DAVITA HEALTHCARE PARTNERS INC.
Form 10-K
February 26, 2016

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-K

For the Fiscal Year Ended December 31, 2015

ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE

SECURITIES EXCHANGE ACT OF 1934

Commission File Number: 1-14106

DAVITA HEALTHCARE PARTNERS INC.

2000 16th Street

Denver, Colorado 80202

Telephone number (303) 405-2100

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

Securities registered pursuant to Section 12(b) of the Act:

Class of Security:	Registered on:
Common Stock, $0.001 par value	New York Stock Exchange

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

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

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

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted 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 and post such files). Yes x No ¨

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

Large accelerated filer x	Accelerated filer ¨
Non-accelerated filer ¨ (Do not check if a smaller reporting company)	Smaller reporting company ¨

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

As of June 30, 2015, the number of shares of the Registrant's common stock outstanding was approximately 215.5 million shares and the aggregate market value of the common stock outstanding held by non-affiliates based upon the closing price of these shares on the New York Stock Exchange was approximately $17.1 billion.

As of January 29, 2016, the number of shares of the Registrant's common stock outstanding held by non-affiliates was approximately 206.1 million shares.

Documents incorporated by reference

Portions of the Registrant's proxy statement for its 2016 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 HealthCare Partners Inc.

The Company consists of two major divisions, Kidney Care and HealthCare Partners (HCP). 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, which is a leading provider of kidney dialysis services in the U.S. for patients suffering from chronic kidney failure, also known as end stage renal disease (ESRD). Our HCP division 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.

For financial information about our reportable segments please read “Note 25 Segment Reporting” 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, 2015, we provided dialysis and administrative services in the U.S. through a network of 2,251 outpatient dialysis centers in 46 states and the District of Columbia, serving a total of approximately 180,000 patients. We also provide acute inpatient dialysis services in approximately 900 hospitals and related laboratory services throughout the U.S. Our U.S. dialysis and related lab services business accounted for approximately 62% of our 2015 consolidated net revenues. All references in this document to dialysis and related lab services refer only to our U.S. dialysis and related lab services business.

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 United States Renal Data System, there were approximately 468,000 ESRD dialysis patients in the U.S. in 2013. The underlying ESRD dialysis patient population has grown at an approximate compound rate of 3.6% from 2000 to 2013, the latest period for which such data is available. The growth rate is attributable to the aging of the population, increased incidence rates for diseases that cause kidney failure such as diabetes and hypertension, lower mortality rates for dialysis patients and growth rates of minority populations with higher than average incidence rates

of ESRD.

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 5 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, 2015, approximately 89% of our total dialysis patients were covered under some form of government-based programs, with approximately 76% 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 dialysis 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. However, peritoneal dialysis is not a suitable method of treatment for many patients, including patients who are unable to perform the necessary procedures and those at greater risk of peritoneal infection.

CAPD introduces dialysis solution into the patient's peritoneal cavity through a surgically placed catheter. Toxins in the blood continuously cross the peritoneal membrane into the dialysis solution. After several hours, the patient drains the used dialysis solution and replaces it with fresh solution. This procedure is usually repeated four times per day.

CCPD is performed in a manner similar to CAPD, but uses a mechanical device to cycle dialysis solution through the patient's peritoneal cavity while the patient is sleeping or at rest.

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.

Dialysis and related lab services we provide

Outpatient hemodialysis services

As of December 31, 2015, we operated or provided administrative services through a network of 2,251 outpatient dialysis centers in the U.S. that are designed specifically for outpatient hemodialysis. In 2015, our overall network of

U.S. outpatient dialysis centers increased by 72 primarily as a result of the opening of new dialysis centers, net of center closures and divestitures, and acquisitions, representing a total increase of approximately 3.3% from 2014.

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 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 25% in both 2015 and 2014. However, in 2015, the overall number of patients to whom we provided services in the U.S. increased by approximately 4.1% from 2014, primarily from the opening of new dialysis centers and acquisitions, and continued growth within the industry.

Hospital inpatient hemodialysis services

As of December 31, 2015, 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 2015, hospital inpatient hemodialysis services accounted for approximately 4.2% of our total U.S. dialysis treatments.

Home-based hemodialysis services

Many of our outpatient dialysis centers offer certain support services for dialysis patients who prefer and are able to perform either home-based 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-based hemodialysis or peritoneal dialysis.

ESRD laboratory services

We own two separately incorporated, 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 and are an integral component of 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.

Management services

We currently operate or provide management and administrative services pursuant to management and administrative services agreements to 31 outpatient dialysis centers located in the U.S. in which we either own a minority equity investment or 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

We employ 240 clinical service teammates in our dialysis and related lab services business. The primary focus of this group is assuring and facilitating processes that aim to achieve superior clinical outcomes at our centers.

Our physician leadership in the Office of the Chief Medical Officer (OCMO) for our dialysis and related lab services business includes twelve 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. The Physician Council is currently composed of three physicians with extensive experience in clinical practice in addition to the members of OCMO and currently nine Group Medical Directors.

Sources of revenue—concentrations and risks

Our U.S. dialysis and related lab services business net revenues represent approximately 62% of our consolidated net revenues for the year ended December 31, 2015. Our U.S. dialysis and related lab services revenues are derived primarily from our core business of providing dialysis services, the administration of pharmaceuticals, related laboratory services and to a lesser extent management fees generated from providing management and administrative services to certain outpatient dialysis centers, as discussed above.

The sources of our dialysis and related lab services revenues are principally from government-based programs, including Medicare and Medicare-assigned plans, Medicaid and Medicaid-assigned plans and commercial insurance plans.

The following table summarizes our U.S. dialysis services revenues by source and modality for the year ended December 31, 2015:

Source	Revenue percentages
Medicare and Medicare-assigned plans	56 %
Medicaid and Medicaid-assigned plans	6 %
Other government-based programs	4 %
Total government-based programs	66 %
Commercial (including hospital inpatient dialysis services)	34 %
Total dialysis and related lab services revenues	100 %

Modality	Revenue percentages
Outpatient hemodialysis centers	79 %
Peritoneal dialysis and home-based hemodialysis	16 %
Hospital inpatient hemodialysis	5 %
Total dialysis and related lab services revenues	100 %

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, 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. Most lab services are also included in the bundled payment. The bundled payment rate is also adjusted for certain patient characteristics, a geographic usage index and certain other factors.

An important provision in the law is an annual adjustment, or market basket update, to the ESRD Prospective Payment System (PPS) base rate. Absent action by Congress, the PPS base rate is automatically updated annually by a formulaic inflation adjustment. In December 2013, the Centers for Medicare and Medicaid Services (CMS) issued the 2014 final rule for the ESRD PPS, which phases in the payment reductions mandated by the American Taxpayer Relief Act of 2012 (ATRA), as modified by the Protecting Access to Medicare Act of 2014, which will reduce our market basket inflation adjustment by 1.25% in each of 2016 and 2017, and 1% in 2018. CMS published the 2015 final rule for the ESRD PPS, which increased payments to dialysis facilities modestly by 0.3% to 0.5%, although rural facilities received a decrease of 0.5%. CMS recently issued the 2016 final rule for the ESRD PPS, which cuts dialysis facilities' bundled payment rate for 2016 as compared to 2015 while increasing funds for certain co-morbidities and other patient health factors, and rural facilities. CMS believes its 2016 final rule for the ESRD PPS will (i) increase overall payments to both hospital-based and freestanding dialysis facilities by approximately 0.2%, and (ii) decrease overall payments to rural dialysis facilities by approximately 0.1%.

As a result of the Budget Control Act of 2011 (BCA) and subsequent activity in Congress, a $1.2 trillion sequester (across-the-board spending cuts) in discretionary programs took effect on March 1, 2013. In particular, a 2% reduction to Medicare payments took effect on April 1, 2013, which was subsequently extended through 2014 and 2015. The Bipartisan Budget Act of 2015 extended the BCA's annual 2% reduction to Medicare payments through fiscal year 2025. These across-the-board spending cuts have affected and will continue to adversely affect our revenues, earnings

and cash flows.

The CMS Center for Medicare & Medicaid 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 currently uncertain of the extent to which the long-term operation and evolution of these models of care, including ACOs, Bundled Payments for Care Improvement Initiative, Comprehensive ESRD Care (CEC) Model (which includes the development of ESRD Seamless Care Organizations (ESCOs)), the Comprehensive Primary Care Initiative, 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 with organizations in Arizona, Florida, New Jersey and Pennsylvania. 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 programs' calculations. As new models of care emerge and evolve, we may be at risk for losing our Medicare patient base, which would have a materially adverse effect on our revenues, earnings and cash flow. Other initiatives in the government or private sector may 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.

We anticipate that we will continue to experience increases in our operating costs in 2016 that will outpace any net Medicare rate increases that we may receive, which could significantly impact our operating results. In addition, we expect to continue experiencing increases in operating costs that are subject to inflation, such as labor and supply costs, regardless of whether there is a compensating inflation-based increase in Medicare payment rates or in payments under the bundled payment rate system.

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 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, can apply for premium payment assistance from charitable organizations through a program offered by the American Kidney Fund. We and other dialysis providers support the American Kidney Fund and similar programs through voluntary contributions. If a patient does not have secondary insurance coverage, we are generally unsuccessful in our efforts to collect 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.

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 have Medicare as their primary payor for dialysis services, a patient's commercial insurance plan, if any, is responsible for payment of such dialysis services for 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 Fee-for-Service (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. In 2015, we continued to enter into some commercial contracts, covering certain patients that will primarily pay us under a single bundled payment rate for all dialysis services provided to these patients. However, some of the contracts will pay us for certain other services and pharmaceuticals in addition to the bundled payment. These 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, our revenues and operating results could be negatively impacted. 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 traditional commercial insurance plans. 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 such financial assistance, our revenues, earnings, and cash flow could be substantially reduced.

Approximately 34% of our dialysis services revenues and approximately 11% of our dialysis patients were associated with commercial payors for the year ended December 31, 2015. Commercial patients as a percentage of our total dialysis patients increased by approximately 1% in 2015 as compared to 2014. Less than 1% of our 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 dialysis and related lab services revenues for the year ended December 31, 2015.

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. Although we cannot predict the long term effects of these exchanges, we believe the healthcare insurance exchanges could ultimately result in a reduction in patients covered by traditional commercial insurance or an increase of patients covered through the exchanges under more restrictive commercial plans with lower reimbursement rates. Approximately 11 million individuals were enrolled in the exchanges in 2015, as compared to approximately eight million in 2014. To the extent that the ongoing implementation of such exchanges results in a reduction in reimbursement rates for our services from commercial and/or government payors, our operating results could be adversely affected.

Revenue from other pharmaceuticals and EPO

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, as well as some additional commercial contracts that pay us a single bundled payment rate. Approximately 2% of our total dialysis and related lab services revenues for the year ended December 31, 2015, as compared to 3% in 2014, are associated with the administration of separately-billable physician-prescribed pharmaceuticals. Of this, the administration of EPO that was separately billable, accounted for approximately half of our separately billable pharmaceuticals of our dialysis and related lab services revenues for the year ended December 31, 2015. EPO is produced by a single manufacturer, Amgen USA Inc. (Amgen). Any interruption of supply or product cost increases could impact our operations.

Evaluations on the utilization and reimbursement for erythropoiesis stimulating agents (ESAs), like EPO, which have occurred in the past and may occur in the future, and related actions by the U.S. Congress and federal agencies, could result in further restrictions on the utilization and reimbursement for ESAs. Additionally, commercial payors have also increasingly examined their administration policies for EPO and, in some cases, have modified those policies. Changes in labeling of EPO and other pharmaceuticals in a manner that alters physician practice patterns or accepted clinical practices, changes in private and governmental payment criteria, including the introduction of EPO administration policies or the conversion to alternate types of administration of EPO or other pharmaceuticals that result in further decreases in utilization of EPO for patients covered by commercial payors, which pay for pharmaceuticals separately, could have a material impact on our operating results. Further increased utilization of EPO for patients for whom the cost of EPO is included in a bundled reimbursement rate could also have a material impact on our operating results.

Physician relationships

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 meet their needs and the needs of their patients are key factors in the success of our dialysis operations. Approximately 4,900 nephrologists currently refer patients to our outpatient dialysis centers. As is typical in the dialysis industry, one or a few physicians, including the outpatient dialysis center's medical director, usually account for all or a significant portion of an outpatient dialysis center's patient base.

Participation in the Medicare ESRD program requires that dialysis services at an outpatient dialysis center be under the general supervision of a medical director who is a licensed physician. 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 to serve as assistant or associate medical directors or to direct specific programs, such as home dialysis training programs. We have approximately 950 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, among others.

Our medical director contracts for our dialysis centers generally include covenants not to compete. Also, except as described below, when we acquire an outpatient dialysis center from one or more physicians or where one or more physicians own minority interests in our outpatient dialysis centers, these physicians have agreed to refrain from owning interests in other competing outpatient dialysis centers within a defined geographic area for various time periods. These non-compete agreements restrict the physicians from owning or providing medical director services to other outpatient dialysis centers, but do not prohibit the physicians from referring patients to any outpatient dialysis center, including competing centers. Many of these non-compete agreements continue for a period of time beyond expiration of the corresponding medical director agreements, although some expire at the same time as the medical director agreement. Occasionally, we experience competition from a new outpatient dialysis center established by a former medical director following the termination of his or her relationship with us. As part of our Corporate Integrity Agreement (CIA), as described below, we also 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.

If a significant number of physicians, including an outpatient dialysis center's medical directors, were to cease referring patients to our outpatient dialysis centers, our business could be adversely affected.

Government regulation

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

Because we are subject to a number of governmental regulations, our business could be adversely impacted by:

- Loss or suspension of federal certifications;
- Loss or suspension of licenses under the laws of any state or governmental authority from which we generate substantial revenues;
- Exclusion from government healthcare programs, including Medicare and Medicaid;
- Significant reductions or lack of inflation-adjusted increases in payment rates or reduction of coverage for dialysis and ancillary services and related pharmaceuticals;
- Civil or criminal liability, fines, damages and monetary penalties for violations of healthcare fraud and abuse laws, including the federal Anti-Kickback Statute, the Physician Self-Referral law (Stark Law), the federal False Claims Act (FCA) and other violations of law or failures to meet regulatory requirements;
- Civil or criminal liability, claims for monetary damages from patients who believe their protected health information (PHI) or other confidential health information has been used or disclosed in violation of federal and state patient privacy laws;
- Mandated changes to our practices or procedures that significantly increase operating expenses; or
- Refunds of payments received from government payors and government healthcare program beneficiaries because of any failures to meet applicable requirements.

We expect that our industry will continue to be subject to substantial regulation, the scope and effect of which are difficult to predict. Our activities could be reviewed or challenged by regulatory authorities at any time in the future. 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.

To date, we have not experienced significant difficulty in maintaining our licenses or enrolling in state Medicaid programs. However, we have experienced some delays in obtaining Medicare certifications from CMS.

Federal Anti-Kickback Statute

The federal Anti-Kickback statute contained in the Social Security Act of 1935, as amended (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 five years and fines of up to $25,000 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 $50,000 in monetary penalties per violation, repayments of up to three times the total payments between the parties and suspension

from future participation in Medicare and Medicaid. 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 (Health Reform Acts) amended the federal Anti-Kickback Statute to clarify the intent that is required to prove a violation. Under the statute as amended, the defendant need not have known of the existence of the federal Anti-Kickback Statute or had the specific intent to violate it. In addition, the Health Reform Acts amended the federal Anti-Kickback Statute to provide that any claims submitted from an arrangement that violates the federal Anti-Kickback Statute are false for purposes of the FCA.

The 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. These arrangements include:

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 the Medical Director Agreements we enter into with physicians 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. We believe that our fair market value arrangements with physicians who serve as medical directors do not violate the federal Anti-Kickback Statute; however, 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, 2015, these joint ventures represented approximately 23% of our dialysis and related lab services revenues. We may continue to increase the number of our 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. Based upon the foregoing, physician joint ventures that fall outside the safe harbors are not, by definition, prohibited by law. Instead, such joint ventures require case-by-case evaluation under the federal Anti-Kickback Statute.

In this regard, we have structured 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. We believe that our joint venture arrangements do not violate the federal Anti-Kickback Statute; however, since the arrangements do not satisfy all of the requirements of an applicable safe harbor, these arrangements could be subject to challenge on the ground that they are intended to induce patient referrals. In that regard, 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 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 have entered into a five-year CIA with the OIG.

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 270 of our dialysis centers as of December 31, 2015. These arrangements comply with the federal Anti-Kickback Statute safe harbor for space rentals in all material respects. Therefore, we believe that these lease arrangements should not be subject to challenge under the federal Anti-Kickback Statute.

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. Therefore, we believe that these investments should not be subject to challenge under the federal Anti-Kickback Statute.

Discounts. Our dialysis centers sometimes acquire certain items and services that may be reimbursed by a federal healthcare program at a discount. We believe that our vendor contracts that include discount or rebate provisions are in compliance with the federal Anti-Kickback Statute safe harbor for discounts, and accordingly, we believe that our discounted vendor contracts should not be subject to challenge under the federal Anti-Kickback Statute.

If any of our business transactions or arrangements, including those described above, were found to violate the federal Anti-Kickback Statute, we could face criminal, civil 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 operations.

Stark Law

The federal Physician Self-Referral law, known as the Stark Law, prohibits a physician who has a financial relationship, or who has an immediate family member who has a financial relationship, with entities providing Designated Health Services (DHS), from referring Medicare patients to such entities for the furnishing DHS, unless an exception applies. DHS includes enumerated items and services, including home health services, outpatient prescription drugs, inpatient and outpatient hospital services and clinical laboratory services. The Stark Law also prohibits the DHS entity receiving a prohibited referral from filing a claim or billing for the services arising out of the prohibited referral. The prohibition applies regardless of the reasons for the financial relationship and the referral; unlike the federal Anti-Kickback Statute, intent to induce referrals is not required. 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, exclusion from the federal healthcare programs, including Medicare and Medicaid, and a civil penalty of up to $100,000 against parties that enter into a scheme to circumvent the Stark Law prohibition. Furthermore, Stark Law violations can form the basis for FCA liability as discussed below. 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 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, unless the DHS services are themselves payable through a composite rate. Although the new 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 composite or bundled rate, the services performed in our facilities generally are not DHS, and the Stark Law referral prohibition does not apply to those services. 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 EPO and other specifically enumerated dialysis drugs when furnished in or by an ESRD facility, in compliance with the federal Anti-Kickback Statute and applicable billing requirements. The exception is available only for drugs included on a list of CPT/HCPCS codes published by CMS, and in the case of home dialysis, the exception applies only to EPO, Aranesp® and equivalent drugs dispensed by the 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 an arrangement does not meet a Stark Law exception, we could in the future 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 believe that our medical director agreements 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 believe that our leases and subleases with referring physicians 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. 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 center would be subject to the Stark Law penalties described above.

While we believe that most of our operations do not implicate the Stark Law, particularly under the ESRD bundled payment system, and that to the extent that our dialysis centers furnish DHS, they either meet an exception or do not bill for services that do not meet a Stark Law exception, if CMS determined that we have submitted claims in violation to 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. Any such penalties and restructuring could have a material adverse effect on our operations.

Fraud and abuse under state law

Many states in which we operate dialysis centers have statutes prohibiting physicians from holding financial interests in various types of medical facilities to which they refer patients. Some of these statutes could potentially be interpreted broadly as prohibiting physicians who hold shares of our publicly traded stock from referring patients to our dialysis centers if the centers use our laboratory subsidiary to perform laboratory services for their patients. Some states also have laws similar to the federal Anti-Kickback Statute that may affect our ability to receive referrals from physicians with whom we have financial relationships, such as our medical directors. Some state Anti-Kickback Statutes also include civil and criminal penalties. Some of these statutes include exemptions applicable to our medical directors and other physician relationships or for financial interests limited to shares of publicly traded stock. Some, however, include no explicit exemption for medical director services or other services for which we contract with and compensate referring physicians or for joint ownership interests of the type held by some of our referring physicians or for financial interests limited to shares of publicly traded stock. If these statutes are interpreted to apply to referring physicians with whom we contract for medical director and similar services, to referring physicians with whom we hold joint ownership interests or to physicians who hold interests in DaVita HealthCare Partners Inc. limited solely to our publicly traded stock, we may be required to terminate or restructure some or all of our relationships with or refuse referrals from these referring physicians and could be subject to criminal, civil and administrative sanctions, refund requirements and exclusions from government healthcare programs, including Medicare and Medicaid. Such events could negatively affect the decision of referring physicians to refer patients to our centers.

The False Claims Act

The 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:

- Knowingly presents or causes to be presented to the federal government, a false or fraudulent claim for payment or approval;
- Knowingly makes, uses or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the federal government;
- Conspires to defraud the federal government by getting a false or fraudulent claim allowed or paid; or
- Knowingly makes, uses or causes to be made or used, a false record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the federal government.

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 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. As a result of these provisions, our procedures for identifying and processing overpayments may be subject to greater scrutiny. We have made significant investments to accelerate the time it takes us to identify and process overpayments and we may be required to make additional investments in the future. Acceleration in our ability to identify and process overpayments could result in us refunding overpayments to government or other payors sooner than we have in the past. A significant acceleration of these refunds could have a material adverse effect on our operating cash flows.

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 is generally equal to the amounts received directly or indirectly

from the government for each such false claim. The federal government has used the FCA to prosecute a wide variety of alleged false claims and fraud allegedly perpetrated against Medicare and state healthcare programs, including coding errors, billing for services not rendered, the submission of false cost reports, billing 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 Health Reform Acts provide 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.

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 our centers to impose compliance obligations by written agreement on certain contractors, known as business associates, to whom they disclose PHI. Covered entities may be subject to penalties as a result of a business associate violating HIPAA if the business associate is found to be an agent of the covered entity. Business associates are also directly subject to liability under the HIPAA privacy and security regulations. In instances where our centers act as a business associate to a covered entity, there is the potential for additional liability beyond the center’s covered entity status.

