plans, compared to smaller provider groups that may have a higher risk of default and may not have the same resources to devote and develop the same level of patient care.
- DMG has over two decades of experience in managing complex disease cases for its population of patients. As a result, DMG has developed a rich dataset of patient care experiences and outcomes which permits DMG to proactively monitor and intervene in improving the care of its members.
- DMG's senior management team possesses substantial experience with the healthcare industry with average experience of approximately 21 years, as of December 31, 2018.

Locations of DMG clinics

As of December 31, 2018, DMG managed a total of 277 medical clinics, of which 72 clinics were located in California, 25 clinics were located in Colorado, 86 clinics were located in Florida, 56 clinics were located in Nevada, 13 clinics were located in New Mexico, and 25 clinics were located in Washington.

Competition

U.S. and International dialysis competition

The U.S. dialysis industry has some consolidation but still remains highly competitive, particularly in terms of acquiring existing outpatient dialysis centers. We continue to face a high degree of competition in the U.S. dialysis industry from large and medium-sized providers, among others, who compete directly with us for the acquisition of dialysis businesses, relationships with physicians to act as medical directors and skilled clinical personnel, as well as for individual patients. In addition, as we continue our international dialysis expansion into various international markets, we face competition from large and medium-sized providers, among others, for acquisition targets as well as physician relationships. Because of the ease of entry into the dialysis business and the ability of physicians to own dialysis centers and/or also be medical directors for their own centers, competition for growth in existing and expanding markets is not limited to large competitors with substantial financial resources. There have also been increasing indications of interest from non-traditional dialysis providers and others to enter the dialysis space and/or develop innovative technologies or business activities that could be disruptive to the industry. Acquisitions, developing new outpatient dialysis centers, patient retention and physician relationships are a critical component of our growth strategy and our business could be adversely affected if we are not able to continue to make dialysis acquisitions on reasonable and acceptable terms, continue to develop new outpatient dialysis centers, maintain or establish new relationships with physicians or if we experience significant patient attrition to our competitors. Competition for qualified physicians to act as medical directors and for inpatient dialysis services agreements with hospitals is also intense. Occasionally, we have also experienced competition from former medical directors or referring physicians who have opened their own outpatient dialysis centers. We also experience competitive pressures

from other dialysis providers in connection with negotiating contracts with commercial healthcare payors and in recruiting and retaining qualified skilled clinical personnel.

Together with Fresenius Medical Care (FMC), we account for approximately 74% of outpatient dialysis patients in the U.S. with our Company serving approximately 37% of the total outpatient dialysis patients. Approximately 44% of the centers not owned by us or FMC are owned or controlled by hospitals or non-profit organizations. Hospital-based and non-profit dialysis units typically are more difficult to acquire than physician-owned dialysis centers.

FMC also manufactures a full line of dialysis supplies and equipment in addition to owning and operating outpatient dialysis centers worldwide. This may give FMC cost advantages over us because of its ability to manufacture its own products or prevent us from accessing existing or new technology on a cost-effective basis. Additionally, FMC has been one of our largest suppliers of dialysis products and equipment over the last several years. In 2018, we entered into and subsequently extended an agreement with FMC to purchase a certain amount of dialysis equipment, parts and supplies from FMC through December 31, 2020. The amount of purchases in future years from FMC will depend upon a number of factors, including the operating requirements of our centers, the number of centers we acquire, and growth of our existing centers.

DMG's competition

DMG's business is highly competitive. DMG competes with managed care organizations, hospitals, medical groups and individual physicians in its markets. DMG competes with other primary care physician groups or physicians who contract with health plans for membership. Health plans contract with care providers on the basis of costs, reputation, scope, efficiency and stability. Individual members select a primary care physician at the time of membership with the health plan. Location, name recognition, quality indicators and other factors go into that decision. For example, in California, DMG's competitors include Permanente Medical Group, which is the exclusive provider for Kaiser, and Heritage Provider Network. However, DMG's principal competitors for members and health plan contracts vary considerably in type and identity by region.

Corporate compliance program

Our businesses are subject to extensive federal, state and local government laws and regulations. Management has designed and implemented a corporate compliance program as part of our commitment to comply fully with applicable criminal, civil and administrative laws and regulations and to maintain the high standards of conduct we expect from all of our teammates. We continuously review this program and enhance it as appropriate. The primary purposes of the program include:

- Assessing and identifying risks for existing and new businesses;
- Training and educating our teammates and affiliated professionals to promote awareness of legal and regulatory requirements and the necessity of complying with all these laws;
- Developing and implementing compliance policies and procedures and creating controls to support compliance with these laws and our policies and procedures;
- Auditing and monitoring the activities of our operating units and business support functions on a regular basis to identify risks and potential instances of noncompliance in a timely manner; and
- Ensuring that we promptly take steps to resolve instances of noncompliance and address areas of weakness or potential noncompliance.

We have a code of conduct that each of our teammates, members of our Board of Directors, affiliated professionals and certain third parties must follow, and we have an anonymous compliance hotline for teammates and patients to report potential instances of noncompliance. Our Chief Compliance Officer administers the compliance program. The Chief Compliance Officer reports directly to our Chief Executive Officer, our Chief Executive Officer of Kidney Care and the Chair of the Compliance Committee of our Board of Directors (Board Compliance Committee).

On October 22, 2014, DaVita entered into a Corporate Integrity Agreement (CIA) with HHS and the OIG. The CIA:

- requires that we maintain certain elements of our compliance programs;
- imposes certain expanded compliance-related requirements during the term of the CIA, including increased training for teammates, physician partners and members of our Board of Directors, implementing a series of procedures prior to entering into arrangements with referrals sources, execution of annual certifications by senior executives of compliance with federal healthcare laws and regulations, internal compliance policies and the CIA, imposition of an executive recoupment program and quarterly and annual reports to the OIG;

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- requires the formal allocation of certain oversight responsibility to the Board Compliance Committee and a resolution from that committee that it has made reasonable inquiry into the operations of the compliance program, the creation of a Management Compliance Committee and the retention of an independent compliance advisor during years three through five of the CIA;
- contains certain business restrictions related to a subset of our joint venture arrangements, including our agreeing to not enter into certain types of partial divestiture joint venture transactions with nephrologists during the term of the CIA, among other restrictions; and
- requires that we engage an Independent Monitor who will provide additional oversight and reporting to the OIG for the term of the CIA.

The costs associated with compliance with the CIA are substantial. In addition, in the event of a breach of the CIA, we may become liable for payment of certain stipulated penalties, and/or be excluded from participation in federal healthcare programs. In April 2015, the OIG notified us that it considered us to be in breach of the CIA because of three implementation deficiencies. We remediated the deficiencies and paid certain stipulated penalties. If we fail to comply with our CIA or adhere to all of the complex governmental laws and regulations that apply to our business, we could suffer severe consequences, including substantial penalties and exclusion from participation in federal healthcare programs that could have a material adverse effect on our business, results of operations, financial condition and cash flows, reputation and stock price.

Insurance

We are predominantly self-insured with respect to professional and general liability and workers' compensation risks through wholly-owned captive insurance companies. We are also predominantly self-insured with respect to employee medical and other health benefits. We also maintain insurance, excess coverage, or reinsurance for property and general liability, professional liability, directors’ and officers’ liability, workers' compensation, cybersecurity and other coverage in amounts and on terms deemed adequate by management, based on our actual claims experience and expectations for future claims. Future claims could, however, exceed our applicable insurance coverage. Physicians practicing at our dialysis centers are required to maintain their own malpractice insurance, and our medical directors are required to maintain coverage for their individual private medical practices. Our liability policies cover our medical directors for the performance of their duties as medical directors at our outpatient dialysis centers. DMG also maintains general and professional liability insurance through various independent and related parties. DMG has purchased its primary general and professional liability insurance from California Medical Group Insurance (CMGI) in which DMG owns a 67% equity interest.

Teammates

As of December 31, 2018, we employed approximately 77,700 teammates, including our international teammates:

Licensed professional staff (physicians, nurses and other healthcare professionals)	26,500
Other patient care and center support staff and laboratory personnel	29,200
Corporate, billing and regional administrative staff	9,400
DMG	12,600

Our businesses require skilled healthcare professionals with specialized training for treating patients with complex care needs. Recruitment and retention of nurses are continuing concerns for healthcare providers due to short supply. We have an active program of investing in our professional healthcare teammates to help ensure we meet our recruitment and retention targets, including expanded training opportunities, tuition reimbursements and other incentives.

Item 1A. Risk Factors

This Annual Report on Form 10-K contains statements that are forward-looking statements within the meaning of the federal securities laws. These statements involve known and unknown risks and uncertainties including those discussed below. The risks and uncertainties discussed below are not the only ones facing our business. In addition, please read the cautionary notice regarding forward-looking statements in Item 7 of Part II of this Annual Report on Form 10-K under the heading "Management's Discussion and Analysis of Financial Condition and Results of Operations."

Risk factors related to our overall business:

If we fail to adhere to all of the complex government laws and regulations that apply to our business, we could suffer severe consequences that could have a material adverse effect on our business, results of operations, financial condition, cash flows, reputation and stock price.

Our operations are subject to extensive federal, state and local government laws and regulations, such as Medicare and Medicaid reimbursement rules and regulations, federal and state anti-kickback laws, the Stark Law and analogous state self-referral prohibition statutes, the 21st Century Cures Act, Federal Acquisition Regulations, the False Claims Act (FCA) and associated regulations, the Civil Monetary Penalty statute and associated regulations, the Foreign Corrupt Practices Act (FCPA), and federal and state laws regarding the collection, use and disclosure of patient health information (e.g., Health Insurance Portability and Accountability Act of 1996 (HIPAA)) and the storage, handling, shipment, disposal and/or dispensing of pharmaceuticals and blood products and other biological materials and many other applicable state and federal laws and requirements. Medicare and Medicaid regulations, manual provisions, local coverage determinations, national coverage determinations and agency guidance impose complex and extensive requirements upon healthcare providers as well. Moreover, the various laws and regulations that apply to our operations are often subject to varying interpretations and additional laws and regulations potentially affecting providers continue to be promulgated that may impact us. A violation or departure from any of the legal requirements implicated by our business may result in, among other things, government audits, lower reimbursements, significant fines and penalties, the potential loss of certification, recoupment efforts or voluntary repayments. These legal requirements are civil, criminal and administrative in nature depending on the law or requirement.

We endeavor to comply with all legal requirements. We further endeavor to structure all of our relationships with physicians and providers to comply with state and federal anti-kickback physician and self-referral laws and other applicable healthcare laws. We utilize considerable resources to monitor laws and regulations and implement necessary changes. However, the laws and regulations in these areas are complex, changing and often subject to varying interpretations. As a result, there is no guarantee that we will be able to adhere to all of the laws and regulations that apply to our business, and any failure to do so could have a material adverse impact on our business, results of operations, financial condition, cash flows and reputation. For example, if an enforcement agency were to challenge the level of compensation that we pay our medical directors or the number of medical directors whom we engage, or otherwise challenge these arrangements, we could be required to change our practices, face criminal or civil penalties, pay substantial fines or otherwise experience a material adverse impact on our business, results of operations, financial condition, cash flows and reputation as a result. Similarly, we may face penalties under the FCA, the federal Civil Monetary Penalty statute or otherwise related to failure to report and return overpayments within 60 days of when the overpayment is identified and quantified. These obligations to report and return overpayments could subject our procedures for identifying and processing overpayments to greater scrutiny. We have made investments in resources to decrease the time it takes to identify, quantify and process overpayments, and may be required to make additional investments in the future.

Additionally, the federal government has used the FCA to prosecute a wide variety of alleged false claims and fraud allegedly perpetrated against Medicare, Medicaid and other federally funded health care programs. Moreover, amendments to the federal Anti-Kickback Statute in the 2010 Affordable Care Act (ACA) make claims tainted by anti-kickback violations potentially subject to liability under the FCA, including *qui tam* or whistleblower suits. The penalties for a violation of the FCA range from $5,500 to $11,000 (adjusted for inflation) for each false claim plus three times the amount of damages caused by each such claim which generally means the amount received directly or indirectly from the government. On January 29, 2018, the Department of Justice (DOJ) issued a final rule announcing

adjustments to FCA penalties, under which the per claim penalty range increases to a range from $11,181 to $22,363 for penalties assessed after January 29, 2018, so long as the underlying conduct occurred after November 2, 2015. Given the high volume of claims processed by our various operating units, the potential is high for substantial penalties in connection with any alleged FCA violations.

In addition to the provisions of the FCA, which provide for civil enforcement, the federal government can use several criminal statutes to prosecute persons who are alleged to have submitted false or fraudulent claims for payment to the federal government.

Certain subpoenas and civil investigative demands received by us or our subsidiaries specifically reference that they are in connection with FCA investigations alleging, among other things, that we or our subsidiaries presented or caused to be presented false claims for payment to the government. See Note 17 to the consolidated financial statements included in this report for further details.

We are subject to a Corporate Integrity Agreement (CIA) which, for our domestic dialysis business, requires us to report probable violations of criminal, civil or administrative laws applicable to any federal health care program for which penalties or exclusions may be authorized under applicable healthcare laws and regulations. See "If we fail to comply with our Corporate Integrity Agreement, we could be subject to substantial penalties and exclusion from participation in federal healthcare programs that could have a material adverse effect on our business, results of operations, financial condition, cash flows and reputation."

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

- Suspension or termination of our participation in government payment programs;
- Refunds of amounts received in violation of law or applicable payment program requirements dating back to the applicable statute of limitation periods;
- Loss of required government certifications or exclusion from government payment programs;
- Loss of licenses required to operate healthcare facilities or administer pharmaceuticals in the states in which we operate;
- Reductions in payment rates or coverage for dialysis and ancillary services and pharmaceuticals;
- Criminal or civil liability, fines, damages or monetary penalties for violations of healthcare fraud and abuse laws, including the federal Anti-Kickback Statute, Civil Monetary Penalties Law, Stark Law and FCA, or other failures to meet regulatory requirements;
- Enforcement actions by governmental agencies and/or state law claims for monetary damages by patients who believe their protected health information (PHI) has been used, disclosed or not properly safeguarded in violation of federal or state patient privacy laws, including HIPAA and the Privacy Act of 1974;
- Mandated changes to our practices or procedures that significantly increase operating expenses;
- Imposition of and compliance with corporate integrity agreements that could subject us to ongoing audits and reporting requirements as well as increased scrutiny of our billing and business practices which could lead to potential fines, among other things;
- Termination of various relationships and/or contracts related to our business, including joint venture arrangements, medical director agreements, real estate leases and consulting agreements with physicians; and
- Harm to our reputation which could negatively impact our business relationships, affect our ability to attract and retain patients and physicians, affect our ability to obtain financing and decrease access to new business opportunities, among other things.

We are, and may in the future be, a party to various lawsuits, demands, claims, *qui tam* suits, governmental investigations and audits (including investigations or other actions resulting from our obligation to self-report suspected violations of law) and other legal matters, any of which could result in, among other things, substantial financial penalties or awards against us, mandated refunds, substantial payments made by us, required changes to our business practices, exclusion from future participation in Medicare, Medicaid and other healthcare programs and possible criminal penalties, any of which could have a material adverse effect on our business, results of operations, financial condition, cash flows and materially harm our reputation.

We are the subject of a number of investigations and audits by governmental agencies. In addition, we are, and may in the future be, subject to other investigations and audits by state or federal governmental agencies and/or private civil *qui tam* complaints filed by relators and other lawsuits, demands, claims and legal proceedings, including investigations or other actions resulting from our obligation to self-report suspected violations of law.

Responding to subpoenas, investigations and other lawsuits, claims and legal proceedings as well as defending ourselves in such matters will continue to require management's attention and cause us to incur significant legal expense. Negative findings or terms and conditions that we might agree to accept as part of a negotiated resolution of pending or future legal or regulatory matters could result in, among other things, substantial financial penalties or awards against us, substantial payments made by us, harm to our reputation, required changes to our business practices, exclusion from future participation in the Medicare, Medicaid and other healthcare programs and, in certain cases, criminal penalties, any of which could have a material adverse effect on us. It is possible that criminal proceedings may be initiated against us and/or individuals in our business in connection with investigations by the federal government. Other than as described in Note 17 to the consolidated financial statements included in this report, we cannot predict the ultimate outcomes of the various legal proceedings and regulatory matters to which we are or may be subject from time to time, including those described in the aforementioned sections of this report, or the timing of their resolution or the ultimate losses or impact of developments in those matters, which could have a material adverse effect on our business, results of operations, financial condition, cash flows and materially harm our reputation. See Note 17 to the consolidated financial statements included in this report for further details regarding these and other matters.

Changes in federal and state healthcare legislation or regulations could have a material adverse effect on our business, results of operations, financial condition and cash flows.

We cannot predict how employers, private payors or persons buying insurance might react to the changes brought on by federal and state healthcare reform, including the ACA and any subsequent legislation, regulation or guidance, or what form many of these regulations will take before implementation.

For example, the ACA introduced healthcare insurance exchanges, which provide a marketplace for eligible individuals and small employers to purchase healthcare insurance. The business and regulatory environment continues to evolve as the exchanges mature, and statutes and regulations are challenged, changed and enforced. If commercial payor participation in the exchanges continues to decrease, it could have a material adverse effect on our business, results of operations, financial condition and cash flows. Although we cannot predict the short- or long-term effects of legislative or regulatory changes, we believe that future market changes could result in more restrictive commercial plans with lower reimbursement rates or higher deductibles and co-payments that patients may not be able to pay. To the extent that changes in statutes, regulations or related guidance or changes in other market conditions result in a reduction in reimbursement rates for our services from commercial and/or government payors, it could have a material adverse effect on our business, results of operations, financial condition and cash flows.

The ACA also added several new tax provisions that, among other things, impose various fees and excise taxes, and limit compensation deductions for health insurance providers and their affiliates. These rules could negatively impact our cash flow and tax liabilities. In addition, the ACA broadened the potential for penalties under the FCA for the knowing and improper retention of overpayments collected from government payors and reduced the timeline to file Medicare claims. Failure to timely identify, quantify and return overpayments may result in significant penalties, which could have a material adverse effect on our business, results of operations, financial condition, cash flows and reputation. Failure to file a claim within the one year window could result in payment denials, adversely affecting our business, results of operations, financial condition and cash flows.

New models of care emerge and evolve and other initiatives in the government or private sector may arise, and any failure on our part to adequately implement strategic initiatives to adjust to these marketplace developments could have a material adverse impact on our business. For example, the Centers for Medicare and Medicaid Services (CMS Innovation Center (Innovation Center) is currently working with various healthcare providers to develop, refine and implement Accountable Care Organizations (ACOs) and other innovative models of care for Medicare and Medicaid beneficiaries, including the Comprehensive ESRD Care Model (CEC Model) (which includes the development of end stage renal disease (ESRD) Seamless Care Organizations), the Duals Demonstration, and other models. We are currently participating in the CEC Model with the Innovation Center, including with organizations in Arizona, Florida, and adjacent markets in New Jersey and Pennsylvania. Our U.S. dialysis business may choose to participate in additional models either as a partner with other providers or independently. Even in areas where we are not directly participating in these or other Innovation Center models, some of our patients may be assigned to an ACO, another

ESRD Care Model, or another program, in which case the quality and cost of care that we furnish will be included in an ACO's, another ESRD Care Model's, or other program's calculations. In addition to the aforementioned new models of care, federal bipartisan legislation in the form of the Dialysis Patient Access to Integrated-care, Empowerment, Nephrologists, Treatment and Services Demonstration Act of 2017 (PATIENTS Act) has been proposed. The PATIENTS Act builds on prior coordinated care models, such as the CEC Model, and would establish a demonstration program for the provision of integrated care to Medicare ESRD patients. We have made and continue to make investments in building our integrated care capabilities, but there can be no assurances that initiatives such as the PATIENTS Act or similar legislation

will be passed. If such legislation is passed, there can be no assurances that we will be able to successfully provide integrated care on the broader scale contemplated by this legislation, and our costs of care could exceed our associated reimbursement rates. In general, if we are unable to efficiently adjust to these and other new models of care, it may erode our patient base or reimbursement rates, which could have a material adverse impact on our business.

There is also a considerable amount of uncertainty as to the continued implementation of the ACA and what similar measures or other changes might be enacted at the federal and/or state level. There have been multiple attempts through legislative action and legal challenges to repeal or amend the ACA. In December 2017, the Tax Cuts and Jobs Act of 2017 was signed into law which, among other things, repealed the penalty under ACA's individual mandate, which had required individuals to pay a fee if they failed to obtain a qualifying health insurance plan. In December 2018, a federal district court in Texas ruled the individual mandate was unconstitutional and inseverable from the ACA. As a result, the court ruled the remaining provisions of the ACA were also invalid, though the court declined to issue a preliminary injunction with respect to the ACA. However, it remains unclear whether the court's ruling will be upheld by appellate courts. In addition, the 2016 Presidential and Congressional elections and subsequent developments in 2017 and 2018 have caused the future state of the exchanges and other ACA reforms to be unclear. However, legislative attempts to completely repeal the ACA have been unsuccessful to date. While there may be significant changes to the healthcare environment in the future, including as a result of potential changes to the political environment, the specific changes and their timing are not yet apparent. Previously enacted reforms and future changes could have a material adverse effect on our business, results of operations, financial condition and cash flows, including, for example, by limiting the scope of coverage or the number of patients who are able to obtain coverage through the exchanges and other health insurance programs, lowering or eliminating the cost-sharing reduction subsidies under the ACA, lowering our reimbursement rates, and/or increasing our expenses.

There have also been several state initiatives to limit payments to dialysis providers. For example, Proposition 8, a California statewide ballot initiative, was proposed by the Service Employees International Union - United Healthcare Workers West and sought to limit the amount of revenue dialysis providers can retain from caring for patients with commercial insurance by requiring rebates to insurers and taking into account only a portion of the costs incurred by dialysis providers. While Proposition 8 was not approved in the November 2018 election, we incurred substantial costs in our efforts to oppose Proposition 8. Ballot initiatives similar to Proposition 8 were also proposed in Ohio and Arizona; however, neither of these initiatives met the applicable requirements for inclusion on the state ballot for the November 2018 elections. Although Proposition 8 and the Ohio and Arizona initiatives did not pass, we expect that similar ballot initiatives or other legislation might be proposed in the future in these or other states.

There has also been potential rule making and/or legislative efforts concerning charitable premium assistance. In December 2016, CMS published an interim final rule that questioned the use of charitable premium assistance for ESRD patients and would have established new conditions for coverage standards for dialysis facilities. In January 2017, a federal district court in Texas issued a preliminary injunction on CMS' interim final rule and in June 2017, at the request of CMS, the court stayed the proceedings while CMS pursues new rulemaking options. CMS has not issued any new rulemaking related to charitable premium assistance yet, but that does not preclude CMS or another regulatory agency or legislative authority from issuing a new rule or guidance that challenges charitable premium assistance. In addition, during the third quarter of 2018, a bill (SB 1156) was passed by the California legislature that would have imposed restrictions and obligations related to the use by patients on commercial plans of charitable premium assistance in the state of California and would have limited the amounts paid to a provider for services provided to those patients, if that provider has a financial relationship with the organization providing charitable premium assistance. SB 1156 was subsequently vetoed by the Governor of California, and the California legislature did not subsequently vote to overturn the Governor's veto. However, we expect that similar legislative or other initiatives might be proposed in the future in these and other states. For example, in January 2019, a bill (AB 290) was introduced in the California legislature that is similar to SB 1156 and would, among other things, limit the amount of reimbursement paid to certain providers for services provided to patients with commercial insurance who receive charitable premium assistance. If passed and implemented, we expect that this bill would have an adverse impact on our business, results of operations, financial condition and cash flows.

Any law, rule or guidance proposed or issued by CMS or other federal or state regulatory or legislative authorities, including any initiatives similar to Proposition 8, SB 1156 or AB 290, described above, or other future ballot or other initiatives restricting or prohibiting the ability of patients with access to alternative coverage from selecting a marketplace plan on or off exchange, limiting the amount of revenue that a dialysis provider can retain for caring for patients with commercial insurance by, among other things, requiring rebates to insurers and taking into account only a portion of the costs incurred by dialysis providers, affecting payments made to providers for services provided to patients who receive charitable premium assistance and/or otherwise restricting or prohibiting the use of charitable premium assistance, could cause us to incur substantial costs to oppose any such proposed measures, impact our dialysis center development plans, and if passed and/or implemented, could adversely impact dialysis centers across the U.S. making certain centers economically unviable, lead to the closure of certain

centers, restrict the ability of dialysis patients to obtain and maintain optimal insurance coverage, and in some cases, have a material adverse effect on our business, results of operations, financial condition and cash flows.

Privacy and information security laws are complex, and if we fail to comply with applicable laws, regulations and standards, including with respect to third-party service providers that utilize sensitive personal information on our behalf, or if we fail to properly maintain the integrity of our data, protect our proprietary rights to our systems or defend against cybersecurity attacks, we may be subject to government or private actions due to privacy and security breaches, any of which could have a material adverse effect on our business, results of operations, financial condition and cash flows or materially harm our reputation.

We must comply with numerous federal and state laws and regulations in both the U.S. and the foreign jurisdictions in which we operate governing the collection, dissemination, access, use, security and privacy of PHI, including HIPAA and its implementing privacy, security, and related regulations, as amended by the federal Health Information Technology for Economic and Clinical Health Act (HITECH) and collectively referred to as HIPAA. We are also required to report known breaches of PHI consistent with applicable breach reporting requirements set forth in applicable laws and regulations. From time to time, we may be subject to both federal and state inquiries or audits related to HIPAA, HITECH and related state laws associated with complaints, desk audits, and self-reported breaches. If we fail to comply with applicable privacy and security laws, regulations and standards, including with respect to third-party service providers that utilize sensitive personal information, including PHI, on our behalf, properly maintain the integrity of our data, protect our proprietary rights, or defend against cybersecurity attacks, it could materially harm our reputation or have a material adverse effect on our business, results of operations, financial condition and cash flows. These risks may be intensified to the extent that the laws change or to the extent that we increase our use of third-party service providers that utilize sensitive personal information, including PHI, on our behalf.

Data protection laws are evolving globally, and may add additional compliance costs and legal risks to our international operations. In Europe, the General Data Protection Regulation (GDPR) became effective on May 25, 2018. The GDPR applies to entities that are established in the European Union (EU), as well as extends the scope of EU data protection laws to foreign companies processing data of individuals in the EU. The GDPR imposes a comprehensive data protection regime with the potential for regulatory fines as well as data breach litigation by impacted data subjects. Under the GDPR, regulatory penalties may be assessed by data protection authorities for up to the greater of 4% of worldwide turnover or €20 million. The costs of compliance with, and other burdens imposed by, the GDPR and other new laws, regulations and policies implementing the GDPR may impact our European operations and/or limit the ways in which we can provide services or use personal data collected while providing services. If we fail to comply with the requirements of GDPR, we could be subject to penalties that would have a material adverse impact on our business, results of operations, financial condition and cash flows.

Data protection laws are also evolving nationally, and may add additional compliance costs and legal risks to our U.S. operations. For example, the California legislature recently passed the California Consumer Protection Act (CCPA), which is scheduled to become effective January 1, 2020. The CCPA is a privacy bill that requires certain companies doing business in California to disclose information regarding the collection and use of a consumer's personal data and to delete a consumer's data upon request. The Act also permits the imposition of civil penalties and expands existing state security laws by providing a private right of action for consumers in certain circumstances where consumer data is subject to a breach. We are still evaluating whether and how this rule will impact our U.S. operations and /or limit the ways in which we can provide services or use personal data collected while providing services. In addition, in December 2018, the U.S. Department of Health and Human Services Office for Civil Rights (OCR) published a request for information (RFI) seeking public input on a broad range of potential reforms to HIPAA regulations with a focus on enhancing care coordination. Though only a preliminary step toward potential regulatory reform, the RFI’s scope is significant as OCR seeks potential modifications to the HIPAA regulations that would facilitate efficient care coordination while preserving the privacy and security of PHI.

Information security risks have significantly increased in recent years in part because of the proliferation of new technologies, the use of the Internet and telecommunications technologies to conduct our operations, and the increased sophistication and activities of organized crime, hackers, terrorists and other external parties, including foreign state

agents. Our business and operations rely on the secure processing, transmission and storage of confidential, proprietary and other information in our computer systems and networks, including sensitive personal information, including PHI, social security numbers, and credit card information of our patients, teammates, physicians, business partners and others.

We continuously are implementing multiple layers of security measures through technology, processes and our people. We utilize security technologies designed to protect and maintain the integrity of our information systems and data, and our defenses are monitored and routinely tested internally and by external parties. Despite these efforts, our facilities and systems and those of our third-party service providers may be vulnerable to privacy and security incidents; security attacks and breaches; acts of vandalism or theft; computer viruses and other malicious code; coordinated attacks by a variety of actors,

including activist entities or state sponsored cyberattacks; emerging cybersecurity risks; cyber risk related to connected devices; misplaced or lost data; programming and/or human errors; or other similar events that could impact the security, reliability and availability of our systems. Internal or external parties may attempt to circumvent our security systems, and we have in the past, and expect that we will in the future, experience external attacks on our network including reconnaissance probes, denial of service attempts, malicious software attacks including ransomware or other attacks intended to render our internal operating systems or data unavailable, and phishing attacks or business email compromise. Cybersecurity requires ongoing investment and diligence against evolving threats. Emerging and advanced security threats, including coordinated attacks, require additional layers of security which may disrupt or impact efficiency of operations. As with any security program, there always exists the risk that employees will violate our policies despite our compliance efforts or that certain attacks may be beyond the ability of our security and other systems to detect. There can be no assurance that investments, diligence and/or our internal controls will be sufficient to prevent or timely discover an attack.

Any security breach involving the misappropriation, loss or other unauthorized disclosure or use of confidential information, including PHI, financial data, competitively sensitive information, or other proprietary data, whether by us or a third party, could have a material adverse effect on our business, results of operations, financial condition, cash flows and materially harm our reputation. We may be required to expend significant additional resources to modify our protective measures, to investigate and remediate vulnerabilities or other exposures, or to make required notifications. The occurrence of any of these events could, among other things, result in interruptions, delays, the loss or corruption of data, cessations in the availability of systems and liability under privacy and security laws, all of which could have a material adverse effect on our business, results of operations, financial condition and cash flows, or materially harm our reputation and trigger regulatory actions and private party litigation. If we are unable to protect the physical and electronic security and privacy of our databases and transactions, we could be subject to potential liability and regulatory action, our reputation and relationships with our patients, physicians, vendors and other business partners would be harmed, and our business, results of operations, financial condition and cash flows could be materially and adversely affected. Failure to adequately protect and maintain the integrity of our information systems (including our networks) and data, or to defend against cybersecurity attacks, could subject us to monetary fines, civil suits, civil penalties or criminal sanctions and requirements to disclose the breach publicly, and could further result in a material adverse effect on our business, results of operations, financial condition and cash flows or harm our reputation. As malicious cyber activity escalates, including activity that originates outside of the U.S., the risks we face relating to transmission of data and our use of service providers outside of our network, as well as the storing or processing of data within our network, intensify. There have been increased international, federal and state and other privacy, data protection and security enforcement efforts and we expect this trend to continue. While we maintain cyber liability insurance, this insurance may not cover us for all types of losses and may not be sufficient to protect us against the amount of all losses.

We may engage in acquisitions, mergers, joint ventures or dispositions, which may affect our results of operations, debt-to-capital ratio, capital expenditures or other aspects of our business, and if businesses we acquire have liabilities we are not aware of or are not adequately addressed, we could suffer severe consequences that would have a material adverse effect on our business, results of operations, financial condition and cash flows and could materially harm our reputation.

Our business strategy includes growth through acquisitions of dialysis centers and other businesses, as well as entry into joint ventures. We may engage in acquisitions, mergers, joint ventures or dispositions or expand into new business lines or models, which may affect our results of operations, debt-to-capital ratio, capital expenditures or other aspects of our business. There can be no assurance that we will be able to identify suitable acquisition targets or merger partners or buyers for dispositions or that, if identified, we will be able to agree to terms with merger partners, acquire these targets or make these dispositions on acceptable terms or on the desired timetable. There can also be no assurance that we will be successful in completing any acquisitions, mergers or dispositions that we announce, executing new business lines or models or integrating any acquired business into our overall operations. There is no guarantee that we will be able to operate acquired businesses successfully as stand-alone businesses, or that any such acquired business will operate profitably or will not otherwise have a material adverse effect on our business, results

of operations, financial condition and cash flows or materially harm our reputation. Further, we cannot be certain that key talented individuals at the business being acquired will continue to work for us after the acquisition or that they will be able to continue to successfully manage or have adequate resources to successfully operate any acquired business. In addition, certain of our newly and previously acquired dialysis centers and facilities have been in service for many years, which may result in a higher level of maintenance costs. Further, our facilities, equipment and information technology may need to be improved or renovated to maintain or increase operational efficiency, compete for patients and medical directors, or meet changing regulatory requirements. Increases in maintenance costs and capital expenditures could have a material adverse effect on our business, results of operations, financial condition and cash flows.

Businesses we acquire may have unknown or contingent liabilities or liabilities that are in excess of the amounts that we originally estimated, and may have other issues, including those related to internal controls over financial reporting or issues

that could affect our ability to comply with healthcare laws and regulations and other laws applicable to our expanded business, which could harm our reputation. As a result, we cannot make any assurances that the acquisitions we consummate will be successful. Although we generally seek indemnification from the sellers of businesses we acquire for matters that are not properly disclosed to us, we are not always successful. In addition, even in cases where we are able to obtain indemnification, we may discover liabilities greater than the contractual limits, the amounts held in escrow for our benefit (if any), or the financial resources of the indemnifying party. In the event that we are responsible for liabilities substantially in excess of any amounts recovered through rights to indemnification or alternative remedies that might be available to us, or any applicable insurance, we could suffer severe consequences that could have a material adverse effect on our business, results of operations, financial condition and cash flows. Additionally, joint ventures, including our Asia Pacific joint venture, and minority investments inherently involve a lesser degree of control over business operations, thereby potentially increasing the financial, legal, operational and/or compliance risks associated with the joint venture or minority investment. In addition, we may be dependent on joint venture partners, controlling shareholders or management who may have business interests, strategies or goals that are inconsistent with ours. Business decisions or other actions or omissions of the joint venture partner, controlling shareholders or management may require us to make capital contributions or necessitate other payments, result in litigation or regulatory action against us, result in reputational harm to us or adversely affect the value of our investment or partnership. There can be no assurances that these joint ventures and/or minority investments, including our Asia Pacific joint venture, ultimately will be successful.

If we are unable to compete successfully, including implementing our growth strategy and/or retaining our physicians and patients, it could materially adversely affect our business, results of operations, financial condition and cash flows.

Acquisitions, patient retention and medical director and physician retention are important parts of our growth strategy. We face intense competition from other companies for acquisition targets. In our U.S. dialysis business, we continue to face increased competition from large and medium-sized providers, among others, which compete directly with us for the limited acquisition targets as well as for individual patients and medical directors. In addition, we compete for individual patients, physicians and medical directors based in part on the quality of our facilities. Moreover, as we continue our international expansion into various international markets, we will continue to face competition from large and medium-sized providers, among others, for these acquisition targets as well. As we and our competitors continue to grow and open new dialysis centers, each center in the U.S. is required by applicable regulations to have a medical director, and we may not be able to retain an adequate number of nephrologists to serve as medical directors. Because of the ease of entry into the dialysis business and the ability of physicians to be medical directors for their own centers, competition in existing and expanding markets is not limited to large competitors with substantial financial resources. Individual nephrologists have opened their own dialysis units or facilities. There also has been increasing indications of interest from non-traditional dialysis providers and others to enter the dialysis space and/or develop innovative technologies or business activities that could be disruptive to the industry. Although these potential new competitors and others may face operational and/or financial challenges, if their efforts to offer dialysis services and/or develop innovative technology or business activities in the dialysis or pre-dialysis space are successful and we are unable to effectively compete, it could have a material adverse impact on our business, results of operations, financial condition and cash flows. Further, competitive pressures and the related risks may be impacted by a continued decline in the rate of growth of the ESRD patient population or other reductions in demand for dialysis treatments.

In addition, Fresenius USA, our largest competitor, manufactures a full line of dialysis supplies and equipment in addition to owning and operating dialysis centers. This may give it cost advantages over us because of its ability to manufacture its own products or prevent us from accessing existing or new technology on a cost-effective basis. See further discussion regarding risks associated with our suppliers under the heading below, "If certain of our suppliers do not meet our needs, if there are material price increases on supplies, if we are not reimbursed or adequately reimbursed for drugs we purchase or if we are unable to effectively access new technology or superior products, it could negatively impact our ability to effectively provide the services we offer and could have a material adverse effect on our business, results of operations, financial condition and cash flows."

If we are not able to effectively implement our growth strategy, including by making acquisitions at the desired pace or at all; if we are not able to continue to maintain the expected or desired level of non-acquired growth; if we experience significant patient attrition as a result of new business activities, new technology or other forms of competition, reduced prevalence of ESRD or other reductions in demand for dialysis treatments; or if physicians choose not to refer to our clinics, it could materially adversely affect our business, results of operations, financial condition and cash flows.

If certain of our suppliers do not meet our needs, if there are material price increases on supplies, if we are not reimbursed or adequately reimbursed for drugs we purchase or if we are unable to effectively access new technology or superior products, it could negatively impact our ability to effectively provide the services we offer and could have a material adverse effect on our business, results of operations, financial condition and cash flows.

We have significant suppliers that may be the sole or primary source of products critical to the services we provide, or to which we have committed obligations to make purchases, sometimes at particular prices. If any of these suppliers do not meet our needs for the products they supply, including in the event of a product recall, shortage or dispute, and we are not able to find adequate alternative sources, if we experience material price increases from these suppliers that we are unable to mitigate, or if some of the drugs that we purchase are not reimbursed or not adequately reimbursed by commercial or government payors, it could have a material adverse impact on our business, results of operations, financial condition and cash flows. In addition, the technology related to the products critical to the services we provide is subject to new developments which may result in superior products. If we are not able to access superior products on a cost-effective basis or if suppliers are not able to fulfill our requirements for such products, we could face patient attrition and other negative consequences which could have a material adverse effect on our business, results of operations, financial condition and cash flows.

DMG operates in a different line of business from our historical business, and we may not realize anticipated benefits from DMG.

DaVita Medical Group (DMG) operates in a different line of business from our historical business. We may not have the expertise, experience and resources to profitably pursue all of our businesses at once, and we may be unable to successfully and profitably operate all businesses in the combined company. The administration of DMG requires implementation of appropriate operations, management, forecasting, and financial reporting systems and controls, all of which pose challenges. The management of DMG requires and will continue to require the focused attention of our management team, including a significant commitment of its time and resources. The need for management to focus on these matters could have a material adverse effect on our business, results of operations, financial condition and cash flows. If the DMG operations continue to be less profitable than we currently anticipate or we do not have the experience, the appropriate expertise or the resources to profitably pursue all businesses in the combined company, our results of operations, financial condition and cash flows may be materially and adversely affected.

Laws regulating the corporate practice of medicine could restrict the manner in which DMG and our other subsidiaries are permitted to conduct their respective business, and the failure to comply with such laws could subject these entities to penalties or require a restructuring of these businesses.

Some states have laws that prohibit business entities, such as DMG and our other subsidiaries, including but not limited to, Nephrology Practice Solutions, DaVita Health Solutions, DaVita IKC, and Lifeline, from practicing medicine, employing physicians to practice medicine, exercising control over medical decisions by physicians (also known collectively as the corporate practice of medicine) or engaging in certain arrangements, such as fee-splitting, with physicians. In some states these prohibitions are expressly stated in a statute or regulation, while in other states the prohibition is a matter of judicial or regulatory interpretation. Of the states in which DMG currently operates, California, Colorado, Nevada and Washington generally prohibit the corporate practice of medicine, and other states may as well.

DMG and other DaVita entities operate in those states by maintaining long-term contracts with their associated physician groups which are each owned and operated by physicians and which employ or contract with additional physicians to provide physician services. Under these arrangements, DMG and such other DaVita entities provide non-medical management services and receive a management fee for providing these services; however, DMG and such other DaVita entities do not represent that they offer medical services, and do not exercise influence or control over the practice of medicine by the physicians or the associated physician groups.

In addition to the above management arrangements, DMG has certain contractual rights relating to the orderly transfer of equity interests in certain of its associated physician groups through succession agreements and other arrangements with their physician equity holders. However, such equity interests cannot be transferred to or held by DMG or by any non-professional organization. Accordingly, neither DMG nor DMG's subsidiaries directly own any equity interests in

any physician groups in California, Colorado, Nevada and Washington. The other DaVita entities operating in these and multiple other states have similar agreements and arrangements. In the event that any of these associated physician groups fail to comply with the management arrangement or any management arrangement is terminated and/or DMG or any of the other DaVita entities is unable to enforce its contractual rights over the orderly transfer of equity interests in its associated physician groups, such events could have a material adverse effect on the business, results of operations, financial condition and cash flows of DMG or such other DaVita entities.