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 U.S. Department of Health and Human Services (HHS), and, in certain situations involving large breaches, to the media. HHS is required to publish on its website a list of all covered entities that report a breach involving more than 500 individuals. 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 up to $50,000 per violation and up to $1.5 million per year for the same type of violation. 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. We believe our HIPAA Privacy and Security Program sufficiently addresses HIPAA requirements.

Healthcare reform

In March 2010, broad healthcare reform legislation was enacted in the U.S. Although many of the provisions of the legislation 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 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 these changes or what form many of these regulations will take before implementation.

The law 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.

In December 2011, the CMS Center for Consumer Information and Insurance Oversight published an Essential Health Benefits Bulletin (EHB Bulletin) describing the approach it was taking regarding the implementation of the EHB Bulletin requirement. For the two year transition period (from 2014 through 2015) the law required states to define an EHB benchmark plan that would set the general standards for the EHB that must be covered by plans in the state, subject to certain overarching federal requirements. States that did not define an EHB benchmark plan must use the small group plan with the largest enrollment in the state.

On February 25, 2013, for example, HHS issued the final rule governing the standards applicable to EHB benchmark plans, new definitions, 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 on health plans applicable to EHBs, (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 for standards for insurance plans provided through the exchanges.

Other aspects of the 2010 healthcare reform laws may affect our business, as well, including changes affecting the Medicare and Medicaid programs.

Other regulations

Our 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. We believe that we are in material compliance with these laws and regulations.

A few states have certificate of need programs regulating the establishment or expansion of healthcare facilities, including dialysis centers. We believe that we are in material compliance with all applicable state certificate of need laws.

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 $2.8 million for leasehold improvements, equipment and first-year working capital. 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 either own a minority equity investment, or 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.

	2015	2014	2013	2012	2011

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

(1) In 2011, we acquired 113 dialysis centers and divested a total of 30 centers in connection with our acquisition of DSI Renal Inc. (DSI).

* Represents dialysis centers in which we either own a minority equity investment, or are wholly-owned by third parties.

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

*** 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, 2015, we operated or provided administrative services to a total of 2,251 U.S. outpatient dialysis centers. A total of 2,220 of such centers are consolidated in our financial statements. Of the remaining 31 unconsolidated U.S. outpatient dialysis centers, we own a minority equity investment in 22 centers and provide management and administrative services to nine centers that are wholly-owned by third parties. The locations of the 2,220 U.S. outpatient dialysis centers consolidated in our financial statements at December 31, 2015 were as follows:

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

Ancillary services and strategic initiatives businesses, including our international operations

As of December 31, 2015, our ancillary services and strategic initiatives consisted primarily of pharmacy services, disease management services, vascular access services, clinical research, physician services, direct primary care and our international dialysis operations. Our ancillary services and strategic initiatives, including our international operations, accounted for approximately 10.0% of our consolidated net revenues for the year ended December 31, 2015, and relate primarily to our core business of providing kidney care services.

Ancillary services and strategic initiatives consist primarily of the following as of December 31, 2015:

- Pharmacy services. DaVita Rx is a pharmacy that specializes in providing oral medications and medication management services to patients with ESRD and other chronic diseases. The main objective of the pharmacy is to improve clinical outcomes and reduce total healthcare costs by facilitating increased patient compliance and to provide our patients a convenient way to fill their prescription needs. Revenues are recognized as prescriptions are filled and shipped to patients or when services are completed.
- Disease management services. VillageHealth provides advanced care management services to health plans and government agencies for employees/members diagnosed with ESRD and/or CKD. Through a combination of clinical coordination, 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. Revenues are typically based upon an established contract fee and are recognized as earned over the contract period and can include additional fees for cost savings recognized by certain customers. In 2015, VillageHealth operated Medicare Advantage ESRD Special Needs Plans in partnership with two 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, VillageHealth entered into a management service agreement to

support three ESCO joint ventures in which the Company is an investor through certain wholly- or majority-owned dialysis clinics. The ESCOs were formed under the Innovation Center's CEC Model to demonstrate the coordination of care for ESRD patients in a dialysis-center oriented ACO setting. Each ESCO joint venture has a shared risk arrangement with CMS for this program.

- 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 nine vascular access clinics and wholly-owns one vascular access clinic. 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, 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 employment opportunities in select markets and 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. Fees generated from these services are recognized as earned typically based upon flat fees or cash collections generated by the physician practice. NPS also provides leading nephrology recruitment and staffing services which are billed on a per search basis.
- Direct primary care. Paladina Health is a healthcare services organization that operates membership-based primary care clinics mainly through employer-based on-site and near-site clinics. The clinics offer patients more personalized and improved access to primary care physicians, including unlimited visits and same-day or next-day appointments. Physicians focus on clinical outcomes and patient satisfaction. Revenues are recognized over the membership period.

International dialysis operations

As of December 31, 2015, we operated or provided administrative services to a total of 118 outpatient dialysis centers located in ten countries outside of the U.S., serving approximately 10,000 patients. Our international dialysis operations continue to grow steadily and expand as a result of developing and acquiring outpatient dialysis centers in various strategic markets. However, our overall net revenues generated from our international operations represented approximately 1% of our consolidated net revenues during 2015. Our international operations are included as a component of our ancillary services and strategic initiatives. The table below summarizes the number and locations of our international outpatient dialysis centers.

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

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

Malaysia	38
Germany	20
Colombia	15
India	13
Saudi Arabia	10
Poland	8
Portugal	5

Taiwan	5
China	3
Singapore	1
	118

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. Corporate administrative support costs were approximately $19 million, $13 million and $53 million in 2015, 2014 and 2013, respectively. These expenses are included in our consolidated general and administrative expenses and are offset by the allocation of management fees. The increase in corporate administrative support costs in 2015 as compared to 2014 was due to an increase in professional fees.

HealthCare Partners Division

HealthCare Partners business overview

HCP 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, 2015, HCP had approximately 807,400 members under its care in southern California, Colorado, central and south Florida, southern Nevada, central New Mexico and central Arizona through capitation contracts with some of the nation's leading health plans. Of these members, approximately 317,400 individuals were patients enrolled in Medicare Advantage, and the remaining approximately 490,000 individuals were managed care members whose health coverage is provided through their employer or who have individually acquired health coverage directly from a health plan or as a result of their eligibility for Medicaid benefits.

HCP patients as well as the patients of HCP'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, 2015, HCP delivered services to its members via a network of 547 associated group full-time primary care physicians, over 2,900 associated group and other network primary care physicians, 240 network hospitals, and several thousand associated group and network specialists. Together with hundreds of case managers, registered nurses and other care coordinators, these medical professionals utilize a comprehensive information technology system, sophisticated risk management techniques and clinical protocols to provide high-quality, cost-effective care to HCP's members.

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, lack of healthy lifestyle both 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. In 2014, CMS reported that healthcare accounted for 17.5% of the U.S. economy and healthcare spending increased 5.3% to reach $3.0 trillion. Medicare spending grew 5.5% to $620 billion in 2014 or 20% of National Health Expenditures, according to CMS. Medicare outlays accounted for 14% of the Federal Budget in 2014 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 population demographics. According to the U.S. Census Bureau, the overall U.S. population grew 57% from 1970 through 2015, while the number of Medicare enrollees grew by 157% from 1970 to 2013 based on the latest publicly available CMS data. As an increasing number of the baby boomers become eligible for Medicare, the senior market is expected to be 20% of the total U.S. population by 2030 according to the U.S. Census Bureau.

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 monthly premium payment per member from CMS. The monthly premium varies based on the county in which the member resides, as adjusted to reflect the plan members' demographics and the members' risk scores. 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.

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 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 2014, Medicare Advantage represents only 31% 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 Health Reform Acts into law in March 2010, which were affirmed, in substantial part, by the U.S. Supreme Court in June 2012. The Health Reform Acts provide for a reduction of up to 27 million uninsured individuals by 2019, while potentially increasing Medicaid coverage by up to 15 million individuals. CMS projects that the total number of uninsured Americans will fall to 23 million in 2023 from 45 million in 2012. 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.

In 2006, Medicare began to pay Medicare Advantage health plans under a bidding process. Plans bid against county-level benchmarks established by Medicare based on the prior year’s Medicare Advantage county payment rate and increased by the projected national growth rate in per capita Medicare spending. Those payment rates were at least as high as per capita FFS Medicare

spending in each county and often substantially higher because Congress set floors to raise the lowest rates to stimulate plan growth in areas where plans historically had not found it profitable to enter. 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 Medicare program retains 25% of the difference as savings and the plan receives 75% of the difference as a rebate, which must be returned to enrollees in the form of additional benefits or reduced premiums. Plan payments are also adjusted based on enrollees' risk profiles. The formula for base payment is a combination of the base rate for the enrollee's county of residence, multiplied by the enrollee's risk score.

One of the primary ways in which the Health Reform Acts will fund increased health insurance coverage is through cuts in Medicare Advantage reimbursement. County benchmarks are transitioning to a system in which each county's benchmark in 2017 will be a certain percentage (ranging from 95% to 115%) of FFS. In a March 2015 report to Congress, the Medicare Payment Advisory Commission (MedPAC) estimated that 2016 Medicare Advantage benchmarks, bids, and payments would average 107%, 94%, and 102% 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 90% of FFS spending, yet 2015 payments for HMO enrollees are estimated to average 101% of FFS spending because the benchmarks, including the quality bonuses, average 106% of FFS spending.

As a result of the above, plans would generally have to bid significantly lower than FFS or the Medicare Advantage benchmark for CMS to begin to save money on Medicare Advantage. As a result of the transition of county benchmarks from 95% to 115% of FFS, Medicare Advantage benchmarks on average are expected to be reduced to parity with FFS by 2017. Given that CMS will retain 25% of the difference of any plans bid below benchmark, the overall Medicare Advantage program should realize savings as compared to FFS in 2017, which would result in lower payments to Medicare Advantage plans and to HCP.

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 HCP and numerous other markets, many health plans subcontract a significant portion of the responsibility for managing patient care to integrated medical systems such as HCP. These integrated healthcare systems, whether medical groups or IPAs, offer a comprehensive medical delivery system and sophisticated care management know-how 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, New Mexico and Arizona often prospectively pay the integrated healthcare system 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 systems, in the aggregate, represent a prospective budget from which the system manages care-related expenses on behalf of the population enrolled with that system. To the extent that these systems manage care-related expenses under the capitated levels, the system realizes an operating profit. On the other hand, if care-related expenses exceed projected levels, the system will realize an operating deficit. Since premiums paid represent a significant amount per person, there is a significant revenue opportunity for an integrated medical system like HCP that is able to effectively manage its costs under a capitated arrangement.

Integrated medical systems, such as HCP, that have scale are positioned to spread an individual member's cost experience across a wider population and realize the benefits of pooling medical risk among large numbers of patients. In addition, integrated medical systems 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 systems, like HCP, have also 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 Health Reform Acts. This legislation made significant changes to the Medicare program and to the health insurance market overall. The Health Reform Acts are 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 Health Reform Acts reflect sweeping legislation that, once fully implemented, may have a significant impact on the U.S. healthcare system generally and the operations of HCP’s business. There are numerous steps required to implement the Health Reform Acts, and implementation remains ongoing. Congress also has enacted, and may continue to seek, legislative changes that alter, delay, or eliminate some of their provisions. For example, under the 2016 Omnibus budget agreement, Congress voted to delay certain new

taxes that the Health Reform Acts had enacted, including the excise tax on certain high-cost health plans, the medical device tax, and the tax on health insurers. These and other changes contribute to the uncertainty of the ongoing implementation and impact of the Health Reform Acts; they also underscore the potential for additional reform going forward.

One provision of the Health Reform Acts 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 2014, HCP entered into an agreement with CMS to participate in the MSSP in California, Florida and Nevada. Under this program, HCP is striving to attain improved clinical outcomes to its Medicare FFS patients in a more cost-effective manner, and will have the opportunity to share with CMS in any financial savings created.

Payor environment

Government programs

HCP 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 $620 billion program in 2014, covering approximately 55 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 $527 billion in 2015 to $866 billion in 2024.

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 1, 2014, President Obama signed into law the Protecting Access to Medicare Act of 2014, which provided for a 0% update to the 2015 Medicare PFS through March 31, 2015. Subsequently, 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 which Alternate Payment Model (APM) the physician participates. 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 on March 1, 2013 that imposed automatic spending cuts on various federal programs. Under the Bipartisan Budget Act of 2013 and a bill signed by the President on February 15, 2014, sequestration has been extended through fiscal year 2024. Medicare payments to providers are subject to such cuts, although the BCA generally limited the Medicare cuts to two percent.

For fiscal year 2024, however, Medicare sequestration amounts will be realigned such that there will be a 4.0 percent sequester for the first six months and a zero percent sequester for the second six months.

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. The Medicare program is frequently mentioned as a target for spending cuts. Spending cuts to the Medicare program could adversely affect our operating results.

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 co-payments or deductibles, availability of preventive care, attractiveness of and access to a network of hospitals, physicians and ancillary providers and 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 systems such as HCP 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 HCP, 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 31% in 2015 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, but prior to the Health Reform Acts, 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 Health Reform Acts require 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 HCP is not a health plan, except for DaVita HealthCare Partners Plan (DHPP) it is not subject to the 85% MLR requirement (see "HealthCare Partners Division—Knox-Keene" below). However, payments that health plans make to HCP 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 will not impact amounts paid by health plans to HCP.

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 HCP. HCP has entered into capitation agreements with health plans to manage approximately 122,600 Medicaid managed care members in its southern California and Florida markets.

Commercial payors

According to a survey conducted from January through June 2015 by the Kaiser Family Foundation and the Health Research and Education Trust, approximately 63% of non-elderly U.S. citizens received their healthcare benefits 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. Commercial employer-sponsored health plan enrollment was approximately 147 million in 2015, according to the survey conducted by the Kaiser Family Foundation and the percentage of workers covered increased by approximately 1% from 62% in 2014. Under the Health Reform Acts, 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. HCP derives a significant amount of its enrollment from commercial members; however, these members represent a disproportionately small share of HCP'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 indirectly trying to influence physicians' behavior through various incentive and penalty schemes, 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 they 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 systems such as HCP'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 system receives payment for managing and providing healthcare services to its members.

Fee-for-service structure. Under traditional FFS reimbursement, physicians are paid a specified FFS that they provide during a patient visit. Under this structure, physician compensation is solely related to 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 HCP's physician services and hospice care.

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 system 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 for a population of patients. 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 system under a capitated arrangement can be significant. This is particularly the case for patients with multiple diseases and senior members. 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. HCP has the scale, comprehensive medical delivery resources, significant infrastructure to support practicing physicians, and demonstrated care management know-how to spread the risk of losses over a large patient population.

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

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, HCP obtained a restricted Knox-Keene license and therefore may enter into global capitation arrangements with health plans through which HCP will assume financial responsibility for both professional and institutional services.

In Nevada, HCP 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 HCP 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 HCP's global capitation arrangements in Nevada, HCP applied for an insurance license from the NDI and obtained the license in 2015. HCP is currently evaluating its ability to assign any of its existing contracts to the NDI license holder. Because of the current global capitation to HCP, and HCP's assumption of nearly the entire professional and institutional risk in Nevada, Florida and Arizona, HCP's health plan customers function primarily to support HCP in undertaking marketing and sales efforts to enroll members and processing claims in these states.

Risk-sharing model. In California, HCP 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, Inc. (collectively HCPAMG), which are medical groups that have entered into management services agreements with HCP, have historically contracted with health plans to receive a PMPM or percentage of premium (POP) capitation payment for professional (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 (hospital) services. 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. In both cases, HCPAMG 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 HCPAMG capitation payment. In the case of institutional services and as a result of its managed care-related administrative services agreements with hospitals, HCPAMG has recognized a percentage of the surplus of institutional revenues less institutional expense as HCPAMG net revenues and has also been responsible for some percentage of any short-fall in the event that institutional expenses exceed institutional revenues. In connection with HCP'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 HCPAMG to DHPP. In addition, HCP now has the legal authority to transition these health plan contracts to global capitation arrangements in which HCP is responsible for arranging professional and institutional services in exchange for a single capitation payment. HCP is in the process of evaluating and identifying which risk-sharing arrangements, if any, will be converted to global capitation arrangements, subject to HCP's and the applicable health plan's satisfactory negotiation and approval, as well as approval from the Department of Managed Healthcare. Completion of such evaluation and possible conversion is expected to occur over time.

Government regulation

In addition to the laws and regulations to which our dialysis and related lab services business are subject to, the internal operations of HCP 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 dialysis and related lab services business. For example:

- HCP's financial relationships with healthcare providers including physicians and hospitals could subject HCP to criminal and civil sanctions and penalties under the federal Anti-Kickback Statute;
- The referral of Medicare patients by HCP-associated physicians for the provision of DHS may subject the parties to sanctions and penalties under the federal Stark Law;
- HCP's financial relationships and those of its associated physicians may subject the parties to penalties and sanctions under state fraud and abuse law;
- HCP'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 HCP to sanction and penalties under the FCA; and
- HCP's handling of PHI may subject HCP 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 often 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, or the imposition of sanctions associated with a violation of any of these healthcare laws and regulations, could result in criminal 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 HCP's business, financial condition and results of operations. We cannot guarantee that the arrangements or business practices of HCP 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 HCP's business. Moreover, changes in healthcare legislation or government regulation may restrict HCP's existing operations, limit their expansion or impose additional compliance requirements and costs, any of which could have a material adverse effect on HCP's business, financial condition and results of operations.

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 dialysis and related lab services business, affect HCP. HCP is also subject to the laws and regulations that apply to our U.S. dialysis and related lab services business, see "The dialysis and related lab services business overview—Government regulation" above.

Licensing, certification, accreditation and related laws and guidelines. HCP clinical personnel are subject to numerous federal, state and local licensing laws and regulations, relating to, among other things, professional credentialing and professional ethics. Since HCP clinical personnel perform services in medical office settings, hospitals and other types of healthcare facilities, HCP 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 and standards, including loss of professional license, civil 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. HCP'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 HCP 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 an HCP-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, Nevada and Arizona are three states in which HCP 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.

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 physician who participates in a scheme that violates California's corporate practice of medicine prohibition may be punished for aiding and abetting a lay entity in the unlawful practice of medicine. In Nevada, violation of the corporate practice of medicine rules by a lay entity also constitutes the unlawful practice of medicine. This violation is a felony punishable by fines and other criminal penalties. Physicians in Nevada can similarly be punished for aiding and abetting in the unlicensed practice of medicine. In Arizona, although state statutes establish professional corporations for the provision of professional services including medical services, state statutes and regulations do not specifically address the corporate practice of medicine prohibition or proscribe penalties for its violation. Accordingly, a violation of the corporate practice of medicine prohibition as set forth in Arizona case law would, at least, be deemed illegal and result in the voiding of the offending employment or contractual relationship at issue.

In California, Nevada and Arizona, where the corporate practice of medicine is prohibited, HCP 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, HCP 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, HCP has full-service management contracts with HCPAMG. The HCPAMG entities are owned by California-licensed physicians and professional medical corporations and contract with physicians to provide professional medical services. In Nevada, HCP's Nevada subsidiaries have similar management agreements with Nevada professional corporations that employ and contract with physicians to provide professional medical services.

In Arizona, HCP arranges for the provision of patient care services through an IPA named Arizona Integrated Physicians (AIP). AIP is a professional corporation that contracts with independent physicians and medical group practices. In this way, the professional medical services required by HCP members in Arizona are provided by AIP and structured to be in compliance with Arizona's corporate practice of medicine laws.

Some of the relevant laws, regulations, and agency interpretations in California, Nevada and Arizona have been subject to limited judicial and regulatory interpretation. Moreover, state laws are subject to change. Regulatory authorities and other parties, including HCP's associated physicians, may assert that, despite the management agreements and other arrangements through which HCP operates, we are engaged in the prohibited corporate practice

of medicine or that HCP's arrangements constitute unlawful fee-splitting. If this were to occur, we could be subject to civil or criminal penalties, HCP's agreements could be found legally invalid and unenforceable (in whole or in part), or we could be required to restructure its contractual arrangements.

If we were required to restructure HCP's operating structures in California, Nevada or Arizona due to determination that a corporate practice of medicine violation existed, such a restructuring might include revisions of the California, Nevada or Arizona management services agreements, which might include a modification of the management fee, and/or establishing an alternative structure. For example, our subsidiaries in Nevada or Arizona 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, HCP's restricted Knox-Keene license has created potential flexibility for HCP in the event regulatory authorities seek to enforce corporate practice of medicine or fee splitting laws based upon current management services relationships with HCPAMG. HCP's restricted Knox-Keene license allows DHPP 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. In addition to administering Knox-Keene's various patient's rights protections for HCSP-enrolled individuals, the DMHC is responsible for ensuring the financial sustainability over time of 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 conducts examinations of the fiscal and administrative affairs of licensed HCSPs to protect consumers and providers from potential insolvencies. Financial examination reviews include examinations of cash flow, premium receivables, intercompany transactions and medical liabilities. 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 HCP, 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. In its sole discretion, 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. Such contractual undertakings may require 130% or more of TNE to be maintained by a licensee.

The DMHC interprets Knox-Keene to apply to both HCSPs and downstream 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 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 granted waivers from meeting marketing and other terms of full Knox-Keene licensure. The consequences of operating without a license include civil penalties, criminal penalties and the issuance of cease and desist orders.

DHPP holds a restricted Knox-Keene license, which was approved by DMHC on December 31, 2013. This allows HCP to contract directly with HCSPs to simplify its historic contractual and financial structure and to facilitate expansion into new markets in California. However, this also subjects HCP and DHPP to additional regulatory burdens, 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, DHPP is prohibited from declaring or paying any dividends or making any distribution of cash or property to DHPP's parent, affiliates, or shareholders, if such a distribution would cause DHPP to fail to maintain 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, DHPP is subject to DMHC oversight and must seek approval before incurring any debt or guaranteeing any debt relating to DHPP's parent, affiliates, or shareholders. DHPP must also submit proposed global capitation contracts to DMHC for approval.

HCP services

Approximately 90% of HCP's operating revenues for the year ended December 31, 2015 were derived from multi-year capitation contracts with health plans. Under these contracts, HCP's health plan customers delegate full responsibility for member care to physicians and healthcare facilities that are part of HCP's provider network. In return, HCP receives a PMPM fee for each HCP member. As a result, HCP has financial and clinical accountability for a population of members. In California, HCP does not assume direct financial risk for institutional (hospital) services in most 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, HCP recognizes the surplus of institutional revenues less institutional expense as HCP net revenues and is also responsible for any short-fall in the event that institutional expenses exceed institutional revenues. In addition to revenues recognized for financial reporting purposes, HCP measures its total care dollars under management. This includes the PMPM fee payable to third parties for institutional (hospital) services where HCP manages the care provided to its members by hospitals and other institutional services. These fees are not included in Generally Accepted Accounting Principles (GAAP) revenues. For the year ended December 31, 2015, HCP's total consolidated operating revenues were $3.755 billion and total care dollars under management were $4.952 billion.

HCP provides complete medical care through a network of participating physicians and other healthcare professionals. Through its group model, HCP employs, directly (where permitted by state law) and through its associated physician groups, approximately 547 associated group full-time primary care physicians. Through its IPA model, HCP contracts with a network of over 2,900 associated groups and other network primary care physicians who provide care for HCP's members in an independent office setting. These physicians are complemented by several thousand network specialists and 240 network hospitals that provide specialty or institutional care to the patients of HCP's associated physicians, physician groups and IPAs.

In order to comply with local regulations prohibiting the corporate practice of medicine, many of HCP's group physicians are employed by associated medical groups with which HCP has entered into long-term management agreements. The largest of these HCP managed medical groups is HCPAMG, which employs, directly or indirectly, over 600 full-time primary care physicians, specialists and hospitalists. See "Governmental Regulations—Corporate Practice of Medicine and Fee Splitting" above.

HCP does not own hospitals, although hospitals are an essential part of its provider network. In most cases, HCP contracts or otherwise aligns with hospitals to manage the utilization, readmission and cost of hospital services. Most HCP patients receive specialty care through HCP'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.

HCP group physicians typically see 15 to 20 patients per day, which we believe is an appropriate benchmark to ensure there is sufficient time to understand all of the patients' clinical needs. HCP care teams, including nurses, engage in outreach to patients in order help monitor fragile and high risk patients, and help improve adherence to physicians' care plans. During these visits, HCP'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.

HCP's information technology system, including HCP's electronic health record and data warehouse, is designed to support the HCP delivery model with data-driven opportunities to improve the quality and cost effectiveness of the care received by its members. Using informatics technology, HCP has created disease registries that track large numbers of patients with defined medical conditions. HCP 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.

HCP 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 HCP's ability to manage its IPA networks, and has resulted in significant back-office efficiencies for HCP and its associated physician groups. HCP 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, provide quality indicators, historical risk-adjustment coding information, pharmacy medication history, and other key information. In addition to its web-portals geared towards physicians, HCP has recently introduced a patient on-line portal to enable HCP's patients to securely view their own clinical information, schedule physician appointments and interact electronically with their physicians. HCP 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, HCP uses its data to carefully track high utilizing patients through robust data warehousing and data mining technologies. HCP 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 HCP's electronic health record by their physician and HCP'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, HCP has achieved improvements in quality of care, satisfaction and cost.

We believe HCP is well positioned to effectively leverage marketplace demands for greater provider accountability, measurable quality results and cost efficient medical care. We believe that HCP's business model is likely to continue to be an attractive alternative for health plans looking for high quality, cost effective delivery systems, 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 HCP'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 HCP 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 HCP 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:

- HCP's clinical leadership and associated group and network physicians devote significant efforts to ensure that HCP's members receive the most appropriate care in the most appropriate manner.
- HCP is committed to maximizing its patients' satisfaction levels.
- HCP 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.
- HCP has over two decades of experience in managing complex disease cases for its population of patients. As a result, HCP has developed a rich dataset of patient care experiences and outcomes which permits HCP to proactively monitor and intervene in improving the care of its members.
- HCP's senior management team possesses substantial experience with the healthcare industry with average experience of nearly 20 years, as of December 31, 2015.

Locations of HCP clinics

As of December 31, 2015, HCP managed a total of 226 medical clinics, of which 62 clinics were located in California, 13 clinics were located in Colorado, 79 clinics were located in Florida, 55 clinics were located in Nevada, 14 clinics were located in New Mexico and three clinics were located in Georgia. As described above, HCP members in Arizona receive services at independent physician and medical group practice offices. In this way, HCP does not directly manage clinics in Arizona.

Competition

U.S. and International dialysis competition

The U.S. dialysis industry has consolidated significantly over time 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 who compete directly with us for the acquisition of dialysis businesses, relationships with physicians to act as medical directors and for individual patients, as well as skilled clinical personnel. In addition, as we continue our international dialysis expansion into various international markets, we face competition from large and medium-sized providers 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. 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.

The two largest dialysis companies, Fresenius Medical Care (FMC) and our Company, account for approximately 72% of outpatient dialysis patients in the U.S. with our Company serving approximately 36% of the total outpatient dialysis patients. Approximately 45% 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. Additionally, FMC has been one of our largest suppliers of dialysis products and equipment over the last several years. In January 2010, we entered into and subsequently extended an agreement with FMC to purchase a certain amount of dialysis equipment, parts and supplies from FMC through February 29, 2016. We are currently renegotiating this agreement to extend the period of the agreement and to finalize the costs of our dialysis products. In addition, we entered in to a product supply agreement with Baxter Healthcare Corporation (Baxter) that commits us to purchase a certain amount of dialysis supplies through 2018. Our purchases of products in these categories generally offered by both FMC and Baxter represent approximately 4% of our total U.S. dialysis operating expenses. In 2015, we purchased hemodialysis products and supplies from both FMC and Baxter that each represented approximately 2% of our total U.S.

dialysis operating expenses. 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.

HCP's competition

HCP's business is highly competitive. HCP competes with managed care organizations, hospitals, medical groups and individual physicians in its markets. HCP 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, HCP competes with both Permanente Medical Group, which is the exclusive provider for Kaiser, and Heritage Provider Network. However, HCP's principal competitors for members and health plan contracts vary by market.

Corporate compliance program

Our businesses are subject to extensive federal, state and local government regulations. Management has designed and implemented a corporate compliance program as part of our commitment to comply fully with all applicable 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 necessary. The primary purposes of the program include:

- Assessing and identifying risks for existing and new businesses;
- Increasing, through training and education, the awareness of our teammates and affiliated professionals of the necessity of complying with all applicable laws, regulations and company policies and procedures;
- Auditing and monitoring the activities of our operating units and business support functions on a regular basis to identify potential instances of noncompliance in a timely manner; and
- Ensuring that we take steps to resolve instances of noncompliance or to address areas of potential noncompliance as promptly as we become aware of them.

We have a code of conduct that each of our teammates and affiliated professionals must follow and we have a confidential toll-free 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 Chair of the Compliance Committee of our Board of Directors (Board Compliance Committee). On October 22, 2014, DaVita signed a CIA with the United States Department of Health and Human Services, Office of Inspector General. 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 board members, implementing a series of procedures prior to entering into arrangements with referrals sources, execution of annual certifications by senior executives that evidence 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;
- 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 and the retention of an independent compliance advisor in year three of the CIA;
- contains certain business restrictions related to a subset of our joint venture arrangements, including our agreeing to:

1. unwind 11 joint venture transactions, 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, and
3. certain other restrictions;

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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 could be substantial and may be greater than we currently anticipate. 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 on federal healthcare programs. The OIG notified us that it considered us to be in breach of the CIA because of three implementation deficiencies. We have remediated the deficiencies and have paid certain stipulated penalties. The costs associated with compliance with the CIA or any liability, or consequences associated with breach thereof, could have an adverse effect on our revenues, earnings and cash flows.

Insurance

We maintain insurance for property and general liability, professional liability, directors' and officers' liability, workers compensation and other coverage in amounts and on terms deemed adequate by management, based on our 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. HCP also maintains general and professional liability insurance through various independent and related parties. HCP has purchased its primary general and professional liability insurance from California Medical Group Insurance (CMGI) in which HCP owns a 67% equity interest.

Teammates

As of December 31, 2015, we employed approximately 60,400 teammates, including our international teammates:

Licensed professional staff (physicians, nurses and other healthcare professionals)	25,000
Other patient care and center support staff and laboratory personnel	24,600
Corporate, billing and regional administrative staff	10,800

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 the risks discussed below. The risks discussed below are not the only ones facing our business. Please read the cautionary notice regarding forward-looking statements in Item 7 of this Part 1 under the heading "Management's Discussion and Analysis of Financial Condition and Results of Operations."

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

If the average rates that commercial payors pay us decline significantly, it would have a material adverse effect on our revenues, earnings and cash flows.

Approximately 34% of our dialysis services revenues for the year ended December 31, 2015 were generated from patients who have commercial payors as their primary payor. The majority of these patients have insurance policies that pay us on terms and at rates that are generally significantly higher than Medicare rates. The payments we receive from commercial payors generate nearly all of our profit and all of our nonacute dialysis profits come from commercial payors. We continue to experience downward pressure on some of our commercial payment rates as a result of general conditions in the market, recent and future consolidations among commercial payors, increased focus on dialysis services and other factors. Specifically, in the second quarter of 2015, two planned mergers of large commercial payors were announced. If completed, these announced mergers could put increased pressure on the dialysis rates we receive from commercial payors. There is no guarantee that commercial payment rates will not be materially lower in the future.

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

If the number of patients with higher-paying commercial insurance declines, then our revenues, earnings and cash flows would be substantially reduced.

Our revenue levels are sensitive to the percentage of our patients with higher-paying commercial insurance coverage. A patient's insurance coverage may change for a number of reasons, including changes in the patient's or a family member's employment status. Currently, for a patient covered by an employer group health plan, Medicare generally becomes the primary payor after 33 months, or earlier, if the patient's employer group health plan coverage terminates. 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 such financial assistance, our revenues, earnings, and cash flow could be substantially reduced. When Medicare becomes the primary payor, the payment rate we receive for that patient decreases from the employer group health plan rate to the lower Medicare payment rate. We have seen an increase in the number of patients who have government-based programs as their primary payors which we believe is largely a result of improved mortality and recent economic conditions which have a negative impact on the percentage of patients covered under commercial insurance plans. To the extent there are sustained or increased job losses in the U.S., independent of whether general economic conditions might be improving, we could experience a continued decrease in the number of patients covered under commercial plans. We could also experience a further decrease if changes to the healthcare regulatory system result in fewer patients covered under commercial plans or an increase of patients covered under more restrictive commercial plans with lower reimbursement rates. In addition, our continuous process of negotiations with commercial payors under existing or potentially new agreements could result in a decrease in the number of patients under commercial plans to the extent that we cannot reach agreement with commercial payors on rates and

other terms, resulting in termination or non-renewals of existing agreements or our inability to enter into new ones. Commercial payors have taken and may continue to take steps to control the cost of and/or the eligibility for access to healthcare services. 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. If there is a significant reduction in the number of patients under higher-paying commercial plans relative to government-based programs that pay at lower rates, it would have a material adverse effect on our revenues, earnings and cash flows.

Changes in the structure of and payment rates under the Medicare ESRD program could substantially reduce our revenues, earnings and cash flows.

Approximately 44% of our dialysis services revenues for the year ended December 31, 2015 was generated from patients who have Medicare as their primary payor. For patients with Medicare coverage, all ESRD payments for dialysis treatments are made under a single bundled payment rate which provides a fixed payment rate to encompass all goods and services provided during the dialysis treatment, including pharmaceuticals that were historically separately reimbursed to the dialysis providers, such as EPO, vitamin D analogs and iron supplements, irrespective of the level of pharmaceuticals administered or additional services performed. Most lab services are also included in the bundled payment. The bundled payment rate is also adjusted for certain patient characteristics, a geographic usage index and certain other factors.

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

- Risk that our rates are reduced by CMS. Uncertainty about future payment rates remains a material risk to our business. In December 2013, CMS published the 2014 final rule for the ESRD PPS, which phases in the payment reductions mandated by the American Taxpayer Relief Act of 2012 as modified by the Protecting Access to Medicare Act of 2014, which will reduce our market basket inflation adjustment by 1.25% in 2016 and 2017, and 1% in 2018. In November 2014, CMS published the 2015 final rule for the ESRD PPS, which increased payments to dialysis facilities in 2015 by 0.3% to 0.5%, although rural facilities received a decrease of 0.5%. CMS also recently issued the 2016 final rule for the ESRD PPS, which cuts dialysis facilities' bundled payment rate for 2016 as compared to 2015 and includes adjustments for certain co-morbidities and other patient health factors and rural facilities. CMS believes its 2016 final rule for the ESRD PPS will (i) increase overall payments to both hospital-based and freestanding dialysis facilities by approximately 0.20%, and (ii) decrease overall payments to rural dialysis facilities by approximately 0.10%.
- Risk that increases in our operating costs will outpace the Medicare rate increases we receive. We expect to continue experiencing increases in operating costs that are subject to inflation, such as labor and supply costs, regardless of whether there is a compensating inflation-based increase in Medicare payment rates or in payments under the bundled payment rate system.
- Risk of federal budget sequestration cuts. As a result of the BCA and subsequent activity in Congress, a $1.2 trillion sequester (across-the-board spending cuts) in discretionary programs took effect on March 1, 2013. In particular, a 2% reduction to Medicare payments took effect on April 1, 2013, which was subsequently extended through 2014 and 2015. The Bipartisan Budget Act of 2015 extended the BCA's annual 2% reduction to Medicare payments through fiscal year 2025. These across-the-board spending cuts have affected and will continue to adversely affect our revenues, earnings and cash flows.
- Risk that, if our clinical systems fail to accurately capture the data we report to CMS 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, we might be over-reimbursed by the government which could subject us to certain liability. For example, we are required to return overpayments including, federal funds, within sixty days of identification or claims associated with those overpayments are subject to FCA penalties.

For additional details regarding the risks we face for failing to adhere to our Medicare and Medicaid regulatory compliance obligations, see the risk factor below under the heading "If we fail to adhere to all of the complex

government regulations that apply to our business, we could suffer severe consequences that would substantially reduce our revenues, earnings, cash flows and stock price."

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

We cannot predict how employers, private payors or persons buying insurance might react to the changes brought on by broad U.S. healthcare reform legislation or what form many of these regulations will take before implementation.

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. While patients have begun receiving insurance coverage through these exchanges, the business and regulatory environment for these exchanges continues to evolve as the exchanges mature. Additionally, there is uncertainty about how the applicable state and federal agencies will enforce regulations relating to the exchanges. Although we cannot predict the short- or long-term effects of these factors, we believe the healthcare insurance exchanges 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. Approximately eight million individuals were enrolled in the exchanges in 2014, with that number increasing to approximately 11 million in 2015. To the extent that the ongoing implementation of such exchanges or changes in regulations or enforcement of regulations regarding the exchanges results in a reduction in reimbursement rates for our services from commercial and/or government payors, our revenues, earnings and cash flows could be adversely affected.

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

The healthcare reform legislation also added several new tax provisions that, among other things, impose various fees and excise taxes, and limit compensation deductions for health insurance providers and their affiliates. These rules could negatively impact our cash flow and tax liabilities. However, under the FY 2016 Omnibus budget agreement, Congress voted to delay certain new taxes that the Health Reform Acts had enacted, including the excise tax on certain high-cost health plans, the medical device tax, and the tax on health insurers. These and other changes contribute to the uncertainty of the ongoing implementation and impact of the Health Reform Acts; they also underscore the potential for additional reform going forward.

The 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 currently uncertain of the extent to which the long-term operation and evolution of these care models, including ACOs, Bundled Payments for Care Improvement Initiative, CEC Model (which includes the development of ESCOs), the Comprehensive Primary Care Initiative, the Duals Demonstration, and 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 are currently participating in the CEC Model with the Innovation Center, including with organizations in Arizona, Florida, New Jersey and Pennsylvania. Even in areas where DaVita 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 or other programs’ calculations. As new models of care emerge and evolve, we may be at risk of losing our Medicare patient base, which would have a materially adverse effect on our revenues, earnings and cash flow. Other initiatives in the government or private sector may arise, including the development of models similar to ACOs, IPAs and integrated delivery systems or evolutions of those concepts which could adversely impact our business.

CMS instituted new screening procedures which we expect will delay the Medicare contractor approval process, potentially causing a delay in reimbursement. We anticipate the new screening and enrollment requirements will require additional personnel and financial resources and will potentially delay the enrollment and revalidation of our

centers which in turn will delay payment. These delays may negatively impact our revenues, earnings and cash flows.

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

There is also a considerable amount of uncertainty as to the prospective implementation of the federal healthcare reform legislation and what similar measures might be enacted at the state level. There have been multiple attempts through legislative action and legal challenges to repeal or amend the Patient Protection and Affordable Care Act of 2010, as modified by the Health Reform Acts, including the case that was recently heard by the U.S. Supreme Court, King v. Burwell. Although the Supreme Court upheld the provision by the federal government of subsidies to individuals in federally facilitated healthcare exchanges in Burwell, which ultimately did not disrupt significantly the implementation of the healthcare reform legislation, we cannot predict whether other current or future efforts to repeal or amend these laws will be successful, nor can we predict the impact that such a repeal or amendment would have on our business and operations, or on our revenues and earnings. The enacted reforms as well as future legislative changes could have a material adverse effect on our results of operations, including lowering our reimbursement rates and increasing our expenses.

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

Approximately 22% of our dialysis services revenues for the year ended December 31, 2015 was generated from patients who have state Medicaid or other non-Medicare government-based programs, such as coverage through the Department of Veterans Affairs (VA), as their primary coverage. As state governments and other governmental organizations face increasing budgetary pressure, we may in turn face reductions in payment rates, delays in the receipt of payments, limitations on enrollee eligibility or other changes to the applicable programs. For example, certain state Medicaid programs and the VA have recently considered, proposed or implemented payment rate reductions.

The VA 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 2% of our dialysis services revenues for the year ended December 31, 2015 was 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 not renew or cancel these agreements for any reason, we may cease accepting patients under this program and may be forced to close centers, which could adversely affect our revenues, earnings and cash flows.

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

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

Medicare bundles EPO into the PPS such that dosing variations do not change the amount paid to a dialysis facility. Although some Medicaid programs and other payors suggest movement towards a bundled payment system inclusive of EPO, some non-Medicare payors continue to pay for EPO separately from the treatment rate.

Additionally, evaluations on the utilization and reimbursement for ESAs, which have occurred in the past and may occur in the future, and related actions by the U.S. Congress and federal agencies, could result in further restrictions on the utilization and reimbursement for ESAs. Commercial payors have increasingly examined their administration policies for EPO and, in some cases, have modified those policies. Changes in labeling of EPO and other pharmaceuticals in a manner that alters physician practice patterns or accepted clinical practices, changes in private

and governmental payment criteria, including the introduction of EPO administration policies could have a material adverse effect on our revenues, earnings and cash flows. Further increased utilization of EPO for patients for whom the cost of EPO is included in a bundled reimbursement rate, or further decreases in reimbursement for EPO and other pharmaceuticals that are not included in a bundled reimbursement rate, could also have a material adverse effect on our revenues, earnings and cash flows.

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

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

Future increases in the cost of EPO without corresponding increases in payment rates for EPO from commercial payors and without corresponding increases in the Medicare bundled rate could have a material adverse effect on our earnings and cash flows and ultimately reduce our income. In November 2011, we entered into a seven year Sourcing and Supply Agreement with Amgen, pursuant to which we committed to purchase EPO in amounts necessary to meet no less than 90% of our requirements for ESAs. As long as we meet certain conditions, the agreement limits Amgen's ability to unilaterally increase the price for EPO during the term of the agreement. Our agreement with Amgen provides for discounted pricing and rebates for EPO. However, some of the rebates are subject to various conditions including, but not limited to, future pricing levels of EPO by Amgen and data submission by us. In addition, the rebates are subject to certain limitations. We cannot predict whether, over the seven year term of the agreement, we will continue to receive the rebates for EPO that we have received in the past, or whether we will continue to achieve the same levels of rebates within that structure as we have historically achieved. Factors that could impact our ability to qualify for rebates provided for in our agreement with Amgen in the future include, but are not limited to, our ability to track certain data elements. We cannot predict whether we will be able to meet the applicable qualification requirements for receiving rebates. Failure to meet certain targets and earn the specified rebates could have a material adverse effect on our earnings and cash flows.

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 may adversely impact our revenues, earnings and cash flows.

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 and paid $406 million in settlement amounts, civil forfeiture, and interest to the United States 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, 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 (i) 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, (ii) not enter into certain types of partial divestiture joint venture transactions with nephrologists during the term of the CIA, (iii) non-enforcement of certain patient-related non-solicitation restrictions, and (iv) certain other restrictions. The costs associated with compliance with the CIA could be 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 notified us that it considered us to be previously in breach of the CIA because of three implementation deficiencies. While we have remediated the deficiencies and have paid certain stipulated penalties, 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 revenues, earnings 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 would have a material adverse effect on our revenues, earnings, cash flows and stock price, including those consequences described under the risk factor "If we fail to adhere to all of the complex government regulations that apply to our business, we could suffer severe consequences that would substantially reduce our revenues, earnings, cash flows and stock price."

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

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

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

As of December 31, 2015, we owned a controlling interest in numerous dialysis-related joint ventures, which represented approximately 23% of our dialysis and related lab services revenues for the year ended December 31, 2015. In addition, we also owned minority equity investments in several other dialysis related joint ventures. We may continue to increase the number of our joint ventures. Many of our joint ventures with physicians or physician groups also have certain physician owners providing medical director services to centers we own and operate. Because our relationships with physicians are governed by the federal and state anti-kickback statutes, we have sought to structure our joint venture arrangements to satisfy as many federal safe harbor requirements as we believe are commercially reasonable. However, although our joint venture arrangements do not satisfy all of the elements of any safe harbor under the federal Anti-Kickback Statute, they are not automatically prohibited under the federal Anti-Kickback Statute but are susceptible to government scrutiny. 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 regarding certain of our joint ventures and paid $406 million in settlement amounts, civil forfeiture, and interest to the United States and certain states. For further details, please see “If we fail to comply with our CIA, we could be subject to substantial penalties and exclusion from participation in federal healthcare programs that may adversely impact our revenues, earnings and cash flows”.