It is possible that a state regulatory agency or a court could determine that DMG's agreements with physician equity holders of certain managed California, Colorado, Nevada and Washington associated physician groups and the way DMG carries out these arrangements as described above, either independently or coupled with the management services agreements with such associated physician groups, are in violation of the corporate practice of medicine doctrine. As a result, these arrangements could be deemed invalid, potentially resulting in a loss of revenues and an adverse effect on results of operations derived from such associated physician groups. Such a determination could force a restructuring of DMG's management arrangements with associated physician groups in California, Colorado, Nevada and/or Washington, which might include revisions of the management services agreements, including a modification of the management fee and/or establishing an alternative structure that would permit DMG to contract with a physician network without violating the corporate practice of medicine prohibition. There can be no assurance that such a restructuring would be feasible, or that it could be accomplished within a reasonable time frame without a material adverse effect on DMG's business, results of operations, financial condition and cash flows. These same risks exist for the other DaVita entities utilizing similar structures.

In December 2013, DaVita Health Plan of California, Inc. (DHPC) obtained a restricted Knox-Keene license in California, which, among other things, permits DHPC to contract with health plans in California and to arrange health care services through a network of employed or contracting physicians and other providers without violating the corporate practice of medicine prohibition. However, DHPC continues to subcontract with DMG associated physician groups in California to arrange physician services. DMG and DMG's California, Colorado, Nevada and Washington associated physician groups, as well as those physician equity holders of associated physician groups who are subject to succession agreements with DMG, could be subject to criminal or civil penalties or an injunction if, for non-physicians, they are found to be practicing medicine without a license or, for licensed physicians, they are found to be aiding and abetting the unlicensed practice of medicine.

The level of our current and future debt could have an adverse impact on our business and our ability to generate cash to service our indebtedness and for other intended purposes depends on many factors beyond our control.

We have substantial debt outstanding, we incurred a substantial amount of additional debt in connection with our entry into the Increase Joinder Agreement in March 2018, and we may continue to incur additional indebtedness in the future. If we are unable to generate sufficient cash to service our substantial indebtedness and for other intended purposes, it could, for example:

- make it difficult for us to make payments on our debt securities;
- increase our vulnerability to general adverse economic and industry conditions;
- require us to dedicate a substantial portion of our cash flows from operations to payments on our indebtedness, thereby reducing the availability of our cash flow to fund working capital, capital expenditures, acquisitions and investments, repurchases of stock at the levels intended or announced, or at all, and other general corporate purposes;
- limit our flexibility in planning for, or reacting to, changes in our business and the markets in which we operate;
- expose us to interest rate volatility that could adversely affect our business, results of operations, financial condition and cash flows, and our ability to service our indebtedness;
- place us at a competitive disadvantage compared to our competitors that have less debt; and
- limit our ability to borrow additional funds, or to refinance existing debt on favorable terms when otherwise available.

In addition, we may continue to incur additional indebtedness in the future, and the amount of that additional indebtedness may be substantial. Although the indentures governing our senior notes and the agreement governing our senior secured credit facilities include covenants that could limit our indebtedness, we currently have the ability to incur substantial additional debt. The related risks described in this risk factor could intensify, in particular, if there is a delay in closing the sale of DMG or the sale of DMG does not close, or if new debt is added to current debt levels.

Further, the variable interest rates payable under our senior secured credit facilities are linked to LIBOR as the benchmark for establishing the rates. LIBOR is the subject of recent national, international and other regulatory guidance and proposals for reform. These reforms may cause LIBOR to disappear entirely or to perform differently than in the past. The consequences of these developments with respect to LIBOR cannot be entirely predicted, but could adversely affect the variable interest rates payable under our senior secured credit facilities.

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Our ability to make payments on our indebtedness, to fund planned capital expenditures and expansion efforts, including any strategic acquisitions we may make in the future, to repurchase our stock at the levels intended or announced and to meet our other liquidity needs, will depend on our ability to generate cash. This depends not only on the success of our business but, to a certain extent, is also subject to general economic, financial, competitive, regulatory and other factors that are beyond our control.

If the pending sale of DMG closes, our cash flows will be reduced accordingly. We cannot provide assurances that our business will generate sufficient cash flows from operations in the future or that future borrowings will be available to us in an amount sufficient to enable us to service our indebtedness or to fund other liquidity needs, including those described above. In that regard, approximately $1.845 billion of indebtedness under secured credit facilities will become due and payable in June 2019 at its stated maturity. Although we plan to seek replacement secured credit facilities to refinance that indebtedness as it becomes due, there can be no assurance that we will be able to do so on terms we consider acceptable or at all. If we are unable to generate sufficient funds to service our outstanding indebtedness or to meet our other liquidity needs, including the intended purposes described above, we would be required to refinance, restructure, or otherwise amend some or all of such indebtedness, sell assets, change or reduce our intended or announced uses or strategy for capital deployment, including for stock repurchases, reduce capital expenditures or planned expansions or raise additional cash through the sale of our equity. In addition, if we are unable to refinance or repay our indebtedness as it becomes due and payable from time to time (including the approximate $1.845 billion of secured credit facilities indebtedness that becomes due in June 2019), we may seek waivers or extensions from the applicable lenders but there can be no assurance that those would be granted, in which case we would have to seek other sources of financing to repay that indebtedness, which might include sales of assets or equity securities or some of the other strategies discussed above. We cannot make any assurances that any such refinancing, restructurings, sales of assets, or issuances of equity can be accomplished, that any such waivers or extensions from lenders can be obtained or, if accomplished or obtained, will be on favorable terms or would raise sufficient funds to meet these obligations or our other liquidity needs. Any failure to pay any of our indebtedness when due, including if we are unable to refinance the approximately $1.845 billion of indebtedness under our senior secured credit facilities that becomes due in June 2019, could have a material adverse effect on our business, results of operations, financial condition and cash flows, and could trigger cross default or cross acceleration provisions in our other debt instruments, thereby permitting the holders of that other indebtedness to demand immediate repayment, and, in the case of secured indebtedness, would generally permit the holders of that indebtedness to possess and sell the collateral to satisfy our obligations.

The borrowings under our senior secured credit facilities and senior indentures are guaranteed by a substantial portion of our direct and indirect wholly owned domestic subsidiaries, including certain of DMG's subsidiaries, and borrowings under our senior secured credit facilities are secured by a substantial portion of our and our subsidiaries' assets, including those of certain of DMG's subsidiaries. If the pending sale of DMG closes, we will have fewer subsidiary guarantors of, and fewer assets with which to secure existing and future debt or refinance or restructure existing debt. This will likely reduce the total amount of secured debt that we will be able to incur and may increase the interest rate we are required to pay on our existing secured debt and any secured debt we issue in the future. In addition, by reducing the amount of assets available to meet the claims of our secured and other creditors and the number of subsidiary guarantors, it may also adversely affect the interest rates on our existing unsecured debt and any unsecured debt we issue in the future and may adversely affect our ability to incur additional unsecured debt.

For additional details regarding specific risks we face regarding the pending sale of DMG, see the discussion in the risk factors under the heading “Risk factors related to the sale of DMG.”

We may be subject to liability claims for damages and other expenses that are not covered by insurance or exceed our existing insurance coverage that could have a material adverse effect on our business, results of operations, financial condition, cash flows and reputation.

Our operations and how we manage our business may subject us, as well as our officers and directors to whom we owe certain defense and indemnity obligations, to litigation and liability for damages. Our business, profitability and growth prospects could suffer if we face negative publicity or we pay damages or defense costs in connection with a claim that is outside the scope or limits of coverage of any applicable insurance coverage, including claims related to

adverse patient events, cybersecurity incidents, contractual disputes, professional and general liability and directors' and officers' duties. In addition, we have received notices of claims from commercial payors and other third parties, as well as subpoenas and CIDs from the federal government, related to our business practices, including our historical billing practices and the historical billing practices of acquired businesses. Although the ultimate outcome of these claims cannot be predicted, an adverse result with respect to one or more of these claims could have a material adverse effect on our business, results of operations, financial condition and cash flows. We maintain insurance coverage for those risks we deem are appropriate to insure against and make determinations about whether to self-insure as to other risks or layers of coverage. However, a successful claim, including a

professional liability, malpractice or negligence claim or a claim related to a cybersecurity incident, which is in excess of any applicable insurance coverage, or that is subject to our self-insurance retentions, could have a material adverse effect on our business, results of operations, financial condition, cash flows and reputation. Additionally, as a result of the broad scope of our DMG division's medical practice, we are exposed to medical malpractice claims, as well as claims for damages and other expenses, that may not be covered by insurance or for which adequate limits of insurance coverage may not be available.

In addition, if our costs of insurance and claims increase, then our earnings could decline. Market rates for insurance premiums and deductibles have been steadily increasing. Our business, results of operations, financial condition and cash flows could be materially and adversely affected by any of the following:

- the collapse or insolvency of our insurance carriers;
- further increases in premiums and deductibles;
- increases in the number of liability claims against us or the cost of settling or trying cases related to those claims; or
- an inability to obtain one or more types of insurance on acceptable terms, if at all.

If we fail to successfully maintain an effective internal control over financial reporting, the integrity of our financial reporting could be compromised, which could have a material adverse effect on our ability to accurately report our financial results, our stock price and the market's perception of our business.

The integration of acquisitions and addition of new business lines into our internal control over financial reporting has required and will continue to require significant time and resources from our management and other personnel and has increased and will continue to, increase our compliance costs. Failure to maintain an effective internal control environment could have a material adverse effect on our ability to accurately report our financial results, our stock price and the market's perception of our business. In addition, we could be required to restate our financial results in the event of a significant failure of our internal control over financial reporting or in the event of inappropriate application of accounting principles.

Deterioration in economic conditions, disruptions in the financial markets or the effects of natural or other disasters or adverse weather events such as hurricanes, earthquakes, fires or flooding could have a material adverse effect on our business, results of operations, financial condition and cash flows.

Deterioration in economic conditions could have a material adverse effect on our business, results of operations, financial condition and cash flows. Among other things, the potential decline in federal and state revenues that may result from such conditions may create additional pressures to contain or reduce reimbursements for our services from Medicare, Medicaid and other government sponsored programs. Increases in job losses in the U.S. as a result of adverse economic conditions has and may continue to result in a smaller percentage of our patients being covered by an employer group health plan and a larger percentage being covered by lower paying Medicare and Medicaid programs. Employers may also select more restrictive commercial plans with lower reimbursement rates. To the extent that payors are negatively impacted by a decline in the economy, we may experience further pressure on commercial rates, a further slowdown in collections and a reduction in the amounts we expect to collect. In addition, uncertainty in the financial markets could adversely affect the variable interest rates payable under our credit facilities or could make it more difficult to obtain or renew such facilities or to obtain other forms of financing in the future, if at all. For additional information regarding the risks related to our indebtedness, see the discussion in the risk factor above under the heading "The level of our current and future debt could have an adverse impact on our business and our ability to generate cash to service our indebtedness and for other intended purposes depends on many factors beyond our control."

Further, some of our operations, including our clinical laboratory, dialysis centers and other facilities, may be adversely impacted by the effects of natural or other disasters or adverse weather events such as hurricanes, earthquakes, fires or flooding. For example, our clinical laboratory is located in Florida, a state that has in the past experienced and may in the future experience hurricanes. Natural or other disasters or adverse weather events could significantly damage or destroy our facilities, disrupt operations, increase our costs to maintain operations and require substantial expenditures and recovery time to fully resume operations.

Any or all of these factors, as well as other consequences of these events, none of which we can currently predict, could have a material adverse effect on our business, results of operations, financial condition and cash flows.

Disruptions in federal government operations and funding create uncertainty in our industry and could have a material adverse effect on our business, results of operations, financial condition and cash flows.

A substantial portion of our revenues is dependent on federal healthcare program reimbursement, and any disruptions in federal government operations could have a material adverse effect on our business, results of operations, financial condition and cash flows. If the U.S. government defaults on its debt, there could be broad macroeconomic effects that could raise our cost of borrowing funds, and delay or prevent our future growth and expansion. Any future federal government shutdown, U.S. government default on its debt and/or failure of the U.S. government to enact annual appropriations could have a material adverse effect on our business, results of operations, financial condition and cash flows. Additionally, disruptions in federal government operations may negatively impact regulatory approvals and guidance that are important to our operations, and create uncertainty about the pace of upcoming regulatory developments.

We could be subject to adverse changes in tax laws, regulations and interpretations or challenges to our tax positions.

We are subject to tax laws and regulations of the U.S. federal, state and local governments as well as various foreign jurisdictions. We compute our income tax provision based on enacted tax rates in the jurisdictions in which we operate. As the tax rates vary among jurisdictions, a change in earnings attributable to the various jurisdictions in which we operate could result in an unfavorable or favorable change in our overall tax provision.

From time to time, changes in tax laws or regulations may be proposed or enacted that could adversely affect our overall tax liability. For example, the recent U.S. tax legislation enacted on December 22, 2017, represented a significant overhaul of the U.S. federal tax code. We have completed our analysis of the initial impact of the 2017 federal tax law changes. However, it is possible that future guidance in connection with the law and/or the issuance of detailed regulations could impact our tax provision and cash taxes in future periods. Additionally, the legislation made significant changes to the tax rules applicable to insurance companies and other entities with which we do business. There can be no assurance that changes in tax laws or regulations, both within the U.S. and the other jurisdictions in which we operate, will not materially and adversely affect our effective tax rate, tax payments, results of operations, financial condition and cash flows. Similarly, changes in tax laws and regulations that impact our patients, business partners and counterparties or the economy generally may also impact our results of operations, financial condition and cash flows.

In addition, tax laws and regulations are complex and subject to varying interpretations, and any significant failure to comply with applicable tax laws and regulations in all relevant jurisdictions could give rise to substantial penalties and liabilities. We are regularly subject to audits by tax authorities. For example, we are currently under audit by the Internal Revenue Service for the years 2014-2016. Although we believe our tax estimates and related reporting are appropriate, the final determination of this and other tax audits and any related litigation could be materially different from our historical income tax provisions and accruals. Any changes in enacted tax laws (such as the recent U.S. tax legislation), rules or regulatory or judicial interpretations; any adverse development or outcome in connection with tax audits in any jurisdiction; or any change in the pronouncements relating to accounting for income taxes could materially and adversely impact our effective tax rate, tax payments, results of operations, financial condition and cash flows.

Expansion of our operations to and offering our services in markets outside of the U.S. subjects us to political, economic, legal, operational and other risks that could have a material adverse effect on our business, results of operations, financial condition, cash flows and reputation.

We are continuing to expand our operations by offering our services and entering new lines of business in certain markets outside of the U.S., which increases our exposure to the inherent risks of doing business in international markets. Depending on the market, these risks include those relating to:

- changes in the local economic environment;
- political instability, armed conflicts or terrorism;
- social changes;
- intellectual property legal protections and remedies;
- trade regulations;

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

- foreign currency;
- repatriating or moving to other countries cash generated or held abroad, including considerations relating to tax-efficiencies and changes in tax laws;
- export controls;
- lack of reliable legal systems which may affect our ability to enforce contractual rights;
- changes in local laws or regulations, or interpretation or enforcement thereof;
- potentially longer ramp-up times for starting up new operations and for payment and collection cycles;
- financial and operational, and information technology systems integration;
- failure to comply with U.S. laws, such as the FCPA, or local laws that prohibit us, our partners, or our partners' or our agents or intermediaries from making improper payments to foreign officials or any third party for the purpose of obtaining or retaining business; and
- data and privacy restrictions.

Issues relating to the failure to comply with applicable non-U.S. laws, requirements or restrictions may also impact our domestic business and/or raise scrutiny on our domestic practices.

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

Any expansion of our international operations through acquisitions or through organic growth could increase these risks. Additionally, while we may invest material amounts of capital and incur significant costs in connection with the growth and development of our international operations, including to start up or acquire new operations, we may not be able to operate them profitably on the anticipated timeline, or at all.

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

Risk factors related to the sale of DMG:

The announcement and pendency of the sale of DMG may continue to adversely affect our business, results of operations, financial condition and cash flows.

The announcement and pending sale of DMG may continue to be disruptive to our business and may continue to adversely affect our relationships with current and prospective teammates, patients, physicians, payors, suppliers and other business partners. Uncertainties related to the pending sale of DMG may continue to impair our ability to attract, retain and motivate key personnel and could continue to cause suppliers and other business partners to defer entering into contracts with us or seek to change existing business relationships with us. The loss or deterioration of significant business and operational relationships could have an adverse effect on our business, results of operations, financial condition and cash flows. In addition, activities relating to the pending sale and related uncertainties could continue to divert the attention of our management and other teammates from our day-to-day business or disrupt our operations in preparation for and during the post-closing separation of DMG. Following the closing of the DMG sale, we will enter into a transition services agreement with Optum, whereby we and Optum will provide various transition services to one another for specified periods beginning on the closing date. In the course of performing our obligations under the transition services agreement, we will allocate certain of our resources, including assets, facilities, equipment and the time and attention of our management and other teammates, for the benefit of the DMG business and not ours, which may negatively impact our business, results of operations, financial condition and cash flows. In addition, it is possible that we could have stranded costs following the closing of the pending sale, which could be material. If we are unable to effectively manage these risks, our business, results of operations, financial condition and cash flows may be adversely affected.

Any continued delay in completing the sale of DMG or any additional modifications to the terms of the sale under the equity purchase agreement may materially adversely affect our business, results of operations, financial condition, cash flows and stock price.

The completion of the proposed sale of DMG is subject to customary closing conditions, including the expiration or termination of the applicable waiting period under the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended (the "HSR Act"). On March 12, 2018, we received a request for additional information and documentary materials (commonly referred to as a "second request") from the U.S. Federal Trade Commission ("FTC") under the HSR Act in connection with the FTC's review of the proposed sale of DMG. In connection with its approval of the proposed sale of DMG, the FTC may impose material conditions, terms and obligations, including making its approval subject to the disposition of certain assets, which could further delay completion of the transaction, or the FTC may impose conditions that would require an adverse modification to the equity purchase agreement. If further delays continue in completing the sale of DMG, or if the terms set forth in the equity purchase agreement are further amended, our business, results of operations, financial condition, cash flows and stock price may be materially adversely affected.

If we fail to complete the proposed sale of DMG, our business, results of operations, financial condition, cash flows and stock price may be materially adversely affected.

The completion of the proposed sale of DMG is subject to customary closing conditions, including FTC approval, and if any condition to the closing of the sale of DMG is neither satisfied nor, where permissible, waived, we may be unable to complete the disposition or complete the disposition on the terms set forth in the equity purchase agreement. In addition, either we or Optum may terminate the equity purchase agreement if, among other things, the sale has not been consummated prior to June 30, 2019. If the equity purchase agreement is terminated and our Board of Directors seeks an alternative transaction or another acquiror for the sale of the DMG business, we may not be able to negotiate a transaction with another party on terms comparable to, or better than, the terms of the equity purchase agreement with Optum, or at all. In the third and fourth quarters of 2018, we recognized valuation adjustments with respect to the DMG business based on an updated assessment of fair value, which includes inputs such as the transaction itself, risks and timing, and performance of the business, and we recorded associated goodwill impairment charges in the fourth quarter of 2018. We may recognize additional valuation adjustments related to DMG in the future.

If the sale of DMG is not completed for any reason, investor confidence could decline. A failed transaction may result in negative publicity, protracted litigation, and may affect our relationships with teammates, patients, physicians, payors, suppliers, regulators and other business partners. In addition, in the event of a failed transaction, we will have expended significant management resources in an effort to complete the sale, and we will have incurred significant transaction costs, including legal fees, financial advisor fees and other related costs, without any commensurate benefit. Furthermore, we have incurred additional debt in anticipation of receiving the sale proceeds but there can be no assurances that we will receive the anticipated sale proceeds to repay such debt. Accordingly, if the proposed sale of DMG is not completed on the terms set forth in the equity purchase agreement or at all, our business, results of operations, financial condition, cash flows and stock price may be materially adversely affected.

Our liquidity following the close of our pending sale of DMG and our planned subsequent entry into new external financing arrangements may be less than we anticipate, and we may use the proceeds from the pending sale of DMG and other available funds, including external financing and cash flow from operations, in ways that may not improve our results of operations, financial condition, cash flows or enhance the value of our common stock.

The purchase price for the sale of the DMG business is subject to customary adjustments, both upward and downward, which could be significant. Following the closing of the pending DMG sale, we plan to use sale proceeds and other available funds, including from external financing and cash flow from operations, to repay debt, make significant stock repurchases and for general corporate purposes, which may include growth investments. A number of factors may impact our ability to repurchase stock and the timing of any such stock repurchases, including market conditions, the price of our common stock, our results of operations, financial condition, cash flows, available financing, leverage ratios, and legal, regulatory and contractual requirements and restrictions. Accordingly, the actual amount of common stock we repurchase may be less, perhaps substantially, and the period of time over which we make any stock repurchases may be substantially longer, than we currently anticipate. In addition, we may identify investments or

other uses for our available funds (other than the DMG sale proceeds that we plan to use to repay debt) that we believe are more attractive than our current intended uses. Further, there can be no assurance that any investment will yield a favorable return.

Under the terms of the equity purchase agreement, we are subject to certain contractual restrictions while the sale of DMG is pending that, in some cases, could have a material adverse effect on our business, results of operations, financial condition and cash flows.

Under the terms of the equity purchase agreement, we are subject to certain restrictions on the conduct of the DMG business prior to completing the sale of DMG, which have adversely affected and may continue to adversely affect our ability to execute certain of our business strategies, including the ability in certain cases to enter into or amend contracts, acquire or dispose of assets, incur indebtedness or incur capital expenditures. Such limitations have negatively affected and could continue to negatively affect our business and operations prior to the completion of the sale of DMG. Each of these risks may be exacerbated by delays or other adverse developments with respect to the completion of the sale of DMG.

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

If patients in commercial plans are subject to restriction in plan designs or the average rates that commercial payors pay us decline significantly, it would have a material adverse effect on our business, results of operations, financial condition and cash flows.

Approximately 31% of our U.S. dialysis and related lab services net revenues for the year ended December 31, 2018, were generated from patients who have commercial payors (including hospital dialysis services) as their primary payor. The majority of these patients have insurance policies that pay us on terms and at rates that are generally significantly higher than Medicare rates. The payments we receive from commercial payors generate nearly all of our profit and all of our nonacute dialysis profits come from commercial payors. We continue to experience downward pressure on some of our commercial payment rates as a result of general conditions in the market, including as employers shift to less expensive options for medical services, recent and future consolidations among commercial payors, increased focus on dialysis services and other factors. In addition, many commercial payors that sell individual plans both on and off exchange have publicly announced losses in the marketplace. These payors may seek discounts on rates for marketplace plans on and off exchange. Commercial payment rates could be materially lower in the future.

We continuously are in the process of negotiating existing and potential new agreements with commercial payors who aggressively negotiate terms with us. Sometimes many significant agreements are being renegotiated at the same time. In the event that our continual negotiations result in overall commercial rate reductions in excess of overall commercial rate increases, the cumulative effect could have a material adverse effect on our business, results of operations, financial condition and cash flows. Consolidations have significantly increased the negotiating leverage of commercial payors. Our negotiations with payors are also influenced by competitive pressures, and we may experience decreased contracted rates with commercial payors or experience decreases in patient volume as our negotiations with commercial payors continue. In addition to downward pressure on contracted commercial payor rates, payors have been attempting to design and implement plans to restrict access to coverage, and the duration and/or the breadth of benefits, which may result in decreased payments. In addition, payors have been attempting to impose restrictions and limitations on patient access to commercial exchange plans and non-contracted or out-of-network providers, and in some circumstances designate our centers as out-of-network providers. Rates for commercial exchange products and out-of-network providers are on average higher than rates for government products and in-network providers, respectively.

A number of commercial payors have incorporated policies into their provider manuals limiting or refusing to accept charitable premium assistance from non-profit organizations, such as the American Kidney Fund, which may impact the number of patients who are able to afford commercial plans. Paying for coverage is a significant financial burden for many patients, and ESRD disproportionately affects the low-income population. Charitable premium assistance supports continuity of coverage and access to care for patients, many of whom are unable to continue working full-time as a result of their severe condition. A material restriction in patients' ability to access charitable premium assistance may restrict the ability of dialysis patients to obtain and maintain optimal insurance coverage, and may adversely impact a large number of dialysis centers across the U.S. by making certain centers economically unviable, and may have a material adverse effect on our business, results of operations, financial condition and cash flows.

We also believe commercial payors have or will begin to restructure their benefits to create disincentives for patients to stay with commercial insurance or to select or remain with out-of-network providers. In addition, payors may seek to decrease payment rates for out-of-network providers. Decreases in the number of patients with commercial plans, decreases in out-of-network rates and restrictions on out-of-network access, our turning away new patients in instances where we are unable to come to agreement with commercial payors on rates, new business activities of commercial payors, or decreases in contracted rates could result in a significant decrease in our overall revenues derived from commercial payors. If the average rates that commercial payors pay us decline significantly, or if we see a decline in commercial patients, it would have a material adverse effect on our business, results of operations, financial condition and cash flows. For additional details regarding specific risks

we face regarding regulatory changes that could result in fewer patients covered under commercial plans or an increase of patients covered under more restrictive commercial plans with lower reimbursement rates, see the discussion in the risk factor under the heading "Changes in federal and state healthcare regulations could have a material adverse effect on our business, results of operations, financial condition and cash flows."

If the number of patients with higher-paying commercial insurance declines, it could have a material adverse effect on our business, results of operations, financial condition and cash flows.

Our revenue levels are sensitive to the percentage of our patients with higher-paying commercial insurance coverage. A patient's insurance coverage may change for a number of reasons, including changes in the patient's or a family member's employment status. Any changes impacting our highest paying commercial payors will have a disproportionate impact on us. In addition, many patients with commercial and government insurance rely on financial assistance from charitable organizations, such as the American Kidney Fund. Certain payors have challenged our patients' and other providers' patients' ability to utilize assistance from charitable organizations for the payment of premiums, including through litigation and other legal proceedings. Regulators have also questioned the use of charitable premium assistance for ESRD patients. CMS or another regulatory agency or legislative authority may issue a new rule or guidance that challenges or restricts charitable premium assistance. If any of these challenges to kidney patients' use of premium assistance are successful or restrictions are imposed on the use of financial assistance from such charitable organizations such that kidney patients are unable to obtain, or continue to receive or receive for a limited duration, such financial assistance, it could have a material adverse effect on our business, results of operations, financial condition and cash flows. In addition, if our assumptions about how kidney patients will respond to any change in financial assistance from charitable organizations are incorrect, it could have a material adverse effect on our business, results of operations, financial condition and cash flows.

When Medicare becomes the primary payor, the payment rate we receive for that patient decreases from the employer group health plan or commercial plan rate to the lower Medicare payment rate. The number of our patients who have government-based programs as their primary payors could increase and the percentage of our patients covered under commercial insurance plans could be negatively impacted as a result of improved mortality or declining macroeconomic conditions. To the extent there are sustained or increased job losses in the U.S., independent of whether general economic conditions improve, we could experience a decrease in the number of patients covered under commercial plans and/or an increase in uninsured and underinsured patients. The percentage of our patients covered under commercial insurance plans could also be negatively impacted by a decline in the rate of growth of the ESRD patient population. We could also experience a further decrease in the payments we receive for services if changes to the healthcare regulatory system result in fewer patients covered under commercial plans or an increase of patients covered under more restrictive commercial plans with lower reimbursement rates. In addition, our continual negotiations with commercial payors under existing and potential new agreements could result in a decrease in the number of our patients covered by commercial plans to the extent that we cannot reach agreement with commercial payors on rates and other terms, resulting in termination or non-renewals of existing agreements and our inability to enter into new agreements. Commercial payors have taken and may continue to take steps to control the cost of and/or the eligibility for access to healthcare services, including relative to products on and off the healthcare exchanges. These efforts could impact the number of our patients who are eligible to enroll in commercial insurance plans, and remain on the plans, including plans offered through healthcare exchanges. Additionally, we continue to experience higher amounts of write-offs due to uninsured and underinsured patients, which has resulted in an increase in uncollectible accounts. Commercial payors could also cease paying in the primary position after providing 30 months of coverage resulting in a material reduction in payment as the patient moves to Medicare primary. If there is a significant reduction in the number of patients under higher-paying commercial plans relative to government-based programs that pay at lower rates or a significant increase in the number of patients that are uninsured and underinsured, it would have a material adverse effect on our business, results of operations, financial condition and cash flows.

Changes in the structure of and payment rates under the Medicare ESRD program could have a material adverse effect on our business, results of operations, financial condition and cash flows.

Approximately 44% of our U.S. dialysis and related lab services net revenues for the year ended December 31, 2018, were generated from patients who have Medicare as their primary payor. For patients with Medicare coverage, all ESRD payments for dialysis treatments are made under a single bundled payment rate which provides a fixed payment rate to encompass all goods and services provided during the dialysis treatment that are related to the treatment of dialysis, including pharmaceuticals that were historically separately reimbursed to the dialysis providers, such as erythropoietin (EPO), vitamin D analogs and iron supplements, irrespective of the level of pharmaceuticals administered or additional services performed, except in the case of calcimimetics, which are subject to a transitional drug add-on payment adjustment for the Medicare Part B ESRD payment. Most lab services are also included in the bundled payment. Under the ESRD PPS, the bundled payments to a dialysis facility may be reduced by as much as 2% based on the facility's performance in specified quality measures set

annually by CMS through the ESRD Quality Incentive Program, which was established by the Medicare Improvements for Patients and Providers Act of 2008. The bundled payment rate is also adjusted for certain patient characteristics, a geographic usage index and certain other factors. In addition, the ESRD PPS is subject to rebasing, which can have a positive financial effect, or a negative one if the government fails to rebase in a manner that adequately addresses the costs borne by dialysis facilities. Similarly, as new drugs, services or labs are added to the ESRD bundle, CMS' failure to adequately calculate the costs associated with the drugs, services or labs could have a material adverse effect on our business, results of operations, financial condition and cash flows.

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

- Risk that our rates are reduced by CMS. Uncertainty about future payment rates remains a material risk to our business.
- Risk that CMS, through its contracted Medicare Administrative Contractors (MACs) or otherwise, implements Local Coverage Determinations (LCDs) or other decisions that limit our ability to bill for treatments or other drugs and services or other rules that may impact reimbursement. Such coverage determinations could have an adverse impact on our revenue. There is also risk commercial insurers could seek to incorporate the requirements or limitations associated with such LCDs into their contracted terms with dialysis providers, which could have an adverse impact on our revenue.
- Risk that a MAC, or multiple MACs, change their interpretations of existing regulations, manual provisions and/or guidance; or seek to implement or enforce new interpretations that are inconsistent with how we have interpreted existing regulations, manual provisions and/or guidance.
- Risk that increases in our operating costs will outpace the Medicare rate increases we receive. We expect operating costs to continue to increase due to inflationary factors, such as increases in labor and supply costs, including increases in maintenance costs and capital expenditures to improve, renovate and maintain our facilities, equipment and information technology to meet changing regulatory requirements and business needs, regardless of whether there is a compensating inflation-based increase in Medicare payment rates or in payments under the bundled payment rate system.
- Risk of federal budget sequestration cuts. As a result of the Budget Control Act of 2011 and the BBA, an annual 2% reduction to Medicare payments took effect on April 1, 2013, and has been extended through 2027. These across-the-board spending cuts have affected and will continue to adversely affect our business, results of operations, financial condition and cash flows.
- Risk that failure to adequately develop and maintain our clinical systems or failure of our clinical systems to operate effectively could have a material adverse effect on our business, results of operations, financial condition and cash flows. For example, in connection with claims for which at least part of the government's payments to us is based on clinical performance or patient outcomes or co-morbidities, if our clinical systems fail to accurately capture the data we report to CMS or we otherwise have data integrity issues with respect to the reported information, we might be over-reimbursed by the government, which could subject us to liability. For example, CMS published a final rule that implemented a provision of the ACA, requiring providers to report and return Medicare and Medicaid overpayments within the later of (a) 60 days after the overpayment is identified and quantified, or (b) the date any corresponding cost report is due, if applicable. An overpayment impermissibly retained under this statute could, among other things, subject us to liability under the FCA, exclusion from participation in the federal healthcare programs, and penalties under the federal Civil Monetary Penalty statute and could adversely impact our reputation.

We are subject to similar risks for services billed separately from the ESRD bundled payment, including the risk that a MAC, or multiple MACs, change their interpretations of existing regulations, manual provisions and/or guidance; or seek to implement or enforce new interpretations that are inconsistent with how we have interpreted existing regulations, manual provisions and/or guidance. For additional details regarding the risks we face for failing to adhere to our Medicare and Medicaid regulatory compliance obligations, see the risk factor above under the heading "If we fail to adhere to all of the complex government laws and regulations that apply to our business, we could suffer severe consequences that could have a material adverse effect on our business, results of operations, financial condition, cash flows, reputation and stock price."

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Changes in state Medicaid or other non-Medicare government-based programs or payment rates could have a material adverse effect on our business, results of operations, financial condition and cash flows.

Approximately 25% of our U.S. dialysis and related lab services net revenues for the year ended December 31, 2018, were generated from patients who have state Medicaid or other non-Medicare government-based programs, such as coverage through the Department of Veterans Affairs (VA), as their primary coverage. As state governments and other governmental organizations face increasing budgetary pressure, we may in turn face reductions in payment rates, delays in the receipt of payments, limitations on enrollee eligibility or other changes to the applicable programs. For example, certain state Medicaid programs and the VA have recently considered, proposed or implemented payment rate reductions.

The VA adopted Medicare's bundled PPS pricing methodology for any veterans receiving treatment from non-VA providers under a national contracting initiative. Since we are a non-VA provider, these reimbursements are tied to a percentage of Medicare reimbursement, and we have exposure to any dialysis reimbursement changes made by CMS. Approximately 3% of our dialysis services revenues for the year ended December 31, 2018 were generated by the VA. In 2013, we entered into a five-year Nationwide Dialysis Services contract with the VA which is subject to one-year renewal periods, consistent with all provider agreements with the VA under this contract. During the length of the contract, the VA has elected not to make adjustments to reimbursement percentages that are tied to a percentage of Medicare reimbursement rates. These agreements provide the VA with the right to terminate the agreements without cause on short notice. Should the VA renegotiate, or not renew or cancel these agreements for any reason, we may cease accepting patients under this program and may be forced to close centers or experience lower reimbursement rates, which could have a material adverse effect on our business, results of operations, financial condition and cash flows.

State Medicaid programs are increasingly adopting Medicare-like bundled payment systems, but sometimes these payment systems are poorly defined and are implemented without any claims processing infrastructure, or patient or facility adjusters. If these payment systems are implemented without any adjusters and claims processing infrastructure, Medicaid payments will be substantially reduced and the costs to submit such claims may increase, which will have a negative impact on our business, results of operations, financial condition and cash flows. In addition, some state Medicaid program eligibility requirements mandate that citizen enrollees in such programs provide documented proof of citizenship. If our patients cannot meet these proof of citizenship documentation requirements, they may be denied coverage under these programs, resulting in decreased patient volumes and revenue. These Medicaid payment and enrollment changes, along with similar changes to other non-Medicare government programs could reduce the rates paid by these programs for dialysis and related services, delay the receipt of payment for services provided and further limit eligibility for coverage which could have a material adverse effect on our business, results of operations, financial condition and cash flows.

Changes in clinical practices, payment rates or regulations impacting pharmaceuticals could have a material adverse effect on our business, results of operations, financial condition, cash flows and negatively impact our ability to care for patients.

Medicare bundles certain pharmaceuticals into the PPS at industry average doses and prices. Any variation above the industry average may be subject to partial reimbursement through the PPS outlier reimbursement policy.

Commercial payors have increasingly examined their administration policies for pharmaceuticals and, in some cases, have modified those policies. Changes in labeling of pharmaceuticals in a manner that alters physician practice patterns, including their independent determinations as to appropriate dosing, or accepted clinical practices, and/or changes in private and governmental payment criteria, including the introduction of administration policies could have a material adverse effect on our business, results of operations, financial condition and cash flows. Further increased utilization of certain pharmaceuticals for patients for whom the cost of which is included in a bundled reimbursement rate, or further decreases in reimbursement for pharmaceuticals that are not included in a bundled reimbursement rate, could also have a material adverse effect on our business, results of operations, financial condition and cash flows.

Additionally, as of January 1, 2018, calcimimetics became part of the Medicare Part B ESRD payment, but subject to a transitional drug add-on payment adjustment. We implemented processes designed to provide the drug as required under the applicable regulations and prescribed by physicians and have entered into agreements to provide for access

to and distribution of the drug. If payors do not pay as anticipated, if we are not adequately reimbursed for the cost of the drug, or the processes we have implemented to provide the drug do not perform as anticipated, then we could be subject to both financial and operational risk, among other things.

We may be subject to increased inquiries or audits from a variety of governmental bodies or claims by third parties related to pharmaceuticals, which would require management's attention and could result in significant legal expense. Any

negative findings could result in substantial financial penalties or repayment obligations, the imposition of certain obligations on and changes to our practices and procedures as well as the attendant financial burden on us to comply with the obligations, or exclusion from future participation in the Medicare and Medicaid programs, and could have a material adverse effect on our business, results of operations, financial condition and cash flows.

If we fail to comply with our Corporate Integrity Agreement, we could be subject to substantial penalties and exclusion from participation in federal healthcare programs that could have a material adverse effect on our business, results of operations, financial condition, cash flows and reputation.

In October 2014, we entered into a Settlement Agreement with the U.S. and relator David Barbetta to resolve the then pending 2010 and 2011 U.S. Attorney physician relationship investigations and paid $406 million in settlement amounts, civil forfeiture, and interest to the U.S. and certain states. In connection with the resolution of these matters, and in exchange for the OIG's agreement not to exclude us from participating in the federal healthcare programs, we have entered into a five-year CIA with the OIG. The CIA (i) requires that we maintain certain elements of our compliance programs; (ii) imposes certain expanded compliance-related requirements during the term of the CIA; (iii) requires ongoing monitoring and reporting by an independent monitor, imposes certain reporting, certification, records retention and training obligations, allocates certain oversight responsibility to the Board's Compliance Committee, and necessitates the creation of a Management Compliance Committee and the retention of an independent compliance advisor to the Board; and (iv) contains certain business restrictions related to a subset of our joint venture arrangements, including our agreeing to (1) unwind 11 joint venture transactions that were created through partial divestitures to, or partial acquisitions from, nephrologists, and that cover 26 of our 2,119 clinics that existed at the time we entered into the Settlement Agreement, all of which have been completed, (2) not enter into certain types of partial divestiture joint venture transactions with nephrologists during the term of the CIA, (3) non-enforcement of certain patient-related non-solicitation restrictions, and (4) certain other restrictions. The costs associated with compliance with the CIA are substantial and may be greater than we currently anticipate. In addition, in the event of a breach of the CIA, we could become liable for payment of certain stipulated penalties, and could be excluded from participation in federal healthcare programs. The OIG has notified us in the past that it considered us to be in breach of the CIA, and we cannot provide any assurances that we may not be found in breach of the CIA in the future. In general, the costs associated with compliance with the CIA, or any liability or consequences associated with a breach, could have a material adverse effect on our business, results of operations, financial condition and cash flows. For our domestic dialysis business, we are required under the CIA to report to the OIG (i) probable violations of criminal, civil or administrative laws applicable to any federal health care program for which penalties or exclusions may be authorized under applicable laws and regulations; (ii) substantial overpayments of amounts of money we have received in excess of the amounts due and payable under the federal healthcare program requirements; and (iii) employment of or contracting with individuals ineligible from participating in the federal healthcare programs (we refer to these collectively as Reportable Events). We have provided the OIG notice of Reportable Events, and we may identify and report additional events in the future. If any of our operations are found to violate government laws and regulations, we could suffer severe consequences that could have a material adverse effect on our business, results of operations, financial condition, cash flows, reputation and stock price, including those consequences described under the risk factor "If we fail to adhere to all of the complex government laws and regulations that apply to our business, we could suffer severe consequences that could have a material adverse effect on our business, results of operations, financial condition, cash flows, reputation and stock price."

Delays in state Medicare and Medicaid certification or other licensing and/or anything impacting the licensing of our dialysis centers could adversely affect our business, results of operations, financial condition and cash flows.

Before we can begin billing for patients treated in our outpatient dialysis centers who are enrolled in government-based programs, we are required to obtain state and federal certification for participation in the Medicare and Medicaid programs. As state agencies responsible for surveying dialysis centers on behalf of the state and Medicare program face increasing budgetary pressure, certain states are having difficulty keeping up with certifying dialysis centers in the normal course resulting in significant delays in certification. If state governments continue to have difficulty keeping up with certifying new centers in the normal course and we continue to experience significant

delays in our ability to treat and bill for services provided to patients covered under government programs, it could cause us to incur write-offs of investments or accelerate the recognition of lease obligations in the event we have to close centers or our centers' operating performance deteriorates, and it could have an adverse effect on our business, results of operations, financial condition and cash flows. Although the BBA passed in February 2018 allows organizations approved by the Department of Health and Human Services (HHS) to accredit dialysis facilities and imposes certain timing requirements regarding the initiation of initial surveys to determine if certain conditions and requirements for payment have been satisfied, we cannot predict the ultimate impact of these changes. In addition to certifications for Medicare and Medicaid, some states have licensing requirements for ESRD facilities. Delays in licensure, denials of licensure, or withdrawal of licensure could also adversely affect our business, results of operations, financial condition and cash flows.