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

There are significant estimating risks associated with the amount of dialysis and related lab services revenues and related refund liabilities that we recognize in a reporting period. The billing and collection process is complex due to ongoing insurance coverage changes, geographic coverage differences, differing interpretations of contract coverage, and other payor issues. Determining applicable primary and secondary coverage for approximately 180,000 U.S. patients at any point in time, together with the changes in patient coverage that occur each month, requires complex, resource-intensive processes. Errors in determining the correct coordination of benefits may result in refunds to payors. Revenues associated with Medicare and Medicaid programs are also subject to estimating risk related to the amounts not paid by the primary government payor that will ultimately be collectible from other government programs paying secondary coverage, the patient’s commercial health plan secondary coverage or the patient. Collections, refunds and payor retractions typically continue to occur for up to three years and longer after services are provided. We generally expect our range of dialysis and related lab services revenues estimating risk to be within 1% of net revenues for the segment, which represents approximately 5% of dialysis and related lab services adjusted operating income. If our estimates of dialysis and related lab services revenues and related refund liabilities are materially inaccurate, it could impact the timing and the amount of our revenues recognition and have a significant impact on our operating results.

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

Our ancillary services and strategic initiatives currently include pharmacy services, disease management services, vascular access services, ESRD clinical research programs, physician services, physician practice management services, direct primary care and our international dialysis operations. We expect to add additional service offerings and pursue additional strategic initiatives in the future as circumstances warrant, which could include healthcare services not related to dialysis. Many of these initiatives require or would require investments of both management and financial resources and can generate significant losses for a substantial period of time and may not become

profitable. There can be no assurance that any such strategic initiative will ultimately be successful. Any significant change in market conditions, or business performance, or in the political, legislative or regulatory environment, may impact the economic viability of any of these strategic initiatives. If any of our ancillary services or strategic initiatives, including our international dialysis operations, do not perform as planned, we may incur a material write-off or an impairment of our investment, including goodwill, in one or more of these activities or we could incur significant termination costs if we were to exit a certain line of business.

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

We believe that physicians prefer to have their patients treated at dialysis centers where they or other members of their practice supervise the overall care provided as medical director of the center. As a result, the primary referral source for most of our centers is often the physician or physician group providing medical director services to the center.

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

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

In addition, we may take actions to restructure existing relationships or take positions in negotiating extensions of relationships to assure compliance with the federal Anti-Kickback Statute, Stark Law and other similar laws. If the terms of any existing agreement are found to violate applicable laws, we may not be successful in restructuring the relationship which could lead to the early termination of the agreement, or cause the physician to stop referring patients to our dialysis centers. These actions in an effort to comply with applicable laws and regulations could negatively impact the decision of physicians to extend their medical director agreements with us or to refer their patients to us. If a significant number of physicians were to cease referring patients to our dialysis centers, our revenues, earnings and cash flows would be substantially reduced.

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

Deterioration in economic conditions could adversely affect our business and our profitability. Among other things, the potential decline in federal and state revenues that may result from such conditions may create additional pressures to contain or reduce reimbursements for our services from Medicare, Medicaid and other government sponsored programs. 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. Any or all of these factors, as well as other consequences of a deterioration in economic conditions which cannot currently be anticipated, could have a material adverse effect on our revenues, earnings and cash flows and otherwise adversely affect our financial condition.

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

We are experiencing increased labor costs and difficulties in hiring nurses due to a nationwide shortage of skilled clinical personnel. We compete for nurses with hospitals and other healthcare providers. This nursing shortage may limit our ability to expand our operations. In addition, changes in certification requirements or increases in the required staffing levels for skilled clinical personnel can impact our ability to maintain sufficient staff levels to the extent our teammates are not able to meet new requirements or we experience a higher than normal turnover rate due to increased competition for qualified clinical personnel. If we are unable to hire skilled clinical personnel when needed, or if we experience a higher than normal turnover rate for our skilled clinical personnel, our operations and treatment growth will be negatively impacted, which would result in reduced revenues, earnings and cash flows.

Our business is labor intensive and could be adversely affected if we are unable to maintain satisfactory relations with our employees or if union organizing activities result in significant increases in our operating costs or decreases in productivity.

Our business is labor intensive, and our results are subject to variations in labor-related costs, productivity and the number of pending or potential claims against us related to labor and employment practices. If political efforts at the national and local level result in actions or proposals that increase the likelihood of union organizing activities at our facilities or if union organizing activities increase for other reasons, or if labor and employment claims, including the filing of class action suits, trend upwards, our operating costs could increase and our employee relations, productivity, earnings and cash flows could be adversely affected.

Complications associated with our new billing and collections system could have a material adverse effect on our revenues, cash flows and operating results.

We recently launched a new billing system that is critical to our billing operations. If there are defects in the new 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. To mitigate this risk, we launched the new system in phases; however, any defects in the new billing and collection system could have a material adverse effect on our revenues, cash flows and operating results.

Our ability to effectively provide the services we offer could be negatively impacted if certain of our suppliers are unable to meet our needs or if we are unable to effectively access new technology, which could substantially reduce our revenues, earnings and cash flows.

We have significant suppliers that are either the sole or primary source of products critical to the services we provide, including Amgen, Baxter, FMC, NxStage Medical, Inc. and others or to which we have committed obligations to make purchases. If any of these suppliers are unable to meet our needs for the products they supply, including in the event of a product recall or shortage, and we are not able to find adequate alternative sources, or if some of the drugs that we purchase are not reimbursed or not adequately reimbursed by commercial payors or through the bundled payment rate by Medicare, our revenues, earnings and cash flows could be substantially reduced. In addition, the technology related to the products critical to the services we provide is subject to new developments and may result in superior products. If we are not able to access superior products on a cost-effective basis or if suppliers are not able to fulfill our requirements for such products, we could face patient attrition which could substantially reduce our revenues, earnings and cash flows.

Risk factors related to HCP:

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

As a participant in the healthcare industry, HCP is subject to many of the same risks to which our dialysis business is subject to as described in the risk factors set forth above in this Part I, Item 1A, any of which could materially and adversely affect HCP’s revenues, earnings or cash flows. Among these risks are the following:

- The healthcare business is heavily regulated and changes in laws, regulations, or government programs could have a material impact on HCP;
- Failure to comply with complex governmental regulations could have severe consequences to HCP, including, without limitation, exclusion from governmental payor programs like Medicare and Medicaid;
- HCP could become the subject of governmental investigations, claims, and litigation;
- HCP may be unable to continue to explore potential acquisition candidates, make acquisitions or successfully integrate such acquisitions into its business, and such acquisitions may include liabilities of which HCP was not aware; and
- As a result of the broad scope of HCP’s medical practice, HCP is exposed to medical malpractice claims, as well as claims for damages and other expenses, that may not be covered by insurance or for which adequate limits of insurance coverage may not be available.

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

Over 90% of HCP's revenue for the year ended December 31, 2015 is derived from fixed PMPM fees paid by health plans under capitation agreements with HCP or its associated physician groups. While there are variations specific to each arrangement, HCP, through DHPP and, in certain instances, HCP'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, HCP enters into managed care-related administrative services agreements or similar arrangements with those third parties (typically hospitals) under which HCP agrees to be responsible for utilization review, quality assurance, and other managed care-related administrative functions and claim payments. As compensation for such administrative services, HCP is entitled to receive a percentage of the amount by which the institutional

capitation revenue received from health plans exceeds institutional expenses; any such risk-share amount to which HCP is entitled is recorded as medical revenues and HCP is also responsible for 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, aggregate fixed PMPM amounts, or capitation payments, may be insufficient to cover the costs associated with treatment. If medical expenses exceed estimates, except in very limited circumstances, HCP will not be able to increase the PMPM fee received under these risk agreements during their then-current terms and could, directly or indirectly through its contracts with its associated physician groups, suffer losses with respect to such agreements.

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

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

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

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

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

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

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

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

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

It is possible that a state regulatory agency or a court could determine that HCP's agreements with physician equity holders of certain managed Arizona, California and Nevada associated physician groups as described above, either independently or coupled with the management services agreements with such associated physician groups, are in violation of the corporate practice of medicine doctrine. As a result, these arrangements could be deemed invalid, potentially resulting in a loss of revenues and an adverse effect on results of operations derived from such associated

physician groups. Such a determination could force a restructuring of HCP's management arrangements with associated physician groups in Arizona, California and/or Nevada, which might include revisions of the management services agreements, including a modification of the management fee and/or establishing an alternative structure, which would permit HCP to contract with a physician network without violating the corporate practice of medicine prohibition. There can be no assurance that such a restructuring would be feasible, or that it could be accomplished within a reasonable time frame without a material adverse effect on HCP's operations and financial results. In December 2013, DHPP obtained a restricted Knox-Keene license in California, which permits DHPP to contract with health plans in California to accept global risk without violating the corporate practice of medicine prohibition. However, HCP and HCP's Arizona and Nevada associated physician groups, as well as those physician equity holders of associated physician groups who are subject to succession agreements with HCP, could be subject to criminal or civil penalties or an injunction for practicing medicine without a license or aiding and abetting the unlicensed practice of medicine.

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

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

If DHPP is not able to satisfy financial solvency or other regulatory requirements, DaVita HealthCare Partners could become subject to sanctions and its license to do business in California could be limited, suspended or terminated.

Knox-Keene requires healthcare service plans operating in California to comply with financial solvency and other requirements overseen by the DMHC. Under Knox-Keene, DHPP is required to, among other things:

- Maintain, at all times, a minimum 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 DaVita HealthCare Partner Plan operations and compliance with Knox-Keene.

In the event that DaVita HealthCare Partners Plan is not in compliance with the provisions of Knox-Keene, it could be subject to sanctions, or limitations on, or suspension of its license to do business in California.

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

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

- Maintain, at all times, a minimum cash-to-claims ratio (where cash-to-claims ratio means the organization's cash, marketable securities, and certain qualified receivables, divided by the organization's total unpaid claims liability). The regulation currently requires a cash-to-claims ratio of 0.75.
- Submit periodic reports to the 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 HCP's associated physician group is not in compliance with any of the above criteria, HCP's associated physician group could be subject to sanctions, or limitations on, or removal of, its ability to do business in California.

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

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

On April 6, 2015, CMS issued its final rule establishing the 2016 Medicare Advantage benchmark payment rates announcing the model it will use to blend risk acuity scores. In 2016, CMS will fully implement the 2014 CMS-Hierarchical Condition Categories (CMS-HCC) Model and will not blend the risk scores calculated using the 2013 CMS-HCC model. Based upon our preliminary analysis of the final rule, we estimate that the reduction in 2016 rates, including adjustments for the new Affordable Care Act (ACA) blended benchmark county rates and qualifying bonuses, will lead to a reduction in Medicare Advantage rates to HCP of approximately 2%, or a net impact of approximately $50 million to our 2016 operating income. This compares to an industry average rate increase of approximately 1.25% as indicated by CMS in its final rule regarding the 2016 rates. The final impact of 2016 Medicare Advantage rates can vary from this estimate and will be impacted by the relative growth of HCP's Medicare Advantage patient volumes across markets as well as by the benefit plan designs submitted. It is possible that we underestimated the impact of the 2016 Medicare Advantage rates on our business, which may have a material adverse effect on our financial position, results of operation or cash flows.

This more significant decline in Medicare Advantage rates for us compared to the industry average is driven by a larger-than-average decline associated with CMS's modification to the risk adjustment model calculation. The move to the 2014 CMS-HCC model negatively affects us and other providers like us who have differentially invested in wellness and prevention programs for patients with chronic conditions, because the 2014 model tends to over-predict costs for very low-cost beneficiaries and under-predict costs for very high-cost beneficiaries.

In addition, we took impairment charges against the goodwill of certain of our HCP reporting units in the fourth quarter of 2015 related to underperformance of the business in recent quarters, as well as changes in other market conditions, including government reimbursement cuts and our expected ability to mitigate them. We may also need to take additional goodwill impairment charges against earnings in a future period, depending on the impact of this decrease in rates on the value of our HCP reporting units. A goodwill impairment occurs when the carrying value of a reporting unit's goodwill is in excess of its implied fair value, and the amount of such non-cash charge, if any, could be significant. In estimating the fair value of our HCP reporting units, we will update our forecasts for each HCP reporting unit to reflect the expected future cash flows that we believe market participants would use in determining the fair values of our HCP reporting units if they were to acquire these reporting units. We will also use certain estimates and key assumptions in determining our estimate of these fair values, including discount and long-term growth rates, market data and future reimbursement rates. Our estimates of the fair value of our HCP reporting units could differ from the actual fair values a market participant would pay for these reporting units.

HCP's Medicare Advantage revenues may continue to be volatile in the future, which could have a material impact on HCP's ongoing financial performance.

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

- Medicare Advantage benchmarks for 2011 were frozen at 2010 levels. Beginning in 2012, Medicare Advantage benchmark rates are being phased down from prior levels to levels that are between 95% and 115% of the Medicare FFS costs, depending on a plan's geographic area. If our costs escalate faster than can be absorbed by the level of revenues implied by these benchmark rates, then it could have a significant negative impact on HCP's earnings and cash flows.
- Rebates received by Medicare Advantage plans that underbid based on payment benchmarks will be reduced, with larger reductions for plans failing to receive certain quality ratings.
- The Secretary of HHS has been granted the explicit authority to deny Medicare Advantage plan bids that propose significant increases in cost sharing or decreases in benefits. If the bids submitted by plans contracted with HCP are denied, this would have a significant negative impact on HCP's revenues, earnings and cash flows.

- 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 an HCP-contracting Medicare Advantage plan experiences a limitation on enrollment or is otherwise terminated from the Medicare Advantage program, HCP may suffer materially adverse consequences to its business or financial condition.
- Prescription drug plans are now required to cover all drugs on a list developed by the Secretary of HHS, which could increase the cost of providing care to Medicare Advantage enrollees, and thereby reduce HCP's revenues and earnings. The Medicare Part D premium subsidy for high-income beneficiaries has been reduced by 25%, which could lower the number of Medicare Advantage enrollees, which would have a negative impact on HCP's revenues, earnings and cash flows.
- CMS increased coding intensity adjustments for Medicare Advantage plans beginning in 2014 and continuing through 2018, which reduces CMS payments to Medicare Advantage plans, which in turn will likely reduce the amounts payable to HCP and its associated physicians, physician groups, and IPAs under its capitation agreements.

The President's 2016 budget proposed nearly $500 billion in cuts to Medicare, Medicaid and other programs run by HHS over the next decade. Although the majority of the cuts were not targeted at Medicare Advantage plans, the broad cuts could signal further downward pressure on reimbursement to Medicare providers and Medicare Advantage plans, which would have a negative impact on HCP's revenues, earnings and cash flows. Future budget cuts could impact HCP's revenues.

There is uncertainty regarding both Medicare Advantage payment rates and beneficiary enrollment, which, if reduced as a result of the implementation of the Health Reform Acts, would reduce HCP's overall revenues and net income. For example, although the CBO predicted in 2012 that Medicare Advantage participation would drop precipitously by 2020, in 2013 the CBO reversed its prediction and instead predicted that enrollment in Medicare Advantage could increase by up to 50% in the next decade. Although Medicare Advantage enrollment increased by approximately 5.6 million, or by 50 percent, 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 were evidenced by CMS's announcement in its final 2015 Call Letter that Medicare Advantage rates would rise an average of 0.4% in 2015, instead of falling 1.9% as it had predicted in February 2014. On April 6, 2015, CMS announced its Medicare Advantage rates for 2016. See above for further details. Uncertainty over Medicare Advantage enrollment and payment rates present a continuing risk to HCP's business.

Medicare Advantage enrollment continues to be highly concentrated among a few Medicare Advantage plans, both nationally and in local markets. In approximately 15 states, more than half of all enrollees are in plans offered by one company – an indicator that those markets may lack competition. Consolidation among Medicare Advantage plans, or the Medicare programs failure to attract additional plans to participate in the Medicare Advantage program, could have a negative impact of HCP's revenues, earnings, and/or cash flows.

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

For the year ended December 31, 2015, 61% of HCP's consolidated capitated medical revenues were earned through contracts with three health plans.

HCP expects that, going forward, substantially all of its revenue will continue to be derived from its contracts with health plans. Each health plan may immediately terminate any of HCP's contracts and/or any individual credentialed physician upon the occurrence of certain events. They may also amend the material terms of the contracts under certain circumstances. Failure to maintain the contracts on favorable terms, for any reason, would materially and

adversely affect HCP's results of operations and financial condition. A material decline in the number of members could also have a material adverse effect on HCP's results of operations.

Notwithstanding each health plan's and HCP's current shared interest in providing service to HCP's members who are enrolled in the subject health plans, the health plans may have different and, at times, opposing economic interests from those of HCP. The health plans provide a wide range of health insurance services across a wide range of geographic regions, utilizing a vast network of providers. As a result, they and HCP may have different views regarding the proper pricing of services and/or the proper pricing of the various service providers in their provider networks, the cost of which HCP bears to the extent that the services of such service providers are utilized. These health plans may also have different views than HCP regarding the efforts and expenditures that they, HCP, and/or other service providers should make to achieve and/or maintain various quality ratings. In addition, several health plans have acquired or announced their intent to acquire provider organizations. If health plans with which HCP contracts acquire a significant number of provider organizations, they may not continue to contract with HCP or contract on less favorable terms or seek

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

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

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

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

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

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

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

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

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

HCP, on behalf of itself and its associated physicians, physician groups and IPAs, submits to health plans claims and encounter data that support the risk adjustment factor (RAF) scores attributable to members. These RAF scores determine, in part, the revenue to which the health plans and, in turn, HCP is entitled for the provision of medical care to such members. The data submitted to CMS by each health plan is based, in part, on medical charts and diagnosis codes prepared and submitted by HCP. Each health plan generally relies on HCP and its employed or affiliated physicians to appropriately document and support such RAF data in HCP's medical records. Each health plan also relies on HCP 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. HCP might also need to refund a portion of the revenue that it received, which refund, depending on its magnitude, could damage its relationship with the applicable health plan and could have a material adverse effect on HCP's results of operations, financial condition or cash flows. We have identified a potentially improper historical HCP coding practice related to a particular condition, which was discontinued following our acquisition of HCP. We have notified CMS and we intend to cooperate with government authorities to address this issue. We are continuing to review other HCP coding practices.

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 HCP should CMS make any payment adjustments to the Medicare Advantage plan as a result of its audits. The plans also may hold HCP liable for any penalties owed to CMS for inaccurate or unsupportable RAF scores provided by HCP. In addition, HCP could be liable for penalties to the government.

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 HCP's revenue and profitability, even if the information HCP submitted to the plan is accurate and supportable.

Separately, as described in further detail below, on March 13, 2015, JSA HealthCare Corporation (JSA), a subsidiary of HCP, received a subpoena from the OIG that relates, in part, to risk adjustment practices and data. On June 18, 2015, we received a subpoena from the OIG requesting information relating to our and our subsidiaries', including HCP and its subsidiary JSA's, provision of services to Medicare Advantage plans and related patient diagnosis coding and risk adjustment submissions and payments.

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

Patient care costs include estimates of future medical claims that have been incurred by the patient but for which the provider has not yet billed HCP. These claim estimates are made utilizing actuarial methods and are continually

evaluated and adjusted by management, based upon HCP's historical claims experience and other factors, including an independent assessment by a nationally recognized actuarial firm. Adjustments, if necessary, are made to medical claims expense and capitated revenues when the assumptions used to determine HCP's claims liability changes and when actual claim costs are ultimately determined.

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

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

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

- As a result of the direct and indirect impacts of the Health Reform Acts, many Medicare beneficiaries may decide that an original Medicare FFS program is more attractive than a Medicare Advantage plan. As a result, enrollment in the health plans HCP serves may decrease.
- Managed care companies offer alternative products such as regional preferred provider organizations (PPOs) and private FFS plans. Medicare PPOs and private FFS plans allow their patients more flexibility in selecting physicians than Medicare Advantage health plans, which typically require patients to coordinate care with a primary care physician. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 has encouraged the creation of regional PPOs through various incentives, including certain risk corridors, or cost reimbursement provisions, a stabilization fund for incentive payments, and special payments to hospitals not otherwise contracted with a Medicare Advantage plan that treat regional plan enrollees. The formation of regional Medicare PPOs and private FFS plans may affect HCP's relative attractiveness to existing and potential Medicare patients in their service areas.
- The payments for the local and regional Medicare Advantage plans are based on a competitive bidding process that may indirectly cause a decrease in the amount of the PMPM fee or result in an increase in benefits offered.
- The annual enrollment process and subsequent lock-in provisions of the Health Reform Acts may adversely affect HCP's level of revenue growth as it will limit the ability of a health plan to market to and enroll new Medicare beneficiaries in its established service areas outside of the annual enrollment period.
- 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, HCP may face a competitive disadvantage in recruiting and retaining Medicare beneficiaries.

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

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

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

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

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

Key primary care physicians with large patient enrollment could retire, become disabled, terminate their provider contracts, get lured away by a competing independent physician association or medical group, or otherwise become unable or unwilling to continue practicing medicine or contracting with HCP or its associated physicians, physician groups, or IPAs. In addition, HCP’s associated physicians, physician groups and IPAs could view the business model as unfavorable or unattractive to such providers, which could cause such associated physicians, physician groups or IPAs to terminate their relationships with HCP. Moreover, given limitations relating to the enforcement of post-termination noncompetition covenants in California, it would be difficult to restrict a primary care physician from competing with HCP’s associated physicians, physician groups, or IPAs. As a result, members who have been served

by such physicians could choose to enroll with competitors' physician organizations or could seek medical care elsewhere, which could reduce HCP's revenues and profits. Moreover, HCP may not be able to attract new physicians to replace the services of terminating physicians or to service its growing membership.