If our joint ventures were found to violate the law, we could suffer severe consequences that would have a material adverse effect on our business, results of operations, financial condition and cash flows.

As of December 31, 2018, we owned a controlling interest in numerous dialysis-related joint ventures, which represented approximately 25% of our net U.S. dialysis and related lab services net revenues for the year ended December 31, 2018. In addition, we also owned noncontrolling equity investments in several other dialysis related joint ventures. We expect to continue to increase the number of our joint ventures. Many of our joint ventures with physicians or physician groups also have certain physician owners providing medical director services to centers we own and operate. Because our relationships with physicians are governed by the federal and state anti-kickback statutes, we have sought to structure our joint venture arrangements to satisfy as many federal safe harbor requirements as we believe are commercially reasonable. Our joint venture arrangements do not satisfy all of the elements of any safe harbor under the federal Anti-Kickback Statute, however, and therefore are susceptible to government scrutiny. For example, in October 2014, we entered into a settlement agreement to resolve the then pending 2010 and 2011 U.S. Attorney physician relationship investigations regarding certain of our joint ventures and paid $406 million in settlement amounts, civil forfeiture, and interest to the U.S. and certain states. For further details on the settlement agreement, see "If we fail to comply with our Corporate Integrity Agreement, we could be subject to substantial penalties and exclusion from participation in federal healthcare programs that could have a material adverse effect on our business, results of operations, financial condition, cash flows, and reputation".

There are significant risks associated with estimating the amount of dialysis revenues and related refund liabilities that we recognize, and if our estimates of revenues and related refund liabilities are materially inaccurate, it could impact the timing and the amount of our revenues recognition or have a material adverse effect on our business, results of operations, financial condition and cash flows.

There are significant risks associated with estimating the amount of U.S. dialysis and related lab services revenues and related refund liabilities that we recognize in a reporting period. The billing and collection process is complex due to ongoing insurance coverage changes, geographic coverage differences, differing interpretations of contract coverage and other payor issues, such as ensuring appropriate documentation. Determining applicable primary and secondary coverage for approximately 202,700 U.S. patients at any point in time, together with the changes in patient coverage that occur each month, requires complex, resource-intensive processes. Errors in determining the correct coordination of benefits may result in refunds to payors. Revenues associated with Medicare and Medicaid programs are also subject to estimating risk related to the amounts not paid by the primary government payor that will ultimately be collectible from other government programs paying secondary coverage, the patient's commercial health plan secondary coverage or the patient. Collections, refunds and payor retractions typically continue to occur for up to three years and longer after services are provided. We generally expect our range of U.S. dialysis and related lab services revenues estimating risk to be within 1% of net revenues for the segment. If our estimates of U.S. dialysis and related lab services revenues and related refund liabilities are materially inaccurate, it could impact the timing and the amount of our revenues recognition and have a material adverse impact on our business, results of operations, financial condition and cash flows.

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

Our ancillary services and strategic initiatives are subject to many of the same risks, regulations and laws, as described in the risk factors related to our dialysis business set forth in this Part I, Item 1A, and are also subject to additional risks, regulations and laws specific to the nature of the particular strategic initiative. We expect to add additional service offerings to our business and pursue additional strategic initiatives in the future as circumstances warrant, which could include healthcare services not related to dialysis. Many of these initiatives require or would require investments of both management and financial resources and can generate significant losses for a substantial period of time and may not become profitable in the expected timeframe or at all. There can be no assurance that any such strategic initiative will ultimately be successful. Any significant change in market conditions, or business performance, or in the political, legislative or regulatory environment, may impact the economic viability of any of

these strategic initiatives. For example, changes in the oral pharmacy space, including reimbursement rate pressures, negatively impacted the economics of our pharmacy services business. As a result, in the second half of 2018 we transitioned the customer service and fulfillment functions of this business to third parties and wound down our distribution operation, which resulted in a decrease in revenues and costs. In the year ended December 31, 2018, we recognized restructuring charges of $11 million and incurred asset impairment charges of $17 million related to the restructuring of our pharmacy business.

If any of our ancillary services or strategic initiatives, including our international operations, are unsuccessful, it would have a negative impact on our business, results of operations, financial condition and cash flows, and we may determine to exit

that line of business. We could incur significant termination costs if we were to exit certain of these lines of business. In addition, we may incur a material write-off or an impairment of our investment, including goodwill, in one or more of our ancillary services or strategic initiatives. In that regard, we have taken, and may in the future take, impairment and restructuring charges in addition to those described above related to our ancillary services and strategic initiatives, including in our international and pharmacy businesses.

If a significant number of physicians were to cease referring patients to our dialysis centers, whether due to regulatory or other reasons, it would have a material adverse effect on our business, results of operations, financial condition and cash flows.

Physicians, including medical directors, choose where they refer their patients. Some physicians prefer to have their patients treated at dialysis centers where they or other members of their practice supervise the overall care provided as medical director of the center. As a result, referral sources for many of our centers include the physician or physician group providing medical director services to the center.

Our medical director contracts are for fixed periods, generally ten years, and at any given time a large number of them could be up for renewal at the same time. Medical directors have no obligation to extend their agreements with us and, under certain circumstances, our former medical directors may choose to provide medical director services for competing providers or establish their own dialysis centers in competition with ours. Neither our current nor former medical directors have an obligation to refer their patients to our centers.

The aging of the nephrologist population and opportunities presented by our competitors may negatively impact a medical director's decision to enter into or extend his or her agreement with us. Moreover, different affiliation models in the changing healthcare environment that limit a nephrologist's choice in where he or she can refer patients, such as an increase in the number of physicians becoming employed by hospitals or a perceived decrease in the quality of service levels at our centers, may limit a nephrologist's ability or desire to refer patients to our centers or otherwise negatively impact treatment volumes.

In addition, if the terms of any existing agreement are found to violate applicable laws, we may not be successful in restructuring the relationship, which would lead to the early termination of the agreement. If we are unable to obtain qualified medical directors to provide supervision of the operations and care provided at our dialysis centers, it could affect physicians' desire to refer patients to our dialysis centers. If a significant number of physicians were to cease referring patients to our dialysis centers, it would have a material adverse effect on our business, results of operations, financial condition and cash flows.

If our labor costs continue to rise, including due to shortages, changes in certification requirements and higher than normal turnover rates in skilled clinical personnel; or currently pending or future rules, regulations or initiatives impose additional requirements or limitations on our operations or profitability; or, if we are unable to attract and retain key leadership talent, we may experience disruptions in our business operations and increases in operating expenses, among other things, which could have a material adverse effect on our business, results of operations, financial condition and cash flows.

We face increasing labor costs generally, and in particular, we face increased labor costs and difficulties in hiring nurses due to a nationwide shortage of skilled clinical personnel. We compete for nurses with hospitals and other healthcare providers. This nursing shortage may limit our ability to expand our operations. Furthermore, changes in certification requirements can impact our ability to maintain sufficient staff levels, including to the extent our teammates are not able to meet new requirements, among other things. In addition, if we experience a higher than normal turnover rate for our skilled clinical personnel, our operations and treatment growth may be negatively impacted, which could adversely affect our business, results of operations, financial condition and cash flows. We also face competition in attracting and retaining talent for key leadership positions. If we are unable to attract and retain qualified individuals, we may experience disruptions in our business operations, including our ability to achieve strategic goals, which could have a material adverse affect on our business, results of operations, financial condition and cash flows.

In addition, proposed ballot initiatives or referendums, legislation, regulations or policy changes could cause us to incur substantial costs to challenge and prepare for and, if implemented, impose additional requirements on our operations, including increases in the required staffing levels or staffing ratios for clinical personnel, minimum

transition times between treatments, limits on how much patients may be charged for care, limitations as to the amount that can be spent on certain medical costs, and limitations on the amount of revenue that providers can retain. Changes such as those mandated by proposed ballot initiatives or referendums, legislation, regulations or policy changes could materially reduce our revenues and increase our operating expense and impact our ability to staff our clinics to any new, elevated staffing levels, in particular given the ongoing

nationwide shortage of healthcare workers, especially nurses. Any of these events or circumstances could materially reduce our revenues and increase our operating and other costs, require us to close or consolidate existing dialysis centers, postpone or not build new dialysis centers, reduce shifts or negatively impact employee relations, treatment growth and productivity, and could have a material adverse effect on our business, results of operations, financial condition and cash flows. For additional information on these risks, see "Changes in federal and state health regulations could have a material adverse effect on our business, results of operations, financial condition and cash flows."

Our business is labor intensive and could be materially adversely affected if we are unable to attract and retain employees or if union organizing activities or legislative or other changes result in significant increases in our operating costs or decreases in productivity.

Our business is labor intensive, and our financial and operating results have been and continue to be subject to variations in labor-related costs, productivity and the number of pending or potential claims against us related to labor and employment practices. Political or other efforts at the national or local level could result in actions or proposals that increase the likelihood or success of union organizing activities at our facilities and ongoing union organizing activities at our facilities could continue or increase for other reasons. We could experience an upward trend in wages and benefits and labor and employment claims, including the filing of class action suits, or adverse outcomes of such claims, or face work stoppages. In addition, we are and may continue to be subject to targeted corporate campaigns by union organizers in response to which we have been and may continue to be required to expend substantial resources, both time and financial. Any of these events or circumstances could have a material adverse effect on our employee relations, treatment growth, productivity, business, results of operations, financial condition and cash flows.

Complications associated with our billing and collections system could materially adversely affect our business, results of operations, financial condition and cash flows.

Our billing system is critical to our billing operations. If there are defects in the billing system, we may experience difficulties in our ability to successfully bill and collect for services rendered, including a delay in collections, a reduction in the amounts collected, increased risk of retractions from and refunds to commercial and government payors, an increase in our provision for uncollectible accounts receivable and noncompliance with reimbursement regulations, any or all of which could materially adversely affect our results of operations.

Risk factors primarily related to DMG:

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

As a participant in the healthcare industry, DMG is subject to many of the same risks as our dialysis business is, as described in the risk factors set forth above in this Part I, Item 1A, many of which could have a material adverse effect on DMG's business, results of operations, financial condition and cash flows.

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

Approximately 84% of DMG's revenue for the year ended December 31, 2018, is derived from fixed per member per month (PMPM) fees paid by health plans under capitation agreements with DMG or its associated physician groups. While there are variations specific to each arrangement, DMG, through DHPC, a subsidiary of HealthCare Partners Holdings, LLC and a restricted Knox-Keene licensed entity, and, in certain instances, DMG's associated physician groups, generally contract with health plans to receive a PMPM fee for professional services and assume the financial responsibility for professional services only. In some cases, the health plans separately enter into capitation contracts with third parties (typically hospitals) who receive directly a PMPM fee and assume contractual financial responsibility for hospital services. In other cases, the health plan does not pay any portion of the PMPM fee to the hospital, but rather administers claims for hospital expenses itself. In both scenarios, DMG enters into managed care-related administrative services agreements or similar arrangements with those third parties (typically hospitals) under which DMG agrees to be responsible for utilization review, quality assurance, and other managed care-related administrative functions. As compensation for such administrative services, DMG is entitled to receive a percentage of the amount by which the institutional capitation revenue received from health plans exceeds institutional expenses; any such risk-share amount to which DMG is entitled is recorded as medical revenues, and DMG is also responsible for a percentage of any short-fall in the event that institutional expenses exceed institutional revenues. To the extent

that members require more care than is anticipated and/or the cost of care increases, aggregate fixed PMPM amounts, or capitation payments, may be insufficient to cover the costs associated with treatment. If medical costs and expenses exceed estimates, except in very limited circumstances, DMG will not be able to increase the PMPM fee received under these risk

agreements during their then-current terms and could, directly or indirectly through its contracts with its associated physician groups, suffer losses with respect to such agreements.

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

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

- the health status of members;
- higher than expected utilization of new or existing healthcare services or technologies;
- an increase in the cost of healthcare services and supplies, including pharmaceuticals, whether as a result of inflation or otherwise;
- changes to mandated benefits or other changes in healthcare laws, regulations and practices;
- periodic renegotiation of provider contracts with specialist physicians, hospitals and ancillary providers;
- periodic renegotiation of contracts with DMG's affiliated primary care physicians and specialists;
- changes in the demographics of the participating members and medical trends;
- contractual or claims disputes with providers, hospitals or other service providers within and outside of a health plan's network;
- the occurrence of catastrophes, major epidemics or acts of terrorism; and
- the reduction of health plan premiums.

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

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

Renegotiation, renewal or termination of capitation agreements with health plans could have a material adverse effect on DMG's business, results operations, financial condition and cash flows.

Under most of DMG's and its associated physician groups' capitation agreements with health plans, the health plan is generally permitted to modify the benefit and risk obligations and compensation rights from time to time during the terms of the agreements. If a health plan exercises its right to amend its benefit and risk obligations and compensation rights, DMG and its associated physician groups are generally allowed a period of time to object to such amendment. If DMG or its associated physician group so objects, under some of the risk agreements, the relevant health plan may terminate the applicable agreement upon 90 to 180 days written notice. If DMG or its associated physician groups enter into capitation contracts or other risk

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sharing arrangements with unfavorable economic terms, or a capitation contract is amended to include unfavorable terms, DMG could, directly or indirectly through its contracts with its associated physician groups, suffer losses with respect to such contract. Since DMG does not negotiate with CMS or any health plan regarding the benefits to be provided under their Medicare Advantage plans, DMG often has just a few months to familiarize itself with each new annual package of benefits it is expected to offer. Depending on the health plan at issue and the amount of revenue associated with the health plan's risk agreement, the renegotiated terms or termination could have a material adverse effect on DMG's business, results of operations, financial condition and cash flows.

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

DMG's financial statements are consolidated in accordance with applicable accounting standards and include the accounts of its majority-owned subsidiaries and certain non-owned DMG-associated and managed physician groups. Such consolidation for accounting and/or tax purposes does not, is not intended to, and should not be deemed to, imply or provide to DMG any control over the medical or clinical affairs of such physician groups. In the event of a change in accounting standards promulgated by FASB or in interpretation of its standards, or if there is an adverse determination by a regulatory agency or a court, or a change in state or federal law relating to the ability to maintain present agreements or arrangements with such physician groups, DMG may not be permitted to continue to consolidate the total revenues of such organizations. A change in accounting for consolidation with respect to DMG's present agreements or arrangements would diminish DMG's reported revenues but would not be expected to materially and adversely affect its reported results of operations, while regulatory or legal rulings or changes in law interfering with DMG's ability to maintain its present agreements or arrangements could materially diminish both revenues and results of operations.

If DHPC is not able to satisfy financial solvency or other regulatory requirements, we could become subject to sanctions and its license to do business in California could be limited, suspended or terminated, which could have a material adverse effect on DMG's business, results of operations, financial condition and cash flows.

Knox-Keene requires healthcare service plans operating in California to comply with financial solvency and other requirements overseen by the California Department of Managed HealthCare (DMHC). Under Knox-Keene, DHPC is required to, among other things:

- Maintain, at all times, a minimum tangible net equity (TNE);
- Submit periodic financial solvency reports to the DMHC containing various data regarding performance and financial solvency;
- Comply with extensive regulatory requirements; and
- Submit to periodic regulatory audits and reviews concerning DHPC operations and compliance with Knox-Keene.

In the event that DHPC is not in compliance with the provisions of Knox-Keene, we could be subject to sanctions, or limitations on, or suspension of its license to do business in California, which could have a material adverse effect on DMG's business, results of operations, financial condition and cash flows.

If DMG's associated physician group is not able to satisfy the California DMHC's financial solvency requirements, DMG's associated physician group could become subject to sanctions and DMG's ability to do business in California could be limited or terminated, which could have a material adverse effect on DMG's business, results of operations, financial condition and cash flows.

The California DMHC has instituted financial solvency regulations to monitor the financial solvency of capitated physician groups. Under these regulations, DMG's associated physician group is required to, among other things:

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

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

In the event that DMG's associated physician group is not in compliance with any of the above criteria, DMG's associated physician group could be subject to sanctions, or limitations on, or termination of, its ability to do business in California, which could have a material adverse effect on DMG's business, results of operations, financial condition and cash flows.

Reductions in Medicare Advantage health plan reimbursement rates stemming from healthcare reforms and any future related regulations could have a material adverse effect on DMG's business, results of operations, financial condition and cash flows.

A significant portion of DMG's revenue is directly or indirectly derived from the monthly premium payments paid by CMS to health plans for medical services provided to Medicare Advantage enrollees. As a result, DMG's results of operations are, in part, dependent on government funding levels for Medicare Advantage programs. Any changes that limit or reduce Medicare Advantage reimbursement levels, such as reductions in or limitations of reimbursement amounts or rates under programs, reductions in funding of programs, expansion of benefits without adequate funding, elimination of coverage for certain benefits, or elimination of coverage for certain individuals or treatments under programs, could have a material adverse effect on DMG's business, results of operations, financial condition and cash flows.

Each year, CMS issues a final rule to establish the Medicare Advantage benchmark payment rates for the following calendar year. Any reduction to Medicare Advantage rates impacting DMG that is greater compared to the industry average rate may have a material adverse effect on DMG's business, results of operations, financial condition and cash flows. The final impact of the Medicare Advantage rates can vary from any estimate we may have and may be further impacted by the relative growth of DMG's Medicare Advantage patient volumes across markets as well as by the benefit plan designs submitted. It is possible that we may underestimate the impact of the Medicare Advantage rates on our business, which could have a material adverse effect on DMG's business, results of operations, financial condition and cash flows.

Before DMG was reclassified as held for sale, we took impairment charges against the goodwill of several of our DMG reporting units based on continuing developments in our DMG business, including recent annual updates to Medicare Advantage benchmark reimbursement rates, changes in our expectations concerning future government reimbursement rates and our expected ability to mitigate them, medical cost and utilization trends, commercial pricing pressures, commercial membership rates, underperformance of certain at-risk reporting units and other market factors. Depending on the impact of continuing developments on the value of our DMG business, for example if DMG's fair value less the costs incurred in the sale of DMG falls below its carrying amount, we may need to recognize additional impairment charges on this business, and the amount of such charges, if any, could be significant. Our estimates of the fair value of this business rely on certain estimates and assumptions, including the terms and pricing agreed for the sale of this business, as well as applicable market multiples, discount and long-term growth rates, market data and future reimbursement rates, as applicable. Our estimates of the fair value of the DMG business could differ from the actual value that a market participant would pay for this business, and as a result, we may recognize valuation adjustments or record other related charges on our DMG business in the future. For example, in the third and fourth quarters of 2018, we recognized valuation adjustments with respect to DMG based on an updated assessment of fair value, which includes inputs such as the transaction itself, risks and timing, and performance of the business, and we recorded associated goodwill impairment charges in the fourth quarter of 2018. For additional information regarding the risks we face related to the pending sale of DMG, see the discussion in the risk factors under the heading "Risk factors related to the sale of DMG."

DMG's Medicare Advantage revenues may continue to be volatile in the future, which could have a material adverse impact on DMG's business, results of operations, financial condition and cash flows.

The ACA contains a number of provisions that negatively impact Medicare Advantage plans, each of which could have a material adverse effect on DMG's business, results of operations, financial condition and cash flows. These provisions include the following:

- Medicare Advantage benchmarks for 2011 were frozen at 2010 levels. From 2012 through 2016, Medicare Advantage benchmark rates were phased down from prior levels. The new benchmarks were fully phased-in in 2017 and range between 95% and 115% of the Medicare Fee-for-Service (Medicare FFS) costs, depending on a plan's geographic area. If our costs escalate faster than can be absorbed by the level of revenues implied by these benchmark rates, then it could have a material adverse effect on DMG's business and results of operations.
- Rebates received by Medicare Advantage plans that were reduced, with larger reductions for plans failing to receive certain quality ratings.
- The Secretary of the HHS has been granted the explicit authority to deny Medicare Advantage plan bids that propose significant increases in cost sharing or decreases in benefits. If the bids submitted by plans contracted with DMG are denied, this could have a material adverse effect on DMG's business and results of operations.
- Medicare Advantage plans with medical loss ratios below 85% are required to pay a rebate to the Secretary of HHS. The rebate amount is the total revenue under the contract year multiplied by the difference between 85% and the plan's actual medical loss ratio. The Secretary of HHS will halt enrollment in any plan failing to meet this ratio for three consecutive years, and terminate any plan failing to meet the ratio for five consecutive years. If a DMG-contracting Medicare Advantage plan experiences a limitation on enrollment or is otherwise terminated from the Medicare Advantage program, it could have a material adverse effect on DMG's business and results of operations.
- Prescription drug plans are required to provide coverage of certain drug categories on a list developed by the Secretary of HHS, which could increase the cost of providing care to Medicare Advantage enrollees, and thereby reduce DMG's revenues and earnings. The Medicare Part D premium amount subsidized for high-income beneficiaries has been reduced, which could lower the number of Medicare Advantage enrollees, which would have a negative impact on DMG's business and results of operations.
- CMS increased coding intensity adjustments for Medicare Advantage plans beginning in 2014 and continuing through 2019, which reduces CMS payments to Medicare Advantage plans, which in turn will likely reduce the amounts payable to DMG and its associated physicians, physician groups, and IPAs under its capitation agreements.

Recent legislative, judicial and executive efforts to enact further healthcare reform legislation have caused the future state of the exchanges, other ACA reforms, and many core aspects of the current U.S. health care system to be unclear. While specific changes and their timing are not yet apparent, enacted reforms and future legislative, regulatory, judicial, or executive changes could have a material adverse effect on DMG's business, results of operations, financial condition and cash flows.

There is also uncertainty regarding both Medicare Advantage payment rates and beneficiary enrollment, which, if reduced, would reduce DMG's overall revenues and net income. For example, although the Congressional Budget Office (CBO) predicted in 2010 that Medicare Advantage participation would drop substantially by 2020, the CBO has more recently predicted, without taking into account potential future reforms, that enrollment in Medicare Advantage (and other contracts covering Medicare Parts A and B) could reach 31 million by 2027. Although Medicare Advantage enrollment increased by approximately 5.6 million, or by 50%, between the enactment of the ACA in 2010 and 2015, there can be no assurance that this trend will continue. Further, fluctuation in Medicare Advantage payment rates are evidenced by CMS's annual announcement of the expected average change in revenue from the prior year: for 2018, CMS announced an average increase of 0.45%; and for 2019, 3.4%. Uncertainty over Medicare Advantage enrollment and payment rates present a continuing risk to DMG's business.

According to the Kaiser Family Foundation (KFF), Medicare Advantage enrollment continues to be highly concentrated among a few payors, both nationally and in local regions. In 2018, the KFF reported that three payors together accounted for more than half of Medicare Advantage enrollment and seven firms accounted for approximately 75% of the lives. Consolidation among Medicare Advantage plans in certain regions, or the Medicare program's failure to attract additional plans to participate in the Medicare Advantage program, could have a material

adverse effect on DMG's business, results of operations, financial condition and cash flows.

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

For the year ended December 31, 2018, 69% of DMG's consolidated capitated medical revenues were earned through contracts with three health plans.

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

Notwithstanding each health plan's and DMG's current shared interest in providing service to DMG's members who are enrolled in the subject health plans, the health plans may have different and, at times, opposing economic interests from those of DMG. The health plans provide a wide range of health insurance services across a wide range of geographic regions, utilizing a vast network of providers. As a result, they and DMG may have different views regarding the proper pricing of services and/or the proper pricing of the various service providers in their provider networks, the cost of which DMG bears to the extent that the services of such service providers are utilized. These health plans may also have different views than DMG regarding the efforts and expenditures that they, DMG, and/or other service providers should make to achieve and/or maintain various quality ratings. In addition, several health plans have acquired or announced their intent to acquire provider organizations. If health plans with which DMG contracts acquire a significant number of provider organizations, they may not continue to contract with DMG or contract on less favorable terms or seek to prevent DMG from acquiring or entering into arrangements with certain providers. Similarly, as a result of changes in laws, regulations, consumer preferences, or other factors, the health plans may find it in their best interest to provide health insurance services pursuant to another payment or reimbursement structure. In the event DMG's interests diverge from the interests of the health plans, DMG may have limited recourse or alternative options in light of its dependence on these health plans. There can be no assurances that DMG will continue to find it mutually beneficial to work with these health plans. As a result of various restrictive provisions that appear in some of the managed care agreements with health plans, DMG may at times have limitations on its ability to cancel an agreement with a particular health plan and immediately thereafter contract with a competing health plan with respect to the same service area.

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

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

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

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

To expand the operations of its network outside of the Existing Geographic Regions, DMG must devote resources to identify and explore perceived opportunities. Thereafter, DMG must, among other things, recruit and retain qualified

personnel, develop new offices, establish potential new relationships with one or more health plans, and establish new relationships with physicians and other healthcare providers. The ability to establish such new relationships may be significantly inhibited by competition for such relationships and personnel in the healthcare marketplace in the targeted new geographic regions. Additionally, DMG may face the risk that a substantial portion of the patients served in a new geographic area may be enrolled

in a Medicare FFS program and will not desire to transition to a Medicare Advantage program, such as those offered through the health plans that DMG serves, or they may enroll with other health plans with which DMG does not contract to receive services, which could reduce substantially DMG's perceived opportunity in such geographic area. In addition, if DMG were to seek to expand outside of the Existing Geographic Regions, DMG would be required to comply with laws and regulations of states that may differ from the ones in which it currently operates, and could face competitors with greater knowledge of such local markets. DMG anticipates that any geographic expansion may require it to make a substantial investment of management time, capital and/or other resources. There can be no assurance that DMG will be able to establish profitable operations or relationships in any new geographic markets.

Reductions in the quality ratings of the health plans DMG serves could have a material adverse effect on its business, results of operations, financial condition and cash flows.

As a result of the ACA, the level of reimbursement each health plan receives from CMS is dependent, in part, upon the quality rating of the Medicare plan. Such ratings impact the percentage of any cost savings rebate and any bonuses earned by such health plan. Since a significant portion of DMG's revenue is expected to be calculated as a percentage of CMS reimbursements received by these health plans with respect to DMG members, reductions in the quality ratings of a health plan that DMG serves could have a material adverse effect on its business, results of operations, financial condition and cash flows.

Given each health plan's control of its plans and the many other providers that serve such plans, DMG believes that it will have limited ability to influence the overall quality rating of any such plan. The BBA passed in February 2018 implements certain changes to prevent artificial inflation of star ratings for Medicare Advantage plans offered by the same organization. In addition, CMS has terminated plans that have had a rating of less than three stars for three consecutive years, whereas Medicare Advantage plans with five stars are permitted to conduct enrollment throughout almost the entire year. Because low quality ratings can potentially lead to the termination of a plan that DMG serves, DMG may not be able to prevent the potential termination of a contracting plan or a shift of patients to other plans based upon quality issues which could, in turn, have a material adverse effect on DMG's business, results of operations, financial condition and cash flows.

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

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

In September 2018, we entered into a settlement agreement with the DOJ and OIG to resolve matters related to our and our subsidiaries' (including DMG and its subsidiary JSA) provision of services to Medicare Advantage plans and related patient diagnosis coding and risk adjustment submissions and payments. See Note 17 to the consolidated financial statements included in this report for further details and discussions of legal proceedings elsewhere in these Risk Factors.

Additionally, CMS audits Medicare Advantage plans for documentation to support RAF-related payments for members chosen at random. The Medicare Advantage plans ask providers to submit the underlying documentation for members that they serve. It is possible that claims associated with members with higher RAF scores could be subject

to more scrutiny in a CMS or plan audit. There is a possibility that a Medicare Advantage plan may seek repayment from DMG should CMS make any payment adjustments to the Medicare Advantage plan as a result of its audits. The plans also may hold DMG liable for any penalties owed to CMS for inaccurate or unsupportable RAF scores provided by DMG. In addition, DMG could be liable for penalties to the government under the FCA that range from $5,500 to $11,000 (adjusted for inflation) for each false claim, plus up to three times the amount of damages caused by each false claim, which can be as much as the amounts received directly or indirectly from the government for each such false claim. On January 29, 2018, the DOJ issued a final rule announcing

adjustments to FCA penalties, under which the per claim penalty range increases to a range from $11,181 to $22,363 for penalties assessed after January 29, 2018, so long as the underlying conduct occurred after November 2, 2015. CMS has indicated that payment adjustments will not be limited to RAF scores for the specific Medicare Advantage enrollees for which errors are found but may also be extrapolated to the entire Medicare Advantage plan subject to a particular CMS contract. CMS has described its audit process as plan-year specific and stated that it will not extrapolate audit results for plan years prior to 2011. Because CMS has not stated otherwise, there is a risk that payment adjustments made as a result of one plan year's audit would be extrapolated to prior plan years after 2011. There can be no assurance that a health plan will not be randomly selected or targeted for review by CMS or that the outcome of such a review will not result in a material adjustment in DMG's revenue and profitability, even if the information DMG submitted to the plan is accurate and supportable.

A failure to accurately estimate incurred but not reported medical expense could adversely affect DMG's results of operations.

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

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

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

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

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

Managed care companies offer alternative products such as regional preferred provider organizations (PPOs) and private FFS plans. Medicare PPOs and private FFS plans allow their patients more flexibility in selecting physicians than Medicare Advantage health plans, which typically require patients to coordinate care with a primary care physician. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 has encouraged the

- creation of regional PPOs through various incentives, including certain risk corridors, or cost reimbursement provisions, a stabilization fund for incentive payments, and special payments to hospitals not otherwise contracted with a Medicare Advantage plan that treat regional plan enrollees. The formation of regional Medicare PPOs and private FFS plans may affect DMG's relative attractiveness to existing and potential Medicare patients in their service areas.
- The payments for the local and regional Medicare Advantage plans are based on a competitive bidding process that may indirectly cause a decrease in the amount of the PMPM fee or result in an increase in benefits offered.

The annual enrollment process and subsequent lock-in provisions of the ACA may adversely affect DMG's level of

- revenue growth as it will limit the ability of a health plan to market to and enroll new Medicare beneficiaries in its established service areas outside of the annual enrollment period.

CMS allows Medicare beneficiaries who are enrolled in a Medicare Advantage plan with a quality rating of 4.5 stars

- or less to enroll in a 5-star rated Medicare Advantage plan at any time during the benefit year. Therefore, DMG may face a competitive disadvantage in recruiting and retaining Medicare beneficiaries.

In addition to the competitive threats intrinsic to the Medicare programs, competition among health plans and among healthcare providers may also have a negative impact on DMG's profitability. For example, due to the large

population of

Medicare beneficiaries, DMG's Existing Geographic Regions have become increasingly attractive to health plans that may compete with DMG. DMG may not be able to continue to compete profitably in the healthcare industry if additional competitors enter the same market. If DMG cannot compete profitably, the ability of DMG to compete with other service providers that contract with competing health plans may be substantially impaired. Furthermore, if DMG is unable to obtain new members or experiences a loss of existing members to competitors during the open enrollment period for Medicare it could have a material adverse effect on DMG's business, results of operations, financial condition and cash flows.

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

A disruption in DMG's healthcare provider networks could have a material adverse effect on DMG's operations and profitability.

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

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

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

Participation in ACO programs is subject to federal regulation, supervision, and evolving regulatory developments that may result in financial liability.

The ACA established the Medicare Shared Savings Program (MSSP) for ACOs, which took effect in January 2012. Under the MSSP, eligible organizations are accountable for the quality, cost and overall care of Medicare beneficiaries assigned to an ACO and may be eligible to share in any savings below a specified benchmark amount. The Secretary of HHS is also authorized, but not required, to use capitation payment models with ACOs. CMS has also implemented the Next Generation ACO model, which allows the ACO to assume higher levels of financial risk and reward than under the MSSP program. DMG has formed an MSSP ACO through a subsidiary in New Mexico and a Next Generation ACO (previously an MSSP ACO) through a subsidiary in California, and is evaluating whether to participate in more ACOs in the future. The continued development and expansion of ACOs, and potential changes to the participation requirements in ACOs, will have an uncertain impact on DMG's revenue and profitability. DaVita Kidney Care is also participating as a dialysis provider in Arizona, Florida, New Jersey, and Pennsylvania for the Innovation Center's CEC Model. Further, in December 2018, CMS issued a final rule for the MSSP, which among other things, requires ACOs to accept a two-sided risk model (as opposed to a one-sided model), wherein ACOs need

to share in the financial risk of their patients' healthcare spending (*i.e.*, shared losses) in addition to shared savings. This rule could negatively impact the revenue and profitability of DMG's MSSP ACO.

The ACO programs are relatively new and therefore operational and regulatory guidance is limited. It is possible that the operations of DMG's subsidiary ACOs may not fully comply with current or future regulations and guidelines applicable to ACOs, may not achieve quality targets or cost savings, or may not attract or retain sufficient physicians or patients to allow

DMG to meet its objectives. Additionally, poor performance could put the DMG ACOs at financial risk with a potential obligation to CMS. Traditionally, other than fee-for-service billing by the medical clinics and healthcare facilities offered by DMG, DMG has not directly contracted with CMS and has not operated any health plans or provider sponsored networks. Therefore, DMG may not have the necessary experience, systems or compliance to successfully achieve a positive return on its investment in the ACOs or to avoid financial or regulatory liability. DMG believes that its historical experience with fully delegated managed care will be applicable to operation of its subsidiary ACOs, but there can be no such assurance.

California hospitals may terminate their agreements with HealthCare Partners Affiliates Medical Group and DaVita Health Plan of California, Inc. (formerly HealthCare Partners Plan, Inc., and, together with HealthCare Partners Affiliates Medical Group (AMG)) or reduce the fees they pay to DMG.

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

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

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

Changes in the rates or methods of third-party reimbursements may materially adversely affect DMG's business, results of operations, financial condition and cash flows.

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

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

DMG depends on a complex, specialized, and integrated management information system and standardized procedures for operational and financial information, as well as for DMG's billing operations. DMG may experience

unanticipated delays, complications or expenses in implementing, integrating, and operating these integrated systems. Moreover, DMG may be unable to enhance its existing management information system or implement new management information systems where necessary. DMG's management information system may require modifications, improvements or replacements that may require both substantial expenditures as well as interruptions in operations. DMG's ability to implement and operate its integrated systems is subject to the availability of information technology and skilled personnel to assist DMG in creating and maintaining these systems.

DMG's failure to successfully implement and maintain all of its systems could have a material adverse effect on its business, results of operations, financial condition and cash flows. For example, DMG's failure to successfully operate its billing systems could lead to potential violations of healthcare laws and regulations. If DMG is unable to handle its claims volume, or if DMG is unable to pay claims timely, DMG may become subject to a health plan's corrective action plan or de-delegation until the problem is corrected, and/or termination of the health plan's agreement with DMG. This could have a material adverse effect on DMG's operations and profitability. In addition, if DMG's claims processing system is unable to process claims accurately, the data DMG uses for its incurred but not reported estimates could be incomplete and DMG's ability to accurately estimate claims liabilities and establish adequate reserves could be adversely affected. Finally, if DMG's management information systems are unable to function in compliance with applicable state or federal rules and regulations, including medical information confidentiality laws such as HIPAA, possible penalties and fines due to this lack of compliance could have a material adverse effect on DMG's results of operations, financial condition and cash flows.

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

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

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

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

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

Risk factors related to ownership of our common stock:

Provisions in our charter documents, compensation programs and Delaware law may deter a change of control that our stockholders would otherwise determine to be in their best interests.

Our charter documents include provisions that may deter hostile takeovers, delay or prevent changes of control or changes in our management, or limit the ability of our stockholders to approve transactions that they may otherwise determine to be in their best interests. These include provisions prohibiting our stockholders from acting by written consent; requiring 90 days advance notice of stockholder proposals or nominations to our Board of Directors (or 120 days for nominations made using proxy access); and granting our Board of Directors the authority to issue preferred stock and to determine the rights and preferences of the preferred stock without the need for further stockholder approval.

Most of our outstanding employee stock-based compensation awards include a provision accelerating the vesting of the awards in the event of a change of control. We also maintain a change of control protection program for our employees who do not have a significant number of stock awards, which has been in place since 2001, and which

provides for cash bonuses to the employees in the event of a change of control. Based on the market price of our common stock and shares outstanding on December 31, 2018, these cash bonuses under the program would total approximately $337 million if a change of control

transaction occurred at that price and our Board of Directors did not modify this program. These and any other change of control provisions may affect the price an acquirer would be willing to pay for our Company.

We are also subject to Section 203 of the Delaware General Corporation Law that, subject to exceptions, would prohibit us from engaging in any business combinations with any interested stockholder, as defined in that section, for a period of three years following the date on which that stockholder became an interested stockholder.

These provisions may discourage, delay or prevent an acquisition of our Company at a price that our stockholders may find attractive. These provisions could also make it more difficult for our stockholders to elect directors and take other corporate actions and could limit the price that investors might be willing to pay for shares of our common stock.

Item 1B. Unresolved Staff Comments.

None.

Item 2. Properties.

Our corporate headquarters are located in Denver, Colorado, consisting of one owned 240,000 square foot building and one leased location consisting of 345,900 square feet. Our headquarters are occupied by teammates engaged in management, finance, marketing, strategy, legal, compliance and other administrative functions. We lease seven business offices located in California, Colorado, Pennsylvania, Tennessee and Washington for our U.S. dialysis services business. For our DMG business we lease 11 business offices located in California, Colorado, Nevada, New Mexico, Florida and Washington. Our laboratory is based in Florida where we operate our lab services out of one leased building. We also own four administrative offices in the U.S. and lease administrative offices worldwide. Our leases on the properties listed above expire at various dates through the year 2037 for Kidney Care and through the year 2033 for DMG.

For our U.S. dialysis and related lab services business we own the land and buildings for 12 of our outpatient dialysis centers. We also own 15 separate land and buildings and 15 land parcels for development. We lease a total of four owned properties to third-party tenants. Our remaining outpatient dialysis centers are located on premises that we lease.

For DMG, we own the land and buildings for 16 of our clinics. We also own one separate land parcel. Our remaining clinics are located on premises that we lease.

The majority of our leases for our U.S. dialysis and related lab services and for DMG cover periods from five years to 15 years and typically contain renewal options of five to ten years at the fair rental value at the time of renewal. Our leases are generally subject to periodic consumer price index increases, or contain fixed escalation clauses. Our outpatient dialysis centers range in size from approximately 900 to 33,000 square feet, with an average size of approximately 7,800 square feet. DMG's clinics range in size from approximately 1,000 to 192,000 square feet, with an average size of approximately 10,400 square feet. Our international leases generally range from one to ten years.

Some of our outpatient dialysis centers are operating at or near capacity. However, we believe that we have adequate capacity within most of our existing dialysis centers to accommodate additional patient volume through increased hours and/or days of operation, or, if additional space is available within an existing facility, by adding dialysis stations. We can usually relocate existing centers to larger facilities or open new centers if existing centers reach capacity. With respect to relocating centers or building new centers, we believe that we can generally lease space at economically reasonable rates in the areas planned for each of these centers, although there can be no assurances in this regard. Expansion of existing centers or relocation of our dialysis centers is subject to review for compliance with conditions relating to participation in the Medicare ESRD program. In states that require a certificate of need or center license, additional approvals would generally be necessary for expansion or relocation.

Item 3. Legal Proceedings.

The information required by this Part I, Item 3 is incorporated herein by reference to the information set forth under the caption "Contingencies" in Note 17 to the consolidated financial statements included in this report.

Item 4. Mine Safety Disclosures.

Not applicable.

PART II

Item 5. Market for the Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities.

Our common stock is traded on the New York Stock Exchange under the symbol DVA. The closing price of our common stock on January 31, 2019 was $56.13 per share. According to Computershare, our registrar and transfer agent, as of January 31, 2019, there were 8,843 holders of record of our common stock. We have not declared or paid cash dividends to holders of our common stock since 1994. We have no current plans to pay cash dividends and we are restricted from paying dividends under the terms of our senior secured credit facilities and the indentures governing our senior notes. See "Liquidity and capital resources" under "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations" and the notes to the consolidated financial statements.

Stock Repurchases

We repurchased a total of 16,844,067 shares for $1,154 million, or an average price of $68.48, during the year ended December 31, 2018. No repurchases were made during the fourth quarter of 2018.

The following tables summarizes our repurchases of our common stock during 2018:

Period	Total Number of Shares Purchased	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Approximate Dollar Value of Shares that May Yet Be Purchased Under the Plans or Programs (in millions)
January 1 - March 31, 2018	4,197,304	$ 71.09	4,197,304	$ 820.7
April 1 - June 30, 2018	7,797,712	$ 65.60	7,797,712	$ 309.2
July 1 - September 30, 2018	4,849,051	$ 70.86	4,849,051	$ 1,355.6
October 1 - December 31, 2018	—	$ —	—	$ 1,355.6
Total	16,844,067	$ 68.48	16,844,067	

On July 11, 2018 our Board of Directors approved an additional share repurchase authorization in the amount of $1,390 million. This share repurchase authorization was in addition to the $110 million remaining at that time under our Board of Directors' prior share repurchase authorization approved in October 2017. We are authorized to make purchases from time to time in the open market or in privately negotiated transactions, including without limitations, through accelerated share repurchase transactions, derivative transactions, tender offers, Rule 10b5-1 plans or any combination of the foregoing, depending upon market conditions and other considerations.