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

The Health Reform Acts established Medicare Shared Savings Programs (MSSP) for ACOs, which took effect in January 2012. Under the MSSP, eligible organizations are accountable for the quality, cost and overall care of Medicare beneficiaries assigned to an ACO and may be eligible to share in any savings below a specified benchmark amount. The Secretary of HHS is also authorized, but not required, to use capitation payment models with ACOs. HCP has formed an MSSP ACO through a subsidiary, which operates in California, Florida, and Nevada and is evaluating whether to participate in more ACOs in the future. The continued development and expansion of ACOs will have an uncertain impact on HCP's revenue and profitability. We also are participating as a dialysis provider in Arizona, Florida, New Jersey, and Pennsylvania for the Innovation Center's CEC Model.

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

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

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

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

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

result, HCP may incur significant expenses and may be unable to effectively operate its business.

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

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

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

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

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

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

Due to potential decreased availability of healthcare through private employers, the number of patients who are uninsured or participate in governmental programs may increase. The Health Reform Acts have 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 HCP or an increase in uncollectible receivables or uncompensated care, with a corresponding decrease in net revenue. Changes in the eligibility requirements for governmental programs such as the Medicaid program under the Health Reform Acts and state decisions on whether to participate in the expansion of such programs also could increase the number of patients who participate in such programs and the number of uninsured patients. Even for those patients who remain in private insurance plans, changes to those plans could increase patient financial responsibility, resulting in a greater risk of uncollectible receivables. These factors and events could have a material adverse effect on HCP's business, financial condition, and results of operations.

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

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

· requiring HCP to change its products and services;

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

Risk factors related to our overall business and ownership of our common stock:

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

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

We endeavor to comply with all legal requirements, however, there is no guarantee that we will be able to adhere to all of the complex government regulations that apply to our business. We further endeavor to structure all of our relationships with physicians to comply with state and federal anti-kickback and physician self-referral laws. We utilize considerable resources to monitor the laws and implement necessary changes. However, the laws and regulations in these areas are complex and often subject to varying interpretations. For example, if an enforcement agency were to challenge the level of compensation that we pay our medical directors or the number of medical directors whom we engage, we could be required to change our practices, face criminal or civil penalties, pay substantial fines or otherwise experience a material adverse effect as a result of a challenge to these arrangements. In addition, the FCA amended the Social Security Act to make the knowing failure to report and return overpayments within 60 days of when the overpayment was identified an obligation for purposes of the FCA, 31 U.S.C. § 3729(b)(3). These amendments could subject our procedures for identifying and processing overpayments to greater scrutiny. We have made significant investments in new resources to decrease the time it takes to identify and process overpayments and we may be required to make additional investments in the future. An acceleration in our ability to identify and process overpayments could result in us refunding overpayments to government and other payors more rapidly than we have in the past which could have a material adverse effect on our operating cash flows. In the fourth quarter of 2015, we recorded an estimated accrual of $22 million for potential damages and liabilities associated with write-offs and discounts of patient co-payment obligations, and credits to payors for returns of prescriptions drugs related to our pharmacy business that were identified during the course of an internally-initiated compliance review. We have disclosed the results of this ongoing review to the government. We may accrue additional reserves for refunds and related damages and potential liabilities arising out of this review. Additionally, amendments to the federal Anti-Kickback Statute in the health reform law make claims tainted by anti-kickback violations potentially subject to liability under the FCA, including qui tam or whistleblower suits. We are subject to a 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 may adversely impact our revenues, earnings and cash flows.”

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. 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. 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. In addition to the provisions of the FCA, which provide for civil enforcement, the federal government can use several criminal statutes to prosecute persons who are alleged to have submitted false or fraudulent claims for payment to the federal government. The Civil Investigative Demand (CID) received by our wholly owned pharmacy services subsidiary, DaVita Rx, LLC, specifically references that it is in connection with an FCA investigation concerning allegations that this subsidiary presented or caused to be presented false claims for payment to the government. See the risk factor that immediately follows below for further details.

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

- Suspension or termination of our participation in government payment programs;
- Refunds of amounts received in violation of law or applicable payment program requirements;
- Loss of required government certifications or exclusion from government payment programs;
- Loss of licenses required to operate healthcare facilities or administer pharmaceuticals in some of the states in which we operate;
- Reductions in payment rates or coverage for dialysis and ancillary services and related pharmaceuticals;
- Criminal or civil liability, fines, damages or monetary penalties for violations of healthcare fraud and abuse laws, including the federal Anti-Kickback Statute, Stark Law violations, FCA, or other failures to meet regulatory requirements;
- Enforcement actions by governmental agencies and/or state claims for monetary damages by patients who believe their PHI has been used, disclosed or not properly safeguarded in violation of federal or state patient privacy laws, including but not limited to HIPAA or 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;
- Termination of relationships with medical directors; and
- Harm to our reputation which could impact our business relationships, affect our ability to obtain financing and decrease access to new business opportunities.

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

We are the subject of a number of investigations by the federal government. We have received subpoenas or other requests for documents from the federal government in connection with the Swoben private civil suit, the 2011 U.S. Attorney Medicaid investigation, the 2015 U.S. Attorney Transportation Investigation, the investigations underlying the two subpoenas regarding patient diagnosis coding received by HCP and its JSA subsidiary, the 2015 DOJ Vascular Access Investigation, and the 2016 U.S. Attorney Prescription Drug Investigation described below.

In the Swoben private civil suit, a relator filed a complaint against us in federal court under the FCA qui tam provisions, as well as the provision of the California False Claims Act. In July 2013, the court granted HCP’s motion and dismissed with prejudice all of the claims in the Third Amended Complaint, and in October 2013 the plaintiff filed an appeal of the dismissal, which is currently pending.

Additionally, in March 2015, JSA, a subsidiary of HCP, received a subpoena from the OIG. We have been advised by an attorney with the Civil Division of the DOJ in Washington, D.C. that the subpoena relates to an ongoing civil investigation concerning Medicare Advantage service providers’ risk adjustment practices and data, including identification and verification of patient diagnoses and factors used in making the diagnoses. The subpoena requests documents and information for the period from January 1, 2008 through December 31, 2013, for certain Medicare Advantage plans for which JSA provided services. It also requests information regarding JSA’s communications about patient diagnoses as they relate to certain Medicare Advantage plans generally, and more specifically as related to two Florida physicians with whom JSA previously contracted.

In June 2015, we received a subpoena from the OIG. This civil subpoena covers the period from January 1, 2008 through the present and seeks production of a wide range of documents relating to our and our subsidiaries' (including HealthCare Partners and its subsidiary JSA HealthCare Corporation) provision of services to Medicare Advantage plans and related patient diagnosis coding and risk adjustment submissions and payments. Some of the information requested relates to a potentially improper historical HCP coding practice related to a particular condition. The practice in question was discontinued following our November 1, 2012 acquisition of HCP and, as we previously disclosed, we notified CMS of the coding practice and potential overpayments. In connection with the

HCP merger, we have certain indemnification rights against the sellers secured by escrow for any and all liabilities incurred. We can make no assurances that the indemnification and escrow would cover the full amount of our potential losses related to this matter. We are cooperating with the government and will gather and produce the requested information.

In November 2015, we announced that RMS Lifeline, Inc., a wholly owned subsidiary of ours that operates under the name Lifeline Vascular Access (Lifeline), received a CID from the DOJ. The CID relates to two vascular access centers in Florida that are part of Lifeline's vascular access business. The CID covers the period from January 1, 2008 through the present. We acquired these two centers in December 2012. Based on the language of the CID, the DOJ appears to be looking at whether the angiograms of ten patients performed at the two centers were medically unnecessary and therefore whether related claims filed with federal healthcare programs possibly violated the FCA. Lifeline does not perform dialysis services but instead provides vascular access management services for dialysis patients. We are in the process of producing the requested documents to the DOJ.

In early February 2016, we announced that our pharmacy services wholly owned subsidiary, DaVita Rx, received a CID from the U.S. Attorney's Office for the Northern District of Texas. Based on the language of the CID, it appears the government is conducting an FCA investigation concerning allegations that DaVita Rx presented or caused to be presented false claims for payment to the government for prescription medications. The CID covers the period from January 1, 2006 through the present. In the spring of 2015, we initiated an internal compliance review of DaVita Rx during which we identified potential billing and operational issues. We notified the government in September 2015 that we were conducting this review of DaVita Rx and began providing regular updates of our review. In the fourth quarter of 2015, we recorded an estimated accrual of $22 million for potential damages and liabilities associated with write-offs and discounts of patient co-payment obligations, and credits to payors for returns of prescriptions drugs, related to DaVita Rx that were identified during the course of this internal compliance review. We may accrue additional reserves for refunds and related damages and potential liabilities arising out of this review. Upon completion of our review, we filed a self-disclosure with the OIG in early February 2016 and we have been working to address and update the practices we identified in the self-disclosure, some of which overlaps with information requested by the U.S. Attorney's Office. We do not know if the U.S. Attorney's Office, which is part of the DOJ, knew when it served the CID on us that we were already in the process of developing a self-disclosure to the OIG. The OIG informed us in late February that our submission was not accepted. They indicated that the OIG is not expressing an opinion regarding the conduct disclosed or our legal positions. We intend to cooperate with the government in this matter.

Responding to subpoenas, investigations and civil suits as well as defending ourselves in such matters will continue to require management's attention and we will continue to incur significant legal expense. Any negative findings or certain terms and conditions that we might agree to accept as part of a negotiated resolution could result in substantial financial penalties or awards against or substantial payments made by us, the imposition of certain obligations on our practices and procedures, exclusion from future participation in the Medicare and Medicaid programs and, in certain cases, criminal penalties. It is possible that criminal proceedings may be initiated against us in connection with investigations by the federal government. To our knowledge, no proceedings have been initiated by the federal government against us at this time. At this time, we cannot predict the ultimate outcome of these inquiries, or the potential outcome of the claims in the relators' civil suit (except as described above), or the potential range of damages, if any. See Note 17 to the consolidated financial statements of this report for additional details regarding these and other matters.

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

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

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

CMS has mandated the use of new patient codes for reporting medical diagnosis and inpatient procedures, referred to as ICD-10, which requires all providers, payors, clearinghouses, and billing services to utilize ICD-10 when submitting claims for payment. ICD-10 will affect diagnosis and inpatient procedure coding for everyone covered by HIPAA, not just those who submit Medicare or Medicaid claims. Claims for services provided on or after October 1, 2015 must use ICD-10 for medical diagnosis and inpatient procedures or they will not be paid. If our services, processes or information systems or those of our payors do not comply with ICD-

10 requirements at any future date, it could potentially delay or even reduce reimbursement payments to us. These delays or reductions could negatively impact our revenues, earnings and cash flows.

Federal and state 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, and our business, reputation, results of operations, financial position and cash flows could be materially and adversely affected.

We must comply with numerous federal and state laws and regulations governing the collection, dissemination, access, use, security and privacy of PHI, including HIPAA and its implementing privacy and security regulations, as amended by the federal HITECH Act and collectively referred to as HIPAA. 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 to our systems, or defend against cybersecurity attacks, our business, reputation, results of operations, financial position and cash flows could be materially and adversely affected.

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 operations rely on the secure processing, transmission and storage of confidential, proprietary and other information in our computer systems and networks.

We are continuously implementing multiple layers of security measures through technology, processes, and our people. We utilize current security technologies 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; coordinated attacks by activist entities; emerging cybersecurity risks; misplaced or lost data; programming and/or human errors; or other similar events. Emerging and advanced security threats, including coordinated attacks, require additional layers of security which may disrupt or impact efficiency of operations.

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, reputation, financial condition, cash flows, or results of operations. The occurrence of any of these events could result in interruptions, delays, the loss or corruption of data, cessations in the availability of systems or liability under privacy and security laws, all of which could have a material adverse effect on our financial position and results of operations and harm our business reputation. 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 and vendors would be harmed, and our business, operations, and financial results may be materially 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 may further result in a material adverse effect on our results of operations, financial position, and cash flows.

There have been increased federal and state HIPAA privacy and security enforcement efforts and we expect this trend to continue. Under HITECH, state attorneys general have the right to prosecute HIPAA violations committed against residents of their states. Several such actions have already been brought against both covered entities and a business

associate, and continued enforcement actions are likely to occur in the future. In addition, HITECH mandates that the Secretary of HHS conduct periodic compliance audits of HIPAA covered entities and business associates. It also tasks HHS with establishing a methodology whereby individuals who are harmed by HIPAA violations may receive a percentage of the civil monetary penalty fine or monetary settlement paid by the violator.

In addition to HIPAA, numerous other state and federal laws govern the collection, dissemination, use, access to and confidentiality of individually identifiable health information. In addition, some states are considering new laws and regulations that further protect the confidentiality, privacy or security of medical records or other types of medical or personal information. These laws may be similar to or even more stringent than the federal provisions and are not preempted by HIPAA. Not only may some of these state laws impose fines and penalties upon violators, but some afford private rights of action to individuals who believe their personal information has been misused.

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

Our business strategy includes growth through acquisitions of dialysis centers and other businesses. We may engage in acquisitions, mergers, dispositions or new business 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 that, if identified, we will be able to acquire these targets on acceptable terms or agree to terms with merger partners. There can also be no assurance that we will be successful in completing any acquisitions, mergers or dispositions that we announce, executing new business 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 adversely impact our results of operations. Further, we cannot be certain that key talented individuals at the business being acquired will continue to work for us after the acquisition or that they will be able to continue to successfully manage or have adequate resources to successfully operate any acquired business.

Businesses we acquire may have unknown or contingent liabilities or liabilities that are in excess of the amounts that we originally estimated, and may have other issues, including those related to internal controls over financial reporting or issues that could affect our ability to comply with healthcare laws and regulations and other laws applicable to our expanded business. As a result, we cannot make any assurances that the acquisitions we consummate will be successful. Although we generally seek indemnification from the sellers of businesses we acquire for matters that are not properly disclosed to us, we are not always successful. In addition, even in cases where we are able to obtain indemnification, we may discover liabilities greater than the contractual limits, the amounts held in escrow for our benefit (if any), or the financial resources of the indemnifying party. In the event that we are responsible for liabilities substantially in excess of any amounts recovered through rights to indemnification or alternative remedies that might be available to us, or any applicable insurance, we could suffer severe consequences that would substantially reduce our earnings and cash flows or otherwise materially and adversely affect our business.

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

Acquisitions, patient retention and medical director and physician retention are an important part of our growth strategy. We face intense competition from other companies for acquisition targets. In our U.S. dialysis business, we continue to face increased competition from large and medium-sized providers which compete directly with us for acquisition targets as well as for individual patients and medical directors. In addition, as we continue our international dialysis expansion into various international markets, we will face competition from large and medium-sized providers for these acquisition targets as well. Because of the ease of entry into the dialysis business and the ability of physicians to be medical directors for their own centers, competition for growth in existing and expanding markets is not limited to large competitors with substantial financial resources. Occasionally, we have experienced competition from former medical directors or referring physicians who have opened their own dialysis centers. In addition, FMC, our largest competitor, manufactures a full line of dialysis supplies and equipment in addition to owning and operating dialysis centers. This may give it cost advantages over us because of its ability to manufacture its own products. If we are not able to continue to make acquisitions, continue to maintain acceptable levels of non-acquired growth, or if we face significant patient attrition to our competitors or a reduction in the number of our medical directors or associated physicians, it could adversely affect our business.

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

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

If we fail to successfully maintain an effective internal control over financial reporting, the integrity of our financial reporting could be compromised which could result in a material adverse effect on our reported financial results.

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

The market price of our common stock may be affected by factors different from those affecting the shares of our common stock prior to consummation of the HCP transaction.

Our historical business differs substantially from that of HCP. Accordingly, the results of operations of the combined company and the market price of our common stock may be affected by factors different from those that previously affected the independent results of operations of each of the Company and HCP.

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

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

- changes in the local economic environment;
- political instability, armed conflicts or terrorism;
- social changes;
- intellectual property legal protections and remedies;
- trade regulations;
- procedures and actions affecting approval, production, pricing, reimbursement and marketing of products and services;
- foreign currency;
- repatriating or moving to other countries cash generated or held abroad, including considerations relating to tax-efficiencies and changes in tax laws;
- export controls;
- lack of reliable legal systems which may affect our ability to enforce contractual rights;
- changes in local laws or regulations;
- potentially longer ramp-up times for starting up new operations and for payment and collection cycles;
- financial and operational, and information technology systems integration; and
- failure to comply with U.S. or local laws that prohibit us or our intermediaries from making improper payments to foreign officials for the purpose of obtaining or retaining business.

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

We anticipate expanding our international operations through acquisitions of varying sizes or through organic growth, which could increase these risks. Additionally, though we might invest material amounts of capital and incur significant costs in connection

with the growth and development of our international operations, there is no assurance that we will be able to operate them profitably anytime soon, if at all. As a result, we would expect these costs to be dilutive to our earnings over the next several years as we start-up or acquire new operations.

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

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 depends on many factors beyond our control.

We have substantial debt outstanding, we incurred a substantial amount of additional debt in connection with the HCP transaction and we may incur additional indebtedness in the future. Our substantial indebtedness could have important consequences to you, for example, it could:

- 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 flow from operations to payments on our indebtedness, thereby reducing the availability of our cash flow to fund working capital, capital expenditures, acquisitions and investments and other general corporate purposes;
- 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 earnings and cash flow 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.

In addition, we may incur substantial additional indebtedness in the future. The terms of the indentures governing our senior notes and the agreement governing our Senior Secured Credit Facilities will allow us to incur substantial additional debt. If new debt is added to current debt levels, the related risks described above could intensify.

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

We cannot provide assurance that our business will generate sufficient cash flow 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. If we are unable to generate sufficient funds to service our outstanding indebtedness, we may be required to refinance, restructure, or otherwise amend some or all of such obligations, sell assets, or raise additional cash through the sale of our equity. We cannot make any assurances that we would be able to obtain such refinancing on terms as favorable as our existing financing terms or that such restructuring activities, sales of assets, or issuances of equity can be accomplished or, if accomplished, would raise sufficient funds to meet these obligations.

The borrowings under our Senior Secured Credit Facilities are guaranteed by a substantial portion of our direct and indirect wholly-owned domestic subsidiaries and are secured by a substantial portion of DaVita HealthCare Partners Inc.’s and its subsidiaries’ assets.

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

Our operations and how we manage the Company may subject the Company, as well as its officers and directors to whom the Company owes certain defense and indemnity obligations, to litigation and liability for damages. Our

business, profitability and growth prospects could suffer if we face negative publicity or we pay damages or defense costs in connection with a claim that is outside the scope or limits of coverage of any applicable insurance coverage, including claims related to adverse patient events, contractual disputes, professional and general liability, and directors' and officers' duties. In addition, we have received several notices of claims from commercial payors and other third parties, as well as subpoenas and CIDs from the federal government, related to our historical billing practices and the historical billing practices of the centers acquired from Gambro Healthcare and other matters related to their settlement agreement with the DOJ. Although the ultimate outcome of these claims cannot be predicted, an adverse

result with respect to one or more of these claims could have a material adverse effect on our financial condition, results of operations, and cash flows. We currently maintain insurance coverage for those risks we deem are appropriate to insure against and make determinations about whether to self-insure as to other risks or layers of coverage. However, a successful claim, including a professional liability, malpractice or negligence claim which is in excess of any applicable insurance coverage, or that is subject to our self-insurance retentions, could have a material adverse effect on our earnings and cash flows.

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

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

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; 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, 2015, these cash bonuses would total approximately $577 million if a change of control transaction occurred at that price and our Board of Directors did not modify this program. These 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.

For our U.S. dialysis and related lab service business, we own the land and buildings for 26 of our outpatient dialysis centers. We also own the buildings for four other outpatient dialysis centers and the building at one of our Florida labs and we own eleven separate land parcels and sublease a total of three properties to third-party tenants. In addition, we also own the land and building for our corporate headquarters. Our remaining outpatient dialysis centers are located on premises that we lease.

For HCP, we own the land and buildings for nine of our clinics. We also own the building for one other clinic and we own one separate land parcel. Our remaining clinics are located on premises that we lease.

Our leases for our dialysis and related lab services and for HCP generally cover periods from five to 20 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 500 to 33,000 square feet, with an average size of approximately 7,500 square feet. HCP's clinics range in size from approximately

800 to 73,000 square feet, with an average size of approximately 9,200 square feet. Our international leases generally range from one to ten years.

The following is a summary of our business, administrative offices, laboratories and pharmacies:

Office	Location	Square Feet	Expiration
U.S. Dialysis and related lab service and other ancillary business:			
Corporate Headquarters	Denver, CO	240,000	Owned
Corporate Headquarters	Denver, CO	116,000	2018
Administrative Office	Vernon Hills, IL	33,000	2019
Administrative Office	Washington DC	4,000	2019
Administrative Office	Centennial, CO	29,000	2018
Business Office	El Segundo, CA	73,700	2017 through 2023
Business Office	Tacoma, WA	119,000	2021
Business Office	Malvern, PA	138,000	2026
Business Office	Brentwood, TN	129,000	2016 through 2025
Business Office	Irvine, CA	66,000	2024
Business Office	Federal Way, WA	188,000	2023
DaVita Rx	Orlando, FL	51,000	2020
DaVita Rx	Coppell, TX	135,000	2019
DaVita Rx	Chandler, AZ	75,000	2027
DaVita Rx	San Bruno, CA	22,200	2017
Laboratory	DeLand, FL	36,000	Owned
Laboratory Warehouse and Offices	DeLand, FL	52,000	2014 through 2016
Laboratory	Hollywood, FL	43,000	2019
Laboratory Office	Miami, FL	1,000	2016
HCP business:			
Administrative Office	Albuquerque, NM	135,000	2016
Administrative Office	Arcadia, CA	24,000	2019
Administrative Office	Colorado Springs, CO	42,000	2018 through 2019
Administrative Office	Coral Springs, FL	4,000	2018
Administrative Office	Costa Mesa, CA	27,000	2017
Administrative Office	El Segundo, CA	185,000	2025
Administrative Office	Fort Harrison, FL	2,000	2018
Administrative Office	Las Vegas, NV	37,000	2016 and Month to Month
Administrative Office	Los Angeles, CA	46,000	2021
Administrative Office	Orlando, FL	2,000	Month-to-Month
Administrative Office	Palm Harbor, FL	3,000	2017
Administrative Office	Peoria, AZ	6,000	2016
Administrative Office	Phoenix, AZ	14,000	2019
Administrative Office	St. Petersburg, FL	43,000	2020
Administrative Office	Torrance, CA	151,000	2017 through 2021
International business:			
Administrative Office	Bogota, Colombia	7,496	2023
Administrative Office	Singapore, Singapore	5,302	2017
Administrative Office	Bangalore, India	4,628	2016 through 2021

Administrative Office	Benxi, China	3,632	2016
Administrative Office	Amsterdam, Netherlands	3,296	2020
Administrative Office	Riyadh, Saudi Arabia	3,122	2017
Administrative Office	Kuala Lumpur, Malaysia	3,115	2016
Administrative Office	Shanghai, China	2,920	2016
Administrative Office	Hamburg, Germany	2,205	2020
Administrative Office	Taipei , Taiwan	2,160	2017
Administrative Office	Wroclaw, Poland	1,162	2017
Administrative Office	Carnaxide, Portugal	842	2016

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.