During the quarter ended December 31, 2018, we did not repurchase any shares of our common stock. As of February 22, 2019, we have a total of $1,356 million remaining in Board authorizations available for share repurchases under our repurchase programs. Although these share repurchase authorizations have no expiration dates, we are subject to share repurchase limitations under the terms of our senior secured credit facilities and the indentures governing our senior notes.

Item 6. Selected Financial Data.

The following financial and operating data should be read in conjunction with "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations" and our consolidated financial statements filed as part of this report. The following table presents selected consolidated financial and operating data for the periods indicated.

	Year ended December 31,				
	2018	2017	2016	2015	2014
	(in thousands, except share data)				
Income statement data:					
Net revenues[1]	$11,404,851	$10,876,634	$10,707,467	$9,982,245	$9,312,049
Operating expenses and charges[2]	9,879,027	9,063,879	8,677,757	8,845,479	7,711,891
Operating income	1,525,824	1,812,755	2,029,710	1,136,766	1,600,158
Debt expense	(487,435)	(430,634)	(414,116)	(408,380)	(410,223)
Debt refinancing and redemption charges	—	—	—	(48,072)	(97,548)
Other income, net	10,089	17,665	7,511	8,073	1,935
Income from continuing operations before income taxes	1,048,478	1,399,786	1,623,105	688,387	1,094,322
Income tax expense[3]	258,400	323,859	431,761	207,510	366,894
Net income from continuing operations	790,078	1,075,927	1,191,344	480,877	727,428
Net (loss) income from discontinued operations, net of tax[4]	(457,038)	(245,372)	(158,262)	(53,467)	135,902
Net income	333,040	830,555	1,033,082	427,410	863,330
Less: Net income attributable to noncontrolling interests	(173,646)	(166,937)	(153,208)	(157,678)	(140,216)
Net income attributable to DaVita Inc.	$159,394	$663,618	$879,874	$269,732	$723,114
Basic income from continuing operations per share attributable to DaVita Inc.[5]	$3.66	$4.78	$5.12	$1.53	$2.77
Diluted income from continuing operations per share attributable to DaVita Inc.[5]	$3.62	$4.71	$5.04	$1.49	$2.71
Weighted average shares outstanding:[5]					
Basic	170,785,999	188,625,559	201,641,173	211,867,714	212,301,827
Diluted	172,364,581	191,348,533	204,904,656	216,251,807	216,927,681
Balance sheet data:					
Working capital[6]	$3,532,998	$5,703,181	$1,283,784	$2,104,143	$1,547,518
Total assets[6]	$19,110,252	$18,974,536	$18,755,776	$18,524,224	$17,624,137
Long-term debt[6]	$8,172,847	$9,158,018	$8,944,676	$12,972,282	$8,298,624
Total DaVita Inc. shareholders' equity[5]	$3,703,442	$4,690,029	$4,648,047	$4,870,781	$5,170,513

(1) On January 1, 2018, we adopted *Revenue from Contracts with Customers* (Topic 606) using the cumulative effect method for those contracts that were not substantially completed as of January 1, 2018. Results related to performance obligations satisfied beginning on and after January 1, 2018 are presented under Topic 606, while results related to the satisfaction of performance obligations in prior periods continue to be reported in accordance with our historical accounting under *Revenue Recognition* (Topic 605). See Notes 1 and 2 of the consolidated financial statements for disclosure on our adoption of Topic 606.

(2) Operating expenses and charges in 2018 included a net gain on changes in ownership interests of $60,603; other asset impairment charges of $17,338 and restructuring charges of $11,366 related to our pharmacy business; an equity investment loss due to the sale of India in our APAC JV of $8,715; an equity investment loss related to impairments at our APAC JV of $7,525; and a goodwill impairment charge of $3,106. Operating expenses and charges for 2017 included goodwill impairment charges of $34,696 related to our vascular access reporting unit; an equity investment loss of $6,293 for goodwill impairments at our APAC JV; an impairment of $280,066 on our investment in the APAC JV; an asset impairment of $15,168 related to the restructuring of our pharmacy business; restructuring charges in our international business of $2,700; a net gain on settlement of $529,504; and a gain adjustment on the 2016 ownership change of our APAC JV of $6,273. Operating expenses and charges in 2016 included goodwill impairment charges of $28,415 related to our vascular access reporting unit; an impairment of an investment of $14,993; an estimated gain on the ownership change of our APAC JV of $374,374; and estimated accruals for certain legal matters of $15,770. Operating expenses and charges for 2015 included a settlement charge of $495,000 related to a private

civil suit; goodwill impairment charges of $4,066 related to our international business; and an estimated accrual for certain legal matters of $22,530. Operating expenses and charges in 2014 included an additional $17,000 loss contingency accrual related to the settlement of the 2010 and 2011 U.S. Attorney physician relationship investigations.

(3) Tax expense for 2017 included a net tax benefit of $251,510 related to U.S. tax legislation passed in December 2017.

(4) In December 2017, we entered into an equity purchase agreement to sell our DMG division to Collaborative Care Holdings, LLC (Optum), a subsidiary of UnitedHealth Group Inc. As a result of this pending transaction, the DMG business has been classified as held for sale and its results of operations are reported as net (loss) income from discontinued operations, net of tax for all periods presented. Net (loss) income from discontinued operations, net of tax, in 2018 included a $468,005 charge on our DMG business which included a $316,840 valuation adjustment, a $41,537 goodwill impairment charge and $109,628 in related tax expense on this held for sale business based on an updated assessment of fair value, as well as a gain on changes in ownership interests of $25,096. Net (loss) income from discontinued operations, net of tax, in 2017 includes estimated goodwill impairment charges of $651,659 related to certain DMG reporting units, a net tax benefit of $163,555 due to a remeasurement of deferred taxes resulting from DMG's reclassification to held for sale; a non-cash gain associated with our Magan acquisition of $17,129; restructuring charges of $9,569; and a reduction in estimated accruals for legal matters of $14,700. Net (loss) income from discontinued operations, net of tax, in 2016 included goodwill impairment charges of $253,000 related to certain DMG reporting units; a gain related to the partial sale of our interest in Tandigm of $40,280; a loss on the DMG Arizona sale of $10,489; an adjustment to reduce receivables associated with the DMG acquisition escrow provision relating to income tax items of $30,934; and estimated accruals for legal matters of $16,000. Net (loss) income from discontinued operations, net of tax, in 2015 included estimated goodwill and other intangible asset impairment charges of $206,169 related to certain DMG reporting units.

(5) Share repurchases consisted of 16,844,067 shares of common stock for $1,153,511 in 2018, 12,966,672 shares of common stock for $810,949 in 2017, 16,649,090 shares of common stock for $1,072,377 in 2016, and 7,779,958 shares of common stock for $575,380 in 2015. No repurchases of common stock were made in 2014. Shares issued in connection with stock awards were 371,347 in 2018, 514,091 in 2017, 1,011,328 in 2016, 1,479,217 in 2015, and 2,179,766 in 2014.

(6) In 2015, we retrospectively adopted ASU 2015-03 related to simplification of debt issuance costs as well as ASU 2015-17 related to classification of deferred taxes. All periods prior to 2015 have been recast to conform to the revised presentation.

Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations.

Forward-looking statements

This Annual Report on Form 10-K, including this Management's Discussion and Analysis of Financial Condition and Results of Operations, contains statements that are forward-looking statements within the meaning of the federal securities laws. All statements that do not concern historical facts are forward-looking statements and include, among other things, statements about our expectations, beliefs, intentions and/or strategies for the future. These forward-looking statements may include statements regarding our future operations, financial condition and prospects, such as expectations for treatment growth rates, revenue per treatment, expense growth, levels of the provision for uncollectible accounts receivable, operating income, cash flow, operating cash flow, earnings per share, estimated tax rates, estimated charges and accruals, capital expenditures, the development of new dialysis centers and dialysis center acquisitions, government and commercial payment rates, revenue estimating risk, the impact of our level of indebtedness on our financial performance, our stock repurchase program, our advocacy costs, and the pending DMG sale transaction. These statements involve substantial known and unknown risks and uncertainties that could cause our actual results to differ materially from those described in the forward-looking statements, including risks resulting from the concentration of profits generated by higher-paying commercial payor plans for which there is continued downward pressure on average realized payment rates, and a reduction in the number of patients under such plans, including as a result of restrictions or prohibitions on the use and/or availability of charitable premium assistance, which may result in the loss of revenues or patients, or our making incorrect assumptions about how our patients will respond to any change in financial assistance from charitable organizations; the extent to which the ongoing implementation of healthcare exchanges or changes in or new legislation, regulations or guidance, or enforcement thereof, including among other things those regarding the exchanges, results in a reduction in reimbursement rates for our services from and/or the number of patients enrolled in higher-paying commercial plans; a reduction in government payment rates under the Medicare End Stage Renal Disease program or other government-based programs; the impact of the Medicare Advantage benchmark structure; risks arising from potential and proposed federal and/or state legislation, regulation or ballot or other initiatives, including healthcare-related and labor-related legislation, regulation or ballot or other initiatives; the impact of the changing political environment and related developments on the current health care marketplace and on our business, including with respect to the future of the Affordable Care Act, the exchanges and many other core aspects of the current health care marketplace; uncertainties related to the impact of federal tax reform legislation; changes in pharmaceutical practice patterns, reimbursement and payment policies and processes, or pharmaceutical pricing, including with respect to calcimimetics; legal compliance risks, such as our continued compliance with complex government regulations and the provisions of our current Corporate Integrity Agreement (CIA) and current or potential investigations by various government entities and related government or private party proceedings, and restrictions on our business and operations required by our CIA and other current or potential settlement terms and the financial impact thereof and our ability to recover any losses related to such legal matters from third parties; continued increased competition from dialysis providers and others, and other potential marketplace changes; our ability to reduce administrative expenses while maintaining targeted levels of service and operating performance, including our ability to achieve anticipated savings from our recent restructurings; our ability to maintain contracts with physician medical directors, changing affiliation models for physicians, and the emergence of new models of care introduced by the government or private sector that may erode our patient base and reimbursement rates, such as accountable care organizations (ACOs), independent practice associations (IPAs) and integrated delivery systems; our ability to complete acquisitions, mergers or dispositions that we might announce or be considering, on terms favorable to us or at all, or to integrate and successfully operate any business we may acquire or have acquired, or to successfully expand our operations and services in markets outside the United States, or to businesses outside of dialysis; noncompliance by us or our business associates with any privacy laws or any security breach by us or a third party involving the misappropriation, loss or other unauthorized use or disclosure of confidential information; the variability of our cash flows; the risk that we may not be able to generate sufficient cash in the future to service our indebtedness or to fund our other liquidity needs, and the risk that we may not be able to refinance our indebtedness as it becomes due, on terms favorable to us or at all; factors that may impact our ability to repurchase stock under our stock repurchase

program and the timing of any such stock repurchases, including market conditions, the price of our common stock, our cash flow position, borrowing capacity and leverage ratios, and legal, regulatory and contractual requirements; the risk that we might invest material amounts of capital and incur significant costs in connection with the growth and development of our international operations, yet we might not be able to consistently operate them profitably anytime soon, if at all; risks arising from the use of accounting estimates, judgments and interpretations in our financial statements; impairment of our goodwill, investments or other assets; the risks and uncertainties associated with the timing, conditions and receipt of regulatory approvals and satisfaction of other closing conditions of the DMG sale transaction and continued disruption in connection with the DMG sale transaction making it more difficult to maintain business and operational relationships; risks and uncertainties related to our ability to complete the DMG sale transaction on the timetable expected, and on the terms set forth in the equity purchase agreement or at all; uncertainties related to our liquidity following the close of the DMG sale transaction and our planned subsequent entry into new external financing arrangements, which may be less than we anticipate; uncertainties related to our use of the proceeds from the DMG sale transaction and other available

funds, including external financing and cash flow from operations, which may be used in ways that may not improve our results of operations or enhance the value of our common stock; risks related to certain contractual restrictions on the conduct of DMG's business while the DMG sale transaction is pending; the risk that we may recognize additional valuation adjustments or goodwill impairment related to DMG; the risk that laws regulating the corporate practice of medicine could restrict the manner in which DMG conducts its business; the risk that the cost of providing services under DMG's agreements may exceed our compensation; the risk that any reductions in reimbursement rates, including Medicare Advantage rates, and future regulations may negatively impact DMG's business, revenue and profitability; the risk that DMG may not be able to successfully establish a presence in new geographic regions or successfully address competitive threats that could reduce its profitability; the risk that a disruption in DMG's healthcare provider networks could have an adverse effect on DMG's business operations and profitability; the risk that reductions in the quality ratings of health plans DMG serves or healthcare services that DMG provides could have an adverse effect on DMG's business; the risk that health plans that acquire health maintenance organizations may not be willing to contract with DMG or may be willing to contract only on less favorable terms; and the other risk factors set forth in Part I, Item 1A. of this Annual Report on Form 10-K. We base our forward-looking statements on information currently available to us, and we undertake no obligation to update or revise any forward-looking statements, whether as a result of changes in underlying factors, new information, future events or otherwise.
The following should be read in conjunction with our consolidated financial statements.

Company overview

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

In December 2017, we entered into an equity purchase agreement to sell our DMG division to Optum, a subsidiary of UnitedHealth Group Inc., subject to receipt of required regulatory approvals and other customary closing conditions. As a result, the DMG business has been classified as held for sale and its results of operations are reported as discontinued operations for all periods presented and DMG is not included in our Management's Discussion and Analysis below.

Our overall financial performance in 2018 benefited from the administration of calcimimetics, increased treatment volume from acquired and non-acquired growth in both our U.S. dialysis and related lab services and our international businesses, and a corresponding increase in revenue. This was offset by increases in labor costs, benefit costs due to the implementation of a 401(k) matching program, pharmaceutical costs due to the administration of calcimimetics, other center related costs and advocacy costs to counter certain union policy initiatives.

Some of our major accomplishments and financial operating performance indicators in 2018 and year over year were as follows:

- improved key clinical outcomes in our U.S. dialysis operations, including that we were an industry leader for the sixth consecutive year in CMS' Quality Incentive Program and for the last five years under the CMS Five-Star Quality Rating system;
- consolidated net revenue growth of 4.9%, which included 10.4% net revenue growth in our U.S. dialysis segment, an increase of $20 in average dialysis net patient service revenue per treatment and international revenue growth of 36%, partially offset by a decrease in revenue of 41% in our U.S. ancillary services and strategic initiatives segment due to the restructuring of DaVita Rx;
- solid performance in our normalized non-acquired U.S. dialysis treatment growth of 3.2%, which contributed to an increase of approximately 4.1% in the overall number of U.S. dialysis treatments;
- a net increase of 154 U.S. dialysis centers and a net increase of 4 international dialysis centers;
- an increase in the overall number of patients we serve of approximately 2.5% in the U.S. and 9.3% internationally in 2018;
- repurchased 16,844,067 shares of our common stock for $1.2 billion;
- Proposition 8, a California state-wide ballot initiative that sought to limit the amount of revenue dialysis providers could retain from caring for patients with commercial insurance, was defeated in California; and
- consolidated operating cash flows of $1.8 billion, or $1.5 billion from continuing operations.

We believe we will face challenges in 2019 similar to those we faced in 2018. We expect to see an increase in dialysis treatment volume and expect U.S. dialysis revenue per treatment to be up slightly from 2018. We expect revenue per treatment to be favorably impacted by an increase in Medicare ESRD rates of approximately 1.2%, offset by anticipated downward pressure on commercial payor rates due to a shift of out-of-network patients to in-network. We expect patient care costs to increase due to inflation and a tight labor market and do not foresee an opportunity to fully offset these pressures with productivity or pharmaceutical cost improvements. In addition, we expect to continue to incur advocacy costs in connection with union policy initiatives, such as AB 290 in California and other potential ballot or other legislative initiatives. As a result of expected costs continuing to outpace our expected revenue increases, we anticipate that margins will continue to experience pressure. We remain committed to our plans for international expansion in certain regions, which will continue to require investment.

Following is a summary of our consolidated operating results for reference in the discussion that follows.

	Year ended December 31,					
	2018		2017		2016	
	(dollars in millions)					
Revenues[1]:						
Dialysis and related lab patient service revenues	$10,710		$10,094		$9,727	
Less: Provision for uncollectible accounts	(50)		(485)		(431)	
Net dialysis and related lab patient service revenues	10,660		9,608		9,296	
Other revenues	744		1,268		1,411	
Total consolidated revenues	11,405	100 %	10,877	100 %	10,707	100 %
Operating expenses and charges:						
Patient care costs	8,196	72 %	7,640	70 %	7,432	69 %
General and administrative	1,135	10 %	1,064	10 %	1,073	10 %
Depreciation and amortization	591	5 %	560	5 %	509	5 %
Provision for uncollectible accounts	(7)	— %	(7)	— %	12	— %
Equity investment loss (income)	4	— %	9	— %	(17)	— %
Investment and other asset impairments	17	— %	295	3 %	15	— %
Goodwill impairment charges	3	— %	36	— %	28	— %
Gain on changes in ownership interests	(61)	(1)%	(6)	— %	(374)	(3)%
Gain on settlement, net	—	— %	(527)	(5)%	—	— %
Total operating expenses and charges	9,879	87 %	9,064	83 %	8,678	81 %
Operating income	$1,526	13 %	$1,813	17 %	$2,030	19 %

Certain columns, rows or percentages may not sum or recalculate due to the use of rounded numbers.

(1) On January 1, 2018, we adopted *Revenue from Contracts with Customers* (Topic 606) using the cumulative effect method for those contracts that were not substantially completed as of January 1, 2018. Results related to performance obligations satisfied beginning on and after January 1, 2018 are presented under Topic 606, while results related to the satisfaction of performance obligations in prior periods continue to be reported in accordance with our historical accounting under *Revenue Recognition* (Topic 605). See Notes 1 and 2 of the consolidated financial statements for further discussion of our adoption of Topic 606.

The following table summarizes our consolidated revenues among our reportable segments:

	Year ended December 31,		
	2018	2017	2016
	(dollars in millions)		
Revenues[1]:			
U.S. dialysis and related lab patient service revenues	$10,367	$9,822	$9,551
Provision for uncollectible accounts	(51)	(482)	(430)
U.S. dialysis and related lab net patient service revenues	10,316	9,340	9,121
Other revenues	20	20	17
Total net U.S. dialysis and related lab services revenues	10,336	9,360	9,138
Other-ancillary services and strategic initiatives other revenues	759	1,273	1,420
Other-ancillary services and strategic initiatives patient service revenues, net	437	323	202
Total net other-ancillary services and strategic initiatives revenues	1,196	1,596	1,621
Total net segment revenues	11,532	10,956	10,759
Elimination of intersegment revenues	(127)	(80)	(52)
Consolidated revenues	$11,405	$10,877	$10,707

Certain columns, rows or percentages may not sum or recalculate due to the use of rounded numbers.

(1) On January 1, 2018, we adopted *Revenue from Contracts with Customers* (Topic 606) using the cumulative effect method for those contracts that were not substantially completed as of January 1, 2018. Results related to performance obligations satisfied beginning on

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and after January 1, 2018 are presented under Topic 606, while results related to the satisfaction of performance obligations in prior periods continue to be reported in accordance with our historical accounting under *Revenue Recognition* (Topic 605). See Notes 1 and 2 of the consolidated financial statements for further discussion of our adoption of Topic 606.

The following table summarizes our consolidated operating income and adjusted consolidated operating income:

	Year ended December 31,		
	2018	2017	2016
	(dollars in millions)		
Operating income (loss):			
U.S. dialysis and related lab services	$1,710	$2,297	$1,777
Other — ancillary services and strategic initiatives	(94)	(439)	267
Corporate administrative support	(90)	(45)	(14)
Operating income	$1,526	$1,813	$2,030
Reconciliation of non-GAAP measure:			
Operating expenses:			
Goodwill impairment charges	$3	$35	$28
Impairment of assets	17	15	—
Impairment of investment	—	280	15
Gain on changes in ownership interests, net	(61)	(6)	(374)
Gain on settlement, net	—	(527)	—
Equity investment loss (income):			
Loss due to business sale in APAC JV	9	—	—
Loss due to impairments in APAC JV	8	6	—
Loss related to restructuring charges	—	1	—
Income related to gain on settlement	—	(3)	—
General and administrative expenses:			
Restructuring charges	11	2	—
Accruals for legal matters	—	—	16
Adjusted operating income[1]	$1,513	$1,616	$1,715

Certain columns, rows or percentages may not sum or recalculate due to the use of rounded numbers.

(1) For the periods presented in the table above adjusted operating income is defined as operating income before certain items which we do not believe are indicative of ordinary results, including goodwill impairment charges, investment and other asset impairments, restructuring charges, a net settlement gain, net gain (loss) on changes in ownership interests and estimated accruals for certain legal matters. Adjusted operating income as so defined is a non-GAAP measure and is not intended as a substitute for GAAP operating income. We have presented these adjusted amounts because management believes that these presentations enhance a user's understanding of our normal consolidated operating income by excluding certain items which we do not believe are indicative of our ordinary results of operations. As a result, adjusting for these amounts allows for comparison to our normalized prior period results.

Consolidated revenues

Consolidated revenues for 2018 increased by approximately $528 million, or 4.9%, from 2017. This increase in consolidated revenues was due to an increase in U.S. dialysis and related lab services revenues of approximately $976 million, principally due to the administration of calcimimetics, an increase in Medicare bad debt revenue, and volume growth from additional treatments in 2018, as discussed below. Revenue for 2018 was negatively impacted by a decrease of approximately $400 million from 2017 in our ancillary services and strategic initiatives driven primarily from decreases in revenue from our pharmacy business due to changes in reimbursement for calcimimetics, as well as restructuring of our pharmacy business, partially offset by an increase in revenues from expansion in our international business and an increase in revenues in DaVita IKC, as described below.

Effective January 1, 2018, both oral and IV forms of calcimimetics, a drug class taken by many patients with ESRD to treat mineral bone disorder, became the financial responsibility of our U.S. dialysis and lab services business for our Medicare

patients and are now reimbursed under Medicare Part B. During an initial pass-through period, Medicare payment for calcimimetics will be based on a pass-through rate of the average sales price plus approximately 4%. CMS has stated intentions to enter calcimimetics into the ESRD bundle two years after transitioning to Part B. Previously, calcimimetics were reimbursed for Medicare patients through Part D once dispensed from traditional pharmacies, including DaVita Rx.

Consolidated revenues for 2017 increased by approximately $170 million, or 1.6%, from 2016. This increase in consolidated revenues was due to an increase in U.S. dialysis and related lab services revenues of approximately $222 million, principally resulting from solid volume growth from additional treatments, partially offset by a decrease of approximately $5 in average dialysis net patient service revenue per treatment and by one less treatment day in 2017, as discussed below. Revenue for 2017 was negatively impacted by a decrease of approximately $25 million from 2016 in our ancillary services and strategic initiatives driven primarily from decreases in revenue from our pharmacy business, partially offset by an increase in revenues from expansion in our international business and increases in DaVita IKC revenues, as described below.

Consolidated operating income

Consolidated operating income of $1.526 billion for 2018, which included a net gain on changes in ownership interests of $61 million, other asset impairment charges of $17 million and restructuring charges of $11 million related to our pharmacy business, an equity investment loss due to the sale of our India business in our APAC JV of $9 million, an equity investment loss related to impairments at our APAC JV of $8 million and a goodwill impairment charge of $3 million, as discussed below, decreased by $287 million as compared to 2017, which included goodwill impairment charges of $35 million related to our vascular access reporting unit, an equity investment loss of $6 million for goodwill impairments at our APAC JV, an impairment of $280 million on our investment in the APAC JV, an asset impairment of $15 million related to the restructuring of our pharmacy business, restructuring charges in our international business of $3 million, a net gain on settlement of $530 million, and a gain adjustment on the 2016 ownership change of our APAC JV of $6 million. Excluding these items from their respective periods, adjusted consolidated operating income for 2018 decreased by approximately $103 million as compared to 2017 due to a decrease in adjusted operating income in U.S. dialysis and related lab services of $86 million, an increase in expenses in our corporate administrative support of $45 million, partially offset by a decrease in adjusted operating losses in our ancillary and strategic initiatives of $29 million, as described below.

Consolidated operating income of $1.813 billion for 2017, which included goodwill impairment charges of $35 million related to our vascular access reporting unit, an equity investment loss of $6 million for goodwill impairments at our APAC JV, an impairment of $280 million on our investment in the APAC JV, an asset impairment of $15 million related to the restructuring of our pharmacy business, restructuring charges in our international business of $3 million, a net gain on settlement of $530 million, and a gain adjustment on the 2016 ownership change of our APAC JV of $6 million, as discussed below, decreased by approximately $217 million from 2016, which included goodwill impairment charges of $28 million, an investment impairment of $15 million, an estimated gain on the ownership change of our APAC JV of $374 million and estimated accruals for legal matters of $16 million. Excluding these items from their respective periods, adjusted consolidated operating income for 2017 decreased by approximately $99 million due to an increase in adjusted operating losses in our ancillary and strategic initiatives of $59 million, an increase in expenses in our corporate administrative support of $31 million, and a decrease in adjusted operating income in U.S. dialysis and related lab services of $9 million, as described below.

U.S. dialysis and related lab services business

Our U.S. dialysis and related lab services business is a leading provider of kidney dialysis services through a network of 2,664 outpatient dialysis centers which we own and manage through management services agreements, in 46 states and the District of Columbia, serving a total of approximately 202,700 patients. We also provide acute inpatient dialysis services in approximately 900 hospitals. We estimate that we have approximately a 37% share of the U.S. dialysis market based upon the number of patients we serve. In 2018, our overall network of U.S. outpatient dialysis centers increased by 154 dialysis centers, primarily as a result of opening new dialysis centers and from acquisitions of existing dialysis centers. The overall number of patients that we serve in the U.S. increased by approximately 2.5% in 2018 as compared to 2017.

The stated mission of our U.S. dialysis and related lab services business is to be the provider, partner and employer of choice. We believe our attention to these three stakeholders—our patients, our business partners, and our teammates—represents a major driver of our long-term performance, although we are subject to the impact of external factors such as government policy, physician practice patterns, commercial payor payment rates and the mix of commercial and government patients, as further described in Item 1A Risk Factors. Two principal non-financial metrics we track are quality clinical outcomes and teammate turnover. We have developed our own composite index for measuring improvements in our clinical outcomes, which we refer to as the DaVita Quality Index. Our key measures for clinical outcomes have improved over each of the past several years. In addition, our patient mortality percentages have decreased from 19.0% in 2001 to 14.0% in 2017. For the sixth year in a row, we were an industry leader in QIP standards and for the last five years, we have been a leader under the

CMS Five-Star Quality Rating system. Over the last two years our clinical teammate turnover has increased slightly due to increased competition for skilled clinical personnel. We will continue to focus on these three stakeholders and our clinical outcomes as we believe these are fundamental long-term value drivers.

We believe our national scale and commitment to our patients, among other things, allows us to provide industry-leading quality care with superior clinical outcomes that attracts patients, referring physicians, and qualified medical directors to our network, which in turn provides our dialysis patient base with a large number of outpatient dialysis centers to choose from with convenient locations and access to a full range of other integrated services, which in turn provides us the ability to effectively and efficiently manage a patient's care and certain costs.

The following graph summarizes our U.S. dialysis patient services revenues by modality for the year ended December 31, 2018:

Approximately 90% of our 2018 consolidated revenues were derived directly from our U.S. dialysis and related lab services business. Approximately 79% of our 2018 dialysis patient services revenues were derived from outpatient hemodialysis services in our 2,630 consolidated U.S. dialysis centers. Other dialysis services, which are operationally integrated with our dialysis operations, are peritoneal dialysis, home-based hemodialysis, hospital inpatient hemodialysis and management and administrative services provided to dialysis centers in which we own a noncontrolling interest or which are wholly owned by third parties. These services collectively accounted for the balance of our 2018 U.S. dialysis and related lab services revenues.

The principal drivers of our U.S. dialysis and related lab services revenues are:

- the number of treatments, which is primarily a function of the number of chronic patients requiring approximately three treatments per week as well as, to a lesser extent, the number of treatments for peritoneal dialysis and home-based dialysis and hospital inpatient dialysis; and
- average dialysis net patient service revenue per treatment, including the mix of commercial and government patients.

Based on the most recent 2018 annual data report from the USRDS, the U.S. ESRD dialysis patient population has grown at an approximate compound rate of 3.8% from 2000 to 2016. The ESRD dialysis patient base has been a relatively stable and growing factor; however, more recent preliminary data from the USRDS suggest that the rate of growth of the ESRD patient population may be declining.

We believe our ability to maintain a stable or growing share of the U.S. dialysis patient base is influenced by the quality of our clinical care, which can lead to reduced patient mortality rates, as described above, our patient, medical director and physician retention, as well as our ability to open and acquire new dialysis centers, among other things. If we experience significant patient attrition as a result of new business activities, new technology or other forms of competition, reduced prevalence of ESRD or other reductions in demand for dialysis treatments, it could have a material adverse effect on our business, results of operations, financial condition and cash flows. For further discussion regarding the competitive pressures we face and related risks, see the risk factor in Item 1A Risk Factors under the heading "If we are unable to compete

successfully, including implementing our growth strategy and/or retaining our physicians and patients, it could materially adversely affect our business, results of operations, financial condition and cash flows."

Our average U.S. dialysis and related lab services net patient service revenue per treatment can be significantly impacted by several major factors, including our commercial payment rates; government payment policies regarding reimbursement amounts for dialysis treatments covered under Medicare's bundled payment rate system, including our ability to capture certain patient characteristics; and changes in the mix of government and commercial patients and the number of commercial patients that are either covered under commercial contracts or are out-of-network.

Government dialysis-related payment rates in the U.S. are principally determined by federal Medicare and state Medicaid policy. For further discussion of government reimbursement and the Medicare ESRD bundled payment system, including QIP, see the discussion in Item 1. Business under the heading "Kidney Care Division-Sources of revenue-concentrations and risks." For a discussion of operational, clinical and financial risks and uncertainties that we face in connection with the Medicare ESRD bundled payment system, see the risk factor in Item 1A. Risk Factors under the heading "Changes in the structure of and payment rates under the Medicare ESRD program could have a material adverse effect on our business, results of operations, financial condition and cash flows."

The CMS Innovation Center is currently working with various healthcare providers to develop, refine and implement ACOs and other innovative models of care for Medicare and Medicaid beneficiaries. We are uncertain of the extent to which the long-term operation and evolution of these models of care, including ACOs, the CEC Model (which includes the development of ESCOs), the Duals Demonstration and other models, will impact the healthcare market over time. We are currently participating in the CEC Model with the Innovation Center in certain geographies, and our U.S. dialysis business may choose to participate in additional models either as a partner with other providers or independently. Even in areas where we are not directly participating in these or other Innovation Center models, some of our patients may be assigned to an ACO, another ESRD Care Model or another program, in which case the quality and cost of care that we furnish will be included in an ACO's, another ESRD Care Model's or other program's calculations. In addition to the aforementioned new models of care, federal bipartisan legislation in the form of the PATIENTS Act has been proposed. The PATIENTS Act builds on prior coordinated care models, such as the CEC Model, and would establish a demonstration program for the provision of integrated care to Medicare ESRD patients. We have made and continue to make investments in building our integrated care capabilities, but there can be no assurances that initiatives such as the PATIENTS Act or similar legislation will be passed. If such legislation is passed, there can be no assurances that we will be able to successfully provide integrated care on the broader scale contemplated by this legislation.

On average, dialysis-related payment rates from contracted commercial payors are significantly higher than Medicare, Medicaid and other government program payment rates, and therefore the percentage of commercial patients in relation to total patients represents a major driver of our total average dialysis net patient service revenue per treatment. The percentage of commercial patients covered under contracted plans as compared to commercial patients with out-of-network providers has continued to increase, which can significantly affect our average dialysis net patient service revenue per treatment since commercial payment rates for patients with out-of-network providers are on average higher than in-network payment rates that are covered under commercial contracted plans.

Dialysis payment rates from commercial payors vary and a major portion of our commercial rates are set at contracted amounts with payors and are subject to intense negotiation pressure. As discussed above, our commercial payment rates also include payments for out-of-network patients that on average are higher than our in-network commercial contract rates. Some of our commercial contracts pay us a single bundled payment rate for all dialysis services provided to covered patients. However, some of our commercial contracts also pay us for certain other services and pharmaceuticals in addition to the bundled payment. We are continuously in the process of negotiating agreements with our commercial payors, and if our negotiations result in overall commercial contract payment rate reductions in excess of our commercial contract payment rate increases, or if commercial payors implement plans that restrict access to coverage or the duration or breadth of benefits or impose restrictions or limitations on patient access to non-contracted or out-of-network providers, it could have a material adverse effect on our business, results of operations, financial condition and cash flows. In addition, if there is an increase in job losses in the U.S., or depending upon changes to the healthcare regulatory system by CMS and/or the impact of healthcare insurance

exchanges, we could experience a decrease in the number of patients covered under commercial insurance plans and/or an increase in uninsured or underinsured patients. Patients with commercial insurance who cannot otherwise maintain coverage frequently rely on financial assistance from charitable organizations, such as the American Kidney Fund. If these patients are unable to obtain or continue to receive or receive for a limited duration such financial assistance, or if our assumptions about how patients will respond to any change in such financial assistance are incorrect, it could have a material adverse effect on our business, results of operations, financial condition and cash flows. For further details, see the risk factor in Item 1A Risk Factors under the heading “If patients in commercial plans are subject to restriction in plan designs or the average

rates that commercial payors pay us decline significantly, it would have a material adverse effect on our business, results of operations, financial condition and cash flows."

Our operating performance with respect to dialysis services billing and collection can also be a significant factor in the average U.S. dialysis and related lab services net patient service revenue per treatment we recognize and are able to collect. For example, as payors change their systems and requirements, such as changes to what is included in the bundled payment from Medicare, we could experience a negative impact to our cash collection performance, which would affect our average U.S. dialysis and related lab services net patient service revenue per treatment.

Our U.S. dialysis and related lab services revenue recognition involves significant estimation risks. Our estimates are developed based on the best information available to us and our best judgment as to the reasonably assured collectability of our billings as of the reporting date based upon our actual historical collection experience. Changes in estimates are reflected in the then-current period financial statements based upon on-going actual experience and trends, or subsequent settlements and realizations depending on the nature and predictability of the estimates and contingencies.

Our annual average U.S. dialysis and related lab services net patient service revenue per treatment was approximately $350, $330 and $336 for 2018, 2017 and 2016, respectively. In 2018, our average U.S. dialysis and related lab services net patient service revenue per treatment increased by approximately $20 per treatment primarily related to the administration of calcimimetics, as discussed above, as well as an increase in Medicare bad debt revenue due to a policy election made under the new revenue recognition accounting standards. In 2017, our average U.S. dialysis and related lab services net patient service revenue per treatment decreased by approximately $5 per treatment due to a decrease in our commercial treatment volume, a decline in our commercial payor mix, including exchange patients, and an increase in our provision for uncollectible accounts.

We anticipate that we will continue to experience increases in our operating costs in 2019 that may outpace any net Medicare rate increases that we may receive, which could significantly impact our operating results. In particular, we expect to continue experiencing increases in operating costs that are subject to inflation, such as labor and supply costs, including increases in maintenance costs, regardless of whether there is a compensating inflation-based increase in Medicare payment rates or in payments under the ESRD bundled payment rate system. We also expect to continue to incur capital expenditures to improve, renovate and maintain our facilities, equipment and information technology to meet changing regulatory requirements.

The principal drivers of our U.S. dialysis and related lab services patient care costs are clinical hours per treatment, labor rates, vendor pricing of pharmaceuticals, utilization levels of pharmaceuticals, business infrastructure costs, which include the operating costs of our dialysis centers, and certain professional fees. However, other cost categories can also present significant cost variability, such as employee benefit costs, payroll taxes, insurance costs and medical supply costs. In addition, proposed ballot initiatives or referendums, legislation, regulations or policy changes could cause us to incur substantial costs to challenge and prepare for and, if implemented, impose additional requirements on our operations, including increases in the required staffing levels or staffing ratios for clinical personnel, minimum transition times between treatments, limits on how much patients may be charged for care, limitations as to the amount that can be spent on certain medical costs, and limitations on the amount of revenue that providers can retain. Changes such as these could materially reduce our revenues and increase our operating expenses and impact our ability to staff our clinics to any new, elevated staffing levels, in particular given the ongoing nationwide shortage of healthcare workers, especially nurses.

Our average clinical hours per treatment increased in 2018 compared to 2017. We are always striving for improved productivity levels, however, changes in federal and state policies or regulatory billing requirements can lead to increased labor costs in order to implement these new requirements, which can adversely impact our ability to achieve optimal productivity levels. In addition, improvements in the U.S. economy have stimulated additional competition for skilled clinical personnel resulting in slightly higher teammate turnover in 2018, which we believe negatively affected productivity levels. In 2018 and 2017, we experienced an increase in our clinical labor rates of approximately 3.0% and 4.0%, respectively, consistent with general industry trends, mainly due to the high demand for and nationwide shortage of skilled clinical personnel, along with general inflation increases. In 2018, we experienced an increase in benefit costs due to the implementation of a 401(k) matching program that went into effect January 1,

2018. We also continue to experience increases in the infrastructure and operating costs of our dialysis centers, primarily due to the number of new dialysis centers opened, and general increases in rent, utilities and repairs and maintenance. In 2018, we continued to implement certain cost control initiatives to manage our overall operating costs, including labor productivity.

Our U.S. dialysis and related lab services general and administrative expenses represented 8.1% of our U.S. dialysis and related lab services revenues in both 2018 and 2017. Increases in general and administrative expenses over the last several years were primarily related to strengthening our dialysis business by improving our regulatory compliance and other operational processes, responding to certain legal and compliance matters, professional fees associated with enhancing our

information technology systems and more recent costs to counter union policy efforts. We expect that these levels of general and administrative expenses will continue in 2019 and could possibly increase as we seek out new business opportunities within the dialysis industry and continue to invest in improving our information technology infrastructure and maintaining the level of support required for our regulatory compliance and legal matters.

Results of Operations

The following table reflects the results of operations for our U.S. dialysis and related lab services business:

	Year ended December 31,		
	2018	2017	2016
	(dollars in millions, except treatment data)		
Revenues:[1]			
U.S. dialysis and related lab patient service revenues	$10,367	$9,822	$9,551
Provision for uncollectible accounts	(51)	(482)	(430)
U.S. dialysis and related lab net patient service revenues	10,316	9,340	9,121
Other revenues	20	20	17
Total U.S. dialysis and related lab net services revenues	10,336	9,360	9,138
Operating expenses and charges:			
Patient care costs	7,280	6,334	6,145
General and administrative	836	760	751
Depreciation and amortization	559	521	483
Equity investment income	(20)	(25)	(18)
Gain on changes in ownership interests	(28)	—	—
Gain on settlement	—	(527)	—
Total operating expenses and charges	8,626	7,063	7,361
Operating income	$1,710	$2,297	$1,777
Reconciliation of non-GAAP measures:			
Gain on changes in ownership interests	(28)	—	—
Gain on settlement, net	—	(527)	—
Equity investment income related to gain on settlement	—	(3)	—
Adjusted operating income[2]	$1,682	$1,768	$1,777
Dialysis treatments	29,435,304	28,271,113	27,162,545
Average dialysis treatments per treatment day	94,073	90,468	86,532
Average U.S. dialysis and related lab services net patient service revenue per treatment	$350.47	$330.38	$335.81

Certain columns, rows or percentages may not sum or recalculate due to the use of rounded numbers.

(1) On January 1, 2018, we adopted *Revenue from Contracts with Customers* (Topic 606) using the cumulative effect method for those contracts that were not substantially completed as of January 1, 2018. Results related to performance obligations satisfied beginning on and after January 1, 2018 are presented under Topic 606, while results related to the satisfaction of performance obligations in prior periods continue to be reported in accordance with our historical accounting under *Revenue Recognition* (Topic 605). See Notes 1 and 2 of the consolidated financial statements for further discussion of our adoption of Topic 606.

(2) For the periods presented in the table above, adjusted operating income is defined as operating income before certain items which we do not believe are indicative of ordinary results, including a non-cash gain on changes in ownership interests and a net settlement gain. Adjusted operating income as so defined is a non-GAAP measure and is not intended as a substitute for GAAP operating income. We have presented these adjusted amounts because management believes that these presentations enhance a user's understanding of our normal consolidated operating income by excluding certain items which we do not believe are indicative of our ordinary results of operations. As a result, adjusting for these amounts allows for comparison to our normalized prior period results.