Inquiries by the Federal Government and Certain Related Civil Proceedings

2011 U.S. Attorney Medicaid Investigation: In October 2011, we announced that we would be receiving a request for documents, which could include an administrative subpoena from the OIG. Subsequent to our announcement of this 2011 U.S. Attorney Medicaid Investigation, we received a request for documents in connection with the inquiry by the U.S. Attorney's Office for the Eastern District of New York. The request related to payments for infusion drugs covered by Medicaid composite payments for dialysis. It is our understanding that this inquiry is civil in nature. We understand further that certain other providers that operate dialysis clinics in New York may have received a similar request for documents. We have cooperated with the government and produced the requested documents. In April 2014, we reached an agreement in principle with the government and expect to execute in the first quarter of 2016 the settlement agreements with the government and the State of New York to finalize the terms of the settlement and to resolve this matter, and have accrued an amount that is immaterial.

Swoben Private Civil Suit: In April 2013, our HCP subsidiary was served with a civil complaint filed by a former employee of SCAN Health Plan (SCAN), an HMO. On July 13, 2009, pursuant to the qui tam provisions of the federal FCA and the California False Claims Act, James M. Swoben, as relator, filed a qui tam action in the United States District Court for the Central District of California purportedly on behalf of the United States of America and the State of California against SCAN, and certain other defendants whose identities were under seal. The allegations in the complaint relate to alleged overpayments received from government healthcare programs. In or about August 2012, SCAN entered into a Settlement Agreement with the United States of America and the State of California. The United States and the State of California partially intervened in the action for the purpose of settlement with and dismissal of the action against SCAN. In or about November 2011, the relator filed his Third Amended Complaint under seal alleging violations of the federal FCA and the California False Claims Act, which named additional defendants, including HCP and certain health insurance companies (the defendant HMOs). The allegations in the complaint against HCP relate to patient diagnosis coding to determine reimbursement in the Medicare Advantage program, referred to as Hierarchical Condition Coding (HCC) and RAF scores. The complaint sought monetary damages and civil penalties as well as costs and expenses. The DOJ reviewed these allegations and in January 2013 declined to intervene in the case. On June 26, 2013, HCP and the defendant HMOs filed their respective motions to dismiss the Third Amended Complaint pursuant to Federal Rules of Civil Procedure 12(b)(6) and 9(b), challenging the legal sufficiency of the claims asserted in the complaint. On July 30, 2013, the court granted HCP's motion and dismissed with prejudice all of the claims in the Third Amended Complaint and judgment was entered in September

2013. The court specifically determined that further amendments to the complaint would be futile because, in part, the allegations were publicly disclosed in reports and other sources relating to audits conducted by CMS. In October 2013, the plaintiff appealed to the United States Court of Appeals for the Ninth Circuit and the court's disposition of the appeal is pending.

2015 U.S. Attorney Transportation Investigation: In February 2015, we announced that we received six administrative subpoenas from the OIG for medical records from six different dialysis centers in southern California operated by us. Specifically, each subpoena seeks the medical records of a single patient of each respective dialysis center. In February 2016, we received four additional subpoenas for four additional dialysis centers in southern California. The subpoenas were similarly limited in scope to the subpoenas received in 2015. We have been advised by an attorney from the United States Attorney's Office for the Central District of California that the subpoenas relate to an investigation concerning the medical necessity of patient transportation. We do not provide transportation nor do we bill for the transport of our dialysis patients. We do not know the scope of the investigation by the government, nor what conduct or activities might be the subject of the investigation.

2015 U.S. OIG Medicare Advantage Civil Investigation: In March 2015, JSA HealthCare Corporation (JSA), a subsidiary of HCP, received a subpoena from the OIG. We have been advised by an attorney with the Civil Division of the United States DOJ in Washington, D.C. that the subpoena relates to an ongoing civil investigation concerning Medicare Advantage service providers' risk adjustment practices and data, including identification and verification of patient diagnoses and factors used in making the diagnoses. The subpoena requests documents and information for the period from January 1, 2008 through December 31, 2013, for certain Medicare Advantage plans for which JSA provided services. It also requests information regarding JSA's communications about patient diagnoses as they relate to certain Medicare Advantage plans generally, and more specifically as related to two Florida physicians with whom JSA previously contracted. We are producing the requested information and are cooperating with the government's investigation.

In addition to the subpoena described above, in June 2015, we received a subpoena from the OIG. This civil subpoena covers the period from January 1, 2008 through the present and seeks production of a wide range of documents relating to our and our subsidiaries' (including HCP and its subsidiary JSA HealthCare Corporation) provision of services to Medicare Advantage plans and related patient diagnosis coding and risk adjustment submissions and payments. We believe that the request is part of a broader industry investigation into Medicare Advantage patient diagnosis coding and risk adjustment practices and potential overpayments by the government. Some of the information requested relates to what we first disclosed in the risk factors of the Company's quarterly report on Form 10-Q for the first quarter of 2015 as a potentially improper historical HCP coding practice related to a particular condition. The practice in question was discontinued following our November 1, 2012 acquisition of HCP and, as we previously disclosed, we notified CMS of the coding practice and potential overpayments. In connection with the HCP merger, we have certain indemnification rights against the sellers and an escrow was established as security for the indemnification. We would pursue an indemnification claim against the sellers secured by the escrow for any and all liabilities incurred. We can make no assurances that the indemnification and escrow would cover the full amount of our potential losses related to this matter. We are cooperating with the government and producing the requested information.

2015 U.S. Department of Justice Vascular Access Investigation: In November 2015, we announced that RMS Lifeline, Inc., a wholly owned subsidiary of ours that operates under the name Lifeline Vascular Access (Lifeline), received a CID from the DOJ. The CID relates to two vascular access centers in Florida that are part of Lifeline's vascular access business. The CID covers the period from January 1, 2008 through the present. We acquired these two centers in December 2012. Based on the language of the CID, the DOJ appears to be looking at whether the angiograms of 10 patients performed at the two centers were medically unnecessary and therefore whether related claims filed with federal healthcare programs possibly violated the FCA. Lifeline does not perform dialysis services but instead provides vascular access management services for dialysis patients. We are in the process of producing the requested documents to the DOJ.

2016 U.S. Attorney Prescription Drug Investigation: In early February 2016, we announced that our pharmacy services wholly owned subsidiary, DaVita Rx, received a CID from the U.S. Attorney's Office for the Northern District of Texas. Based on the language of the CID, it appears the government is conducting an FCA investigation concerning allegations that DaVita Rx presented or caused to be presented false claims for payment to the government for prescription medications. The CID covers the period from January 1, 2006 through the present. In the spring of 2015, we initiated an internal compliance review of DaVita Rx during which we identified potential billing and operational issues. We notified the government in September 2015 that we were conducting this review of DaVita Rx and began providing regular updates of our review. In the fourth quarter of 2015, we recorded an estimated accrual of $22 million for potential damages and liabilities associated with write-offs and discounts of patient co-payment obligations, and credits to payors for returns of prescriptions drugs, related to DaVita Rx that were identified during the course of this internal compliance review. We may accrue additional reserves for refunds and related damages and potential liabilities arising out of this review. Upon completion of our review, we filed a self-disclosure with the OIG

in early February 2016 and we have been working to address and update the practices we identified in the self-disclosure, some of which overlaps with information requested by the U.S. Attorney's Office. We do not know if the U.S. Attorney's Office, which is part of the DOJ, knew when it served the CID on us that we were already in the process of developing a self-disclosure to the OIG. The OIG informed us in late February that our submission was not accepted. They indicated that the OIG is not expressing an opinion regarding the conduct disclosed or our legal positions. We intend to cooperate with the government in this matter.

Except for the private civil complaints filed by the relators in the Swoben litigation as described above, to our knowledge, no proceedings have been initiated against us at this time in connection with any of the inquiries by the federal government. Although we cannot predict whether or when proceedings might be initiated or when these matters may be resolved, 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. Responding to the subpoenas or inquiries and defending the Company in the relator proceedings will continue to require management's attention and significant legal expense. Any negative findings in the inquiries or relator proceedings could result in substantial financial penalties or awards against us, exclusion from future participation in the Medicare and Medicaid programs and if criminal proceedings were initiated against us, possible criminal penalties. At this time, we cannot predict the ultimate

outcome of these inquiries, or the potential outcome of the relators' claims (except as described above), or the potential range of damages, if any.

Other

We have received several notices of claims from commercial payors and other third parties related to historical billing practices and claims against DVA Renal Healthcare (formerly known as Gambro Healthcare), a subsidiary of ours, related to historical Gambro Healthcare billing practices and other matters covered by its 2004 settlement agreement with the DOJ and certain agencies of the U.S. government. We have not received any further indication that any of these claims are active, except for one payor claim relating to a special needs plan, and some of the other claims may be barred by applicable statutes of limitations. We are working to resolve the one active claim of which we are aware and, based on the dollar amount of the claim, expect that its eventual resolution will involve an amount that is immaterial.

In April 2008, a wage and hour claim lawsuit was filed against us in the Superior Court of California that was styled as a class action and was subsequently amended. The complaint, as amended, alleges that we failed to provide meal periods, failed to pay compensation in lieu of providing rest or meal periods, failed to pay overtime, and failed to comply with certain other California Labor Code requirements. After we prevailed on certain trial court rulings, the plaintiffs later appealed to the California Court of Appeals, and some of the issues on appeal were remanded to the trial court. We reached an agreement with the plaintiffs to settle the case in June 2015. The settlement has now been approved by the court. The amount of the settlement is not material to our consolidated financial statements.

In addition to the foregoing, we are subject to claims and suits, including from time to time, contractual disputes and professional and general liability claims, as well as audits and investigations by various government entities, in the ordinary course of business. We believe that the ultimate resolution of any such pending proceedings, whether the underlying claims are covered by insurance or not, will not have a material adverse effect on our financial condition, results of operations or cash flows.

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 following table sets forth, for the periods indicated, the high and low sales prices for our common stock as reported by the New York Stock Exchange.

	High	Low
Year ended December 31, 2015:		
1st quarter	$83.04	$71.89
2nd quarter	85.17	79.31
3rd quarter	81.89	70.12
4th quarter	78.94	67.34
Year ended December 31, 2014:		
1st quarter	$69.81	$62.74
2nd quarter	72.95	67.12
3rd quarter	74.94	70.44
4th quarter	78.07	72.03

The closing price of our common stock on January 29, 2016 was $67.12 per share. According to Computershare, our registrar and transfer agent, as of January 29, 2016, there were 10,273 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. Also, see the heading "Liquidity and Capital Resources" under "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations" and the notes to our consolidated financial statements.

Stock Repurchases

The following table summarizes our repurchases of our common stock during the fourth quarter of 2015:

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

			Programs(1)	(in millions)
October 1 - October 31, 2015	2,200	$ 71.01	2,200	$ 659.3
November 1 - November 30, 2015	—	$ —	—	$ 659.3
December 1 - December 31, 2015	2,154,751	$ 69.85	2,154,751	$ 508.7
Total	2,156,951	$ 69.86	2,156,951	$ 508.7

(1) In November 2010, our Board of Directors authorized repurchases of our common stock in an aggregate amount of up to $800 million. We are authorized to make purchases from time to time in the open market or in privately negotiated transactions, depending upon market conditions and other considerations. On April 14, 2015, our Board of Directors approved additional share repurchases in the amount of $726 million. These share repurchases were in addition to the approximately $274 million remaining under our Board of Directors' prior share repurchase approval announced in November 2010. During the twelve months ended December 31, 2015, we purchased a total of 7,779,958 shares of our common stock for $575 million, or an average price of $73.96. We also repurchased 3,689,738 shares of our common stock for $249 million, or an average price of $67.61 per share, during January 2016. As a result of these transactions, there was approximately $259 million available under our current Board authorizations for additional share repurchases. These share repurchase authorizations have no expiration dates. However, we are subject to share repurchase limitations under the terms of the 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. These selected consolidated financial results have been recast for all prior periods presented to reflect the retrospective application of these new presentation and disclosure requirements for patient service revenues.

	Year ended December 31,				
	2015	2014	2013	2012 [5]	2011
	(in thousands, except share data)				
Income statement data:					
Net revenues(1)	$13,781,837	$12,795,106	$11,764,050	$8,186,280	$6,731,806
Operating expenses and charges(2)	12,611,142	10,979,965	10,213,916	6,889,196	5,577,093
Operating income	1,170,695	1,815,141	1,550,134	1,297,084	1,154,713
Debt expense	(408,380)	(410,294)	(429,943)	(288,554)	(241,090)
Debt refinancing and redemption charges	(48,072)	(97,548)	—	(10,963)	—
Other income, net	8,893	2,374	4,787	3,737	2,982
Income from continuing operations before income taxes	723,136	1,309,673	1,124,978	1,001,304	916,605
Income tax expense	295,726	446,343	381,013	359,845	325,292
Income from continuing operations	427,410	863,330	743,965	641,459	591,313
Income from operations of discontinued operations, net of tax(3)	—	—	(139)	(222)	(13,162)
Loss on disposal of discontinued operations, net of tax(3)	—	—	13,375	—	(4,756)
Net income	$427,410	$863,330	$757,201	$641,237	573,395
Less: Net income attributable to noncontrolling interests	(157,678)	(140,216)	(123,755)	(105,220)	(95,394)
Net income attributable to DaVita HealthCare Partners Inc.	$269,732	$723,114	$633,446	$536,017	$478,001
Basic income from continuing operations attributable to DaVita HealthCare Partners Inc.(3)(4)	$1.27	$3.41	$2.95	$2.79	$2.62
Diluted income from continuing operations attributable to DaVita HealthCare Partners Inc.(3)(4)	$1.25	$3.33	$2.89	$2.74	$2.57
Weighted average shares outstanding:(4)					
Basic	211,868,000	212,302,000	209,939,000	192,036,000	189,316,000
Diluted	216,252,000	216,928,000	214,764,000	195,942,000	193,064,000
Ratio of earnings to fixed charges(6)	1.95:1	3.05:1	2.73:1	3.17:1	3.39:1

Balance sheet data:					
Working capital(1)	$2,104,142	$1,547,519	$600,788	$546,478	$848,110
Total assets(1)	18,514,875	17,617,432	16,612,401	15,594,345	8,570,168
Long-term debt(1)	9,001,308	8,298,624	8,064,196	8,230,393	4,364,366
Total DaVita HealthCare Partners Inc. shareholders equity(4)	4,870,780	5,170,513	4,432,479	3,763,137	2,141,075

(1) Effective January 1, 2012, we were required to present our provision for uncollectible accounts related to patient service revenues as a reduction from our patient service revenues, which changed the classification of our provision for uncollectible accounts related to patient service revenues. 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 (see “New Accounting Standards” below). All prior periods have been recast to conform to the current year presentation.

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

(3) Income from operations of discontinued operations, net of tax includes the operations for all prior periods presented of HomeChoice Partners Inc. (HomeChoice) which was divested on February 1, 2013. The income from operations of discontinued operations in 2011 also includes a $24,000 non-cash goodwill impairment charge related to HomeChoice. During 2011, we divested a total of 28 outpatient dialysis centers in conjunction with a consent order issued by the Federal Trade Commission on September 30, 2011 in order for us to complete the acquisition of DSI. We completed the sale of two additional centers that were previously pending state regulatory approval in conjunction with the acquisition of DSI on October 31, 2011. The operating results of the historical DaVita HealthCare Partners Inc. divested centers are reflected as discontinued operations in our consolidated financial statements for all prior periods before the centers were sold. In addition, the operating results for the historical DSI divested centers are reflected as discontinued operation in our consolidated financial statements from September 1, 2011 until the dates of sale.

(4) In the third quarter of 2013, the Board of Directors approved a two-for-one stock split of our common stock in the form of a stock dividend payable on September 6, 2013 to stockholders of record on August 23, 2013. Our common stock began trading on a post-split basis on September 9, 2013. All share and per share data for all prior periods presented have been adjusted to reflect the effects of the stock split. Share repurchases consisted of 7,779,958 shares of common stock for $575,380 in 2015 and 7,589,372 shares of common stock for $323,348 in 2011. Shares issued in connection with stock awards were 1,479,217 in 2015, 2,179,766 in 2014, 1,928,137 in 2013, 4,751,142 in 2012, and 2,518,518 in 2011.

(5) On November 1, 2012, we completed our acquisition of HCP whereby HCP became a wholly-owned subsidiary of the Company. The total consideration paid for all of the outstanding common units of HCP was approximately $4.71 billion, which consisted of $3.65 billion in cash, net of cash acquired, and 18,760,624 shares of our common stock valued at approximately $1.06 billion. The operating results of HCP are included in our consolidated results beginning November 1, 2012.

(6) The ratio of earnings to fixed charges was computed by dividing earnings by fixed charges. Earnings for this purpose is defined as pretax income from continuing operations adjusted by adding back fixed charges expensed during the period, less noncontrolling interests. Fixed charges include debt expense (interest expense and the write-off and amortization of deferred financing costs), the estimated interest component of rental expense on operating leases and capitalized interest.

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 include statements regarding our future operations, financial condition and prospects, expectations for treatment growth rates, revenue per treatment, expense growth, levels of the provision for uncollectible accounts receivable, operating income, cash flow, operating cash flow, estimated tax rates, capital expenditures, the development of new dialysis centers and dialysis center acquisitions, government and commercial payment rates, revenue estimating risk and the impact of our level of indebtedness on our financial performance and including earnings per share. These statements involve substantial known and unknown risks and uncertainties that could cause our actual results to differ materially from those described in the forward-looking statements, including but not limited to, risks resulting from the concentration of profits generated by higher-paying commercial payor plans for which there is continued downward pressure on average realized payment rates, and a reduction in the number of patients under such plans, which may result in the loss of revenues or patients, a reduction in government payment rates under the Medicare ESRD program or other government-based programs, the impact of the CMS 2015 Medicare Advantage benchmark structure, risks arising from potential federal and/or state legislation that could have an adverse effect on our operations and profitability, changes in pharmaceutical or anemia management practice patterns, payment policies, or pharmaceutical pricing, legal compliance risks, including our continued compliance with complex government regulations including compliance with the provisions of our current CIA and current or potential investigations by various government entities and related government or private-party proceedings, and the related restrictions on our business and operations required by the CIA and other settlement terms, and the financial impact thereof, continued increased competition from large- and medium-sized dialysis providers that compete directly with us, our ability to maintain contracts with physician medical directors, changing affiliation models for physicians, and the emergence of new models of care introduced by the government or private sector that may erode our patient base and reimbursement rates such as ACOs, IPAs and integrated delivery systems, or to businesses outside of dialysis and

HCP's business, our ability to complete acquisitions, mergers or dispositions that we might be considering or announce, or to integrate and successfully operate any business we may acquire or have acquired, including HCP, or to expand our operations and services to markets outside the U.S., the variability of our cash flows, the risk that we might invest material amounts of capital and incur significant costs in connection with the growth and development of our international operations, yet we might not be able to operate them profitably anytime soon, if at all, risks arising from the use of accounting estimates, judgments and interpretations in our financial statements, risk of losing key HCP employees, potential disruption from the HCP transaction making it more difficult to maintain business and operational relationships with customers, partners, associated physicians and physician groups, hospitals and others, the risk that laws regulating the corporate practice of medicine could restrict the manner in which HCP conducts its business, the risk that the cost of providing services under HCP's agreements may exceed our compensation, the risk that reductions in reimbursement rates, including Medicare Advantage rates, and future regulations may negatively impact HCP's business, revenue and profitability, the risk that HCP may not be able to successfully establish a presence in new geographic regions or successfully address competitive threats that could reduce its profitability, the risk that a disruption in HCP's healthcare provider networks could have an adverse effect on HCP's business operations and profitability, the risk that reductions in the quality ratings of health maintenance organization plan customers of HCP could have an adverse effect on HCP's business, or the risk that health plans that acquire health maintenance organizations may not be willing to contract with HCP or may be willing to contract only on less favorable terms, and the other risk factors set forth in Part II, Item 1A. of this Annual Report on Form 10-K. We base our forward-looking statements on information currently available to us at the time of this Annual Report on Form 10-K, and except as required by law 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 and “Item 1. Business”.

Company overview

The Company consists of two major divisions, Kidney Care and HCP. 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, which is a leading provider of kidney dialysis services in the U.S. for patients suffering from chronic kidney failure, also known as ESRD. Our HCP division 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.

Our overall financial performance was once again strong for 2015, excluding certain non-GAAP items, and was characterized by solid treatment volume growth, primarily from non-acquired growth at existing and new dialysis centers, cost control initiatives, and productivity and payor mix improvements in our dialysis business, and solid growth in HCP’s adjusted operating income. However, HCP continued to experience a reduction in Medicare Advantage reimbursement rates in 2015, which negatively impacted its operations. In addition, our dialysis segment experienced a large increase in our pharmaceutical costs.