Revenues

U.S. dialysis and related lab services revenues for 2018 increased by approximately $976 million, or 10.4%, from 2017. This increase in revenues was primarily driven by an increase of approximately $20 in average dialysis net patient service

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revenue per treatment due to the administration of calcimimetics, as discussed above, an increase in Medicare bad debt revenue of $36 million due to a policy election made under the new revenue recognition accounting standards and volume growth from additional treatments of approximately 4.1% due to an increase in acquired and non-acquired treatments.

U.S. dialysis and related lab services revenues for 2017 increased by approximately $222 million, or 2.4%, from 2016. This increase in revenues was primarily driven by solid volume growth from additional treatments of approximately 4.1% due to an increase in acquired and non-acquired treatments, including the acquisition of Renal Ventures. U.S. dialysis and related lab services' revenues was negatively impacted by approximately one less treatment day in 2017 as compared to 2016, and a decrease in the average dialysis net patient service revenue per treatment of approximately $5, primarily due to a decrease in our commercial payor mix, including exchange patients. In addition, our provision for uncollectible accounts increased by $52 million in 2017.

The following table summarizes our U.S. dialysis and related lab patient services revenues by source:

	2018	2017	2016
Medicare and Medicare-assigned plans	59 %	56 %	58 %
Medicaid and managed Medicaid plans	6	7	3
Other government-based programs	4	4	2
Total government-based programs	69	67	63
Commercial (including hospital dialysis services)	31	33	37
Total U.S. dialysis and related lab services revenues	100%	100%	100%

Approximately 69% of our total U.S. dialysis and related lab patient services revenues for the year ended December 31, 2018 were from government-based programs, principally Medicare, Medicaid, Medicare-assigned and managed Medicaid plans, representing approximately 89.6% of our total patients. Over the last year, we have seen a decline in the growth of our commercial patients, which has been outpaced by the growth of our government-based patients. Less than 1% of our U.S. dialysis and related lab services revenues are due directly from patients. There is no single commercial payor that accounted for more than 10% of total U.S. dialysis and related lab services revenues for the year ended December 31, 2018.

On average, dialysis-related payment rates from contracted commercial payors are significantly higher than Medicare, Medicaid and other government program payment rates, and therefore the percentage of commercial patients as a relationship to total patients represents a major driver of our total average dialysis net patient service revenue per treatment. For a patient covered by a commercial insurance plan, Medicare generally becomes the primary payor after 33 months, which includes the three month waiting period, or earlier if the patient's commercial insurance plan coverage terminates. When Medicare becomes the primary payor, the payment rates we receive for that patient shift from the commercial insurance plan rates to Medicare payment rates, which on average are significantly lower than commercial insurance rates. Medicare payment rates are insufficient to cover our costs associated with providing dialysis services, and we therefore lose money on each Medicare treatment that we provide.

Nearly all of our net earnings from our U.S. dialysis and related lab services are derived from commercial payors, some of which pay at established contract rates and others of which pay negotiated payment rates based on an established fee schedule for out-of-network patients, which are typically higher than commercial contracted rates. If we experience an overall net reduction in our contracted and non-contracted commercial payment rates as a result of negotiations, restrictions or changes to the healthcare regulatory system, including the potential impact of healthcare insurance exchanges, it could have a material adverse effect on our business, results of operations, financial condition and cash flows.

Operating expenses and charges

Patient care costs. U.S. dialysis and related lab services patient care costs are those costs directly associated with operating and supporting our dialysis centers and consist principally of labor, benefits, pharmaceuticals, medical supplies and other operating costs of the dialysis centers. U.S. dialysis and related lab services patient care costs on a per treatment basis were $247 and $224 for 2018 and 2017, respectively. The $23 increase in per treatment costs in 2018 as compared to 2017 was primarily related to the administration of calcimimetics, an increase in labor and benefits costs due to an increase in teammate headcount and the transition to the 401(k) matching program, as

described above, as well as an increase in other direct operating expenses associated with our dialysis centers. These increases were partially offset by a decrease in other pharmaceutical costs.

U.S. dialysis and related lab services patient care costs on a per treatment basis were $224 and $226 for 2017 and 2016, respectively. The $2 decrease in per treatment costs in 2017 as compared to 2016 was primarily attributable to a decrease in

pharmaceutical unit costs due to a net price reduction as well as a decrease in profit sharing expense. These decreases were partially offset by an increase in labor and benefit costs due to an increase in teammates and clinical labor rates, and an increase in other direct operating expenses associated with our dialysis centers, including the impact of the hurricanes during the third quarter of 2017.

General and administrative expenses. U.S. dialysis and related lab services general and administrative expenses in 2018 increased by approximately $76 million as compared to 2017. This increase was primarily due to increases in advocacy costs, benefit costs related to the 401(k) matching program that began in 2018, occupancy costs and consulting fees, partially offset by a decrease in labor costs. The increase in advocacy spending was primarily due to our efforts to oppose certain legislative and ballot initiatives.

U.S. dialysis and related lab services general and administrative expenses in 2017 increased by approximately $9 million as compared to 2016. This increase was primarily due to an increase in our labor and benefit costs and occupancy costs, partially offset by a decrease in long-term incentive compensation, profit sharing and travel expenses.

Depreciation and amortization. U.S. dialysis and related lab services depreciation and amortization expenses increased by approximately $38 million for both 2018 as compared to 2017 and 2017 as compared to 2016. The increases were primarily due to growth through new dialysis center developments and acquisitions, as well as additional informational technology initiatives.

Gain on changes in ownership interests, net. During 2018 we acquired a controlling interest in a previously nonconsolidated dialysis partnership. As a result of this transaction, we consolidated this partnership and recognized a non-cash gain of $28 million on our previously held ownership interest in the partnership.

Gain on settlement, net. During 2017, we reached an agreement with the government for amounts owed to us for dialysis services provided from 2005 through 2011 to patients covered by the Department of Veterans Affairs (VA). As a result of this settlement we recognized a one-time net gain of $527 million as well as equity investment income of $3 million for our share of the settlement recognized by our nonconsolidated joint ventures. As such, the total effect of this settlement on our operating income was an increase of $530 million.

Equity investment income. Equity investment income was approximately $20 million, $25 million and $18 million in 2018, 2017 and 2016, respectively. The decrease in equity investment income in 2018 as compared to 2017 was primarily due to our receipt in 2017 of equity investment income related to the VA settlement of $3 million. The increase in equity investment income in 2017 compared to 2016 was primarily due to the increase in the number of our nonconsolidated dialysis joint ventures and an increase in profitability at some of these joint ventures.

Segment operating income

U.S. dialysis and related lab services operating income for 2018, which includes a gain on ownership changes of $28 million, decreased by approximately $587 million as compared to 2017, which includes a net gain on the VA settlement of $530 million. Excluding these items from their respective periods, U.S. dialysis and related lab services adjusted operating income decreased by approximately $86 million from 2017. This decrease in adjusted operating income was primarily due to an increase in labor and benefits costs, an increase in other direct operating expenses and increases in advocacy costs, occupancy costs and consulting fees, as described above. This decrease was partially offset by a net increase related to the administration of calcimimetics and additional treatment growth, as described above.

U.S. dialysis and related lab services operating income for 2017, which includes a net gain on the VA settlement of $530 million, increased by approximately $520 million as compared to 2016. Excluding this item from 2017, U.S. dialysis and related lab services adjusted operating income decreased by approximately $9 million from 2016. This decrease in adjusted operating income was primarily due to a decrease in the average dialysis net patient service revenue per treatment of approximately $5, one less treatment day, partially offset by treatment growth, as described above. Adjusted operating income also decreased due to an increase in general and administrative expenses, partially offset by lower patient care costs, as described above.

Other—Ancillary services and strategic initiatives business

Our other operations include ancillary services and strategic initiatives which are primarily aligned with our core business of providing dialysis services to our network of patients. As of December 31, 2018, these consisted primarily

of disease management services, vascular access services, clinical research programs, physician services, ESRD seamless care organizations, and comprehensive care as well as our international operations. These ancillary services and strategic initiatives,

including our international operations and our pharmacy business, generated approximately $1.196 billion of revenues in 2018, representing approximately 10% of our consolidated revenues. If any of our ancillary services or strategic initiatives, such as our international operations, are unsuccessful, it would have a negative impact on our business, results of operations, financial condition and cash flows, and we may determine to exit that line of business, which could result in significant termination costs. In addition, we may incur a material write-off or an impairment of our investment, including goodwill, in one or more of our ancillary services or strategic initiatives. In that regard, we have incurred, and may in the future incur, impairment and restructuring charges in addition to those incurred by our pharmacy business, described below.

Recent changes in the oral pharmacy space, including reimbursement rate pressures, have negatively affected the economics of our pharmacy services business. As a result, we have transitioned the customer service and fulfillment functions of this business to third parties and have ceased our distribution operation, which will result in a decline in revenues and costs. In 2018, we recognized restructuring charges of $11 million and other asset impairment charges of $17 million related to our pharmacy services business.

We expect to add additional service offerings to our business and pursue additional strategic initiatives in the future as circumstances warrant, which could include healthcare services not related to dialysis. In addition, in connection with our previously announced capital allocation strategy, in 2019 we plan to continue our evaluation of strategic alternatives for various assets in our portfolio. In the second quarter of 2018, we sold Paladina Health (described below), our direct primary care business, as a result of the implementation of this strategy.

As of December 31, 2018, our international dialysis operations provided dialysis and administrative services through a network of 241 outpatient dialysis centers located in nine countries outside of the U.S. The total revenues generated from our international operations, as reflected below, were approximately 4% of our 2018 consolidated revenues.

The following table reflects the results of operations for the ancillary services and strategic initiatives:

	Year ended December 31,		
	2018	2017	2016
	(dollars in millions)		
U.S. revenues:[1]			
Other revenues	$749	$1,268	$1,413
Total	749	1,268	1,413
International revenues:[1]			
Net dialysis patient service revenues	437	323	202
Other revenues	10	5	6
Total	447	328	208
Total net revenues:[1]	1,196	1,596	1,621
Operating expenses and charges:			
Operating and other general expenses	1,302	1,711	1,686
Goodwill impairment	3	36	28
Investment and other asset impairments	17	295	15
Gain on changes in ownership changes, net	(32)	(6)	(374)
Total operating expenses and charges	1,290	2,036	1,355
Total ancillary services and strategic initiatives operating (loss) income	$(94)	$(439)	$267
U.S. operating loss	$(70)	$(110)	$(65)
Reconciliation of non-GAAP:			
Restructuring charges	11	—	—
Gain on changes in ownership interests, net	(34)	—	—
Goodwill impairment	—	35	28
Impairment of assets	17	15	—
Accruals for legal matters	—	—	16
Adjusted operating loss[2]	$(75)	$(60)	$(21)
International operating (loss) income	$(23)	$(329)	$332
Reconciliation of non-GAAP:			
Goodwill impairment	3	—	—
Impairment of investment	—	280	15
Loss (gain) on changes in ownership interests, net	1	(6)	(374)
Equity investment loss:			
Loss due to business sale in APAC JV	9	—	—
Loss due to impairments in APAC JV	8	6	—
Loss related to restructuring charges	—	1	—
Restructuring charges	—	2	—
Adjusted operating loss[2]	$(3)	$(46)	$(27)
Total adjusted ancillary services and strategic initiatives loss[2]	$(78)	$(107)	$(48)

Certain columns, rows or percentages may not sum or recalculate due to the use of rounded numbers.

(1) On January 1, 2018, we adopted *Revenue from Contracts with Customers* (Topic 606) using the cumulative effect method for those contracts that were not substantially completed as of January 1, 2018. Results related to performance obligations satisfied beginning on and after January 1, 2018 are presented under Topic 606, while results related to the satisfaction of performance obligations in prior periods continue to be reported in accordance with our historical accounting under *Revenue Recognition* (Topic 605). See Notes 1 and 2 of the consolidated financial statements for further discussion of our adoption of Topic 606.

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(2) For the periods presented in the table above adjusted operating loss is defined as operating loss before certain items which we do not believe are indicative of ordinary results, including goodwill impairment charges, investment and other asset impairments, restructuring charges, gains on ownership changes and accruals for legal matters. Adjusted operating loss as so defined is a non-GAAP measure and is not intended as a substitute for GAAP operating (loss) income. We have presented these adjusted amounts because management believes that these presentations enhance a user's understanding of our normal consolidated operating (loss) income by excluding certain items which we do not believe are indicative of our ordinary results of operations. As a result, adjusting for these amounts allows for comparison to our normalized prior period results.

Revenues

Ancillary services and strategic initiatives revenues for 2018 decreased by approximately $400 million, or 25.1%, as compared to 2017. This decrease was primarily due to a decline in volume in our pharmacy business due to changes in calcimimetics reimbursement, as well as the restructuring of our pharmacy business, as discussed above, a decrease in our shared savings revenue from our ESCO joint ventures and a decrease in revenue related to the sale of our direct primary care business in the second quarter of 2018. These decreases were partially offset by an increase in revenues from our international expansion due to acquired and non-acquired growth and an increase in DaVita IKC revenues from special needs plans.

Ancillary services and strategic initiatives revenues for 2017 decreased by approximately $25 million, or 1.5%, as compared to 2016. This decrease was primarily related to a decrease in volume in our pharmacy business, partially offset by an increase in pharmaceutical rates, an increase in DaVita IKC special needs plan revenues, an increase in shared savings revenue recognized by our ESCO joint ventures and an increase in revenues from expansions in our international business and other strategic initiatives.

Operating and general expenses

Ancillary services and strategic initiatives operating and general expenses for 2018, which included restructuring charges of $11 million related to our pharmacy business, an equity investment loss on the sale of our India business in our APAC JV of $9 million and an equity investment loss of $8 million related to impairments at our APAC JV, decreased by approximately $409 million compared to 2017, which included restructuring charges in our international business of $3 million and an equity investment loss of $6 million for goodwill impairments at our APAC JV. Excluding these items from their respective periods, ancillary services and strategic initiatives adjusted operating and general expenses decreased by $428 million compared to 2017. This decrease was primarily due to a decrease in pharmaceutical costs due to decreased volume related to the changes in calcimimetics reimbursement and restructuring at our pharmacy business, as discussed above, a decrease in expenses related to the sale of our direct primary care business and decreases in labor and benefit costs and professional fees. These decreases in operating expenses were partially offset by an increase in expenses associated with growth in our international operations, an increase in medical costs at DaVita IKC related to the cost of calcimimetics and an increase in members in our special needs plans.

Ancillary services and strategic initiatives operating and general expenses for 2017, which included restructuring charges in our international business of $3 million, as discussed below, and an equity investment loss of $6 million for goodwill impairments at our APAC JV, increased by approximately $25 million from 2016, which included an estimated accrual for certain legal matters of $16 million. Excluding these items from their respective periods, ancillary services and strategic initiatives adjusted operating and general expenses increased by $32 million. This increase in adjusted operating and general expenses was primarily related to an increase in medical costs at DaVita IKC, an increase in labor and benefits costs and additional expenses associated with our international dialysis growth, including losses from adverse changes in foreign exchange rates included in equity investment income, partially offset by a decrease in pharmaceutical costs due to decreased volume in our pharmacy services business.

Goodwill impairment charges. During the year ended December 31, 2018, we recognized a goodwill impairment charge of $3 million at our German other health operations, and during the year ended December 31, 2017, we recognized a goodwill impairment charge of $2 million at one of our international kidney care businesses.

During the years ended December 31, 2017 and December 31, 2016, we also recognized goodwill impairment charges of $35 million and $28 million, respectively, at our vascular access reporting unit. These charges resulted primarily from changes in future governmental reimbursement rates for this business and our then-evolving plans and expected ability to mitigate them. As of December 31, 2017, there was no goodwill remaining at our vascular access reporting

unit.

Restructuring charges and other impairments. During the year ended December 31, 2018, we announced a plan to restructure our pharmacy business, as discussed above. As a result of this plan, we recognized restructuring charges of $11 million which are included in operating and other general expenses. We also recognized other asset impairment charges of $17 million and $15 million in 2018 and 2017, respectively, related to the restructuring of our pharmacy business.

During the year ended December 31, 2017, we recognized restructuring charges related to our international business of $2 million and recognized equity investment losses of $1 million related to restructuring charges at our APAC JV. These restructuring charges were related to a reorganization of our international general and administrative infrastructure at the global, regional and country level in order to improve efficiency.

During the year ended December 31, 2017, we recognized a non-cash other-than-temporary impairment charge of $280 million on our investment in the APAC JV. This charge resulted from changes in our expectations for the joint venture based on continuing market research and assessments by both us and DaVita Care Pte. Ltd. (the APAC JV) concerning the size of the addressable market available to the joint venture at attractive risk-adjusted returns. We estimated the fair value of our retained interest in the APAC JV with the assistance of an independent third party valuation firm based on information available to management as of December 31, 2017.

During the year ended December 31, 2016, we recognized an impairment of $15 million related to an investment in one of our international reporting units.

Gain on changes in ownership interests, net. We sold 100% of the stock of Paladina Health, our direct primary care business, effective June 1, 2018 and recognized a gain of approximately $34 million on this transaction. In addition, we recognized a loss of approximately $1 million related to the unwinding of an international business in the second quarter of 2018.

During the year ended December 31, 2017, we recognized a $6 million non-cash gain related to the 2016 formation of the APAC JV which resulted from a change in estimate for post-closing adjustments that were pending at the formation of this joint venture.

In 2016, we deconsolidated our Asia Pacific dialysis business and recognized an initial non-cash non-taxable estimated gain of $374 million on our retained investment in the APAC JV net of contingent obligations as a result of adjusting the carrying value of our retained interest in the APAC JV to our proportionate share of the estimated fair value of the business.

Segment operating (loss) income

Ancillary services and strategic initiatives operating results for 2018, which included a net gain on changes in ownership interests of $32 million, other asset impairment charges of $17 million and restructuring charges of $11 million related to our pharmacy business, an equity investment loss due to the sale of our India business in our APAC JV of $9 million, an equity investment loss related to impairments at our APAC JV of $8 million and a goodwill impairment charge of $3 million, increased by approximately $345 million from the same period in 2017, which included goodwill impairment charges of $35 million related to our vascular access reporting unit, an impairment of $280 million on our investment in the APAC JV, an asset impairment of $15 million related to the restructuring of our pharmacy business, an equity investment loss of $6 million related to goodwill impairments at our APAC JV, restructuring charges in our international business of $3 million, and an adjustment to the gain on the 2016 ownership change of our APAC JV of $6 million. Excluding these items from their respective periods, adjusted operating losses decreased by $29 million, primarily due to an improvement in our international business, an increase from DaVita IKC revenues from special needs plans, partially offset by a decrease in our shared savings revenue from our ESCO joint ventures, as described above.

Ancillary services and strategic initiatives operating results for 2017, which included goodwill impairment charges of $35 million related to our vascular access reporting unit, an impairment of $280 million on our investment in the APAC JV, an asset impairment of $15 million related to the restructuring of our pharmacy business, an equity investment loss of $6 million related to goodwill impairments at our APAC JV, restructuring charges in our international business of $3 million, and an adjustment to the gain on the 2016 ownership change of our APAC JV of $6 million, decreased by approximately $706 million from 2016, which included an estimated gain on the ownership change of our APAC JV of $374 million, goodwill impairment charges of $28 million at our vascular access reporting unit, estimated accruals for legal matters of $16 million and an investment impairment of $15 million. Excluding these items from their respective periods, adjusted operating losses increased by $59 million, primarily due to a decrease in revenues in our pharmacy services business, an increase in medical costs, higher labor and benefits costs, and additional expenses associated with our international operations, partially offset by an increase in DaVita IKC special needs plan revenues, an increase in shared savings revenue recognized by our ESCO joint ventures, an increase in

revenues from expansion in our international business, and a decrease in pharmaceutical costs due to decreased volume in our pharmacy services business.

Corporate level charges

Debt expense. Debt expense for 2018, 2017, and 2016 consisted of interest expense of approximately $462 million, $407 million and $394 million, respectively, and amortization and accretion of debt discounts and premiums, amortization of deferred financing costs and amortization of interest rate cap agreements of approximately $26 million, $24 million, and $20 million, respectively. The increase in debt expense in 2018 as compared to 2017 was primarily due to an increase in our average interest rate and an increase in our average outstanding debt balance. Our overall weighted average effective interest rate in 2018 was 4.96% as compared to 4.70% in 2017.

The increase in debt expense in 2017 as compared to 2016 was primarily due to an increase in our average interest rate, partially offset by a decrease in our average outstanding debt balance. Our overall weighted average effective interest rate in 2017 was 4.70% as compared to 4.43% in 2016.

Corporate administrative support. Corporate administrative support consists primarily of labor, benefits and long-term incentive compensation expense, as well as professional fees for departments which provide support to all of our various operating lines of business. This is partially offset by internal management fees charged to our other lines of business for that support.

Corporate administrative support costs were approximately $90 million in 2018 and $45 million in 2017. Corporate administrative support costs increased $45 million due to an increase in long-term incentive compensation expense due to the adoption of a retirement policy for certain executive officers, as discussed below in "Long-term incentive compensation", as well as a reduction in internal management fees charged to our ancillary lines of business, partially offset by a decrease in legal fees.

Corporate administrative support costs were approximately $45 million in 2017 and $14 million in 2016. Corporate administrative support costs increased $31 million due to a decrease in internal management fees charged to our ancillary lines of business and increases in long-term incentive compensation expense and labor and benefits expenses, partially offset by decreases in professional fees and other general and administrative expenses.

Other income. Other income was approximately $10 million in 2018, $18 million in 2017 and $8 million in 2016, and consisted principally of interest income on cash and cash-equivalents and short- and long-term investments, other non-operating gains from investment transactions, and foreign currency transaction gains and losses. Other income in 2018 as compared to 2017 decreased approximately $8 million, primarily due to an increase of recognized losses on the sale and market valuation of investments and an increase in foreign currency transaction losses. Other income in 2017 as compared to 2016 increased approximately $10 million primarily due to a decrease in foreign currency transaction losses.

Provision for income taxes. The provision for income taxes for 2018, 2017 and 2016 represented an effective annualized tax rate of 24.6%, 23.1% and 26.6% of income from continuing operations, respectively. The 2018 effective tax rate is higher than the 2017 effective tax rate primarily due to the fact that the 2017 effective tax rate reflects a $252 million tax benefit recognized in 2017 related to the enactment of the Tax Cuts and Jobs Act in 2017 (“2017 Tax Act”). Excluding this item, our effective tax rate from continuing operations for 2017 was 41.1%. The decrease in our effective tax rate in 2018 compared to this adjusted effective income tax rate in 2017 of 41.1% was primarily driven by the lower corporate statutory tax rate of 21%, partially offset by an increase in certain items that are no longer deductible under the 2017 Tax Act. The effective tax rate in 2016 was lower than the 2017 adjusted effective tax rate of 41.1%, primarily due to the gain on the APAC JV ownership changes, partially offset by goodwill impairment charges, as discussed above. See Note 13 to the consolidated financial statements for further information.

Noncontrolling interests

Net income attributable to noncontrolling interests for 2018, 2017 and 2016 was approximately $174 million, $167 million and $153 million, respectively. The increase in noncontrolling interests in 2018 as compared to 2017 was primarily due to an increase in earnings at our DMG physician groups offset by a decrease in noncontrolling interests due to one-time items impacting 2017 including the impairment of our vascular access reporting unit, which reduced income to noncontrolling interests by $10 million, partially offset by the additional income to noncontrolling interests due to the net gain on the settlement with the VA of $24 million.

The increase in noncontrolling interests in 2017 as compared to 2016 was primarily due to additional income to noncontrolling interests related to the net gain on the settlement with the VA of $24 million, partially offset by the

impairment of our vascular access reporting unit, which impacted income to noncontrolling interests by $10 million in 2017 and $8 million in 2016, for a net impact of $2 million.

The percentage of net U.S. dialysis and related lab services revenues generated from dialysis-related joint ventures was approximately 25% in 2018, 24% in 2017 and 23% in 2016.

Accounts receivable

Our consolidated accounts receivable balances at December 31, 2018 and December 31, 2017 were $1.859 billion and $1.715 billion, respectively, representing approximately 62 days and 57 days of revenue (DSO), respectively, net of the allowance for uncollectible accounts. The increase in consolidated DSO was primarily due to higher DSO at our international operations and the cessation of operations at our pharmacy business. Historically, our pharmacy business experienced relatively lower DSO than the rest of our business. Our DSO calculation is based on the current quarter's average revenues per day. There were no significant changes during 2018 from 2017 in the amount of unreserved accounts receivable over one year old or the amounts pending approval from third-party payors.

As of December 31, 2018 and 2017, our net patient services accounts receivable balances more than six months old represents approximately 18% and 21% of our dialysis accounts receivable balances, respectively. The decrease was primarily due to collections at DaVita Health Solutions and in certain international operations. Substantially all revenue realized is from government and commercial payors, as discussed above. There were no significant unreserved balances over one year old. Less than 1% of our revenues are classified as patient pay.

Amounts pending approval from third-party payors associated with Medicare bad debt claims as of December 31, 2018 and 2017, other than the standard monthly billing, consisted of approximately $136 million and $104 million, respectively, and are classified as other receivables. A significant portion of our Medicare bad debt claims are typically paid to us before the Medicare fiscal intermediary audits the claims but are subject to adjustment based upon the actual results of these audits. Such audits typically occur one to four years after the claims are filed.

Liquidity and capital resources

Available liquidity. As of December 31, 2018, our Kidney Care cash balance was $323 million and Kidney Care also had approximately $3 million in short-term investments. As of December 31, 2018, our DMG cash balance was $415 million and DMG also had approximately $4 million in short-term investments. As of December 31, 2018, we had $175 million drawn on our $1.0 billion revolving line of credit under our senior secured credit facilities, in addition to the approximately $14 million committed for outstanding letters of credit. As of December 31, 2018, we also have approximately $23 million of additional outstanding letters of credit under a separate bilateral secured letter of credit facility and $0.2 million of committed outstanding letters of credit which are backed by a certificate of deposit.

Consolidated cash flows from operations during 2018 was $1.8 billion, of which $1.5 billion was from continuing operations, compared with consolidated cash flows from operations of $1.9 billion for 2017, of which $1.6 billion was from continuing operations. Consolidated cash flows decreased due to increases in DSO, cash interest payments, advocacy spend and the timing of other working capital items partially offset by a decrease in cash taxes. Cash flows from operations in 2018 included cash interest payments of approximately $489 million and cash tax payments of $93 million. Cash flows from operations in 2017 included cash interest payments of approximately $425 million and cash tax payments of $387 million.

Non-operating cash outflows in 2018 included $987 million for capital asset expenditures, including $528 million for new center developments and relocations and $459 million for maintenance and information technology. We also spent an additional $183 million for acquisitions. In addition, during 2018 we received $14 million associated with stock award exercises and other share issuances. We also made distributions to noncontrolling interests of $196 million and received contributions from noncontrolling interests of $52 million associated with new or existing joint ventures. We also repurchased a total of 16,844,067 shares of our common stock for $1.2 billion, or an average price of $68.48 per share, in 2018. In addition, we settled $8 million in share repurchases related to 2017. Our proceeds from the sale of self-developed properties in 2018 was $45 million.

Consolidated cash flows from operations during 2017 was $1.9 billion, of which $1.6 billion was from continuing operations, compared with cash flows from operations of $2.0 billion for 2016, of which $1.7 billion was from continuing operations. Consolidated cash flows declined due to an increase in DSO and the timing of other working capital items, partially offset by the payment received from the settlement with the VA, net of associated tax payments. Cash flows from operations in 2017 included cash interest payments of approximately $425 million and cash tax payments of $387 million. Cash flows from operations in 2016 included cash interest payments of

approximately $407 million and cash tax payments of $339 million.
Non-operating cash outflows in 2017 included $905 million for capital asset expenditures, including $559 million for new center developments and relocations and $346 million for maintenance and information technology. We also spent an

additional $804 million for acquisitions in 2017. In addition, during 2017 we received $21 million associated with stock award exercises and other share issuances. We also made distributions to noncontrolling interests of $211 million, which included $24 million related to the noncontrolling interest portion of the VA settlement gain, and received contributions from noncontrolling interests of $75 million associated with new or existing joint ventures. We also repurchased a total of 12,966,672 shares of our common stock for $811 million, or an average price of $62.54 per share, of which $8 million was unsettled at December 31, 2017. Our proceeds from the sale of self-developed properties in 2017 was $58 million.

During 2018, in the U.S. we opened 152 dialysis centers, acquired 18 dialysis centers, closed and merged eight dialysis centers, closed two dialysis centers, sold one dialysis center, and terminated management and administrative services agreements covering five dialysis centers. In addition, our international dialysis operations acquired 28 dialysis centers, developed three dialysis centers, and closed two dialysis centers. Our APAC JV also acquired two dialysis centers, closed five dialysis centers and sold 22 dialysis centers.

During 2018, our DMG business acquired one primary care physician practice and four private medical practices.

In December 2017, we entered into an equity purchase agreement to sell our DMG division to Optum, a subsidiary of UnitedHealth Group Inc., subject to receipt of required regulatory approvals and other customary closing conditions. On December 11, 2018, we entered into an amendment to the equity purchase agreement, which, among other things, reduced the purchase price for DMG from $4.900 billion to $4.340 billion.

During 2017, in the U.S. we opened 121 dialysis centers, acquired 66 dialysis centers, including dialysis centers associated with the acquisition of Renal Ventures, closed and merged ten dialysis centers, closed nine dialysis centers, divested six dialysis centers, deconsolidated seven dialysis centers which we continue to operate under management services agreements, and terminated two management services agreements. In addition, our international dialysis operations acquired 68 dialysis centers, opened eight dialysis centers, and closed one dialysis center. Our APAC JV acquired two dialysis centers, opened nine dialysis centers and closed three dialysis centers.

During 2017, our DMG business acquired four primary care physician practices, including the acquisition of Magan, seven private medical practices and one independent physician association.

During the year ended December 31, 2018, we made mandatory principal payments under our senior secured credit facilities totaling $100 million on Term Loan A and $35 million on Term Loan B. During the year ended December 31, 2017, we made mandatory principal payments under our senior secured credit facilities totaling $88 million on Term Loan A and $35 million on Term Loan B.

Interest rate cap agreements

As of December 31, 2018, we maintain several interest rate cap agreements that were entered into in October 2015 with notional amounts totaling $3.5 billion. These cap agreements became effective June 29, 2018, have the economic effect of capping the LIBOR variable component of our interest rate at a maximum of 3.50% on an equivalent amount of our debt, and expire on June 30, 2020. As of December 31, 2018, the total fair value of these cap agreements was an asset of approximately $0.9 million. During the year ended December 31, 2018, we recognized debt expense of $4.3 million from these cap agreements and recorded a loss of $0.2 million in other comprehensive income due to a decrease in the unrealized fair value of these cap agreements.

Previously, we maintained other interest rate cap agreements that were entered into in November 2014 with notional amounts also totaling $3.5 billion. These cap agreements had the economic effect of capping the LIBOR variable component of our interest rate at a maximum of 3.50% on an equivalent amount of our debt and expired on June 30, 2018. During the year ended 2018, we recognized debt expense of $4.1 million from these cap agreements and recorded an immaterial loss in other comprehensive income due to a decrease in the unrealized fair value of these cap agreements through expiration.

Other items

As of December 31, 2018, our Term Loan B debt bears interest at LIBOR plus an interest rate margin of 2.75%. Term Loan B is subject to an interest rate cap if LIBOR should rise above 3.50%. Term Loan A bears interest at LIBOR plus an interest rate margin of 2.00% and Term Loan A-2 bears interest at LIBOR plus an interest rate margin of 1.00%. The capped portion of Term Loan A if LIBOR should rise above 3.50% is $157.5 million. Both the uncapped portion of Term Loan A of $517.5 million and the entire balance of Term Loan A-2 are subject to the variability of

LIBOR. Interest rates on our Senior Notes are fixed by their terms.

Our overall weighted average effective interest rate on the senior secured credit facilities at the end of 2018 was 5.11%, based upon the current margins in effect of 2.00% for Term Loan A, 1.00% for Term Loan A-2 and 2.75% for Term Loan B.

As of December 31, 2018, the interest rates were fixed on approximately 48% of our total debt, and were fixed and economically fixed, including via interest rate cap agreements, on approximately 82% of our total debt.

Our overall weighted average effective interest rate during the year ended December 31, 2018 was 4.96% and as of December 31, 2018 was 5.19%.

As of December 31, 2018, we had $175 million drawn on our $1.0 billion revolving line of credit under our senior secured credit facilities, in addition to approximately $14 million committed for outstanding letters of credit. As of December 31, 2018, we also have approximately $23 million of additional outstanding letters of credit under a separate bilateral secured letter of credit facility, and $0.2 million of committed outstanding letters of credit which are backed by a certificate of deposit.

We believe that our cash flow from operations and other sources of liquidity, including from amounts available under our existing credit facilities and anticipated debt refinancing, as well as proceeds from the anticipated sale of our DMG business if consummated, will be sufficient to fund our scheduled debt service under the terms of our debt agreements and other obligations for the foreseeable future, including the next 12 months. However, our primary recurrent sources of liquidity are cash from operations and cash from borrowings, which are subject to general, economic, financial, competitive, regulatory and other factors that are beyond our control, as described in Item 1A Risk Factors under the heading "The level of our current and future debt could have an adverse impact on our business and our ability to generate cash to service our indebtedness and for other intended purposes depends on many factors beyond our control."

Goodwill

We elected to early adopt ASU No. 2017-04, *Intangibles-Goodwill and Other (Topic 350): Simplifying the Test for Goodwill Impairment*, effective January 1, 2017. The amendments in this ASU simplify the test for goodwill impairment by eliminating the second step in the assessment. All goodwill impairment tests performed since adoption of this ASU were performed under this new guidance.

During the year ended December 31, 2018, we performed annual and other impairment assessments for various reporting units. As a result of these assessments, we recognized a goodwill impairment charge of $3 million at our German other health operations during the year ended December 31, 2018. We also recognized a goodwill impairment charge of $2 million at one of our international kidney care businesses during the year ended December 31, 2017. During the years ended December 31, 2017 and December 31, 2016, we recognized goodwill impairment charges of $35 million and $28 million, respectively, at our vascular access reporting unit. These charges resulted primarily from changes in future governmental reimbursement rates for this business and our then-evolving plans and expected ability to mitigate them. As of December 31, 2017, there was no goodwill remaining at our vascular access reporting unit. Based on our most recent assessments, we determined that reductions in reimbursement rates, changes in actual or expected growth rates, or other significant adverse changes in expected future cash flows or valuation assumptions could result in goodwill impairment charges in the future for the following reporting units, which remain at risk of goodwill impairment as of December 31, 2018:

Reporting unit	Goodwill balance as of December 31, 2018 (in millions)	Carrying amount coverage[1]	Sensitivities	
			Operating income[2]	Discount rate[3]
Germany Kidney Care	$ 403	0.5 %	(1.5)%	(10.3)%
Brazil Kidney Care	$ 39	9.8 %	(2.5)%	(7.3)%
Germany other health operations	$ 13	8.1 %	(2.2)%	(11.1)%

(1) Excess of estimated fair value of the reporting unit over its carrying amount as of the latest assessment date.

(2) Potential impact on estimated fair value of a sustained, long-term reduction of 3% in operating income as of the latest assessment date.
(3) Potential impact on estimated fair value of an increase in discount rates of 100 basis points as of the latest assessment date.

There were no major changes in the business, prospects, or expected future results of these reporting units from their latest assessment date through December 31, 2018.

Except as described above, none of our various other reporting units was considered at risk of significant goodwill impairment as of December 31, 2018. Since the dates of our last annual goodwill impairment tests, there have been certain developments, events, changes in operating performance and other changes in key circumstances that have affected our businesses. However, except as further described above, these did not cause management to believe it is more likely than not that the fair values of any of our reporting units would be less than their respective carrying amounts as of December 31, 2018.

Long-term incentive compensation

Long-term incentive program (LTIP) compensation includes both stock-based awards (principally stock-settled stock appreciation rights, restricted stock units and performance stock units) as well as long-term performance-based cash awards. Long-term incentive compensation expense, which was primarily general and administrative in nature, was attributed among our U.S. dialysis and related lab services business, corporate administrative support, and the ancillary services and strategic initiatives.

Our stock-based compensation expense for stock-settled awards are measured at the estimated fair value of awards on the date of grant and recognized on a cumulative straight-line basis over the vesting terms of the awards unless the stock awards are based on non-market based performance metrics, in which case expense is adjusted for expected ultimate payouts as of the end of each reporting period. Stock-based compensation expense for cash-settled awards is based on the estimated fair values as of the end of each reporting period. The expense for all stock-based awards is recognized net of expected forfeitures.

During 2018, we granted 1,902,652 stock-settled stock appreciation rights with an aggregate grant-date fair value of $30.9 million and a weighted-average expected life of approximately 4.2 years and 1,101,388 stock units with an aggregate grant-date fair value of $72.9 million and a weighted-average expected life of approximately 3.3 years. We did not grant any cash-settled stock-based awards during 2018.

For the year ended December 31, 2018, long-term incentive compensation expense of $85.8 million increased by approximately $23.8 million as compared to 2017. This increase in long-term incentive compensation expense was primarily due to the adoption of a retirement policy (Rule of 65 policy). The Rule of 65 policy generally provides that Section 16 executive officers that are a minimum age of 55 with five years of continuous service with the Company receive certain benefits with respect to their outstanding equity awards upon a qualifying retirement if the sum of their age plus years of service is greater than or equal to 65. These benefits include accelerated vesting of restricted stock unit awards, continued vesting of stock-settled stock appreciation rights and performance stock unit awards and an exercise window from the original vest date through the original expiration date regardless of continued employment, with pro rata vesting for a Rule of 65 retirement within one year of the award grant date. The adoption of the Rule of 65 policy resulted in a $14.7 million modification charge and a net acceleration of expense of $9.7 million during the year ended December 31, 2018 that is included in the expense amounts reported above. Future equity awards to Rule of 65 eligible executives will be expensed over the period during which risk of forfeiture exists.

For the year ended December 31, 2017, long-term incentive compensation expense of $62.0 million decreased by approximately $3.0 million as compared to 2016. This decrease in long-term incentive compensation expense was primarily due to cumulative revaluation of liability-based awards for reductions in estimated ultimate payouts, as well as the final vesting of a prior broad grant that is no longer contributing expense.

As of December 31, 2018, there was $99.9 million in total estimated but unrecognized long-term incentive compensation expense for LTIP awards outstanding, including $88.6 million relating to stock-based awards under our equity compensation plans. We expect to recognize the performance-based cash component of this LTIP expense over a weighted average remaining period of 0.8 years and the stock-based component of this LTIP expense over a weighted average remaining period of 1.5 years.

For the years ended December 31, 2018, 2017 and 2016, we received $8.0 million, $13.5 million and $28.4 million, respectively, in actual tax benefits upon the exercise of stock awards. Since we issue stock-settled stock appreciation rights rather than stock options, we did not receive cash proceeds from stock option exercises during the years ended December 31, 2018, 2017 and 2016.

Stock repurchases

We repurchased a total of 16,844,067 shares for $1.2 billion, or an average price of $68.48, during the year ended December 31, 2018. We also repurchased a total of 12,966,672 shares for $811 million, or an average price of $62.54, during the year ended December 31, 2017 and a total of 16,649,090 shares for $1.1 billion, or an average price of $64.41, during the

year ended December 31, 2016. Subsequent to December 31, 2018, we have not repurchased any shares of our common stock through February 22, 2019. We retired all shares held in treasury effective December 31, 2018 and December 31, 2017.

On July 11, 2018, our Board of Directors approved an additional share repurchase authorization in the amount of $1.4 billion. This share repurchase authorization was in addition to the $110 million remaining at that time under our Board of Directors' prior share repurchase authorization approved in October 2017. Accordingly, as of February 22, 2019, we have a total of $1.4 billion available under the current Board repurchase authorizations for additional share repurchases. Although these share repurchase authorizations do not have expiration dates, we remain subject to share repurchase limitations under the terms of our senior secured credit facilities and the indentures governing our senior notes.

Off-balance sheet arrangements and aggregate contractual obligations

In addition to the debt obligations reflected on our balance sheet, we have commitments associated with operating leases and letters of credit, as well as potential obligations associated with our equity investments in nonconsolidated businesses and to dialysis centers that are wholly-owned by third parties. Substantially all of our U.S. dialysis facilities are leased. We have potential obligations to purchase the noncontrolling interests held by third parties in several of our majority-owned joint ventures and other nonconsolidated entities. These obligations are in the form of put provisions that are exercisable at the third-party owners’ discretion within specified periods as outlined in each specific put provision. If these put provisions were exercised, we would be required to purchase the third-party owners’ equity interests at either the appraised fair market value or a predetermined multiple of earnings or cash flows attributable to the equity interests put to us, which is intended to approximate fair value. The methodology we use to estimate the fair values of noncontrolling interests subject to put provisions assumes the higher of either a liquidation value of net assets or an average multiple of earnings, based on historical earnings, patient mix and other performance indicators that can affect future results, as well as other factors. The estimated fair values of noncontrolling interests subject to put provisions are a critical accounting estimate that involves significant judgments and assumptions and may not be indicative of the actual values at which the noncontrolling interests may ultimately be settled, which could vary significantly from our current estimates. The estimated fair values of noncontrolling interests subject to put provisions can fluctuate and the implicit multiple of earnings at which these noncontrolling interests obligations may be settled will vary significantly depending upon market conditions including potential purchasers’ access to the capital markets, which can impact the level of competition for dialysis and non-dialysis related businesses, the economic performance of these businesses and the restricted marketability of the third-party owners’ equity interests. The amount of noncontrolling interests subject to put provisions that employ a contractually predetermined multiple of earnings rather than fair value are immaterial. For additional information see Note 18 to the consolidated financial statements.

We also have certain other potential commitments to provide operating capital to several dialysis centers that are wholly-owned by third parties or businesses in which we own a noncontrolling equity interest as well as to physician-owned vascular access clinics or medical practices that we operate under management and administrative services agreements.

The following is a summary of these contractual obligations and commitments as of December 31, 2018:

	1 year	2-3 years	4-5 years	After 5 years	Total
	(dollars in millions)				
Scheduled payments under contractual obligations:					
Long-term debt principal	$1,907	$3,345	$1,283	$3,336	$9,871
Interest payments on the senior notes	237	473	401	202	1,313
Interest payments on Term Loan B[(1)]	178	263	—	—	441
Interest payments on Term Loan A[(2)]	15	—	—	—	15
Interest payments on Term Loan A-2[(2)]	18	—	—	—	18
Kidney Care capital lease obligations	22	49	46	166	283
Kidney Care operating leases	483	895	745	1,590	3,714
DMG capital lease obligations	35	—	—	—	35
DMG operating leases	90	154	117	267	628
	$2,985	$5,179	$2,592	$5,561	$16,318
Potential cash requirements under other commitments:					
Letters of credit	$37	$—	$—	$—	$37
Noncontrolling interests subject to put provisions	624	265	113	123	1,125
Non-owned and minority owned put provisions	2	—	456	—	458
Operating capital advances	1	2	1	1	5
Purchase commitments	304	571	251	—	1,126
	$968	$838	$821	$124	$2,751

(1) Based upon current LIBOR-based interest rates in effect at December 31, 2018 plus an interest rate margin of 2.75% for Term Loan B.

(2) Based upon current LIBOR-based interest rates in effect at December 31, 2018 plus an interest rate margin of 2.00% for Term Loan A and plus an interest rate margin of 1.00% for Term Loan A-2.

In addition to the commitments listed above, we have an agreement with Fresenius Medical Care (FMC) to purchase a certain amount of dialysis equipment, parts and supplies from FMC, which was extended through December 31, 2020. The actual amount of purchases in future years from FMC will depend upon a number of factors, including the operating requirements of our centers, the number of centers we acquire, and growth of our existing centers.

We also have an agreement with Baxter Healthcare Corporation (Baxter) that commits us to purchase a certain amount of peritoneal dialysis supplies at fixed prices through 2022.

In 2017, we entered into a Sourcing and Supply Agreement with Amgen USA Inc. (Amgen) that expires on December 31, 2022. Under the terms of this agreement, we will purchase EPO in amounts necessary to meet no less than 90% of our requirements for erythropoiesis stimulating agents (ESAs) through the expiration of the contract with Amgen. The actual amount of EPO that we will purchase will depend upon the amount of EPO administered during dialysis as prescribed by physicians and the overall number of patients that we serve.

Settlements of approximately $49 million of existing income tax liabilities for unrecognized tax benefits, including interest, penalties and other long-term tax liabilities, are excluded from the above table as reasonably reliable estimates of their timing cannot be made.

Supplemental information concerning certain physician groups and unrestricted subsidiaries

The following information is presented as supplemental data as required by the indentures governing our senior notes. We provide services to certain physician groups, including those within our DMG business, which while consolidated in our financial statements for financial reporting purposes, are not subsidiaries of or owned by us, do not constitute “Subsidiaries” as defined in the indentures governing our outstanding senior notes, and do not guarantee those senior notes. In addition, we have entered into management agreements with these physician groups pursuant to which we receive management fees from the physician groups.

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As of December 31, 2018, if these physician groups were not consolidated in our financial statements, our consolidated assets would have been approximately $18.578 billion and our consolidated other liabilities would have been approximately $3.571 billion. Our consolidated indebtedness would have remained approximately $10.154 billion since almost all of these physician groups are classified as held for sale and the remainder of them do not carry third party debt. For the year ended December 31, 2018, if these physician groups were not consolidated in our financial statements, our consolidated net income would have been reduced by approximately $30 million. Our consolidated total net revenues and consolidated operating income would have remained approximately $11.405 billion and $1.526 billion, respectively, since almost all of these physician groups are being reported as discontinued operations.

In addition, our DMG business owns a 67% equity interest in California Medical Group Insurance (CMGI), which is an Unrestricted Subsidiary as defined in the indentures governing our outstanding senior notes, and does not guarantee those senior notes. DMG's equity interest in CMGI is accounted for under the equity method of accounting, meaning that, although CMGI is not consolidated in our financial statements for financial reporting purposes, our consolidated income statement reflects our pro rata share of CMGI’s net income within net loss from discontinued operations. For the year ended December 31, 2018, excluding DMG's equity investment income attributable to CMGI, our consolidated net income would be decreased by approximately $92 thousand. See Note 29 to the consolidated financial statements for further details.

Contingencies

The information in Note 17 to the consolidated financial statements included in this report is incorporated by reference in response to this item.

Critical accounting policies, estimates and judgments

Our consolidated financial statements and accompanying notes are prepared in accordance with United States generally accepted accounting principles. These accounting principles require us to make estimates, judgments and assumptions that affect the reported amounts of revenues, expenses, assets, liabilities, contingencies and temporary equity. All significant estimates, judgments and assumptions are developed based on the best information available to us at the time made and are regularly reviewed and updated when necessary. Actual results will generally differ from these estimates, and such differences may be material. Changes in estimates are reflected in our financial statements in the period of change based upon on-going actual experience trends, or subsequent settlements and realizations depending on the nature and predictability of the estimates and contingencies. Interim changes in estimates are applied prospectively within annual periods. Certain accounting estimates, including those concerning revenue recognition and accounts receivable, impairments of goodwill and investments, accounting for income taxes, consolidation of variable interest entities, and fair value estimates are considered to be critical to evaluating and understanding our financial results because they involve inherently uncertain matters and their application requires the most difficult and complex judgments and estimates.

Dialysis and related lab services revenue recognition and accounts receivable. There are significant estimating risks associated with the amount of dialysis and related lab services revenue that we recognize in a given reporting period. Payment rates are often subject to significant uncertainties related to wide variations in the coverage terms of the commercial healthcare plans under which we receive payments. In addition, ongoing insurance coverage changes, geographic coverage differences, differing interpretations of contract coverage, and other payor issues complicate the billing and collection process. Net revenue recognition and allowances for uncollectible billings require the use of estimates of the amounts that will ultimately be realized considering, among other items, retroactive adjustments that may be associated with regulatory reviews, audits, billing reviews and other matters.

Revenues associated with Medicare and Medicaid programs are recognized based on (a) the payment rates that are established by statute or regulation for the portion of the payment rates paid by the government payor (e.g., 80% for Medicare patients) and (b) for the portion not paid by the primary government payor, the estimated amounts that will ultimately be collectible from other government programs paying secondary coverage (e.g., Medicaid secondary coverage), the patient’s commercial health plan secondary coverage, or the patient. Our dialysis related reimbursements from Medicare are subject to certain variations under Medicare’s single bundled payment rate system whereby our reimbursements can be adjusted for certain patient characteristics and certain other factors. Our revenue

recognition depends upon our ability to effectively capture, document and bill for Medicare's base payment rate and these other factors. In addition, as a result of the potential range of variations that can occur in our dialysis-related reimbursements from Medicare under the single bundled payment rate system, our revenue recognition is subject to a greater degree of estimating risk.

Commercial healthcare plans, including contracted managed-care payors, are billed at our usual and customary rates; however, revenue is recognized based on estimated net realizable revenue for the services provided. Net realizable revenue is estimated based on contractual terms for the patients covered under commercial healthcare plans with which we have formal agreements, non-contracted commercial healthcare plan coverage terms if known, estimated secondary collections, historical collection experience, historical trends of refunds and payor payment adjustments (retractions), inefficiencies in our billing and collection processes that can result in denied claims for payments, a slowdown in collections, a reduction in the amounts that we expect to collect and regulatory compliance issues. Determining applicable primary and secondary coverage for our approximately 202,700 U.S. dialysis patients at any point in time, together with the changes in patient coverages that occur each month, requires complex, resource-intensive processes. Collections, refunds and payor retractions typically continue to occur for up to three years or longer after services are provided.

We generally expect the range of our dialysis and related lab services revenues estimating risk to be within 1% of its revenue, which can represent as much as approximately 5% of dialysis and related lab services' adjusted operating income. Changes in estimates are reflected in the then-current financial statements based on on-going actual experience trends, or subsequent settlements and realizations depending on the nature and predictability of the estimates and contingencies. Changes in revenue estimates for prior periods are separately disclosed and reported if material to the current reporting period and longer term trend analyses, and have not been significant.

Laboratory service revenues for current period dates of services are recognized at the estimated net realizable amounts to be received.

Impairments of goodwill and investments. We account for impairments of goodwill and equity method and other investments in accordance with the provisions of applicable accounting guidance. Goodwill is not amortized, but is assessed for impairment when changes in circumstances warrant and at least annually. An impairment charge is recorded when and to the extent a reporting unit's carrying amount is determined to exceed its estimated fair value. Equity method and other investments are assessed for other-than-temporary impairment when changes in circumstances warrant. An other-than-temporary impairment charge is recorded when the fair value of an investment has fallen below its carrying amount and the shortfall is expected to be indefinitely or permanently unrecoverable. Such changes in circumstance can include, among others, changes in the legal environment, addressable market, business strategy, development or business plans, reimbursement structure, operating performance, future prospects, relationships with partners, and/or market value indications for the subject business. We use a variety of factors to assess changes in the financial condition, future prospects and other circumstances concerning the subject businesses and to estimate their fair value when applicable. Any change in the factors, assessments or assumptions involved could affect a determination of whether and when to assess goodwill or an investment for impairment as well as the outcome of such an assessment. These assessments and the related valuations can involve significant uncertainties and require significant judgment on various matters, some of which could be subject to reasonable disagreement.

Accounting for income taxes. Our income tax expense, deferred tax assets and liabilities, and liabilities for unrecognized tax benefits reflect management's best assessment of estimated current and future taxes to be paid. We are subject to income taxes in the United States and numerous state and foreign jurisdictions, and changes in tax laws or regulations may be proposed or enacted that could adversely affect our overall tax liability. The actual impact of any such laws or regulations could be materially different from our current estimates.

Significant judgments and estimates are required in determining our consolidated income tax expense. Deferred income taxes arise from temporary differences between the tax basis of assets and liabilities and their reported amounts in the financial statements, which will result in taxable or deductible amounts in the future. In evaluating our ability to recover our deferred tax assets within the jurisdiction from which they arise, we consider all available positive and negative evidence, including scheduled reversals of deferred tax liabilities, projected future taxable income, tax planning strategies, results of recent operations, and assumptions about the amount of future federal, state, and foreign pre-tax operating income adjusted for items that do not have tax consequences. The assumptions about future taxable income require significant judgments and are consistent with the plans and estimates we use to manage the underlying businesses. To the extent that recovery is not likely, a valuation allowance is established. The allowance is regularly reviewed and updated for changes in circumstances that would cause a change in judgment

about the realizability of the related deferred tax assets.

Consolidation of variable interest entities. We rely on the operating activities of certain entities that we do not directly own or control, but over which we have indirect influence and of which we are considered the primary beneficiary. Under accounting guidance applicable to variable interest entities, we have determined that these entities are to be included in our consolidated financial statements. The analyses upon which these determinations rest are complex, involve uncertainties, and require judgment on various matters, some of which could be subject to reasonable disagreement. While these determinations

have a meaningful effect on the description and classification of various amounts in our consolidated financial statements, non-consolidation of these entities would not have had a material effect on our results of operations.

Fair value estimates. The FASB defines fair value generally as the amount at which an asset (or liability) could be bought (or incurred) or sold (or settled) in a current transaction between willing parties, that is, other than in a forced or liquidation sale. It also defines fair value more specifically for most purposes as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date.

We rely on fair value measurements and estimates for purposes that require the recording, reassessment, or adjustment of the carrying amounts of certain assets, liabilities and noncontrolling interests subject to put provisions (temporary equity). These purposes can include the accounting for business combination transactions; impairment assessments for goodwill, other intangible assets, and other long-lived assets; recurrent revaluation of investments in debt and equity securities, interest rate cap agreements or other derivative instruments, contingent earn-out obligations, and noncontrolling interests subject to put provisions; and the accounting for equity method and other investments and stock-based compensation, among others. The criticality of a particular fair value estimate to our consolidated financial statements depends upon the nature and size of the item being measured, the extent of uncertainties involved and the nature and magnitude or potential effect of assumptions and judgments required. Critical fair value estimates can involve significant uncertainties and require significant judgment on various matters, some of which could be subject to reasonable disagreement.

Significant new accounting standards

See Note 1 to the consolidated financial statements included in this report for information regarding certain recent financial accounting standards that have been issued by the FASB.

Item 7A. Quantitative and Qualitative Disclosures about Market Risk.

Interest rate sensitivity

The tables below provide information about our financial instruments that are sensitive to changes in interest rates. The table below presents principal repayments and current weighted average interest rates on our debt obligations as of December 31, 2018. The variable rates presented reflect the weighted average LIBOR rates in effect for all debt tranches plus interest rate margins in effect as of December 31, 2018. The Term Loan A margin in effect at December 31, 2018 is 2.00%, and along with the revolving line of credit, is subject to adjustment depending upon changes in certain of our financial ratios, including a leverage ratio. Term Loan A-2 currently bears interest at LIBOR plus an interest rate margin of 1.00%. Term Loan B currently bears interest at LIBOR plus an interest rate margin of 2.75%.

	Expected maturity date					Thereafter	Total	Average interest rate	Fair value
	2019	2020	2021	2022	2023				
	(dollars in millions)								
Long term debt:									
Fixed rate	$37	$34	$29	$1,279	$28	$3,494	$4,901	5.29%	$4,643
Variable rate	$1,892	$46	$3,285	$12	$10	$8	$5,253	5.11%	$5,259

	Notional amount	Contract maturity date					Receive variable	Fair value
		2019	2020	2021	2022	2023		
		(dollars in millions)						
Cap agreements	$3,500	$—	$3,500	$—	$—	$—	LIBOR above 3.5%	$0.9

On March 29, 2018, we entered into an Increase Joinder No. 1 (Increase Joinder Agreement) under our existing senior secured credit facilities. Pursuant to this Increase Joinder Agreement, we entered into an additional $995 million Term Loan A-2.

Our senior secured credit facilities, which include Term Loan A, Term Loan A-2, and Term Loan B, consist of various individual tranches of debt that can range in maturity from one month to twelve months (currently, all tranches are one month in duration). For Term Loan A, Term Loan A-2, and Term Loan B, each tranche bears interest at a LIBOR rate that is determined by the duration of such tranche plus an interest rate margin. The LIBOR variable component of the

interest rate for

each tranche is reset as such tranche matures and a new tranche is established. LIBOR can fluctuate significantly depending upon conditions in the credit and capital markets.

As of December 31, 2018, our Term Loan A bears interest at LIBOR plus an interest rate margin of 2.00%, our Term Loan A-2 bears interest at LIBOR plus an interest rate margin of 1.00%, and our Term Loan B bears interest at LIBOR plus an interest rate margin of 2.75%. LIBOR was greater than the 0.75% embedded LIBOR floor on Term Loan B, resulting in Term Loan B being subject to LIBOR-based interest rate volatility on the LIBOR variable component of our interest rate as of December 31, 2018. However, this LIBOR-based interest component is effectively limited to a maximum LIBOR rate of 3.50% on the outstanding principal debt on Term Loan B and on $157.5 million of Term Loan A as a result of the interest rate cap agreements, as described below. In addition, the uncapped portion of Term Loan A of $517.5 million and the entire balance of Term Loan A-2 are subject to the variability of LIBOR. See the table above for further details. Interest rates on our Senior Notes are fixed by their terms.

As of December 31, 2018, we maintain several interest rate cap agreements that were entered into in October 2015 with notional amounts totaling $3.5 billion. These cap agreements became effective June 29, 2018, have the economic effect of capping the LIBOR variable component of our interest rate at a maximum of 3.50% on an equivalent amount of our debt, and will expire on June 30, 2020. As of December 31, 2018, the total fair value of these cap agreements was an asset of approximately $0.9 million. During the year ended December 31, 2018, we recognized debt expense of $4.3 million from these cap agreements and recorded a loss of $0.2 million in other comprehensive income due to a decrease in the unrealized fair value of these cap agreements.

Previously, we maintained other interest rate cap agreements that were entered into in November 2014 with notional amounts also totaling $3.5 billion. These cap agreements had the economic effect of capping the LIBOR variable component of our interest rate at a maximum of 3.50% on an equivalent amount of our debt and expired on June 30, 2018. During the year ended 2018, we recognized debt expense of $4.1 million from these cap agreements and recorded an immaterial loss in other comprehensive income due to a decrease in the unrealized fair value of these cap agreements through expiration.

Our overall weighted average effective interest rate on the senior secured credit facilities at the end of 2018 was 5.11%, based upon the current margins in effect of 2.00% for Term Loan A, 1.00% for Term Loan A-2 and 2.75% for Term Loan B as of December 31, 2018.

Our overall weighted average effective interest rate during the year ended December 31, 2018 was 4.96% and as of December 31, 2018 was 5.19%.

As of December 31, 2018, we had $175 million drawn on our $1.0 billion revolving line of credit under our senior secured credit facilities, in addition to approximately $14.2 million committed for outstanding letters of credit. We also have approximately $22.6 million of additional outstanding letters of credit under a separate bilateral secured letter of credit facility, and $0.2 million of committed outstanding letters of credit which are backed by a certificate of deposit.

We believe that our cash flow from operations and other sources of liquidity, including from amounts available under our existing credit facilities and anticipated debt refinancing, as well as proceeds from the anticipated sale of our DMG business if consummated, will be sufficient to fund our scheduled debt service under the terms of our debt agreements and other obligations for the foreseeable future, including the next 12 months. Our primary sources of liquidity are cash from operations and cash from borrowings.

One means of assessing exposure to debt-related interest rate changes is a duration-based analysis that measures the potential loss in net income resulting from a hypothetical increase in interest rates of 100 basis points across all variable rate maturities (referred to as a parallel shift in the yield curve). Under this model, with all else constant, it is estimated that such an increase would have reduced net income by approximately $37.8 million, $27.6 million, and $11.6 million, net of tax, for the years ended December 31, 2018, 2017, and 2016, respectively.

Exchange rate sensitivity

While our business is predominantly conducted in the U.S. we have developing operations in nine other countries as well. For financial reporting purposes, the U.S. dollar is our reporting currency. However, the functional currencies of our operating businesses in other countries are typically those of the countries in which they operate. Therefore,

changes in the rate of exchange between the U.S. dollar and the local currencies in which our international operations are conducted affect our results of operations and financial position as reported in our consolidated financial statements.

We have consolidated the balance sheets of our non-U.S. dollar denominated operations into U.S. dollars at the exchange rates prevailing at the balance sheet dates and have translated their revenues and expense at average exchange rates during each period. Additionally, our individual subsidiaries are exposed to transactional risks mainly resulting from intercompany transactions between and among subsidiaries with different functional currencies. This exposes the subsidiaries to fluctuations in the rate of exchange between the invoicing or obligation currencies and the currency in which their local operations are conducted.

We evaluate our exposure to foreign exchange risk through the judgment of our regional and corporate management teams. Through 2018, our international operations remained fairly small relative to the size of our consolidated financial statements, constituting less than 7% of our consolidated assets as of December 31, 2018 and approximately 4% of our consolidated net revenues for the year ended December 31, 2018. In addition, our foreign currency translation (losses) gains were less than approximately (3)%, 6%, and (2)% of our consolidated operating income for the years ended December 31, 2018, 2017 and 2016.

Given the still small size of our international operations, management does not consider our exposure to foreign exchange risk to be significant to the consolidated enterprise. As such, through December 31, 2018 we have not engaged in transactions to hedge the exposure of our international transactions or net investments to foreign currency risk. However, we may do so in the future.

Item 8. Financial Statements and Supplementary Data.

See the Index to Financial Statements and Index to Financial Statement Schedules included at “Item 15. Exhibits, Financial Statement Schedules.”

Item 9. Changes in and Disagreements with Accountants on Accounting and Financial Disclosure.

None.

Item 9A. Controls and Procedures.

Management has established and maintains disclosure controls and procedures designed to ensure that information required to be disclosed in the reports that it files or submits pursuant to the Securities Exchange Act of 1934 (Exchange Act) as amended is recorded, processed, summarized and reported within the time periods specified in the SEC’s rules and forms, and that such information is accumulated and communicated to our management including our Chief Executive Officer and Chief Financial Officer as appropriate to allow for timely decisions regarding required disclosures.

At the end of the period covered by this report, we carried out an evaluation, under the supervision and with the participation of our Chief Executive Officer and Chief Financial Officer, of the effectiveness of the design and operation of our disclosure controls and procedures in accordance with the Exchange Act requirements. Based upon that evaluation, the Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures are effective for timely identification and review of material information required to be included in our Exchange Act reports, including this report on Form 10-K. Management recognizes that these controls and procedures can provide only reasonable assurance of desired outcomes, and that estimates and judgments are still inherent in the process of maintaining effective controls and procedures.

Beginning January 1, 2018, we adopted FASB Accounting Standards Codification Topic 606, *Revenue from Contracts with Customers*. Although the new standard is expected to have an immaterial impact on our ongoing net income, we did implement new business processes and related control activities in order to maintain appropriate controls over financial reporting. There was no other change in our internal control over financial reporting that was identified during the evaluation that occurred during the fourth fiscal quarter and that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

Item 9B. Other Information.

None.

PART III

Item 10. Directors, Executive Officers and Corporate Governance.

We intend to disclose any amendments or waivers to the Code of Ethics applicable to our principal executive officer, principal financial officer, principal accounting officer or controller or persons performing similar functions, on our website located at http://www.davita.com. In 2002, we adopted a Corporate Governance Code of Ethics that applies to our principal executive officer, principal financial officer, principal accounting officer or controller, and to all of our financial accounting and legal professionals who are directly or indirectly involved in the preparation, reporting and fair presentation of our financial statements and Exchange Act reports. The Code of Ethics is posted on our website, located at http://www.davita.com. We also maintain a Corporate Code of Conduct that applies to all of our employees, officers and directors, which is posted on our website.

Under our Corporate Governance Guidelines all Board Committees including the Audit Committee, Nominating and Governance Committee and the Compensation Committee, which are comprised solely of independent directors as defined within the listing standards of the New York Stock Exchange, have written charters that outline the committee's purpose, goals, membership requirements and responsibilities. These charters are regularly reviewed and updated as necessary by our Board of Directors. All Board Committee charters as well as the Corporate Governance Guidelines are posted on our website located at http://www.davita.com.

The other information required to be disclosed by this item will appear in, and is incorporated by reference from, the sections entitled "Proposal 1 Election of Directors", "Corporate Governance", and "Security Ownership of Certain Beneficial Owners and Management" included in our definitive proxy statement relating to our 2019 annual stockholder meeting.

Item 11. Executive Compensation.

The information required by this item will appear in, and is incorporated by reference from, the sections entitled "Executive Compensation", "Pay Ratio Disclosure", "Compensation of Directors" and "Compensation Committee Interlocks and Insider Participation" included in our definitive proxy statement relating to our 2019 annual stockholder meeting. The information required by Item 407(e)(5) of Regulation S-K will appear in and is incorporated by reference from the section entitled "Compensation Committee Report" included in our definitive proxy statement relating to our 2019 annual stockholder meeting; however, this information shall not be deemed to be filed.

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters.

The following table provides information about our common stock that may be issued upon the exercise of stock-settled stock appreciation rights, restricted stock units and other rights under all of our existing equity compensation plans as of December 31, 2018, which consist of our 2011 Incentive Award Plan and our Employee Stock Purchase Plan. The material terms of these plans are described in Note 19 to the consolidated financial statements.

Plan category	Number of shares to be issued upon exercise of outstanding options, warrants and rights	Weighted average exercise price of outstanding options, warrants and rights	Number of shares remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a))	Total of shares reflected in columns (a) and (c)
	(a)	*(b)*	*(c)*	*(d)*
Equity compensation plans approved by shareholders	8,155,501[1]	69.90[2]	29,818,042	37,973,543
Equity compensation plans not requiring shareholder approval	—	—	—	—
Total	8,155,501	$ 69.90	29,818,042	37,973,543

(1) Includes 722,412 shares of common stock reserved for issuance in connection with performance share units and performance stock appreciation rights at the maximum number of shares issuable thereunder.

(2) This weighted-average includes performance stock appreciation rights at 100% of target amount and excludes full value awards such as restricted stock units and performance share units.

Other information required to be disclosed by Item 12 will appear in, and is incorporated by reference from, the section entitled “Security Ownership of Certain Beneficial Owners and Management” included in our definitive proxy statement relating to our 2019 annual stockholder meeting.

Item 13. Certain Relationships and Related Transactions, and Director Independence.

The information required by this item will appear in, and is incorporated by reference from, the section entitled “Certain Relationships and Related Transactions” and the section entitled “Corporate Governance” included in our definitive proxy statement relating to our 2019 annual stockholder meeting.

Item 14. Principal Accounting Fees and Services.

The information required by this item will appear in, and is incorporated by reference from, the section entitled “Proposal 2 Ratification of the Appointment of our Independent Registered Public Accounting Firm” included in our definitive proxy statement relating to our 2019 annual stockholder meeting.

PART IV

Item 15. Exhibits, Financial Statement Schedules.

(a) Documents filed as part of this Report:

(1) Index to Financial Statements:

	Page
Management's Report on Internal Control Over Financial Reporting	F-1
Report of Independent Registered Public Accounting Firm	F-2
Report of Independent Registered Public Accounting Firm	F-3
Consolidated Statements of Income for the years ended December 31, 2018, 2017, and 2016	F-4
Consolidated Statements of Comprehensive Income for the years ended December 31, 2018, 2017, and 2016	F-5
Consolidated Balance Sheets as of December 31, 2018, and 2017	F-6
Consolidated Statements of Cash Flow for the years ended December 31, 2018, 2017, and 2016	F-7
Consolidated Statements of Equity for the years ended December 31, 2018, 2017, and 2016	F-8
Notes to Consolidated Financial Statements	F-10

(2) Index to Financial Statement Schedules:

Schedule II—Valuation and Qualifying Accounts S-3

(3) Exhibits

The information required by this Item is set forth in the Exhibit Index that precedes the signature pages of this Annual Report on Form 10-K.

Item 16. Form 10-K Summary.

None.

DAVITA INC.

MANAGEMENT'S REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING

Management is responsible for establishing and maintaining an adequate system of internal control over financial reporting designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with U.S. generally accepted accounting principles and which includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the Company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with U.S. generally accepted accounting principles, and that receipts and expenditures of the Company are being made only in accordance with authorizations of management and directors of the Company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the Company's assets that could have a material effect on the financial statements.

During the last fiscal year, the Company conducted an evaluation, under the oversight of the Chief Executive Officer and Chief Financial Officer, of the effectiveness of the design and operation of the Company's internal control over financial reporting. This evaluation was completed based on the criteria established in the report titled "Internal Control—Integrated Framework (2013)" issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

Based upon our evaluation under the COSO framework, we have concluded that the Company's internal control over financial reporting was effective as of December 31, 2018.

The Company's independent registered public accounting firm, KPMG LLP, has issued an attestation report on the Company's internal control over financial reporting, which report is included in this Annual Report.

Report of Independent Registered Public Accounting Firm

To the Stockholders and Board of Directors
DaVita Inc.:

Opinion on the Consolidated Financial Statements

We have audited the accompanying consolidated balance sheets of DaVita Inc. and subsidiaries (the Company) as of December 31, 2018 and 2017, the related consolidated statements of income, comprehensive income, equity, and cash flows for each of the years in the three-year period ended December 31, 2018, and the related notes and financial statement Schedule II - Valuation and Qualifying Accounts (collectively, the consolidated financial statements). In our opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the Company as of December 31, 2018 and 2017, and the results of its operations and its cash flows for each of the years in the three-year period ended December 31, 2018, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the Company's internal control over financial reporting as of December 31, 2018, based on criteria established in *Internal Control - Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission, and our report dated February 22, 2019 expressed an unqualified opinion on the effectiveness of the Company's internal control over financial reporting.

Change in Accounting Principle

As discussed in Notes 1 and 2 to the consolidated financial statements, the Company has changed its method of accounting for revenue recognition in 2018 due to the adoption of the Financial Accounting Standards Board's Accounting Standards Codification Topic 606 *Revenue from Contracts with Customers.*

Basis for Opinion

These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the consolidated financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements. We believe that our audits provide a reasonable basis for our opinion.

/s/ KPMG LLP
We have served as the Company's auditor since 2000.
Seattle, Washington
February 22, 2019

Report of Independent Registered Public Accounting Firm

To the Stockholders and Board of Directors
DaVita Inc.:

Opinion on Internal Control Over Financial Reporting

We have audited DaVita Inc. and subsidiaries' (the Company) internal control over financial reporting as of December 31, 2018, based on criteria established in *Internal Control - Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission. In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2018, based on criteria established in *Internal Control - Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the consolidated balance sheets of the Company as of December 31, 2018 and 2017, the related consolidated statements of income, comprehensive income, equity, and cash flows for each of the years in the three-year period ended December 31, 2018, and the related notes and financial statement Schedule II - Valuation and Qualifying Accounts (collectively, the consolidated financial statements), and our report dated February 22, 2019 expressed an unqualified opinion on those consolidated financial statements.

Basis for Opinion

The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Management's Report on Internal Control Over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audit also included performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definition and Limitations of Internal Control Over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ KPMG LLP

Seattle, Washington

February 22, 2019

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DAVITA INC.
CONSOLIDATED STATEMENTS OF INCOME
(dollars in thousands, except per share data)

	Year ended December 31,		
	2018	**2017**	**2016**
Dialysis and related lab patient service revenues	$10,709,981	$10,093,670	$9,727,360
Provision for uncollectible accounts	(49,587)	(485,364)	(431,304)
Net dialysis and related lab patient service revenues	10,660,394	9,608,306	9,296,056
Other revenues	744,457	1,268,328	1,411,411
Total revenues	11,404,851	10,876,634	10,707,467
Operating expenses and charges:			
Patient care costs and other costs	8,195,513	7,640,005	7,431,582
General and administrative	1,135,454	1,064,026	1,072,841
Depreciation and amortization	591,035	559,911	509,497
Provision for uncollectible accounts	(7,300)	(7,033)	11,677
Equity investment income	4,484	8,640	(16,874)
Investment and other asset impairments	17,338	295,234	14,993
Goodwill impairment charges	3,106	36,196	28,415
Gain on changes in ownership interest, net	(60,603)	(6,273)	(374,374)
Gain on settlement, net	—	(526,827)	—
Total operating expenses and charges	9,879,027	9,063,879	8,677,757
Operating income	1,525,824	1,812,755	2,029,710
Debt expense	(487,435)	(430,634)	(414,116)
Other income, net	10,089	17,665	7,511
Income from continuing operations before income taxes	1,048,478	1,399,786	1,623,105
Income tax expense	258,400	323,859	431,761
Net income from continuing operations	790,078	1,075,927	1,191,344
Net loss from discontinued operations, net of tax	(457,038)	(245,372)	(158,262)
Net income	333,040	830,555	1,033,082
Less: Net income attributable to noncontrolling interests	(173,646)	(166,937)	(153,208)
Net income attributable to DaVita Inc.	$159,394	$663,618	$879,874
Earnings per share attributable to DaVita Inc.:			
Basic net income from continuing operations per share	$3.66	$4.78	$5.12
Basic net income per share	$0.93	$3.52	$4.36
Diluted net income from continuing operations per share	$3.62	$4.71	$5.04
Diluted net income per share	$0.92	$3.47	$4.29
Weighted average shares for earnings per share:			
Basic	170,785,999	188,625,559	201,641,173
Diluted	172,364,581	191,348,533	204,904,656
Amounts attributable to DaVita Inc.:			
Net income from continuing operations	$624,321	$901,277	$1,032,373
Net loss from discontinued operations	(464,927)	(237,659)	(152,499)
Net income attributable to DaVita Inc.	$159,394	$663,618	$879,874

See notes to consolidated financial statements.

DAVITA INC.
CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME
(dollars in thousands)

	Year ended December 31,		
	2018	2017	2016
Net income	$333,040	$830,555	$1,033,082
Other comprehensive (loss) income:			
Unrealized losses on interest rate cap and swap agreements, net:			
Unrealized losses	(133)	(5,437)	(3,670)
Reclassification into net income	6,286	5,058	2,566
Unrealized gains (losses) on investments, net:			
Unrealized losses	—	3,705	1,427
Reclassification into net income	—	(220)	(423)
Foreign currency translation adjustments:			
Foreign currency translation adjustments	(45,944)	99,770	(39,614)
Reclassification into net income	—	—	10,087
Other comprehensive (loss) income	(39,791)	102,876	(29,627)
Total comprehensive income	293,249	933,431	1,003,455
Less: Comprehensive income attributable to noncontrolling interests	(173,646)	(166,935)	(153,398)
Comprehensive income attributable to DaVita Inc.	$119,603	$766,496	$850,057

See notes to consolidated financial statements.

DAVITA INC.
CONSOLIDATED BALANCE SHEETS
(dollars in thousands, except per share data)

	December 31, 2018	December 31, 2017
ASSETS		
Cash and cash equivalents	$ 323,038	$ 508,234
Restricted cash and equivalents	92,382	10,686
Short-term investments	2,935	32,830
Accounts receivable, net	1,858,608	1,714,750
Inventories	107,381	181,799
Other receivables	469,796	399,262
Prepaid and other current assets	111,840	112,058
Income tax receivable	68,614	49,440
Current assets held for sale, net	5,389,565	5,761,642
Total current assets	8,424,159	8,770,701
Property and equipment, net	3,393,669	3,149,213
Intangible assets, net	118,846	113,827
Equity method and other investments	224,611	245,534
Long-term investments	35,424	37,695
Other long-term assets	71,583	47,287
Goodwill	6,841,960	6,610,279
	$ 19,110,252	$ 18,974,536
LIABILITIES AND EQUITY		
Accounts payable	$ 463,270	$ 509,116
Other liabilities	595,850	579,005
Accrued compensation and benefits	658,913	616,116
Current portion of long-term debt	1,929,369	178,213
Current liabilities held for sale	1,243,759	1,185,070
Total current liabilities	4,891,161	3,067,520
Long-term debt	8,172,847	9,158,018
Other long-term liabilities	450,669	365,325
Deferred income taxes	562,536	486,247
Total liabilities	14,077,213	13,077,110
Commitments and contingencies:		
Noncontrolling interests subject to put provisions	1,124,641	1,011,360
Equity:		

Preferred stock ($0.001 par value, 5,000,000 shares authorized; none issued)	—	—
Common stock ($0.001 par value, 450,000,000 shares authorized; 166,387,307 and 182,462,278 shares issued and outstanding, respectively)	166	182
Additional paid-in capital	995,006	1,042,899
Retained earnings	2,743,194	3,633,713
Accumulated other comprehensive (loss) income	(34,924)	13,235
Total DaVita Inc. shareholders' equity	3,703,442	4,690,029
Noncontrolling interests not subject to put provisions	204,956	196,037
Total equity	3,908,398	4,886,066
	$ 19,110,252	$ 18,974,536

See notes to consolidated financial statements.

DAVITA INC.
CONSOLIDATED STATEMENTS OF CASH FLOW
(dollars in thousands)

	Year ended December 31,		
	2018	**2017**	**2016**
Cash flows from operating activities:			
Net income	$333,040	$830,555	$1,033,082
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	591,035	777,485	720,252
Impairment charges	61,981	981,589	296,408
Valuation adjustment on disposal group	316,840	—	—
Stock-based compensation expense	73,061	35,092	38,338
Deferred income taxes	273,660	(395,217)	52,010
Equity investment income, net	26,449	28,925	17,766
Gain on sales of business interests, net	(85,699)	(23,402)	(404,165)
Other non-cash charges, net	82,374	66,920	(7,343)
Changes in operating assets and liabilities, net of effect of acquisitions and divestitures:			
Accounts receivable	(81,176)	(156,305)	(152,240)
Inventories	73,505	(18,625)	22,920
Other receivables and other current assets	236,995	(111,432)	(45,351)
Other long-term assets	3,497	(11,945)	35,893
Accounts payable	(35,959)	26,876	11,897
Accrued compensation and benefits	84,165	(78,239)	68,272
Other current liabilities	(157,462)	1,908	176,494
Income taxes	(23,635)	(52,176)	77,376
Other long-term liabilities	(1,031)	11,157	30,517
Net cash provided by operating activities	1,771,640	1,913,166	1,972,126
Cash flows from investing activities:			
Additions of property and equipment	(987,138)	(905,250)	(829,095)
Acquisitions	(183,156)	(803,879)	(563,856)
Proceeds from asset and business sales	150,205	92,336	64,725
Purchase of investments available for sale	(8,448)	(13,117)	(13,539)
Purchase of investments held-to-maturity	(5,963)	(228,990)	(1,133,192)
Proceeds from sale of investments available for sale	9,526	6,408	18,963
Proceeds from investments held-to-maturity	34,862	492,470	1,240,502
Purchase of equity investments	(19,177)	(4,816)	(27,096)
Proceeds from sale of equity investments	—	—	40,920
Distributions received on equity investments	3,646	106	—
Net cash used in investing activities	(1,005,643)	(1,364,732)	(1,201,668)
Cash flows from financing activities:			
Borrowings	59,934,750	50,991,960	51,991,490
Payments on long-term debt and other financing costs	(59,239,973)	(50,837,112)	(52,116,120)
Purchase of treasury stock	(1,161,511)	(802,949)	(1,097,822)
Distributions to noncontrolling interests	(196,441)	(211,467)	(192,401)
Stock award exercises and other share issuances, net	13,577	21,252	23,543
Excess tax benefits from stock award exercises	—	—	13,251
Contributions from noncontrolling interests	52,311	74,552	47,590
Proceeds from sales of additional noncontrolling interests	15	2,864	—
Purchases of noncontrolling interests	(28,082)	(5,357)	(21,512)

Net cash used in financing activities	(625,354)	(766,257)	(1,351,981)
Effect of exchange rate changes on cash, cash equivalents and restricted cash	(3,350)	254	4,276
Net increase (decrease) in cash, cash equivalents and restricted cash	137,293	(217,569)	(577,247)
Less: Net increase (decrease) in cash, cash equivalents and restricted cash from discontinued operations	240,793	(53,026)	(15,793)
Net decrease in cash, cash equivalents and restricted cash from continuing operations	(103,500)	(164,543)	(561,454)
Cash, cash equivalents and restricted cash of continuing operations at beginning of the year	518,920	683,463	1,244,917
Cash, cash equivalents and restricted cash of continuing operations at end of the year	$415,420	$518,920	$683,463

See notes to consolidated financial statements.