Some of our major accomplishments and financial operating performance indicators in 2015 and year over year were as follows:

- improved clinical outcomes in our U.S. dialysis operations, including second year in a row as leader of the CMS five star rating system;
- consolidated net revenue growth of approximately 7.7%;
- a 5.2% net revenue growth related to our U.S. dialysis segment operations related to an increase of $6 per treatment;
- an increase in HCP’s net revenue of approximately 9.6% related to an increase of its FFS business and senior capitated revenue;
- an increase in other ancillary services and strategic initiatives net revenue of 21.3%;
- continued growth in U.S. dialysis treatments related to an increase of approximately 4.1% in the overall number of U.S. dialysis related treatments;
- normalized non-acquired U.S. dialysis treatment growth of 3.9%;
- added a net total of 72 U.S. dialysis centers and added a net total of 27 international dialysis centers; and
- strong operating cash flows of $1.557 billion, which have been reduced by approximately $304 million of after-tax payments made in connection with the settlement of the Vainer private civil suit.

However, we face uncertainty and various challenges in 2016 as we undertake initiatives to mitigate increases in clinical costs that we expect to experience due to inflation and other factors without any corresponding increase in our dialysis Medicare reimbursement rates. In addition, Congress could still make significant changes to Medicare and Medicaid under the healthcare reform legislation that was enacted in the U.S. and there is uncertainty around the potential negative impact of healthcare insurance exchanges. We could also experience delays in state certification and other regulatory issues. HCP also faces uncertainty in Medicare Advantage reimbursement rates as the government continues to modify adjustments to the rates. Additionally, there is the potential for non-renewal of payor contracts for HCP, which could cause significant patient and employer disruption. Physician practices of prescribing pharmaceuticals and pharmaceutical costs could also have a significant impact on our operating results. We also remain committed to our international expansion plans that will continue to require investment. In addition, if the percentage of our dialysis patients with commercial payors deteriorates or if we experience a decrease in our overall commercial rates, our operating results could be adversely affected.

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

	Year ended December 31,					
	2015		2014		2013	
	(dollar amounts rounded to nearest million)					
Net revenues:						
Patient service revenues	$9,481		$8,869		$8,307	
Less: Provision for uncollectible accounts	(428)		(367)		(293)	
Net patient service revenues	9,053		8,502		8,014	
Capitated revenues	3,509		3,261		2,987	
Other revenues	1,220		1,032		763	
Total net consolidated revenues	$13,782	100%	$12,795	100%	$11,764	100%
Operating expenses and charges:						
Patient care costs	$9,825	71 %	$9,119	71 %	$8,198	70 %
General and administrative	1,452	11 %	1,262	10 %	1,177	10 %
Depreciation and amortization	638	5 %	591	5 %	529	4 %
Provision for uncollectible accounts	9	—	14	—	5	—
Equity investment income	(18)	—	(23)	—	(35)	—
Settlement charge	495	4 %	—	—	—	—
Goodwill and other intangible asset impairment charges	210	2 %	—	—	—	—
Loss contingency accruals	—	—	17	—	397	3 %
Contingent earn-out obligation adjustment	—	—	—	—	(57)	—
Total operating expenses and charges	12,611	92 %	10,980	86 %	10,214	87 %
Operating income	$1,171	8 %	$1,815	14 %	$1,550	13 %

The following table summarizes consolidated net revenues:

	Year ended December 31,		
	2015	2014	2013
	(dollar amounts rounded to nearest million)		
Net revenues:			
Dialysis and related lab services patient service revenues	$9,034	$8,551	$8,033
Less: Provision for uncollectible accounts	(406)	(353)	(281)
Dialysis and related lab services net patient service revenues	8,628	8,198	7,752
Other revenues	14	13	12
Total net dialysis and related lab services revenues	8,642	8,211	7,764
HCP capitated revenues	3,437	3,191	2,920
HCP net patient service revenues (less provision for uncollectible accounts of $15, $13 and $12, respectively)	318	219	220
Other revenue	82	92	56
Total net HCP revenues	3,837	3,502	3,196
Other-ancillary services and strategic initiatives revenues	1,150	947	709

Other-capitated revenues	72	70	67
Other-ancillary services and strategic initiatives net patient service revenues (less provision for uncollectible accounts)	160	122	76
Total net other-ancillary services and strategic initiatives revenues	1,382	1,139	852
Total net segment revenues	13,861	12,852	11,812
Elimination of intersegment revenues	(79)	(57)	(48)
Consolidated net revenues	$13,782	$12,795	$11,764

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

	Year ended December 31,		
	2015	2014	2013
	(dollar amounts rounded to nearest million)		
Dialysis and related lab services	$1,260	$1,638	$1,200
HCP services	34	215	385
Other — ancillary services and strategic initiatives loss	(104)	(25)	(39)
Total segment operating income	1,190	1,828	1,546
Reconciling corporate items:			
Contingent earn-out obligations	—	—	57
Corporate administrative support	(19)	(13)	(45)
Adjustment to reduce a tax asset associated with HCP acquisition escrow provisions	—	—	(8)
Consolidated operating income	1,171	1,815	1,550
Reconciliation of non-GAAP measure:			
Add:			
Goodwill and other intangible asset impairment charges	210	—	—
Pharmacy accrual	22		
Settlement charge	495	—	—
Loss contingency accruals	—	17	397
Contingent earn-out obligation adjustment	—	—	(57)
Adjustment to reduce a tax asset associated with HCP acquisition escrow provisions	—	—	8
Adjusted consolidated operating income[(1)]	$1,898	$1,832	$1,898

(1) For the year ended December 31, 2015, we have excluded estimated non-cash goodwill and other intangible asset impairment charges of $210 million primarily related to certain HCP reporting units, an estimated accrual of $22 million for damages and liabilities associated with our pharmacy business, which is included in general and administrative expenses, and $495 million related to a settlement charge in connection with the Vainer private civil suit. In addition, for the years ended December 31, 2014 and 2013, we have excluded $17 million and $397 million, respectively, related to loss contingency accruals for the settlement of the 2010 and 2011 U.S. Attorney physician relationship investigations. In 2013, we have also excluded $57 million related to a decrease in HCP's 2013 contingent earn-out obligation and an adjustment of $8 million to reduce a tax asset associated with the HCP acquisition escrow provisions. These are non-GAAP measures and are not intended as substitutes for the GAAP equivalent measures. 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 unusual 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 normal prior period results.

Consolidated net revenues

Consolidated net revenues for 2015 increased by approximately $987 million, or 7.7%, from 2014. This increase in consolidated net revenues was due to an increase in dialysis and related lab services net revenues of approximately $431 million, principally due to solid volume growth from additional treatments from non-acquired growth and from an increase of $6 in the average dialysis revenue per treatment, primarily from an increase in our average commercial payment rates and improvement in our commercial payor mix. Consolidated net revenues also increased by $335 million as a result of HCP's growth from acquisitions and timing of the recognition of additional Medicaid risk sharing revenue, as described below. In addition, revenue increased by approximately $243 million in our ancillary services and strategic initiatives driven primarily from growth in our pharmacy services and our disease management services, as well as expansion in our international operations. These increases were partially offset by an increase in reserves for refunds of prior period pharmacy reimbursements.

Consolidated net revenues for 2014 increased by approximately $1.031 billion, or 8.8%, from 2013. This increase in consolidated net revenues was due to an increase in dialysis and related lab services net revenues of approximately $447 million, principally due to strong volume growth from additional treatments from non-acquired growth and dialysis center acquisitions and from an increase of $2 in the average dialysis revenue per treatment, primarily from the recognition of certain California Medicaid revenue that was previously reserved and an increase in some of our commercial payment rates, partially offset by changes in our commercial payor mix. Consolidated net revenues also increased by $306 million as a result of an increase in HCP's senior capitated members and growth from acquisitions. In addition, revenue increased by approximately $287 million in our ancillary services and strategic initiatives driven primarily from growth in our pharmacy services, our international operations and our disease management services.

Consolidated operating income

Consolidated operating income of $1.171 billion for 2015 decreased by approximately $644 million from 2014, which includes estimated goodwill and other intangible asset impairment charges of approximately $210 million, an estimated pharmacy accrual of $22 million and a private litigation settlement charge of $495 million in 2015 and a $17 million loss contingency accrual in 2014. Excluding these items from their respective periods, adjusted consolidated operating income for 2015 would have increased by $66 million, or 3.6%. Adjusted consolidated operating income increased primarily as a result of strong volume growth from additional treatments from non-acquired growth in the dialysis and related lab services business, as well as an increase in our average dialysis revenue per treatment of approximately $6, as discussed above. Adjusted consolidated operating income also increased due to improved results at HCP, excluding the impairment charges, due to growth from acquisitions and an increase in Medicaid risk sharing revenue. These increases were negatively impacted by an increase in the amount of losses in our ancillary services and strategic initiatives and increased losses in our international operations, as discussed below. In addition, we experienced higher pharmaceutical unit costs, an increase in long-term incentive compensation, an increase in HCP's medical claims expenses from higher utilization, and an increase in our dialysis provision for uncollectible accounts of approximately $53 million.

Consolidated operating income of $1.815 billion for 2014 increased by approximately $265 million, or 17.1% from 2013, which includes the estimated loss contingency reserve of $17 million and $397 million in 2014 and 2013, respectively. In addition, 2013 includes a contingent earn-out obligation adjustment of $57 million and an adjustment to reduce a tax asset associated with the HCP acquisition escrow provisions of $8 million. Excluding these items from their respective periods, adjusted consolidated operating income would have decreased by $66 million, or 3.5%, primarily as a result of a decrease in HCP's operating income of approximately $170 million, principally driven by a decline in Medicare Advantage rates. Adjusted consolidated operating income for 2014 also decreased as a result of higher pharmaceutical unit costs, an increase in long-term incentive compensation, an increase in HCP's medical claims expenses from higher utilization and an increase in our dialysis provision for uncollectible accounts of approximately $72 million. Adjusted consolidated operating income was positively impacted by an increase in the dialysis and related lab services net revenues as a result of strong volume growth from additional treatments due to non-acquired growth and acquisitions. In addition, our average dialysis revenue per treatment increased by approximately $2. Adjusted consolidated income also benefited from improved productivity, lower losses associated with our ancillary services and strategic initiatives and growth in HCP's senior capitated members.

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 2,251 outpatient dialysis centers in 46 states and the District of Columbia, serving a total of approximately 180,000 patients. We also provide acute inpatient dialysis services in approximately 900 hospitals. We estimate that we have approximately a 36% market share in the U.S. based upon the number of patients that we serve. In 2015, our overall network of U.S. outpatient dialysis centers net increased by 72 dialysis centers primarily as a result of the opening

new dialysis centers and from acquisitions of dialysis centers. In addition, the overall number of patients that we serve in the U.S. increased by approximately 4.1% in 2015 as compared to 2014. All references in this document to dialysis and related lab services refer only to our U.S. dialysis and related lab services business.

Our dialysis and related lab services stated mission 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 the major driver of our long-term performance, although we are subject to the impact of several external factors such as government policy, physician practice patterns, commercial payor payment rates and the mix of commercial and government patients. 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 (DQI). Our clinical outcomes as measured by DQI have improved over each of the past several years which we believe directly decreases patient mortalities. Our patient mortality percentages have decreased from 19.0% in 2001 to 13.7% in 2014. Although it is difficult to reliably measure clinical performance across our industry, we believe our clinical outcomes compare favorably with other dialysis providers in the U.S. and generally exceed the dialysis outcome quality indicators of the National Kidney Foundation. In addition, over the past several years our clinical teammate turnover has remained relatively constant and we believe that a relatively stable teammate turnover in 2015 was a major

contributor to our continued clinical performance improvements and can also be a major driver of our ability to maintain or improve clinical hours per treatment. 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, size 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 provides our dialysis patient base with a large number of out-patient dialysis centers to choose from with convenient locations and access to a full range of other integrated services which provides us the ability to effectively and efficiently manage a patient's care and certain costs while still maintaining strong legal and compliance programs.

Approximately 62% of our 2015 consolidated net revenues were derived directly from our dialysis and related lab services business. Approximately 79% of our 2015 dialysis and related lab services revenues were derived from outpatient hemodialysis services in the 2,220 U.S. centers that we consolidate. Other dialysis services, which are operationally integrated with our dialysis operations, are peritoneal dialysis, home-based hemodialysis, hospital inpatient hemodialysis services and management and administrative services provided to minority-owned and non-owned dialysis centers. These services collectively accounted for the balance of our 2015 dialysis and related lab services revenues.

The principal drivers of our 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 services and home-based dialysis and hospital inpatient dialysis services; and
- average dialysis revenue per treatment including the mix of commercial and government patients.

The total patient base is a relatively stable factor, which we believe is influenced by a demographically growing need for dialysis services as indicated by the United States Renal Data System that reported an approximate compound growth rate of 3.6% over the last several years for the dialysis patient population, our relationships with referring physicians, together with the quality of our clinical care which can lead to reduced patient mortality rates as indicated above, and our ability to open and acquire new dialysis centers.

Our average dialysis and related lab services revenue per treatment is driven by changes in our mix of commercial and government (principally Medicare and Medicaid) patients, commercial and government payment rates, our billing and collecting operations performance, and to a lesser extent the mix and intensity of physician-prescribed pharmaceuticals that are separately billable since payment for these pharmaceuticals are primarily included in Medicare's single bundled payment rate system and can also be included as part of a single bundled payment rate for all dialysis services provided under some of our commercial contracts.

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 revenue per treatment. The percentage of commercial patients covered under contracted plans as compared to commercial patients with out-of-network providers continued to increase, which can significantly affect our average dialysis 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. For the first time in several years, the growth of our commercial patients slightly outpaced the growth of our government-based patients as more of our patients are covered by commercial contracted plans.

The following table summarizes our U.S. dialysis and related lab services revenues by source for the year ended December 31, 2015:

Source	Revenue percentages	
Medicare and Medicare-assigned plans	56	%
Medicaid and Medicaid-assigned plans	6	%
Other government-based programs	4	%
Total government-based programs	66	%
Commercial (including hospital inpatient dialysis services)	34	%
Total dialysis and related lab services' revenues	100	%

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, including certain pharmaceuticals, such as EPO, vitamin D analogs and iron supplements, irrespective of the level of pharmaceuticals administered to the patient or additional services performed. Most lab services are also included in the bundled payment. The bundled payment rate is also adjusted for certain patient characteristics, a geographic usage index and certain other factors.

The bundled payment system presents operating, clinical and financial risks. For example, with regard to the expanded list of case-mix adjustors, there is a risk that our dialysis centers or billing and other systems may not accurately document and track the appropriate patient-specific characteristics, resulting in a reduction or overpayment in the amounts of the payments that we would otherwise be entitled to receive.

An important provision in the law is an annual adjustment, or market basket update, to the ESRD PPS base rate. Absent action by Congress, the PPS base rate is automatically updated annually by a formulaic inflation adjustment.

In December 2013, CMS issued the 2014 final rule for the ESRD PPS, which phases in the payment reductions mandated by ATRA, as modified by the "Protecting Access to Medicare Act of 2014" which will reduce our market basket inflation adjustment by 1.25% in 2016 and 2017, and 1% in 2018. CMS published the 2015 final rule for the ESRD PPS, which increased payments to dialysis facilities by 0.3% to 0.5%, although rural facilities received a decrease of 0.5%. CMS recently issued the 2016 final rule for the ESRD PPS, which cuts dialysis facilities' bundled payment rate for 2016 as compared to 2015 while increasing funds for certain co-morbidities and other patient health factors, and rural facilities. CMS believes its 2016 final rule for the ESRD PPS will (i) increase overall payments to both hospital-based and freestanding dialysis facilities by approximately 0.2%, and (ii) decrease overall payments to rural dialysis facilities by approximately 0.1%.

As a result of the BCA and subsequent activity in Congress, a $1.2 trillion sequester (across-the-board spending cuts) in discretionary programs took effect on March 1, 2013. In particular, a 2% reduction to Medicare payments took effect on April 1, 2013, which was subsequently extended through 2014 and 2015. The Bipartisan Budget Act of 2015 extended the BCA's annual 2% reduction to Medicare payments through fiscal year 2025. These across-the-board spending cuts have affected and will continue to adversely affect our revenues, earnings and cash flows.

The 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 currently uncertain of the extent to which the long-term operation and evolution of these models of care, including ACOs, Bundled Payments for Care Improvement Initiative, CEC Model (which includes the development of ESCOs), the Comprehensive Primary Care Initiative, 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 with organizations in Arizona, Florida, New Jersey and Pennsylvania. In areas where DaVita 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 programs' calculations. As new models of care emerge and evolve, we may be at risk for losing our Medicare patient base, which would have a materially adverse effect on our revenues, earnings and cash flow. Other initiatives in the government or private sector also may arise, including the development of models similar to ACOs, IPAs and integrated delivery systems or evolutions of those concepts which could adversely impact our business.

We anticipate that we will continue to experience increases in our operating costs in 2016 that will outpace any net Medicare rate increases that we may receive, which could significantly impact our operating results. In addition, we

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

Dialysis payment rates from commercial payors can vary and a major portion of our commercial rates are set at contracted amounts with payors and are subject to intense negotiation pressure. Our commercial payment rates also include payments for out-of-network patients that on average are higher than our in-network commercial contract rates. In 2015, we were successful in increasing some of our commercial contracted payment rates which contributed to an increase in our average dialysis revenue per treatment. We continue to enter into some commercial contracts covering certain patients that will primarily pay us a single bundled payment rate for all dialysis services provided to these patients. However, some of the contracts will 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, our revenues and operating results could be negatively impacted. 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 traditional commercial insurance plans. 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 such financial assistance, our revenues, earnings, and cash flows could be substantially reduced.

Approximately 2% of our dialysis and related lab services revenues for the year ended December 31, 2015, were from physician-prescribed pharmaceuticals that are separately billable, with EPO accounting for approximately 1% of our dialysis and related lab services revenues. 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, as well as some additional commercial contracts that pay us a single bundled payment rate.

Our operating performance with respect to dialysis services billing and collection can also be a significant factor in the average dialysis and related lab services revenue per treatment we recognize and are able to collect. Over the past several years we have invested heavily in upgrades to our systems and internal processes that we believe have helped improve our operating performance and reduced our regulatory compliance risks, and we expect to continue to improve these systems and processes. In 2015, we continued to upgrade our information technology systems and implemented process changes. We continue to upgrade our billing and other systems and modify our processes to improve our ability to capture the necessary patient characteristics, co-morbidities and certain other factors under Medicare's bundled payment system. We believe this will potentially enable us to capture additional reimbursement amounts from Medicare and enhance our overall billing and collection performance. However, as we continue to make upgrades to our systems and processes, or as payors change their systems and requirements, such as changes to Medicare's billing codes, we could experience a negative impact to our cash collection performance which would affect our average dialysis and related lab services revenue per treatment.

Our 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 trends, or subsequent settlements and realizations depending on the nature and predictability of the estimates and contingencies.

Our annual average dialysis and related lab services revenue per treatment was approximately $348, $342 and $340 for 2015, 2014 and 2013, respectively. In 2015, the average dialysis and related lab services revenue per treatment increased by approximately $6 per treatment due to an increase in our average commercial payment rates and improvements in our commercial payor mix, partially offset by an increase in our provision for uncollectible accounts. In 2014, the average dialysis and related lab services revenue per treatment increased by approximately $2 per treatment primarily from the recognition of certain California Medicaid revenue that was previously reserved, an increase in some of our commercial payment rates, partially offset by changes in our commercial payor mix.

Our average dialysis and related lab services 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; 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.

The principal drivers of our 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 represent significant cost variability, such as employee benefit costs, payroll taxes, insurance costs and medical supply costs. Our average clinical hours per treatment or productivity levels in 2015 improved slightly compared to 2014, which was primarily the result of improvements in our internal procedures and processes. 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 2015, which we believe negatively affected productivity levels. In 2015 and 2014, we experienced an increase in our clinical labor rates of approximately 0.9% and 1.5%, respectively, as clinical labor rates have increased consistent with general industry trends, mainly due to the high demand for skilled clinical personnel, along with general inflation increases. In 2015, we experienced a significant increase in our pharmaceutical unit costs. We also continue to experience increases in our 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. However, in 2015, we continued to implement certain cost control initiatives to manage our overall operating costs, including labor productivity.

Our dialysis and related lab services general and administrative expenses represented 8.2% and 8.3% of our dialysis and related lab services net revenues in 2015 and 2014, respectively. The slight decrease was primarily due to a decrease in professional fees for compliance matters and information technology initiatives and lower travel expenses, partially offset by higher labor and benefit costs and long-term incentive compensation. Increases in general and administrative expenses over the last several years primarily related to strengthening our dialysis business, improving our regulatory compliance and other operational processes, responding to certain legal and compliance matters, and professional fees associated with enhancing our information technology systems. We expect that these levels of expenditures on our dialysis and related lab services general and administrative expenses will continue in 2016 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 the level of support required for our regulatory compliance and legal matters.

Results of Operations

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

	Year ended December 31,					
	2015		2014		2013	
	(dollar amounts rounded to nearest million)					
Dialysis and related lab services patient service revenues	$9,034		$8,551		$8,033	
Less: Provision for uncollectible accounts	(406)		(353)		(281)	
Dialysis and related lab services net patient service revenues	8,628		8,198		7,752	
Other revenues	14		13		12	
Total net dialysis and related lab services revenues	$8,642	100%	$8,211	100%	$7,764	100%
Operating expenses and charges:						
Patient care costs	5,755	67%	5,485	67%	5,117	66%
General and administrative	709	8%	682	8%	706	9%
Depreciation and amortization	438	5%	403	5%	356	4%
Settlement charge and loss contingency accruals	495	6%	17	—	397	5%
Equity investment income	(15)	—	(14)	—	(12)	—
Total operating expenses and charges	7,382	85%	6,573	80%	6,564	84%
Operating income	$1,260	15%	$1,638	20%	$1,200	16%
Dialysis treatments	25,986,719		24,981,553		23,637,584	
Average dialysis treatments per treatment day	83,104		79,864		75,495	
Average dialysis and related lab services revenue per treatment	$348		$342		$340	

Net revenues

Dialysis and related lab services net revenues for 2015 increased by approximately $431 million, or 5.2%, from 2014. The increase in net revenues was primarily due to solid volume growth from additional treatments of approximately 4.0% due to an increase in non-acquired treatment growth at existing and new dialysis centers and an increase in the average dialysis revenue per treatment of approximately $6. The increase in the average dialysis revenue per treatment in 2015, as compared to 2014, was due to an increase in our average commercial payment rates and improvements in our commercial payor mix. Dialysis and related lab services net revenues were negatively impacted by an increase in the provision for uncollectible accounts of $53 million.