DAVITA INC.
CONSOLIDATED STATEMENTS OF EQUITY
(dollars and shares in thousands)

		DaVita Inc. Shareholders' Equity							
	Non-controlling interests subject to put provisions	Common stock		Additional paid-in capital	Retained earnings	Treasury stock		Accumulated other comprehensive income (loss)	Total	Non-controlling interests not subject to put provisions
		Shares	Amount			Shares	Amount			
Balance at December 31, 2015	$ 864,066	217,120	$ 217	$ 1,118,326	$ 4,356,835	(7,366)	$ (544,772)	$ (59,826)	$ 4,870,780	$ 213,392
Comprehensive income:										
Net income	99,834				879,874				879,874	53,374
Other comprehensive loss								(29,817)	(29,817)	190
Stock purchase shares issued		438	1	23,902					23,903	
Stock unit shares issued		4	—	(19,815)		276	19,815		—	
Stock-settled SAR shares issued		218	—	(36,685)		513	36,685		—	
Stock-settled stock-based compensation expense				37,970					37,970	
Excess tax benefits from stock awards exercised				13,251					13,251	
Changes in non-controlling interests from:										
Distributions	(111,092)									(81,309)
Contributions	33,517									14,073
Acquisitions and divestitures	28,874			3,423					3,423	2,585
Partial purchases	(6,660)			(13,105)					(13,105)	(1,747)
Fair value remeasurements	65,855			(65,855)					(65,855)	
Reclassifications and expirations of puts	(1,136)									1,136
Purchase of treasury stock						(16,649)	(1,072,377)		(1,072,377)	
Retirement of treasury stock		(23,226)	(23)	(34,230)	(1,526,396)	23,226	1,560,649			
Balance at December 31, 2016	$ 973,258	194,554	$ 195	$ 1,027,182	$ 3,710,313	—	$ —	$ (89,643)	$ 4,648,047	$ 201,694
Comprehensive income:										
Net income	103,641				663,618				663,618	63,296
Other comprehensive income								102,878	102,878	(2)
Stock purchase shares issued		360		22,131					22,131	
Stock unit shares issued		117		(101)					(101)	
Stock-settled SAR shares issued		398		—					—	
Stock-settled stock-based compensation expense				34,981					34,981	
Changes in noncontrolling interest from:										
Distributions	(128,853)									(82,614)
Contributions	52,911									21,641
Acquisitions and divestitures	43,799			(823)					(823)	(5,770)
Partial purchases	(397)			(2,752)					(2,752)	(2,208)
Fair value remeasurements	(32,999)			32,999					32,999	
Purchase of treasury stock						(12,967)	(810,949)		(810,949)	
Retirement of treasury stock		(12,967)	(13)	(70,718)	(740,218)	12,967	810,949			
Balance at December 31, 2017	$ 1,011,360	182,462	$ 182	$ 1,042,899	$ 3,633,713	—	$ —	$ 13,235	$ 4,690,029	$ 196,037

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DAVITA INC.
CONSOLIDATED STATEMENTS OF EQUITY - continued
(dollars and shares in thousands)

	Non-controlling interests subject to put provisions	DaVita Inc. Shareholders' Equity								Non-controlling interests not subject to put provisions
		Common stock		Additional paid-in capital	Retained earnings	Treasury stock		Accumulated other comprehensive income (loss)	Total	
		Shares	Amount			Shares	Amount			
Comprehensive income:										
Net income	105,531				159,394				159,394	68,115
Cumulative effect of change in accounting principle					8,368			(8,368)	—	
Comprehensive income								(39,791)	(39,791)	
Stock purchase shares issued		398		17,398					17,398	
Stock unit shares issued		158		(448)					(448)	
Stock-settled SAR shares issued		213	1	(4,887)					(4,886)	
Stock-settled stock-based compensation expense				73,081					73,081	
Changes in noncontrolling interest from:										
Distributions	(119,173)									(77,268)
Contributions	32,918									19,393
Acquisitions and divestitures	79,078			3,546					3,546	318
Partial purchases	(8,546)			(17,897)					(17,897)	(1,639)
Fair value remeasurements	23,473			(23,473)					(23,473)	
Purchase of treasury stock						(16,844)	(1,153,511)		(1,153,511)	
Retirement of treasury stock		(16,844)	(17)	(95,213)	(1,058,281)	16,844	1,153,511		—	
Balance at December 31, 2018	$ 1,124,641	166,387	$ 166	$ 995,006	$ 2,743,194	—	$ —	$ (34,924)	$ 3,703,442	$ 204,956

See notes to consolidated financial statements.

DAVITA INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
(dollars in thousands, except per share data)

1. Organization and summary of significant accounting policies

Organization

DaVita Inc. (the Company) consists of two major divisions, DaVita Kidney Care (Kidney Care) and DaVita Medical Group (DMG). The Kidney Care division is comprised of the Company's U.S. dialysis and related lab services, its ancillary services and strategic initiatives, including its international operations, and its corporate administrative support. The Company's largest line of business is its U.S. dialysis and related lab services business, which operates kidney dialysis centers in the U.S. for patients suffering from chronic kidney failure also known as end stage renal disease (ESRD). As of December 31, 2018, the Company operated or provided administrative services through a network of 2,664 U.S. outpatient dialysis centers in 46 states and the District of Columbia, serving a total of approximately 202,700 patients. In addition, as of December 31, 2018, the Company operated or provided administrative services to a total of 241 outpatient dialysis centers serving approximately 25,000 patients located in nine countries outside of the U.S.

The Company's DMG division is a patient- and physician-focused integrated healthcare delivery and management company that provides medical services to members primarily through capitation contracts with some of the nation's leading health plans. In December 2017, the Company entered into an agreement to sell its DMG division to Collaborative Care Holdings, LLC (Optum), a subsidiary of UnitedHealth Group Inc., subject to receipt of required regulatory approvals and other customary closing conditions. As a result, the DMG business has been classified as held for sale and its results of operations are reported as discontinued operations for all periods presented in these consolidated financial statements. For financial information about the DMG business, see Note 22.

The Company's U.S. dialysis and related lab services business qualifies as a separately reportable segment and the Company's other ancillary services and strategic initiatives, including its international operations, have been combined and disclosed in the other segments category.

Basis of presentation

These consolidated financial statements are prepared in accordance with United States generally accepted accounting principles (U.S. GAAP). The financial statements include DaVita Inc. and its subsidiaries, partnerships and other entities in which it maintains a majority voting interest or other controlling financial interest (collectively, the Company). All significant intercompany transactions and balances have been eliminated. Equity investments in investees over which the Company has significant influence are recorded on the equity method, while investments in other equity securities are recorded at fair value or pursuant to an adjusted cost method measurement alternative, as applicable. For the Company's international subsidiaries, local currencies are considered their functional currencies. Translation adjustments result from translating the Company's international subsidiaries' financial statements from their functional currencies into the Company's reporting currency (the U.S. dollar, or USD). Prior year balances and amounts have been reclassified to conform to the current year presentation.

The Company has evaluated subsequent events through the date these consolidated financial statements were issued and has included all necessary adjustments and disclosures.

Use of estimates

The preparation of financial statements in conformity with U.S. GAAP requires the use of estimates and assumptions that affect the reported amounts of revenues, expenses, assets, liabilities, contingencies and noncontrolling interests subject to put provisions. Although actual results in subsequent periods will differ from these estimates, such estimates are developed based on the best information available to management and management's best judgments at the time. All significant assumptions and estimates underlying the amounts reported in the financial statements and accompanying notes are regularly reviewed and updated when necessary. Changes in estimates are reflected in the financial statements based upon on-going actual experience trends, or subsequent settlements and realizations depending on the nature and predictability of the estimates and contingencies. Interim changes in estimates related to annual operating costs are applied prospectively within annual periods.

The most significant assumptions and estimates underlying these financial statements and accompanying notes involve revenue recognition and accounts receivable, contingencies, impairments of goodwill and investments, accounting for income taxes, consolidation of variable interest entities, and certain fair value estimates. Specific estimating risks and contingencies are further addressed within these notes to the consolidated financial statements.

DAVITA INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS - (continued)
(dollars in thousands, except per share data)

Revenues

On January 1, 2018, the Company adopted Financial Accounting Standards Board (FASB) Accounting Standards Codification Topic 606 *Revenue from Contracts with Customers* (Topic 606) using the cumulative effect method for those contracts that were not substantially completed as of January 1, 2018. Results for reporting periods beginning on and after January 1, 2018 are presented under Topic 606, while prior period amounts continue to be presented in accordance with the Company's historical accounting under *Revenue Recognition* (Topic 605).

The adoption of this new standard primarily changed the Company's presentation of revenues, provision for uncollectible accounts and allowance for doubtful accounts. Topic 606 requires revenue to be recognized based on the Company's estimate of the transaction price the Company expects to collect as a result of satisfying its performance obligations. Accordingly, for performance obligations satisfied after the adoption of Topic 606, the Company no longer separately presents a provision for uncollectible accounts on the consolidated income statement and no longer presents the related allowance for doubtful accounts on the consolidated balance sheet. However, as a result of the Company's election to apply Topic 606 only to contracts not substantially completed as of January 1, 2018, the Company continues to maintain an allowance for doubtful accounts related to performance obligations satisfied prior to the adoption of Topic 606. Net collections or write-offs of accounts receivable generated prior to January 1, 2018, beyond amounts previously reserved thereon, are presented in the provision for uncollectible accounts on the consolidated income statement in accordance with Topic 605.

Dialysis and related lab patient service revenues

Dialysis patient service revenues are recognized in the period services are provided. Revenues consist primarily of payments from government and commercial health plans for dialysis and related lab services provided to patients. A usual and customary fee schedule is maintained for the Company's dialysis treatments and related lab services; however, actual collectible revenue is normally recognized at a discount from the fee schedule.

Revenues associated with Medicare and Medicaid programs are estimated based on: (a) the payment rates that are established by statute or regulation for the portion of payment rates paid by the government payor (e.g., 80% for Medicare patients) and (b) for the portion not paid by the primary government payor, estimates of the amounts ultimately collectible from other government programs paying secondary coverage (e.g., Medicaid secondary coverage), the patient's commercial health plan secondary coverage, or the patient.

Under Medicare's bundled payment rate system, services covered by Medicare are subject to estimating risk, whereby reimbursements from Medicare can vary significantly depending upon certain patient characteristics and other variable factors. Even with the bundled payment rate system, Medicare payments for bad debt claims as established by cost reports require evidence of collection efforts. As a result, billing and collection of Medicare bad debt claims can be delayed significantly and final payment is subject to audit. The Company's revenue recognition is estimated based on its judgment regarding its ability to collect, which depends upon its ability to effectively capture, document and bill for Medicare's base payment rate as well as these other variable factors.

Medicaid payments, when Medicaid coverage is secondary, can also be difficult to estimate. For many states, Medicaid payment terms and methods differ from Medicare, and may prevent accurate estimation of individual payment amounts prior to billing.

Revenues associated with commercial health plans are estimated based on contractual terms for the patients under healthcare plans with which the Company has formal agreements, non-contracted health plan coverage terms if known, estimated secondary collections, historical collection experience, historical trends of refunds and payor payment adjustments (retractions), inefficiencies in the Company's billing and collection processes that can result in denied claims for payments, and regulatory compliance matters.

Commercial revenue recognition also involves significant estimating risks. With many larger commercial insurers, the Company has several different contracts and payment arrangements, and these contracts often include only a subset of the Company's centers. In certain circumstances, it may not be possible to determine which contract, if any, should be applied prior to billing. In addition, for services provided by non-contracted centers, final collection may require

specific negotiation of a payment amount, typically at a significant discount from the Company's usual and customary rates.

DAVITA INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS - (continued)
(dollars in thousands, except per share data)

Other revenues
Other revenues consist of the revenues associated with the non-dialysis ancillary services and strategic initiatives, management and administrative support services that are provided to outpatient dialysis centers that the Company does not own or in which the Company owns a noncontrolling interest, and administrative and management support services to certain other non-dialysis joint ventures in which the Company owns a noncontrolling interest. Revenues associated with pharmacy services are estimated as prescriptions are filled and shipped to patients. Revenues associated with dialysis management services, disease management services, clinical research programs, physician services, ESRD seamless care organizations, and comprehensive care are estimated in the period services are provided. Revenues associated with direct primary care were estimated over the membership period.
Other income
Other income includes interest income on cash and cash-equivalents and short- and long-term investments, other non-operating gains from investment transactions, and foreign currency transaction gains and losses.
Cash and cash equivalents
Cash equivalents are short-term highly liquid investments with maturities of three months or less at date of purchase.
Restricted cash and equivalents
Restricted cash and equivalents are restricted cash or cash equivalents held in trust to satisfy insurer and state regulatory requirements related to the Company's self-insurance for professional and general liability and workers' compensation risks administered by wholly-owned captive insurance entities.
Investments in debt and equity securities
The Company classifies certain debt securities as held-to-maturity and records them at amortized cost based on the Company’s intentions and strategies concerning those investments. Equity securities that have readily determinable fair values or redemption values are classified as short-term or long-term investments and recorded at estimated fair value with changes in fair value recognized in current earnings. See Note 5 for further details, including recent changes to the Company's accounting for these investments.
Inventories
Inventories are stated at the lower of cost (first-in, first-out) or net realizable value and consist principally of pharmaceuticals and dialysis-related supplies. Rebates related to inventory purchases are recorded when earned and are based on certain qualification requirements which are dependent on a variety of factors including future pricing levels by the manufacturer and data submission.
Property and equipment
Property and equipment is stated at cost less accumulated depreciation and amortization and is further reduced by any impairments. Maintenance and repairs are charged to expense as incurred. Depreciation and amortization expenses are computed using the straight-line method over the useful lives of the assets estimated as follows: buildings, 20 years to 40 years; leasehold improvements, the shorter of ten years or the expected lease term; and equipment and information systems, principally three years to 15 years. Disposition gains and losses are included in current operating expenses.
Amortizable intangibles
Amortizable intangible assets and liabilities include non-competition and similar agreements, lease agreements and hospital acute services contracts, each of which have finite useful lives. Amortization expense is computed using the straight-line method over the useful lives of the assets estimated as follows: non-competition and similar agreements, two years to ten years; and lease agreements and hospital acute service contracts, over the term of the lease or contract period, respectively.

DAVITA INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS - (continued)
(dollars in thousands, except per share data)

Indefinite-lived intangibles
Indefinite-lived intangible assets include international licenses and accreditations that allow the Company to be reimbursed for providing dialysis services to patients, each of which has an indefinite useful life. Indefinite-lived intangibles are not amortized, but are assessed for impairment at least annually and whenever significant events or changes in circumstances indicate that an impairment may have occurred.
Equity method and other investments
Equity investments that do not have readily determinable fair values are carried on the equity method if the Company maintains significant influence over the investee, or on an adjusted cost method measurement alternative representing either the Company's cost or a subsequent observation of fair value, in each case net of any applicable other-than-temporary impairment. The Company classifies its equity and adjusted cost method investments as “Equity method and other investments” on its balance sheet. See Note 10 to these consolidated financial statements for further details, including recent changes to the Company's accounting for these investments.
Goodwill
Goodwill represents the difference between the fair value of businesses acquired and the fair value of the identifiable tangible and intangible net assets acquired. Goodwill is not amortized, but is assessed by individual reporting unit for impairment as circumstances warrant and at least annually. An impairment charge is recorded when and to the extent a reporting unit's carrying amount is determined to exceed its fair value. The Company operates multiple reporting units. See Note 11 to these consolidated financial statements for further details.
Impairment of equity method and other investments
Equity method and other investments are assessed for other-than-temporary impairment when significant events or changes in circumstances indicate that an other-than-temporary impairment may have occurred. An other-than-temporary impairment charge is recorded when the fair value of an investment has fallen below its carrying amount and the shortfall is expected to be indefinitely or permanently unrecoverable.
Impairment of other long-lived assets
Other long-lived assets, including property and equipment and intangible assets, are reviewed for possible impairment whenever significant events or changes in circumstances indicate that an impairment may have occurred. Such changes can include changes in the Company’s business strategy and plans, changes in the quality or structure of its relationships with its partners or deteriorating performance of individual outpatient dialysis centers or other business units. An impairment of an amortizable or depreciable asset is indicated when the sum of the expected future undiscounted net cash flows identifiable to the related asset group is less than its carrying amount. Impairment losses are measured based on the difference between the estimated fair value and the carrying amount of the subject asset group and are included in operating expenses.
Self-insurance
The Company is predominantly self-insured with respect to professional and general liability and workers' compensation risks through wholly-owned captive insurance companies, with excess or reinsurance coverage for additional risk. The Company is also predominantly self-insured with respect to employee medical and other health benefits. The Company records insurance liabilities for the professional and general liability, workers’ compensation, and employee health benefit risks that it retains and estimates its liability for those risks using third party actuarial calculations that are based upon historical claims experience and expectations for future claims.
Income taxes

Federal and state income taxes are computed at currently enacted tax rates less tax credits using the asset and liability method. Deferred taxes are adjusted both for items that do not currently have tax consequences and for the cumulative effect of any changes in tax rates from those previously used to determine deferred tax assets or liabilities. Tax provisions include amounts that are currently payable, changes in deferred tax assets and liabilities that arise because of temporary differences between the timing of when items of income and expense are recognized for financial

reporting and income tax purposes, changes in the recognition of tax positions and any changes in the valuation allowance caused by a change in judgment about

the realizability of the related deferred tax assets. A valuation allowance is established when necessary to reduce deferred tax assets to amounts expected to be realized.

The Company uses a recognition threshold of more-likely-than-not and a measurement attribute on all tax positions taken or expected to be taken in a tax return in order to be recognized in the financial statements. Once the recognition threshold is met, the tax position is then measured to determine the actual amount of benefit to recognize in the financial statements.

Stock-based compensation

The Company's stock-based compensation expense for stock-settled awards is measured at the estimated fair value of awards on the date of grant and recognized on a cumulative straight-line basis over the vesting terms of the awards unless the stock awards are based on non-market based performance metrics, in which case expense is adjusted for expected ultimate payouts as of the end of each reporting period. Stock-based compensation expense for cash-settled awards is based on the estimated fair values as of the end of each reporting period. The expense for all stock-based awards is recognized net of expected forfeitures.

Interest rate cap and swap agreements

The Company often carries a combination of current or forward interest rate caps or interest rate swaps on portions of its variable rate debt as a means of hedging its exposure to changes in LIBOR interest rates as part of its overall interest rate risk management strategy. These interest rate caps and swaps are not held for trading or speculative purposes and are typically designated as qualifying cash flow hedges. See Note 14 to these consolidated financial statements for further details.

Noncontrolling interests

Noncontrolling interests represent third-party equity ownership interests in entities which are consolidated by the Company for financial statement reporting purposes. As of December 31, 2018, third parties held noncontrolling equity interests in 653 consolidated legal entities, including 650 legal entities classified within continuing operations.

Fair value estimates

The Company relies on fair value measurements and estimates for purposes that require the recording, reassessment, or adjustment of the carrying amounts of certain assets, liabilities and noncontrolling interests subject to put provisions (temporary equity). These purposes can include the accounting for business combination transactions; impairment assessments for goodwill, other intangible assets, or other long-lived assets; recurrent revaluation of investments in debt and equity securities, interest rate cap agreements or other derivative instruments, contingent earn-out obligations, and noncontrolling interests subject to put provisions; and the accounting for equity method and other investments and stock-based compensation, as applicable. The Company has also classified its assets, liabilities and temporary equity into the appropriate fair value hierarchy levels as defined by the FASB. See Note 24 to these consolidated financial statements for further details.

New accounting standards

On May 28, 2014, the FASB issued ASU No. 2014-09, *Revenue from Contracts with Customers (Topic 606),* which requires an entity to recognize the amount of revenue to which it expects to be entitled for the transfer of promised goods or services to customers. In 2015, 2016 and 2017, the FASB issued ASU 2015-14, ASU 2016-08, ASU 2016-10, ASU 2016-11, ASU 2016-12, and ASU 2017-10, each of which amended the guidance in ASU 2014-09. These ASUs replaced most existing revenue recognition guidance in GAAP. The Company adopted these ASUs beginning January 1, 2018. See Note 2 for further details.

In January 2016, the FASB issued ASU No. 2016-01, *Financial Instruments - Overall (Subtopic 825-10): Recognition and Measurement of Financial Assets and Financial Liabilities*. In February 2018, the FASB issued ASU 2018-03, which provides various related technical corrections and improvements. The Company adopted these ASUs beginning January 1, 2018. See Note 5 for further details.

In February 2016, the FASB issued ASU No. 2016-02, *Leases (Topic 842)*. The amendments in this ASU include revisions to lessee accounting, requiring lessees to recognize a lease liability and a right-of-use asset for substantially all leases with lease terms in excess of twelve months. The Company plans to adopt the amendments in this ASU as of January 1, 2019 using a modified retrospective transition approach for leases existing at, or entered into after, the adoption date with a cumulative effect adjustment. The Company is planning on electing the package of practical expedients to not reassess prior

conclusions related to contracts containing leases, lease classification and initial direct costs. The Company estimates the impact of this guidance will result in recognition of additional net lease liabilities of approximately $3,000,000 as of January 1, 2019. The Company is still finalizing its calculations, including the amount of right of use assets to recognize as well as, the cumulative effect adjustment to beginning retained earnings. The Company does not believe this new guidance will have a material effect on its results of operations or liquidity.

In August 2016, the FASB issued ASU No. 2016-15, *Statement of Cash Flows (Topic 230): Classification of Certain Cash Receipts and Cash Payments*. The amendments in this ASU clarify how certain cash receipts and cash payments should be classified on the statement of cash flows. In November 2016, the FASB issued ASU No. 2016-18, *Statement of Cash Flows (Topic 230): Restricted cash.* The amendments in this ASU require that the statement of cash flows explain the change during the period in the total of cash, cash equivalents, and amounts generally described as restricted cash or restricted cash equivalents. The adoption of these ASUs did not have a material impact on the Company's consolidated financial statements when adopted on January 1, 2018.

In October 2016, the FASB issued ASU No. 2016-16, *Income Taxes (Topic 740): Intra-Entity Transfers of Assets Other Than Inventory*. The amendments in this ASU allow entities to recognize the income tax consequences of an intra-entity transfer of an asset other than inventory when the transfer occurs. The prior guidance did not allow recognition until the asset had been sold to an outside party. The amendments in this ASU were effective for the Company beginning on January 1, 2018 and have been applied on a modified retrospective basis. The adoption of this ASU did not have a material impact on the Company's consolidated financial statements.

In August 2017, the FASB issued ASU No. 2017-12, *Derivatives and Hedging (Topic 815): Targeted Improvements to Accounting for Hedging Activities.* The amendments in this ASU better align an entity's risk management activities and financial reporting for hedging relationships through changes to both the designation and measurement guidance for qualifying hedging relationships and the presentation of hedge results. The amendments in this ASU are effective for the Company on January 1, 2019 and are to be applied prospectively. The adoption of this ASU is not expected to have a material impact on the Company's consolidated financial statements.

In February 2018, the FASB issued ASU No. 2018-02, *Income Statement - Reporting Comprehensive Income (Topic 220), Reclassification of Certain Tax Effects from Accumulated Other Comprehensive Income*, which allows for the reclassification of certain income tax effects related to the Tax Cuts and Jobs Act (2017 Tax Act) between "Accumulated other comprehensive income" and "Retained earnings." This ASU relates to the requirement that adjustments to deferred tax liabilities and assets related to a change in tax laws or rates be included in "Income from continuing operations", even in situations where the related items were originally recognized in "Other comprehensive income" (rather than in "Income from continuing operations"). The amendments in this ASU were effective for all entities for fiscal years beginning after December 15, 2018, and interim periods within those fiscal years, with early adoption permitted. The Company elected to early adopt this ASU on January 1, 2018 and applied the change in the period of adoption. The adoption of this ASU resulted in the reclassification of an immaterial amount of deferred tax effects from accumulated other comprehensive income to retained earnings via a cumulative change in accounting principle effective January 1, 2018. See Note 20 for more details.

In August 2018, the FASB issued ASU No. 2018-13, *Fair Value Measurement (Topic 820): Disclosure Framework -Changes to the Disclosure Requirements for Fair Value Measurement*. The applicable amendments in this ASU remove requirements for disclosures concerning transfers between fair value measurement Levels 1, 2 and 3 and disclosures concerning valuation processes for Level 3 fair value measurements. The applicable amendments in this ASU also add a requirement to separately disclose the changes in unrealized gains and losses included in other comprehensive income for the reporting period for Level 3 items measured at fair value on a recurring basis, and require disclosure of the range and weighted average of significant unobservable inputs used to develop Level 3 fair value measurements. The amendments in this ASU are effective for the Company beginning on January 1, 2020 and its new requirements are to be applied on a prospective basis. The adoption of this ASU is not expected to have a material impact on the Company's consolidated financial statements.

DAVITA INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS - (continued)
(dollars in thousands, except per share data)

2. Revenue recognition and accounts receivable

The following table summarizes the Company's segment revenues by primary payor source:

	Year ended December 31, 2018		
	U.S. dialysis and related lab services	Other - Ancillary services and strategic initiatives	Consolidated
Patient service revenues:			
Medicare and Medicare Advantage	$6,063,891	$—	$6,063,891
Medicaid and Managed Medicaid	628,766	—	628,766
Other government	446,999	335,594	782,593
Commercial	3,176,413	101,681	3,278,094
Other revenues:			
Medicare and Medicare Advantage	—	492,812	492,812
Medicaid and Managed Medicaid	—	44,246	44,246
Commercial	—	90,890	90,890
Other[1]	19,880	130,865	150,745
Eliminations of intersegment revenues	(92,950)	(34,236)	(127,186)
Total	$10,242,999	$1,161,852	$11,404,851

(1) Other consists of management service fees earned in the respective Company line of business as well as revenue from the Company's ancillary services and strategic initiatives.

	Year ended December 31, 2017[1]		
	U.S. dialysis and related lab services	Other - Ancillary services and strategic initiatives	Consolidated
Patient service revenues:			
Medicare and Medicare Advantage	$5,253,012	$—	$5,253,012
Medicaid and Managed Medicaid	606,827	—	606,827
Other government	362,567	259,651	622,218
Commercial	3,117,920	63,505	3,181,425
Other revenues:			
Medicare and Medicare Advantage	—	902,289	902,289
Medicaid and Managed Medicaid	—	71,426	71,426
Commercial	—	116,503	116,503
Other[2]	19,739	182,974	202,713
Eliminations of intersegment revenues	(55,176)	(24,603)	(79,779)
Total	$9,304,889	$1,571,745	$10,876,634

(1) As noted above, prior period amounts have not been adjusted under the cumulative effect method. In this table, the Company's dialysis and related lab services revenues for the year ended December 31, 2017 has been presented net of the provision for uncollectible accounts of $485,364 to conform to the current period presentation.

(2) Other consists of management service fees earned in the respective Company line of business as well as revenue from the Company's ancillary services and strategic initiatives.

DAVITA INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS - (continued)
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	Year ended December 31, 2016[1]		
	U.S. dialysis and related lab services	Other - Ancillary services and strategic initiatives	Consolidated
Patient service revenues:			
Medicare and Medicare Advantage	$5,303,718	$—	$5,303,718
Medicaid and Managed Medicaid	319,553	—	319,553
Other government	143,207	165,193	308,400
Commercial	3,355,066	36,674	3,391,740
Other revenues:			
Medicare and Medicare Advantage	—	974,146	974,146
Medicaid and Managed Medicaid	—	82,428	82,428
Commercial	—	128,824	128,824
Other[2]	16,645	234,107	250,752
Eliminations of intersegment revenues	(27,355)	(24,739)	(52,094)
Total	$9,110,834	$1,596,633	$10,707,467

(1) As noted above, prior period amounts have not been adjusted under the cumulative effect method. In this table, the Company's dialysis and related lab services revenues for the year ended December 31, 2016 has been presented net of the provision for uncollectible accounts of $431,304 to conform to the current period presentation.

(2) Other consists of management service fees earned in the respective Company line of business as well as revenue from the Company's ancillary services and strategic initiatives.

The Company’s allowance for doubtful accounts related to performance obligations satisfied prior to the adoption of Topic 606 was $52,924 and $218,399 as of December 31, 2018 and 2017, respectively.

There are significant risks associated with estimating revenue, which generally take several years to resolve. These estimates are subject to ongoing insurance coverage changes, geographic coverage differences, differing interpretations of contract coverage and other payor issues, as well as patient issues including determining applicable primary and secondary coverage, changes in patient coverage and coordination of benefits. As these estimates are refined over time, both positive and negative adjustments to revenue are recognized in the current period. As a result of changes in these estimates, additional revenue was recognized during the year ended December 31, 2018 associated with performance obligations satisfied in years prior to the adoption of Topic 606 of $88,495, which includes a benefit of $36,000 for the year ended December 31, 2018 from electing to apply Topic 606 only to contracts not substantially completed as of January 1, 2018.

There is no single commercial payor that accounted for more than 10% of total consolidated accounts receivable or consolidated net revenues at or for the year ended December 31, 2018 and 2017.

Net dialysis and related lab services accounts receivable and other receivables from Medicare, including Medicare-assigned plans, and Medicaid, including managed Medicaid plans, were approximately $1,080,561 and $874,971 as of December 31, 2018 and 2017, respectively. Approximately 18% and 21% of the Company’s net patient services accounts receivable balances as of December 31, 2018 and 2017, respectively, were more than six months old. The decrease was primarily due to improved collections at DaVita Health Solutions and in certain international operations. There were no significant balances over one year old at December 31, 2018. Accounts receivable are principally from Medicare and Medicaid programs and commercial insurance plans.

3. Earnings per share

Basic earnings per share is calculated by dividing net income attributable to the Company, adjusted for any change in noncontrolling interest redemption rights in excess of fair value, by the weighted average number of common shares, net of the weighted average shares held in escrow that under certain circumstances may have been returned to the

Company.
Diluted earnings per share includes the dilutive effect of outstanding stock-settled stock appreciation rights and unvested stock units (under the treasury stock method) as well as the weighted average shares held in escrow that were outstanding during the period.

DAVITA INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS - (continued)
(dollars in thousands, except per share data)

The reconciliations of the numerators and denominators used to calculate basic and diluted earnings per share were as follows:

	Year ended December 31,		
	2018	2017	2016
	(shares in thousands)		
Numerators:			
Net income from continuing operations attributable to DaVita Inc.	$624,321	$901,277	$1,032,373
Net loss from discontinued operations attributable to DaVita Inc.	(464,927)	(237,659)	(152,499)
Net income attributable to DaVita Inc. for earnings per share calculation	$159,394	$663,618	$879,874
Basic:			
Weighted average shares outstanding during the period	171,886	190,820	203,835
Weighted average contingently returnable shares previously held in escrow for the DaVita HealthCare Partners merger	(1,100)	(2,194)	(2,194)
Weighted average shares for basic earnings per share calculation	170,786	188,626	201,641
Basic net income from continuing operations per share attributable to DaVita Inc.	$3.66	$4.78	$5.12
Basic net loss from discontinued operations per share attributable to DaVita Inc.	(2.73)	(1.26)	(0.76)
Basic net income per share attributable to DaVita Inc.	$0.93	$3.52	$4.36
Diluted:			
Weighted average shares outstanding during the period	171,886	190,820	203,835
Assumed incremental shares from stock plans	479	529	1,070
Weighted average shares for diluted earnings per share calculation	172,365	191,349	$204,905
Diluted net income from continuing operations per share attributable to DaVita Inc.	$3.62	$4.71	$5.04
Diluted net loss from discontinued operations per share attributable to DaVita Inc.	(2.70)	(1.24)	(0.75)
Diluted net income per share attributable to DaVita Inc.	$0.92	$3.47	$4.29
Anti-dilutive stock-settled awards excluded from calculation[(1)]	5,295	4,350	2,523

(1) Shares associated with stock-settled stock appreciation rights excluded from the diluted denominator calculation because they were anti-dilutive under the treasury stock method.

4. Restricted cash and equivalents

The Company had restricted cash and cash equivalents of $92,382 and $10,686 at December 31, 2018 and 2017, respectively. Approximately $79,329 of the balance at December 31, 2018 represents restricted cash equivalents held in trust to satisfy insurer and state regulatory requirements related to the Company's self-insurance for professional and general liability and workers' compensation risks administered by wholly-owned captive insurance entities. Prior to the first quarter of 2018, these requirements were satisfied by a letter of credit rather than restricted cash held in trust. The remaining restricted cash and equivalents held at December 31, 2018 and 2017 primarily represent cash pledged to third parties in connection with two of the Company's ancillary and strategic initiatives businesses.

5. Short-term and long-term investments

Effective January 1, 2018, the Company adopted ASU No. 2016-01, *Financial Instruments - Overall (Subtopic 825-10): Recognition and Measurement of Financial Assets and Financial Liabilities.* The amendments in this ASU revise accounting related to (i) the classification and measurement of investments in equity securities and (ii) the presentation of certain fair value changes for financial liabilities at fair value. The Company also adopted ASU 2018-03 which provides related technical corrections and improvements. The principal effect of these ASUs on the Company's consolidated financial statements is that, prior to adoption of ASU 2016-01, changes in the fair values of available-for-sale equity investments with readily determinable fair values or redemption values were recognized in

other comprehensive income until realized, while under ASU 2016-01 all changes in the fair values of such equity securities are recognized in current earnings within "Other income, net". The adoption of these ASUs did not have a material effect on these consolidated financial statements.

DAVITA INC.
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Effective January 1, 2018, the Company recognized a cumulative effect of change in accounting principle upon adoption of ASUs 2016-01 and 2018-03, in conjunction with ASU 2018-02, the effect of which was to decrease accumulated other comprehensive income, and to increase retained earnings, by $5,662 in after-tax unrealized gains accumulated in other comprehensive income through December 31, 2017 from equity securities classified as available-for-sale investments prior to adoption of ASU 2016-01.

From January 1, 2018, equity securities that have readily determinable fair values or redemption values are recorded at estimated fair value with changes in their value recognized in current earnings. The Company classifies its debt securities as held-to-maturity and records them at amortized cost based on its intentions and strategy concerning those investments.

The Company classifies these debt and equity investments as "Short-term investments" or "Long-term investments" on its consolidated balance sheet, as applicable, based on the characteristics of the financial instrument or the Company's intentions or expectations for the investment.

The Company’s investments in these short-term and long-term debt and equity investments consist of the following:

	December 31, 2018			December 31, 2017		
	Debt securities	Equity securities	Total	Debt securities	Equity securities	Total
Certificates of deposit and other time deposits	$2,235	$—	$2,235	$31,630	$—	$31,630
Investments in mutual funds and common stock	—	36,124	36,124	—	38,895	38,895
	$2,235	$36,124	$38,359	$31,630	$38,895	$70,525
Short-term investments	$2,235	$700	$2,935	$31,630	$1,200	$32,830
Long-term investments	—	35,424	35,424	—	37,695	37,695
	$2,235	$36,124	$38,359	$31,630	$38,895	$70,525

Debt securities: The Company's short-term debt investments are principally bank certificates of deposit with contractual maturities longer than three months but shorter than one year. These debt securities are accounted for as held-to-maturity and recorded at amortized cost, which approximates their fair values at December 31, 2018 and 2017.

Equity securities: The Company's equity investments in mutual funds and common stock are held within a trust to fund existing obligations associated with several of the Company’s non-qualified deferred compensation plans. During 2018, the Company recognized pre-tax net losses of $1,208 in the income statement associated with changes in the fair value of these equity securities, comprised of pre-tax realized gains of $4,490 and a net decrease in unrealized gains of $5,698. During 2017, the Company recognized pre-tax realized gains on the sale or redemption of equity securities of $360, or $220 after tax, which were previously recorded in other comprehensive income.

6. Other receivables

Other receivables were comprised of the following:

	December 31,	
	2018	2017
Supplier rebates and non-trade receivables	$334,156	$295,292
Medicare bad debt claims	135,640	103,970
	$469,796	$399,262

7. Prepaid and other current assets

Other current assets were comprised of the following:

	December 31,	
	2018	2017
Prepaid expenses	$108,315	$104,727
Other	3,525	7,331

$111,840	$112,058

8. Property and equipment

Property and equipment were comprised of the following:

	December 31,	
	2018	2017
Land	$37,384	$33,814
Buildings	467,181	473,489
Leasehold improvements	3,164,943	2,816,675
Equipment and information systems, including internally developed software	2,586,564	2,352,246
New center and capital asset projects in progress	661,695	576,651
	6,917,767	6,252,875
Less accumulated depreciation	(3,524,098)	(3,103,662)
	$3,393,669	$3,149,213

Depreciation expense on property and equipment was $574,799, $544,129, and $494,945 for 2018, 2017 and 2016, respectively.

During 2018 and 2017, the Company recognized asset impairment charges of $17,338 and $15,168, respectively, related to the restructuring of its pharmacy business.

Interest on debt incurred during the development of new centers and other capital asset projects is capitalized as a component of the asset cost based on the respective in-process capital asset balances. Interest capitalized was $25,978, $19,176 and $12,990 for 2018, 2017 and 2016, respectively.

9. Intangibles

Intangible assets other than goodwill were comprised of the following:

	December 31,	
	2018	2017
Noncompetition and other agreements	$131,360	$429,140
Lease agreements	7,584	7,623
Indefinite-lived assets	59,885	33,255
Other	583	583
	199,412	470,601
Less accumulated amortization	(80,566)	(356,774)
	$118,846	$113,827

Amortization expense from amortizable intangible assets, other than lease agreements, was $16,236, $15,782, and $14,552 for 2018, 2017 and 2016, respectively. Lease agreement intangible assets and liabilities were amortized to rent expense in the amounts of $(296), $(203) and $(232) for 2018, 2017 and 2016, respectively.

During the years ended December 31, 2018, 2017 and 2016, the Company recognized no impairment charges on any intangible assets other than goodwill.

Amortizable intangible liabilities as of December 31, 2018 and 2017 were comprised of lease agreements of $5,930 and $5,447, respectively, which were net of accumulated amortization of $4,362 and $3,508, respectively.

Lease agreement intangible liabilities are classified in other long-term liabilities and amortized to rent expense.

DAVITA INC.
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Scheduled amortization charges from amortizable intangible assets and liabilities as of December 31, 2018 were as follows:

	Noncompetition and other agreements	Lease liabilities	Other
2019	$ 14,442	$(901)	$91
2020	13,020	(895)	45
2021	10,816	(871)	—
2022	7,001	(864)	—
2023	4,235	(704)	—
Thereafter	9,311	(1,695)	—
Total	$ 58,825	$(5,930)	$136

10. Equity method and other investments

Equity investments in nonconsolidated businesses over which the Company maintains significant influence, but which do not have readily determinable fair values, are carried on the equity method.

As described in Note 5 to these consolidated financial statements, effective January 1, 2018, the Company adopted ASU 2016-01 and related ASU 2018-03 concerning recognition and measurement of financial assets and financial liabilities. In adopting this new guidance, the Company has made an accounting policy election to adopt an adjusted cost method measurement alternative for investments in equity securities without readily determinable fair values. Specifically, under this measurement alternative, unless elected otherwise for a particular investment, the Company initially records equity investments that qualify for the measurement alternative at cost but remeasures them to fair value through earnings when there is an observable transaction involving the same or a similar investment with the same issuer or upon an impairment.

The Company maintains equity method and minor adjusted cost method investments in the private securities of certain other healthcare and healthcare-related businesses. The Company classifies these investments as "Equity method and other investments" on its consolidated balance sheet.

The Company's equity method and other investments were comprised of the following:

	December 31,	
	2018	2017
APAC joint venture	$129,173	$160,481
Other equity method partnerships	83,052	79,667
Adjusted cost method investments	12,386	5,386
	$224,611	$245,534

During 2018, 2017 and 2016, the Company recognized equity investment (loss) income of $(4,484), $(8,640) and $16,874, respectively, from equity method investments in nonconsolidated businesses.

The Company's largest equity method investment is its ownership interest in DaVita Care Pte. Ltd. (the APAC joint venture, or APAC JV). As of December 31, 2018 and 2017, the Company held a 60% voting interest and a 73.3% current economic interest in the APAC JV. Based on the governance structure and voting rights established for the APAC JV at its formation on August 1, 2016, certain key decisions affecting the joint venture’s operations are not subject to the unilateral discretion of the Company, but rather are shared with the other noncontrolling investors. These other noncontrolling investors currently collectively hold a 40% voting interest and a 26.7% economic interest in the APAC JV. During the third quarter of 2018, the investors in the APAC JV jointly agreed to a six-month deferral of the subscribed incremental capital contributions originally scheduled for August 1, 2018 based upon revised assessments of the capital needs of the joint venture. Subsequent to December 31, 2018, the investors have jointly agreed to a further deferral of those capital contributions originally scheduled for August 1, 2018, which will now be

due with the final capital contributions originally scheduled for August 1, 2019. The Company continues to expect the economic interests of the noncontrolling investors in the APAC JV to adjust to match their voting interests by August 1, 2019.

DAVITA INC.
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Upon formation of the APAC JV on August 1, 2016, the Company deconsolidated this Asia Pacific dialysis business based on the governance structure and voting rights put in place at that time and recognized an initial non-cash non-taxable estimated gain of $374,374 on its retained investment, net of contingent obligations. This retained interest in the APAC JV was adjusted to the Company's proportionate share of the estimated fair value of the business, as implied by the investment commitments from the JV partners and adjusted for certain time value of money and uncertainty discounts. The Company then recognized an additional $6,273 gain in the first quarter of 2017 upon resolution of certain post-closing adjustments related to this transaction. Subsequent to its deconsolidation on August 1, 2016, the Company's retained interest in the APAC JV has been accounted for under the equity method.

During the year ended December 31, 2017, the Company recognized a non-cash other-than-temporary impairment charge of $280,066 on its investment in the APAC JV. This charge resulted from changes in its expectations for the joint venture based on continuing market research and assessments by both the Company and the APAC JV concerning the size of the addressable market available to the joint venture at attractive risk-adjusted returns. The Company estimated the fair value of its retained interest in the APAC JV with the assistance of an independent third party valuation firm based on information available to management as of December 31, 2017.

The Company's other equity method investments include 22 legal entities over which the Company has significant influence but in which it does not maintain a controlling financial interest. Almost all of these are U.S. partnerships in the form of limited liability companies. The Company's ownership interests in these partnerships vary, but typically range from 30% to 50%.

The total carrying amount of equity investments carried under the adjusted cost method measurement alternative at December 31, 2018 was $12,386. During 2018, there have been no meaningful impairments or other downward or upward valuation adjustments recognized on these investments.

11. Goodwill

Changes in the carrying value of goodwill by reportable segments were as follows:

	U.S. dialysis and related lab services	Other ancillary services and strategic initiatives	Consolidated total
Balance at December 31, 2016	$5,691,587	$323,788	$6,015,375
Acquisitions	485,434	131,598	617,032
Divestitures	(32,260)	(126)	(32,386)
Impairment charges	—	(36,196)	(36,196)
Foreign currency and other adjustments	—	46,454	46,454
Balance at December 31, 2017	$6,144,761	$465,518	$6,610,279
Acquisitions	130,574	147,774	278,348
Divestitures	(331)	(15,166)	(15,497)
Impairment charges	—	(3,106)	(3,106)
Foreign currency and other adjustments	—	(28,064)	(28,064)
Balance at December 31, 2018	$6,275,004	$566,956	$6,841,960
Goodwill	$6,275,004	$594,229	$6,869,233
Accumulated impairment charges	—	(27,273)	(27,273)
	$6,275,004	$566,956	$6,841,960

The Company elected to early adopt ASU No. 2017-04, *Intangibles-Goodwill and Other (Topic 350): Simplifying the Test for Goodwill Impairment* effective January 1, 2017. The amendments in this ASU simplify the test for goodwill impairment by eliminating the second step in the assessment. All goodwill impairment tests performed since adoption

of this ASU were performed under this new guidance.

Each of the Company's operating segments described in Note 25 to these consolidated financial statements represents an individual reporting unit for goodwill impairment testing purposes and each sovereign jurisdiction within the Company's international operating segments is considered a separate reporting unit.

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(dollars in thousands, except per share data)

Within the U.S. dialysis and related lab services operating segment, the Company considers each of its dialysis centers to constitute an individual business for which discrete financial information is available. However, since these dialysis centers have similar operating and economic characteristics, and the allocation of resources and significant investment decisions concerning these businesses are highly centralized and the benefits broadly distributed, the Company has aggregated these centers and deemed them to constitute a single reporting unit.

The Company has applied a similar aggregation to the vascular access service centers in its vascular access services reporting unit, to the physician practices in its physician services reporting units, and to the dialysis centers and other health operations within each international reporting unit. For the Company's other operating segments, discrete business components below the operating segment level constitute individual reporting units.

During the year ended December 31, 2018, the Company performed annual and other impairment assessments for various reporting units. As a result of these assessments, the Company recognized a goodwill impairment charge of $3,106 at its German other health operations during the year ended December 31, 2018.

During the years ended December 31, 2017 and December 31, 2016 the Company recognized goodwill impairment charges of $34,696 and $28,415, respectively, at its vascular access reporting unit. These charges resulted primarily from changes in future governmental reimbursement rates for this business and the Company's then-evolving plans and expected ability to mitigate them. As of December 31, 2017, there was no goodwill remaining at the Company's vascular access reporting unit. The Company also recognized a goodwill impairment charge of $1,500 at one of its international reporting units during the year ended December 31, 2017.

Based on the most recent assessments, the Company determined that reductions in reimbursement rates, changes in actual or expected growth rates, or other significant adverse changes in expected future cash flows or valuation assumptions could result in goodwill impairment charges in the future for the following reporting units, which remain at risk of goodwill impairment as of December 31, 2018:

Reporting unit	Goodwill balance as of December 31, 2018	Carrying amount coverage[1]	Sensitivities	
			Operating income[2]	Discount rate[3]
Germany Kidney Care	$403,200	0.5 %	(1.5)%	(10.3)%
Brazil Kidney Care	$39,452	9.8 %	(2.5)%	(7.3)%
Germany other health operations	$12,646	8.1 %	(2.2)%	(11.1)%

(1) Excess of estimated fair value of the reporting unit over its carrying amount as of the latest assessment date.
(2) Potential impact on estimated fair value of a sustained, long-term reduction of 3% in operating income as of the latest assessment date.
(3) Potential impact on estimated fair value of an increase in discount rates of 100 basis points as of the latest assessment date.

There were no major changes in the business, prospects, or expected future results of these reporting units from their latest assessment date through December 31, 2018.

Except as described above, none of the Company's other reporting units were considered at risk of significant goodwill impairment as of December 31, 2018. Since the dates of the Company's last annual goodwill impairment tests, there have been certain developments, events, changes in operating performance and other changes in key circumstances that have affected the Company's businesses. However, except as further described above, these did not cause management to believe it is more likely than not that the fair values of any of the Company's reporting units would be less than their respective carrying amounts as of December 31, 2018.

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS - (continued)
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12. Other liabilities

Other liabilities were comprised of the following:

	December 31,	
	2018	2017
Payor refunds and retractions	$302,244	$292,370
Insurance and self-insurance accruals	58,569	64,924
Accrued interest	82,827	83,362
Accrued non-income tax liabilities	28,663	28,317
Other	123,547	110,032
	$595,850	$579,005

13. Income taxes

The Company accounts for income taxes under the asset and liability method, which requires the recognition of deferred tax assets and liabilities for the expected future tax consequences of events that have been included in the financial statements. Under this method, deferred tax assets and liabilities are determined on the basis of the differences between the financial statement and tax basis of assets and liabilities using enacted tax rates in effect for the year in which the differences are expected to reverse.

Income before income taxes from continuing operations consisted of the following:

	Year ended December 31,		
	2018	2017	2016
Domestic	$1,083,578	$1,725,822	$1,278,754
International	(35,100)	(326,036)	344,351
	$1,048,478	$1,399,786	$1,623,105

Income tax expense for continuing operations consisted of the following:

	Year ended December 31,		
	2018	2017	2016
Current:			
Federal	$140,064	$330,191	$322,940
State	32,990	47,228	44,525
International	7,557	3,422	1,928
Total current income tax	180,611	380,841	369,393
Deferred:			
Federal	52,034	(98,760)	88,412
State	21,096	37,347	(28,530)
International	4,659	4,431	2,486
Total deferred income tax	77,789	(56,982)	62,368
	$258,400	$323,859	$431,761

Income taxes are allocated between continuing and discontinued operations as follows:

	Year ended December 31,		
	2018	2017	2016
Continuing operations	$258,400	$323,859	$431,761
Discontinued operations	99,768	(364,856)	24,052
	$358,168	$(40,997)	$455,813

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The reconciliation between the Company's effective tax rate from continuing operations and the U.S. federal income tax rate is as follows:

	Year ended December 31,		
	2018	2017	2016
Federal income tax rate	21.0 %	35.0 %	35.0 %
State income taxes, net of federal benefit	4.1	3.7	2.6
Gain on APAC JV ownership changes	—	(0.2)	(9.9)
Political advocacy costs	2.3	—	—
APAC investment impairment	—	6.4	—
Impact of 2017 Tax Act	(0.1)	(20.5)	—
Other	1.9	2.0	1.8
Impact of noncontrolling interests primarily attributable to non-tax paying entities	(4.6)	(3.3)	(2.9)
Effective tax rate	24.6 %	23.1 %	26.6 %

On December 22, 2017, the President signed into law tax legislation known as the Tax Cuts and Jobs Act ("2017 Tax Act"). Consistent with Securities and Exchange Commission (SEC) Staff Accounting Bulletin No. 118, the Company completed its analysis of certain aspects of the 2017 Tax Act in the prior year and recorded provisional amounts for those items for which the accounting was not complete as of December 31, 2017. As of December 31, 2018, the Company has completed its analysis of these provisional items and recorded immaterial adjustments to the original estimates.

Deferred tax assets and liabilities arising from temporary differences for continuing operations were as follows:

	December 31,	
	2018	2017
Receivables	$19,327	$19,705
Accrued liabilities	106,506	96,537
Net operating loss carryforwards	117,511	108,429
Other	36,712	37,794
Deferred tax assets	280,056	262,465
Valuation allowance	(70,474)	(61,282)
Net deferred tax assets	209,582	201,183
Intangible assets	(555,822)	(501,763)
Property and equipment	(118,008)	(100,376)
Investments in partnerships	(67,354)	(61,529)
Other	(30,934)	(23,762)
Deferred tax liabilities	(772,118)	(687,430)
Net deferred tax liabilities	$(562,536)	$(486,247)

At December 31, 2018, the Company had federal net operating loss carryforwards of approximately $124,935 that expire through 2037, although a substantial amount expire by 2028. The Company also had state net operating loss carryforwards of $459,558 that expire through 2038 and international net operating loss carryforwards of $186,757, some of which have an indefinite life. The utilization of a portion of these losses may be limited in future years based on the profitability of certain entities. The net increase of $9,192 in the valuation allowance is primarily due to newly created net operating loss carryforwards in state and foreign jurisdictions that the Company does not anticipate being able to utilize.

The Company's foreign earnings continue to be indefinitely reinvested as of December 31, 2018. As a result of the passage of the 2017 Tax Act, the Company does not expect such earnings to be taxable if remitted.

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Unrecognized tax benefits
A reconciliation of the beginning and ending liability for unrecognized tax benefits that do not meet the more-likely-than-not threshold is as follows:

	Year ended December 31,	
	2018	2017
Beginning balance	$32,776	$24,066
Additions for tax positions related to current year	6,111	7,606
Additions for tax positions related to prior years	4,134	804
Reductions related to lapse of applicable statute	(338)	(1,380)
Impact of 2017 Tax Act	—	3,731
Reductions related to settlements with taxing authorities	(2,301)	(2,051)
Ending balance	$40,382	$32,776

As of December 31, 2018, the Company's total liability for unrecognized tax benefits relating to tax positions that do not meet the more-likely-than-not threshold is $40,382, of which $37,538 would impact the Company's effective tax rate if recognized. This balance represents an increase of $7,606 from the December 31, 2017 balance of $32,776, primarily due to additions for tax positions related to the current year.
The Company recognizes accrued interest and penalties related to unrecognized tax benefits in income tax expense. At December 31, 2018 and 2017, the Company had approximately $9,019 and $4,195, respectively, accrued for interest and penalties related to unrecognized tax benefits, net of federal tax benefit.
The Company and its subsidiaries file U.S. federal and state income tax returns and various foreign income tax returns. The Company is no longer subject to U.S. federal and state examinations by tax authorities for years before 2014 and 2009, respectively. In addition to being under audit in various state and local tax jurisdictions, the Company's federal tax returns are under audit by the Internal Revenue Service for the years 2014-2016.

14. Long-term debt
Long-term debt was comprised of the following:

	December 31,			
	2018	2017	Interest rate	Maturity date
Senior Secured Credit Facilities:				
Term Loan A	$675,000	$775,000	2.00% + LIBOR	6/24/2019
Term Loan A-2	995,000	—	1.00% + LIBOR	6/24/2019
Term Loan B	3,342,500	3,377,500	2.75% + LIBOR[2]	6/24/2021
Revolver	175,000	300,000	2.00% + LIBOR	6/24/2019
Senior Notes:				
5 3/4% Senior Notes	1,250,000	1,250,000	5.75%	8/15/2022
5 1/8% Senior Notes	1,750,000	1,750,000	5.125%	7/15/2024
5% Senior Notes	1,500,000	1,500,000	5%	5/1/2025
Acquisition obligations and other notes payable[1]	183,979	150,512	6.24%	2019-2025
Capital lease obligations[1]	282,737	297,170	5.49%	2019-2036
Total debt principal outstanding	10,154,216	9,400,182		
Discount and deferred financing costs	(52,000)	(63,951)		
	10,102,216	9,336,231		
Less current portion	(1,929,369)	(178,213)		
	$8,172,847	$9,158,018		

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(1) For acquisition obligations and other notes payable and capital lease obligations, the interest rate is the weighted average interest rate as of December 31, 2018 and the maturity date is the range of maturity dates as of December 31, 2018.
(2) Term Loan B has a floor of 0.75%.

Scheduled maturities of long-term debt at December 31, 2018 were as follows:

2019	$1,929,369
2020	80,016
2021	3,314,149
2022	1,291,472
2023	37,881
Thereafter	$3,501,329

During the year ended December 31, 2018, the Company made mandatory principal payments under its senior secured credit facilities totaling $100,000 on Term Loan A and $35,000 on Term Loan B.

Term Loans

On March 29, 2018, the Company entered into an Increase Joinder No. 1 (Increase Joinder Agreement) under its existing senior secured credit facilities. Pursuant to this Increase Joinder Agreement, the Company entered into an additional $995,000 Term Loan A-2.

Total outstanding borrowings under Term Loan A, Term Loan A-2 and Term Loan B consist of various individual tranches that can range in maturity from one month to twelve months (currently all tranches are one month in duration). For Term Loan A, Term Loan A-2 and Term Loan B, each tranche bears interest at a London Interbank Offered Rate (LIBOR) that is determined by the duration of such tranche plus an interest rate margin. The LIBOR variable component of the interest rate for each tranche is reset as such tranche matures and a new tranche is established. At December 31, 2018, the overall weighted average interest rate for Term Loan A, Term Loan A-2 and Term Loan B was determined based upon the LIBOR interest rates in effect for all of the individual tranches plus their respective interest rate margins noted in the table above.

The Company maintains several interest rate cap agreements that have the economic effect of capping the LIBOR variable component of the Company's interest rate at a maximum of 3.50% on $3,500,000 of outstanding principal debt, including all of Term Loan B and part of Term Loan A. However, the remaining $517,500 outstanding principal balance of Term Loan A and the entire outstanding balance on Term Loan A-2 would still be subject to LIBOR-based interest rate volatility. See below for further details. The Company is restricted from paying dividends under the terms of its senior secured credit facilities.

Revolving lines of credit

As of December 31, 2018, the Company has $175,000 drawn on its $1,000,000 revolving line of credit under its senior secured credit facilities, in addition to approximately $14,155 committed for outstanding letters of credit. The Company also has approximately $22,621 of additional outstanding letters of credit under a separate bilateral secured letter of credit facility, and $211 of committed outstanding letters of credit which are backed by a certificate of deposit.

Senior Notes

The Senior Notes are unsecured obligations, rank equally in right of payment with the Company's existing and future unsecured senior indebtedness, are guaranteed by substantially all of the Company's direct and indirect wholly-owned domestic subsidiaries, and require semi-annual interest payments. The Company may redeem some or all of the Senior Notes at any time on or after certain specific dates and at certain specific redemption prices as outlined in each senior note agreement. Interest rates on the Senior Notes are fixed by their terms, and the Company is restricted from paying dividends under the indentures governing its Senior Notes.

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Interest rate cap and swap agreements

As of December 31, 2018, the Company maintains several interest rate cap agreements as a means of hedging its exposure to and volatility from variable-based interest rate changes as part of its overall interest rate risk management strategy. These agreements are not held for trading or speculative purposes and had the economic effect of capping the Company's maximum exposure to LIBOR variable interest rate changes on specific portions of the Company's floating rate debt, as described below. These cap agreements are also designated as cash flow hedges and, as a result, changes in the fair values of these cap agreements are reported in other comprehensive income. The amortization of the original cap premium is recognized as a component of debt expense on a straight-line basis over the term of the cap agreements. These cap agreements do not contain credit-risk contingent features.

The Company's current interest rate cap agreements were entered into in October 2015 with notional amounts totaling $3,500,000. These cap agreements became effective June 29, 2018, have the economic effect of capping the LIBOR variable component of the Company's interest rate at a maximum of 3.50% on an equivalent amount of the Company's debt, and will expire on June 30, 2020. As of December 31, 2018, the total fair value of these cap agreements was an asset of approximately $851. During the year ended December 31, 2018, the Company recognized debt expense of $4,327 from these cap agreements and recorded a loss of $181 in other comprehensive income due to a decrease in the unrealized fair value of these cap agreements.

Previously, the Company maintained other interest rate cap agreements that were entered into in November 2014 with notional amounts also totaling $3,500,000. These cap agreements had the economic effect of capping the LIBOR variable component of the Company's interest rate at a maximum of 3.50% on an equivalent amount of the Company's debt and expired on June 30, 2018. During the year ended 2018, the Company recognized debt expense of $4,140 from these cap agreements and recorded an immaterial loss in other comprehensive income due to a decrease in the unrealized fair value of these cap agreements through expiration.

The following table summarizes the Company's derivative instruments as of December 31, 2018 and 2017:

		Fair value	
		December 31,	December 31,
Derivatives designated as hedging instruments	**Balance sheet location**	**2018**	**2017**
Interest rate cap agreements	Other long-term assets	$851	$ 1,032

The following table summarizes the effects of the Company's interest rate cap and swap agreements for the years ended December 31, 2018, 2017 and 2016:

	Amount of unrealized losses in OCI on interest rate cap and swap agreements Year ended December 31,			Location of losses	Amount of losses reclassified from accumulated OCI into income Year ended December 31,		
Derivatives designated as cash flow hedges	**2018**	**2017**	**2016**		**2018**	**2017**	**2016**
Interest rate cap agreements	$(181)	$(8,897)	$(5,198)	Debt expense	$8,466	$8,278	$3,899
Interest rate swap agreements	—	—	(815)	Debt expense	—	—	299
Tax benefit	48	3,460	2,343	Tax expense	(2,180)	(3,220)	(1,632)
Total	$(133)	$(5,437)	$(3,670)		$6,286	$5,058	$2,566

The Company's overall weighted average effective interest rate on the senior secured credit facilities at the end of 2018 was 5.11%, based upon the current margins in effect as of December 31, 2018.

The Company's overall weighted average effective interest rate during the year ended December 31, 2018 was 4.96% and as of December 31, 2018 was 5.19%.

Debt expense

Debt expense consisted of interest expense of $461,897, $406,341 and $394,013 and the amortization and accretion of debt discounts and premiums, amortization of deferred financing costs and the amortization of interest rate cap

agreements of

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$25,538, $24,293 and $20,103 for 2018, 2017 and 2016, respectively. These interest expense amounts are net of capitalized interest.

15. Leases

The majority of the Company's facilities are leased under non-cancellable operating leases ranging in terms from five years to 15 years and which contain renewal options of five years to ten years at the fair rental value at the time of renewal. The Company's leases are generally subject to periodic consumer price index increases or contain fixed escalation clauses. The Company also leases certain facilities and equipment under capital leases.

Future minimum lease payments under non-cancellable operating and capital leases are as follows:

	Operating leases	Capital leases
2019	$483,488	$36,754
2020	462,154	41,044
2021	432,950	34,026
2022	395,462	33,690
2023	349,649	33,845
Thereafter	1,589,949	194,611
	$3,713,652	373,970
Less portion representing interest		(91,233)
Total capital lease obligations, including current portion		$282,737

Rent expense under all operating leases for 2018, 2017, and 2016 was $596,117, $530,748 and $478,531, respectively. Rent expense is recorded on a straight-line basis over the term of the lease for leases that contain fixed escalation clauses or include abatement provisions. Leasehold improvement incentives are deferred and amortized to rent expense over the term of the lease. The net book value of property and equipment under capital leases was $235,194 and $257,772 at December 31, 2018 and 2017, respectively. Capital lease obligations are included in long-term debt. See Note 14 to these consolidated financial statements.

16. Employee benefit plans

The Company has a 401(k) retirement savings plan for substantially all of its Kidney Care employees which has been established pursuant to the applicable provisions of the Internal Revenue Code (IRC). The plan allows for employees to contribute a percentage of their base annual salaries on a tax-deferred basis not to exceed IRC limitations. Beginning in 2018, the Company implemented a 401(k) matching program under which the Company matches 50% of the employee's contribution up to 6% of the employee's salary, subject to certain limitations. The matching contributions are subject to certain eligibility and vesting conditions. For the year ended December 31, 2018, the Company accrued matching contributions totaling approximately $67,807. Prior to 2018, the Company did not provide matching contributions in connection with the 401(k) savings plan for its Kidney Care employees.

The Company also maintains a voluntary compensation deferral plan, the Deferred Compensation Plan, as well as other legacy deferral plans. The Deferred Compensation Plan plan is non-qualified and permits certain employees whose annualized base salary equals or exceeds a minimum annual threshold amount as set by the Company to elect to defer all or a portion of their annual bonus payment and up to 50% of their base salary into a deferral account maintained by the Company. Total contributions to this plan in 2018, 2017 and 2016 were $3,090, $4,497 and $5,344, respectively. Deferred amounts are generally paid out in cash at the participant's election either in the first or second year following retirement or in a specified future period at least three to four years after the deferral election was effective. During 2018, 2017 and 2016 the Company distributed $4,652, $2,789 and $1,065, respectively, to participants from its deferred compensation plans. Participants are credited with their proportional amount of annual earnings from the plans. The assets of these plans are held in rabbi trusts and as such are subject to the claims of the Company's general creditors in the event of its bankruptcy. As of December 31, 2018 and 2017, the total fair value of

assets held in these plans' trusts was $36,124 and $38,895, respectively. The assets of these plans are recorded at fair value with changes in fair value recorded in other comprehensive income prior to 2018 and recognized in "Other income, net" since January 1, 2018. Any fair value changes to the corresponding liability balance are recorded as compensation expense. See Note 5 to these consolidated financial statements.

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Most of the Company's outstanding employee stock plan awards include a provision accelerating the vesting of the award in the event of a change of control. The Company also maintains a change of control protection program for its employees who do not have a significant number of stock awards, which has been in place since 2001, and which provides for cash bonuses to employees in the event of a change of control. Based on the market price of the Company's common stock and shares outstanding at December 31, 2018, these cash bonuses would total approximately $336,530 if a change of control transaction occurred at that price and the Company's Board of Directors did not modify the program. This amount has not been accrued at December 31, 2018, and would only be accrued upon a change of control. These change of control provisions may affect the price an acquirer would be willing to pay for the Company.

17. Contingencies

The majority of the Company's revenues are from government programs and may be subject to adjustment as a result of: (i) examination by government agencies or contractors, for which the resolution of any matters raised may take extended periods of time to finalize; (ii) differing interpretations of government regulations by different Medicare contractors or regulatory authorities; (iii) differing opinions regarding a patient's medical diagnosis or the medical necessity of services provided; and (iv) retroactive applications or interpretations of governmental requirements. In addition, the Company's revenues from commercial payors may be subject to adjustment as a result of potential claims for refunds, as a result of government actions or as a result of other claims by commercial payors.

The Company operates in a highly regulated industry and is a party to various lawsuits, claims, *qui tam* suits, governmental investigations and audits (including investigations resulting from its obligation to self-report suspected violations of law) and other legal proceedings. The Company records accruals for certain legal proceedings and regulatory matters to the extent that the Company determines an unfavorable outcome is probable and the amount of the loss can be reasonably estimated. As of December 31, 2018, and December 31, 2017, the Company's total recorded accruals, including DMG, with respect to legal proceedings and regulatory matters, net of anticipated third party recoveries, were immaterial. While these accruals reflect the Company's best estimate of the probable loss for those matters as of the dates of those accruals, the recorded amounts may differ materially from the actual amount of the losses for those matters, and any anticipated third party recoveries for any such losses may not ultimately be recoverable. Additionally, in some cases, no estimate of the possible loss or range of loss in excess of amounts accrued, if any, can be made because of the inherently unpredictable nature of legal proceedings and regulatory matters, which also may be impacted by various factors, including that they may involve indeterminate claims for monetary damages or may involve fines, penalties or non-monetary remedies; present novel legal theories or legal uncertainties; involve disputed facts; represent a shift in regulatory policy; are in the early stages of the proceedings; or result in a change of business practices. Further, there may be various levels of judicial review available to the Company in connection with any such proceeding.

The following is a description of certain lawsuits, claims, governmental investigations and audits and other legal proceedings to which the Company is subject.

Inquiries by the Federal Government and Certain Related Civil Proceedings

2016 U.S. Attorney Texas Investigation: In early February 2016, the Company announced that its pharmacy services' wholly-owned subsidiary, DaVita Rx, LLC (DaVita Rx), received a Civil Investigative Demand (CID) from the U.S. Attorney's Office, Northern District of Texas. The government is conducting a federal False Claims Act (FCA) investigation concerning allegations that DaVita Rx presented or caused to be presented false claims for payment to the government for prescription medications, as well as an investigation into the Company's relationships with pharmaceutical manufacturers. The CID covers the period from January 1, 2006 through the present. In connection with the Company's ongoing efforts working with the government, the Company learned that a *qui tam* complaint had been filed covering some of the issues in the CID and practices that had been identified by the Company in a self-disclosure filed with the Office of Inspector General (OIG) for the U.S. Department of Health and Human Services (HHS) in February 2016. In December 2017, the Company finalized and executed a settlement agreement

with the government and relators in the *qui tam* matter that included total monetary consideration of $63,700, as previously disclosed, of which $41,500 was an incremental cash payment and $22,200 was for amounts previously refunded, and all of which was previously accrued. The government’s investigation into certain of the Company's relationships with pharmaceutical manufacturers is ongoing, and in July 2018 the OIG served the Company with a subpoena seeking additional documents and information relating to those relationships. The Company is continuing to cooperate with the government in this investigation.

2017 U.S. Attorney Massachusetts Investigation: In January 2017, the Company was served with an administrative subpoena for records by the U.S. Attorney’s Office, District of Massachusetts, relating to an investigation into possible federal

health care offenses. The subpoena covers the period from January 1, 2007 through the present, and seeks documents relevant to charitable patient assistance organizations, particularly the American Kidney Fund, including documents related to efforts to provide patients with information concerning the availability of charitable assistance. The Company is continuing to cooperate with the government in this investigation.

2017 U.S. Attorney Colorado Investigation: In November 2017, the U.S. Attorney's Office, District of Colorado informed the Company of an investigation it was conducting into possible federal health care offenses involving DaVita Kidney Care, as well as several of the Company's wholly-owned subsidiaries, including DMG, DaVita Rx, DaVita Laboratory Services, Inc. (DaVita Labs), and RMS Lifeline Inc. (Lifeline). In August 2018, the Company received a CID from the U.S. Attorney's Office. The CID was issued pursuant to the FCA and covers the period from January 2005 through the present. In connection with the resolution of the *2015 U.S. OIG Medicare Advantage Civil Investigation* referred to below, the Company resolved possible claims relating to DMG in this investigation. The Company is continuing to cooperate with the government in this investigation.

2017 U.S. Attorney Florida Investigation: In November 2017, the U.S. Attorney's Office, Southern District of Florida informed the Company of an investigation it was conducting into possible federal healthcare offenses involving the Company's wholly-owned subsidiary, Lifeline. The Company is continuing to cooperate with the government in this investigation.

2018 U.S. Attorney Florida Investigation: In March 2018, DaVita Labs received two CIDs from the U.S. Attorney's Office, Middle District of Florida that were identical in nature but directed to the two different labs. According to the face of the CIDs, the U.S. Attorney's Office is conducting an investigation as to whether the Company's subsidiary submitted claims for blood, urine, and fecal testing, where there were insufficient test validation or stability studies to ensure accurate results, in violation of the FCA. In October 2018, DaVita Labs received a subpoena from the OIG in connection with this matter requesting certain patient records linked to clinical laboratory tests. The Company is continuing to cooperate with the government in this investigation.

* * *

Although the Company cannot predict whether or when proceedings might be initiated or when these matters may be resolved (other than as may be described above), it is not unusual for inquiries such as these to continue for a considerable period of time through the various phases of document and witness requests and on-going discussions with regulators and to develop over the course of time. In addition to the inquiries and proceedings specifically identified above, the Company frequently is subject to other inquiries by state or federal government agencies and/or private civil *qui tam* complaints filed by relators. Negative findings or terms and conditions that the Company might agree to accept as part of a negotiated resolution of pending or future government inquiries or relator proceedings could result in, among other things, substantial financial penalties or awards against the Company, substantial payments made by the Company, harm to the Company's reputation, required changes to the Company's business practices, exclusion from future participation in the Medicare, Medicaid and other federal health care programs and, if criminal proceedings were initiated against the Company, possible criminal penalties, any of which could have a material adverse effect on the Company.

Shareholder and Derivative Claims

Peace Officers' Annuity and Benefit Fund of Georgia Securities Class Action Civil Suit: On February 1, 2017, the Peace Officers' Annuity and Benefit Fund of Georgia filed a putative federal securities class action complaint in the U.S. District Court for the District of Colorado against the Company and certain executives. The complaint covers the time period of August 2015 to October 2016 and alleges, generally, that the Company and its executives violated federal securities laws concerning the Company's financial results and revenue derived from patients who received charitable premium assistance from an industry-funded non-profit organization. The complaint further alleges that the process by which patients obtained commercial insurance and received charitable premium assistance was improper and "created a false impression of DaVita's business and operational status and future growth prospects." In November 2017, the court appointed the lead plaintiff and an amended complaint was filed on January 12, 2018. On March 27,

2018, the Company and various individual defendants filed a motion to dismiss. Briefing on the motion is complete. The plaintiffs filed an opposition to the motion to dismiss on June 6, 2018. The Company filed a reply in support of the motion on July 19, 2018. The Company disputes these allegations and intends to defend this action accordingly.
In re DaVita Inc. Stockholder Derivative Litigation: On August 15, 2017, the U.S. District Court for the District of Delaware consolidated three previously disclosed shareholder derivative lawsuits: the Blackburn Shareholder action filed on February 10, 2017, the Gabilondo Shareholder action filed on May 30, 2017, and the City of Warren Police and Fire Retirement

System Shareholder action filed on June 9, 2017. The complaint covers the time period from 2015 to present and alleges, generally, breach of fiduciary duty, unjust enrichment, abuse of control, gross mismanagement, corporate waste, and misrepresentations and/or failures to disclose certain information in violation of the federal securities laws in connection with an alleged practice to direct patients with government-subsidized health insurance into private health insurance plans to maximize the Company's profits. An amended complaint was filed in September 2017, and on December 18, 2017, the Company filed a motion to dismiss and a motion to stay proceedings in the alternative. The plaintiffs filed an opposition to the motion to dismiss on March 9, 2018. On June 25, 2018, the U.S. District Court for the District of Delaware granted the Company's motion to stay proceedings and stayed the case until January 7, 2019, the date of the next status conference. During the status conference on January 7, 2019 the court further extended the stay until February 8, 2019. The parties submitted a proposed scheduling order on that date. The Company asked the Court to rule on the fully-briefed motion to dismiss before opening discovery. The Company disputes these allegations and intends to defend this action accordingly.

Other Proceedings

In addition to the foregoing, from time to time the Company is subject to other lawsuits, demands, claims, governmental investigations and audits and legal proceedings that arise due to the nature of its business, including contractual disputes, such as with payors, suppliers and others, employee-related matters and professional and general liability claims. From time to time, the Company also initiates litigation or other legal proceedings as a plaintiff arising out of contracts or other matters.

Resolved Matters

2011 Suit against the U.S. Department of Veterans Affairs: As previously disclosed, the Company had a pending lawsuit in the U.S. Court of Federal Claims against the federal government which was originally filed in May 2011. The lawsuit related to the U.S. Department of Veterans Affairs (VA) underpayment of dialysis services the Company provided from 2005 through 2011 to veterans pursuant to VA regulations. In the first quarter of 2017, the Company received a payment of $538,000 related to the settlement with the VA. The Company's consolidated entities recognized a net gain of $527,000 on this settlement. The Company's nonconsolidated and managed entities recognized a gain of $9,000, of which the Company's equity investment share was $3,000. The net effect was a net increase of $530,000 to the Company's operating income.

2015 OIG Medicare Advantage Civil Investigation: In March 2015, JSA HealthCare Corporation (JSA), a subsidiary of DMG, received a subpoena from the OIG requesting documents and information for the period from January 1, 2008 through December 31, 2013, for certain MA plans for which JSA provided services. It also requested information regarding JSA's communications about patient diagnoses as they related to certain MA plans generally, and more specifically as related to two Florida physicians with whom JSA previously contracted.

In addition to the subpoena described above, in June 2015, the Company received a civil subpoena from the OIG seeking production of a wide range of documents relating to the Company's and its subsidiaries' (including DMG and its subsidiary JSA) provision of services to MA plans and related patient diagnosis coding and risk adjustment submissions and payments. The Company believes that the request was part of a broader industry investigation into MA patient diagnosis coding and risk adjustment practices and potential overpayments by the government. The information requested included information related to patient diagnosis coding practices for a number of conditions, including potentially improper historical DMG coding for a particular condition. With respect to that condition, the guidance related to that coding issue was discontinued following the Company's November 1, 2012, acquisition of HealthCare Partners (now known as the Company's DMG business), and the Company notified Centers for Medicare and Medicaid Services (CMS) in April 2015 of the coding practice and potential overpayments. In that regard, the Company identified certain additional coding practices which may have been problematic, some of which were the subject of the previously disclosed and dismissed *Swoben Private Civil Suit*.

The Company entered into a settlement agreement with the DOJ and OIG to resolve these matters on September 28, 2018. As previously disclosed, an escrow established in connection with the Company's acquisition of HealthCare

Partners in 2012 held back a portion of the purchase price to the prior owners of HealthCare Partners as security for the indemnification rights of the Company. The settlement amount of $270,000 was paid with these escrowed funds. White, Kathleen, et al. v. DaVita Healthcare Partners, Inc., Civil Action No. 15-cv-2106, U.S. District Court for the District of Colorado: Three actions (Menchaca v. DaVita Healthcare Partners, Inc., Saldana v. DaVita Healthcare Partners, Inc. and Hardin v. DaVita Healthcare Partners, Inc.) were consolidated in December 2016 into one action in U.S. District Court for the District of Colorado. In all three actions, the plaintiffs brought claims for wrongful death based on allegations related to Granuflo®, a product used as a component of the dialysis process. The Menchaca and Saldana actions arose out of the treatment of patients in California, while the Hardin action arose out of the treatment of a patient in Illinois. On June 27, 2018,

the jury returned a verdict in favor of the plaintiffs, collectively awarding $8,500 in compensatory damages and $375,000 in punitive damages. Judgment on this verdict was not entered. In November 2018, the parties settled all three of the consolidated actions collectively for $25,500, and all three cases were dismissed with prejudice. One of the Company's insurance carriers paid $9,200 of the settlement. The Company believes it is probable that it will be able to recover the remainder of the settlement amount from other insurers, indemnitors, and the like; however, the Company can make no assurances that it will recover the full amount.

* * *

Other than as described above, the Company cannot predict the ultimate outcomes of the various legal proceedings and regulatory matters to which the Company is or may be subject from time to time, including those described in this Note 17 to these consolidated financial statements, or the timing of their resolution or the ultimate losses or impact of developments in those matters, which could have a material adverse effect on the Company's revenues, earnings and cash flows. Further, any legal proceedings or regulatory matters involving the Company, whether meritorious or not, are time consuming, and often require management's attention and result in significant legal expense, and may result in the diversion of significant operational resources, or otherwise harm the Company's business, results of operations, financial condition, cash flows or reputation.

18. Noncontrolling interests subject to put provisions and other commitments

Noncontrolling interests subject to put provisions

The Company has potential obligations to purchase the equity interests held by third parties in several of its majority-owned joint ventures and other nonconsolidated entities. These obligations are in the form of put provisions that are exercisable at the third-party owners' discretion within specified periods as outlined in each specific put provision. If these put provisions were exercised, the Company would be required to purchase the third-party owners' equity interests at either the appraised fair market value or a predetermined multiple of earnings or cash flows attributable to the equity interests put to the Company, which is intended to approximate fair value. The methodology the Company uses to estimate the fair values of noncontrolling interests subject to put provisions assumes the higher of either a liquidation value of net assets or an average multiple of earnings, based on historical earnings, patient mix and other performance indicators that can affect future results, as well as other factors. The estimated fair values of noncontrolling interests subject to put provisions are a critical accounting estimate that involves significant judgments and assumptions and may not be indicative of the actual values at which the noncontrolling interests may ultimately be settled, which could vary significantly from the Company's current estimates. The estimated fair values of noncontrolling interests subject to put provisions can fluctuate and the implicit multiple of earnings at which these noncontrolling interests obligations may be settled will vary significantly depending upon market conditions including potential purchasers' access to the capital markets, which can impact the level of competition for dialysis and non-dialysis related businesses, the economic performance of these businesses and the restricted marketability of the third-party owners' equity interests. The amount of noncontrolling interests subject to put provisions that employ a contractually predetermined multiple of earnings rather than fair value is immaterial.

The Company has certain other potential commitments to provide operating capital to a number of dialysis centers that are wholly-owned by third parties or businesses in which the Company owns a noncontrolling equity interest as well as to physician-owned vascular access clinics or medical practices that the Company operates under management and administrative service agreements of approximately $4,675.

Certain consolidated joint ventures are originally contractually scheduled to dissolve after terms ranging from ten years to 50 years. While noncontrolling interests in these limited life entities qualify as mandatorily redeemable financial instruments, they are subject to a classification and measurement scope exception from the accounting guidance generally applicable to other mandatorily redeemable financial instruments. Future distributions upon dissolution of these entities would be valued below the related noncontrolling interest carrying balances in the consolidated balance sheet.

Other commitments

In 2017, the Company entered into a Sourcing and Supply Agreement with Amgen USA Inc. (Amgen) that expires on December 31, 2022. Under the terms of the agreement, the Company will purchase EPO in amounts necessary to meet no less than 90% of its requirements for erythropoiesis-stimulating agents (ESAs) through the expiration of the contract from Amgen. The actual amount of EPO that the Company will purchase will depend upon the amount of EPO administered during dialysis as prescribed by physicians and the overall number of patients that the Company serves.

DAVITA INC.
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(dollars in thousands, except per share data)

The Company has an agreement with Fresenius Medical Care (FMC) to purchase a certain amount of dialysis equipment, parts and supplies from FMC, which was extended through December 31, 2020. During 2018, 2017 and 2016, the Company purchased $182,446, $176,212 and $164,766, respectively, of certain equipment, parts and supplies from FMC.

The Company also has an agreement with Baxter Healthcare Corporation (Baxter) that commits the Company to purchase a certain amount of peritoneal dialysis supplies at fixed prices through 2022. During 2018, 2017 and 2016, the Company purchased $162,858, $166,764 and $162,109 of peritoneal dialysis supplies from Baxter under this agreement.

Other than operating leases disclosed in Note 15 to these consolidated financial statements, the letters of credit disclosed in Note 14 to these consolidated financial statements, and the arrangements as described above, the Company has no off balance sheet financing arrangements as of December 31, 2018.

19. Long-term incentive compensation and shareholders' equity

Long-term incentive compensation

Long-term incentive program (LTIP) compensation includes both stock-based awards (principally stock-settled stock appreciation rights, restricted stock units and performance stock units) as well as long-term performance-based cash awards. Long-term incentive compensation expense, which was primarily general and administrative in nature, was attributed to the Company's U.S. dialysis and related lab services business, corporate administrative support, and the ancillary services and strategic initiatives.

The Company's stock-based compensation expense for stock-settled awards is measured at the estimated fair value of awards on the date of grant and recognized on a cumulative straight-line basis over the vesting terms of the awards unless the stock awards are based on non-market based performance metrics, in which case expense is adjusted for expected ultimate payouts as of the end of each reporting period. Stock-based compensation expense for cash-settled awards is based on the estimated fair values as of the end of each reporting period. The expense for all stock-based awards is recognized net of expected forfeitures.

Stock-based compensation to be settled in shares is recorded to the Company's shareholders' contributed capital, while stock-based compensation to be settled in cash is recorded to a liability. Shares issued upon exercise of stock awards are issued from authorized but unissued shares.

Long-term incentive compensation plans

The Company's 2011 Incentive Award Plan (the 2011 Plan) is the Company's omnibus equity compensation plan and provides for grants of stock-based awards to employees, directors and other individuals providing services to the Company, except that incentive stock options may only be awarded to employees. The 2011 Plan authorizes the Company to award stock options, stock appreciation rights, restricted stock units, restricted stock, and other stock-based or performance-based awards, and is designed to enable the Company to grant equity and cash awards that qualified as performance-based compensation under Section 162(m) of the Internal Revenue Code for tax years 2017 and prior. The 2011 Plan mandates a maximum award term of five years and stipulates that stock appreciation rights and stock options be granted with prices not less than fair market value on the date of grant. The 2011 Plan also requires that full value share awards such as restricted stock units reduce shares available under the 2011 Plan at a ratio of 3.5:1. The Company's nonqualified stock appreciation rights and stock units awarded under the 2011 Plan generally vest over 36 months to 48 months from the date of grant. At December 31, 2018, there were 6,162,797 stock-settled stock appreciation rights, 1,860,475 stock-settled stock units, 23,000 cash-settled stock appreciation rights and 1,600 cash-settled stock units outstanding, and 23,091,764 shares available for future grants, under the 2011 Plan.

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(dollars in thousands, except per share data)

A combined summary of the status of the Company's stock-settled awards under the 2011 Plan, including base shares for stock-settled stock appreciation rights (SSARs) and stock-settled stock unit awards is as follows:

	Year ended December 31, 2018			
	Stock appreciation rights		Stock units	
	Awards	Weighted average exercise price	Awards	Weighted average remaining contractual life
Outstanding at beginning of year	6,648,929	$67.99	1,075,572	
Granted	1,962,652	$62.53	1,101,388	
Exercised	(2,059,347)	$59.47	(165,543)	
Canceled	(387,184)	$78.84	(150,942)	