Dialysis and related lab services net revenues for 2014 increased by approximately $447 million, or 5.8%, from 2013. The increase in net revenues was primarily due to strong volume growth from additional treatments of approximately 5.7% due to an increase in non-acquired treatment growth at existing and new dialysis centers and growth through acquisitions of dialysis centers and an increase in the average dialysis revenue per treatment of approximately $2. The increase in the average dialysis revenue per treatment in 2014, as compared to 2013, was due to the recognition of certain California Medicaid revenue that was previously reserved, an increase in some of our commercial payment rates, partially offset by changes in the commercial payor mix. Dialysis and related lab services net revenues were negatively impacted by an increase in the provision for uncollectible accounts of $72 million.

The following table summarizes our dialysis and related lab services revenues by modality for the year ended December 31, 2015:

Modality	Revenue percentages	
Outpatient hemodialysis centers	79	%
Peritoneal dialysis and home-based hemodialysis	16	%
Hospital inpatient hemodialysis	5	%
Total dialysis and related lab services' revenues	100	%

Approximately 66% of our total dialysis and related lab services revenues for the year ended December 31, 2015 were from government-based programs, principally Medicare, Medicaid, and Medicare-assigned plans, representing approximately 89% of our total patients. Prior to 2015, we had experienced growth in our government-based patients that had been outpacing the growth in our commercial patients which had negatively impacted our average dialysis and related lab services revenue per treatment since we receive higher reimbursement rates from our commercial payors. However, in 2015, for the first time in several years, the growth of our commercial patients slightly outpaced the growth of our government-based patients as more of our patients are covered by commercial contracted plans. Less than 1% of our dialysis and related lab services revenues are due directly from patients. There is no single commercial payor associated with our dialysis and related lab services business that accounted for more than 10% of total dialysis and related lab services revenues for the year ended December 31, 2015.

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 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 shifts from the commercial insurance plan rates to Medicare payment rates, which are significantly lower than commercial insurance rates. Medicare payment rates are insufficient to cover our costs associated with providing dialysis services, and therefore we lose money on each Medicare treatment that we provide.

Nearly all of our net earnings from our dialysis and related lab services are derived from commercial payors, some of which pay at established contract rates and others which pay negotiated payment rates based on our usual and customary fee schedule for our out-of-network patients, which are typically higher than commercial contracted rates. If we experience a net overall 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 operating results.

Operating expenses and charges

Patient care costs. 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. The dialysis and related lab services patient care costs on a per treatment basis were $221 and $219 for 2015 and 2014, respectively. The $2 increase in the per treatment costs in 2015 as compared to 2014 was primarily attributable to higher overall pharmaceutical costs due to higher pharmaceutical unit costs, an increase in our other direct operating expenses associated with our dialysis centers, and a slight increase in

labor costs, partially offset by improvements in productivity, and lower general and professional insurance costs.

The dialysis and related lab services patient care costs on a per treatment basis were $219 and $216 for 2014 and 2013, respectively. The $3 increase in the per treatment costs in 2014 as compared to 2013 was primarily attributable to higher overall pharmaceutical costs due to an increase in intensities of physician-prescribed pharmaceuticals and higher pharmaceutical unit costs, an increase in our other direct operating expenses associated with our dialysis centers, and a slight increase in labor costs, partially offset by improvements in productivity and lower general and professional insurance costs.

General and administrative expenses. Dialysis and related lab services general and administrative expenses in 2015 increased by approximately $27 million as compared to 2014. The increase was primarily due to an increase in our labor and benefit costs and long-term compensation costs.

Dialysis and related lab services general and administrative expenses in 2014 decreased by approximately $24 million as compared to 2013. The decrease was primarily due to a decrease in our professional expenses for legal and compliance matters and for information technology initiatives, a decrease in labor costs and related payroll taxes, a decrease in travel expenses for management meetings, and the write-off of certain obsolete software costs that occurred in 2013, partially offset by higher long-term incentive compensation.

Depreciation and amortization. Dialysis and related lab services depreciation and amortization expenses for 2015 increased by approximately $35 million as compared to 2014 and increased by $47 million in 2014 as compared to 2013. The increases were primarily due to both growth through new dialysis center developments and additional informational technology initiatives.

Provision for uncollectible accounts receivable. The provision for uncollectible accounts receivable for U.S. dialysis and related lab services was 4.5% for 2015, 4.1% for 2014, and 3.5% for 2013. The increase in the provision for uncollectible accounts receivable in 2015 and 2014 was primarily due to higher write-offs of Medicare secondary billings. We currently expect the 2015 level of the provision for uncollectible accounts to continue into 2016, although it may increase if we encounter any collection issues.

Settlement charge. In June 2015, we finalized the terms of the settlement agreement with plaintiffs regarding the Vainer private civil suit, which includes a settlement amount of $450 million and attorney fees and other costs of $45 million.

Equity investment income. Equity investment income was approximately $15 million, $14 million and $12 million in 2015, 2014 and 2013, respectively. The increases in equity investment income in 2015 and 2014 were primarily due to the profitability of certain of our dialysis nonconsolidated joint ventures.

Segment operating income

Dialysis and related lab services operating income for 2015 decreased by approximately $378 million as compared to 2014, which includes a settlement charge of $495 million in 2015 and a loss contingency accrual of $17 million in 2014. Excluding these items from their respective periods, dialysis and related lab services adjusted operating income for 2015 would have increased by $100 million. The increase in the adjusted operating income for 2015 as compared to 2014 was primarily due to solid treatment growth as a result of additional dialysis treatments and an increase in the average dialysis revenue per treatment of approximately $6, as described above. In addition, dialysis and related lab services adjusted operating income also increased due to improved productivity and lower general and professional insurance costs, partially offset by higher overall pharmaceutical costs, as described above, and an increase in our provision for uncollectible accounts of $53 million.

Dialysis and related lab services operating income for 2014 increased by approximately $438 million as compared to 2013, which includes loss contingency accruals of $17 million and $397 million in 2014 and 2013, respectively. Excluding these items from their respective periods, dialysis and related lab services adjusted operating income would have increased by $58 million. The increase in the adjusted operating income for 2014 as compared to 2013 was primarily due to strong treatment growth as a result of additional dialysis treatments from non-acquired growth and acquisitions of dialysis centers, and an increase in the average dialysis revenue per treatment of approximately $2 as described above. In addition, dialysis and related lab services adjusted operating income also increased due to a decrease in professional expenses, the write-off of certain obsolete software costs that occurred in 2013 and improved productivity. Dialysis and related lab services adjusted operating income was negatively impacted by higher overall pharmaceutical costs as described above and an increase in our provision for uncollectible accounts of $72 million.

HCP business

HCP 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, 2015, HCP had approximately 807,400 members under its care in southern California, Colorado, central and south Florida, southern Nevada, central New Mexico and central Arizona through capitation contracts with some of the nation's leading health plans. Of these 807,400 members, approximately 317,400 individuals were patients enrolled in Medicare Advantage, and the remaining approximately 490,000 individuals were managed care members whose health coverage is provided through their employer or who have individually acquired health coverage directly from a health plan or as a result of their eligibility for Medicaid benefits. In addition to its managed care business, during the year ended December 31, 2015, HCP provided care in all markets to over 612,100 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.

HCP's patients as well as the patients of HCP'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, 2015, HCP delivered services to its members via a network of approximately 547 associated full-time primary care physicians, over 2,900 associated groups and other network primary care physicians, 240 network hospitals, and several thousand associated group and network specialists. Together with

hundreds of case managers, registered nurses and other care coordinators, these medical professionals utilize a comprehensive information technology system, sophisticated risk management techniques and clinical protocols to provide high-quality, cost-effective care to HCP's members. The total amount of revenue from HCP for the year ended December 31, 2015, was approximately $3.837 billion, or approximately 27.8% of our consolidated net revenues.

Key Financial Measures and Indicators

Operating revenues

HCP's consolidated revenues consist primarily of capitated revenues, including revenues attributable to capitated contracts with health plans and, to a lesser extent, revenues from patient services rendered and other operating revenues, each as described in more detail below.

HCP capitated revenues consist primarily of fees for medical services provided under capitated contracts with various health plans or under FFS arrangements with privately insured individuals. Capitation revenue derived from health plans typically results from either (i) premium payments by CMS to HCP's health plan customers under Medicare Advantage with respect to seniors, disabled and other eligible persons (which are referred to herein as HCP's senior membership), (ii) premium payments by state governments to HCP's health plan customers under Medicaid managed care programs (which are referred to herein as HCP's Medicaid membership), and (iii) premium payments from public and private employers and individuals to HCP's health plan customers with respect to their employees (which are referred to herein as HCP's commercial membership). Capitation payments under health plan contracts are made monthly based on the number of enrollees selecting an HCP associated group physician employed or associated with one of HCP's medical group entities as their primary healthcare provider. The amount of monthly capitation HCP receives from health plans on behalf of a member generally does not vary during a given calendar year, regardless of the level of actual medical services utilized by the member. As described in more detail below, in central Florida, southern Nevada and Arizona, HCP principally utilizes a global capitation model in which it assumes the financial responsibility for both professional (physician) and institutional (or hospital) services for covered benefits, whereas in New Mexico, HCP assumes the financial responsibility for professional services only. In southern California, HCP utilizes variants of a different model for capitation under which it is directly financially responsible for covered professional services, but indirectly financially responsible for covered institutional expenses. See below for further discussion regarding changes to HCP's revenue recognition for hospital services. HCP's associated medical groups also receive specified incentive payments from health plans based on specified performance and quality criteria. These amounts are accrued when earned, and the amounts can be reasonably estimated.

- Global capitation model. HCP records the aggregate global capitation PMPM fee as revenue and the amounts paid with respect to claims as medical expenses or hospital expenses, as applicable, in its combined financial statements (see "Patient Care Costs-Medical Expenses" and "Operating Expenses-Hospital Expenses" below). Revenue with respect to both professional and institutional capitation is recorded in the month in which enrollees are entitled to receive healthcare. In HCP's central Florida market, HCP also receives capitation revenue and is liable for corresponding expenses for prescription drug activity rendered on behalf of HCP's senior members through the Part D component under the Medicare Advantage program.
- Risk-sharing model. As compensation under its various managed care-related administrative services agreements with hospitals, HCP is entitled to receive a percentage of the amount by which the institutional capitation revenue received from health plans exceeds institutional expenses, and any such risk-share amount to which HCP is entitled is recorded as medical revenues. In addition, pursuant to such managed care-related administrative services agreements, HCP agrees to be responsible should the third party incur institutional expenses in excess of institutional capitation revenue. As with global capitation, revenue with respect to professional capitation is reported in the month in which enrollees are entitled to receive healthcare. However, risk-share revenues (that is, the portion of the excess or deficit of institutional capitation revenue to which HCP is entitled less institutional expenses), in contrast,

are based on the number of enrollees and estimates of institutional utilization and associated costs incurred by assigned health plan enrollees, and the amounts accrued when earned can be reasonably estimated. Differences between actual contract settlements and estimated receivables and payables are recorded in the year of final settlement. In December 2013, HCP obtained a restricted Knox-Keene license in California, which permits HCP to enter into global capitation agreements with health plans that allow HCP to assume financial responsibility for both professional and institutional services. HCP is in the process of evaluating and identifying which risk-sharing arrangements, if any, will be converted to global capitation arrangements, subject to HCP's and the applicable health plan's satisfactory negotiation and approval, as well as approval from the Department of Managed Healthcare. Completion of such evaluation and possible conversion is expected to occur over time.

- Retroactive revenue-adjustments. The Medicare Advantage revenue received by HCP's health plan customers is adjusted periodically to give effect to the relative clinical and demographic profile of the members for whom HCP is financially responsible. The model employed by CMS bases a portion of the total 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. Capitation payments under this methodology are paid at interim rates during the year and retroactive adjustments occur in subsequent periods (generally in the third quarter of the same year, with a final adjustment in the third quarter of the following year) after the data is compiled by CMS. HCP estimates the amount of the current year adjustments in revenues during the first and second quarters of any given year and adjusts its estimates during the third quarter, upon receipt of payments from CMS. Differences between actual contract settlements and estimated revenues are recorded in the year of final settlement. To date, all such adjustments have resulted in increases in revenue.
- Patient service revenues. Patient service revenues are recorded when the services are provided. Such revenues are based on a negotiated fixed-fee schedule with the applicable health plan.
- Other operating revenues. In addition to the revenues discussed above, other operating revenues primarily represents, (i) management fees HCP receives with respect to its role as the manager of its unconsolidated joint ventures, (ii) revenues from the maintenance of existing physicians' networks, (iii) revenues recognized under meaningful use programs established by federal and state governments which provide financial incentives for providers to implement and utilize electronic health record technology to improve patient care, and (iv) medical consulting revenues.

Patient care costs

HCP's largest patient care costs are the costs of medical services provided pursuant to its capitation contracts, which consist of medical expenses, hospital expenses and clinical support and other operating costs, as further described below. Under both the global capitation and the risk-share capitation models, costs of medical services are recognized in the month in which the related services are provided. In addition, medical expenses and hospital expenses include an estimate of such expenses that have been incurred but not yet reported. For further information on how HCP estimates such claims, see "Critical accounting policies, estimates and judgments–Medical liability claims associated with HCP" below.

Medical expenses. Medical expenses consist of payments for professional and ancillary services to independent primary care physicians, specialists, ancillary providers and hospitals (including, with respect to hospitals, for outpatient services) pursuant to agreements with those entities. The structure of such expenses can consist of, among other things, sub-capitation and FFS payments. In addition, medical expenses include compensation and related expenses incurred with respect to HCP's associated group primary care physicians and specialists, registered nurses, physician assistants and hospitalists.

Hospital expenses. Hospital expenses consist of payments for institutional services to contracted and non-contracted hospitals for both inpatient and outpatient services, skilled nursing facilities, and to other institutional providers. Hospital expenses are only incurred in connection with the services HCP provides in Florida, Nevada and Arizona. In those regions, as described above, HCP enters into contracts with health plans pursuant to which it assumes the risk for institutional hospital services. In contrast in California, HCP's medical groups were not permitted to contract with health plans to directly assume the risk for institutional services. Accordingly, the risk-share revenue that HCP records in California is net of reported claims and estimates of hospital utilization and associated costs incurred by assigned health plan enrollees, and no portion of institutional hospital costs incurred with respect to HCP's California operations is included in hospital expenses as presented. However, as a result of HCP obtaining a restricted Knox-Keene license in December 2013 as discussed above, HCP may now assume the risk for institutional services in California.

Clinic support and other operating costs. Clinic support and other operating costs primarily consist of the costs incurred with respect to compensation of administrative and other support staff employed at HCP's medical clinics, clinic rent and utilities, medical supplies and other direct costs incurred to support clinic operations.

Other operating expenses

General and administrative. General and administrative expenses are those costs directly related to corporate administrative functions in supporting HCP and consist primarily of salaries and benefits, professional fees and occupancy costs.

Equity investment income. HCPAMG is a 50% owner of the Magan joint venture with The Magan Medical Clinic, Inc. HCP also owns a 67% ownership interest in CMGI. HCP is a 50% owner of a joint venture with Independence Blue Cross, Tandigm Health, LLC, and is also a 50% owner of FullWell, LLC, a joint venture with Centura Health Corporation. We account for these equity investment interests under the equity method of accounting, meaning that their assets and liabilities are not consolidated with ours, but we recognize our pro rata ownership share of the entities' earnings as equity investment income.

Results of Operations

The following table reflects the results of operations for the HCP business:

	Year ended December 31,								
	2015			2014			2013		
	(dollar amounts rounded to nearest millions)								
Net revenues:									
HCP capitated revenue	$3,437	90	%	$3,191	91	%	$2,920	91	%
Patient service revenue	333	—		232	—		232	—	
Less: Provision for uncollectible accounts	(15)	—		(13)	—		(12)	—	
Net patient service revenue	318	8	%	219	6	%	220	7	%
Other revenues	82	2	%	92	3	%	56	2	%
Total net revenues	$3,837	100	%	$3,502	100	%	$3,196	100	%
Operating expenses:									
Patient care costs	$3,006	78	%	$2,796	80	%	$2,405	75	%
General and administrative expense	421	11	%	331	9	%	270	9	%
Depreciation and amortization	174	5	%	170	5	%	159	5	%
Goodwill and other intangible asset impairment charges	206	5	%	—	—		—	—	
Equity investment income	(4)	—		(10)	—		(23)	(1	%)
Total expenses	3,803	99	%	3,287	94	%	2,811	88	%
Operating income	$34	1	%	$215	6	%	$385	12	%

Capitated membership information

The table set forth below provides (i) the total number of capitated members to whom HCP provided healthcare services as of December 31, 2015, 2014 and 2013, and (ii) the aggregate member months as of December 31, 2015, 2014 and 2013. Member months represent the aggregate number of months of healthcare services HCP has provided to capitated members during a period of time.

	Members at December 31,			Member months for the year ended December 31,		
	2015	2014	2013	2015	2014	2013
Payor classification:						
Senior	317,400	310,500	265,000	3,774,300	3,587,900	2,911,700
Commercial	367,400	387,400	403,400	4,497,900	4,713,100	4,955,000
Medicaid	122,600	139,400	96,100	1,556,400	1,465,200	1,106,700

	807,400	837,300	764,500	9,828,600	9,766,200	8,973,400

In addition to the members above, HCP provided healthcare services to members in two of its operating unconsolidated joint ventures that are accounted for as equity investments. These joint ventures provided healthcare services for approximately 131,000, 45,700 and 45,100 members as of December 31, 2015, 2014 and 2013, respectively, and for approximately 1,564,200, 538,000 and 557,000 member months as of December 31, 2015, 2014 and 2013, respectively. The increase in members and member months was due to Tandigm Health beginning operations in 2015.

During the year ended December 31, 2015, HCP members decreased by approximately 29,900 and member months increased approximately 62,400. The decrease in members is due to a planned reduction in Medicaid members and a decline in commercial members as employers shift to less expensive options for medical services for their employees, partially offset by an increase in senior members due to non-acquired growth. The increase in member months was primarily attributable to an increase in senior members resulting from non-acquired growth, new acquisitions and an increase in Medicaid members due to Medicaid expansion. This increase in member months was partially offset by a planned non-renewal of certain plans in certain markets due to unfavorable economics.

During the year ended December 31, 2014, HCP members and member months increased by approximately 72,800 and 792,800, respectively. The increases in members and member months were primarily attributable to an increase in senior members resulting from non-acquired growth, new acquisitions and an increase in Medicaid members due to Medicaid expansion, partially offset by a decline in commercial members.

Revenues

The following table provides a breakdown of HCP's revenue by source:

	Year ended December 31,								
	2015			2014			2013		
	(dollars in millions)								
HCP revenues:									
Commercial revenues	$727	19	%	$726	21	%	$715	22	%
Senior revenues	2,473	65	%	2,319	66	%	2,137	67	%
Medicaid revenues	237	6	%	146	4	%	68	2	%
Total capitated revenues	3,437	90	%	3,191	91	%	2,920	91	%
Patient service revenue, net of provision for uncollectible accounts	318	8	%	219	6	%	220	7	%
Other revenues	82	2	%	92	3	%	56	2	%
Total net revenues	$3,837	100	%	$3,502	100	%	$3,196	100	%

Net revenues

HCP's net revenue for 2015 increased $335 million, or 9.6%, primarily driven by an increase in FFS revenue from acquisitions, an increase in senior capitated revenue due to an increase in the number of senior capitated members during the year that is attributable to non-acquired growth and acquisitions, an increase in Medicaid memberships due to Medicaid expansion, recognition of additional Medicaid risk-share revenue due to decreased costs related to lower claims, as well as higher commercial negotiated rates for commercial members. These increases in net revenues are partially offset by a decrease in senior capitated revenues due to the planned non-renewal of some plans due to unfavorable economics in certain markets.

HCP's net revenue for 2014 increased $306 million, or 9.6%, primarily driven by an increase in the number of senior capitated members during the year due to organic growth and acquisitions, an increase in Medicaid memberships due to Medicaid expansion and recognition of additional HCP revenue related to the maintenance of existing physician networks, partially offset by a decline in Medicare Advantage reimbursement rates, and a decline in the number of commercial members to whom HCP provides healthcare services.

On April 6, 2015, CMS issued final guidance for 2016 Medicare Advantage rates, which incorporated a modification to the risk adjustment model calculation that CMS utilizes to determine the risk acuity scores of Medicare Advantage patients. We estimate that the final cumulative impact of the 2016 rate structure will represent a decrease of approximately 2.0% of HCP's average Medicare Advantage revenues it manages on behalf of its senior capitated population as compared to 2015, which compares to the industry average rate increase of approximately 1.25% as indicated by CMS.

The more significant decline in Medicare Advantage rates for HCP compared to the industry average is driven by a larger-than-average decline associated with CMS's modification to the risk adjustment model calculations. The full implementation of the 2014 CMS-HCC Risk Adjustment model negatively affects HCP and other providers like us who have invested more heavily in wellness and prevention programs for patients with chronic conditions.

Patient care costs

The following table reflects HCP's patient care costs comprised of medical expenses, hospital expenses, clinic support and other operating costs:

	Year ended December 31,		
	2015	2014	2013
	(dollars in millions)		
Medical expenses	$1,865	$1,734	$1,545
Hospital expenses	602	586	434
Clinic support and other operating costs	539	476	426
Total	$3,006	$2,796	$2,405

Operating expenses

Patient care costs. HCP's patient care costs for 2015 increased by approximately $210 million from 2014. The increase was primarily attributable to increases in medical claim expenses and hospital expenses due to increases in senior and Medicaid member months from acquisitions, non-acquired growth, Medicaid expansion, as well as market expansion and the timing of the recognition of additional benefit expense related to higher Medicaid risk sharing revenues. The increase was also driven by an increase in clinic support costs due to acquisitions. The increase in costs was partially offset by a decrease in commercial members to whom HCP provides healthcare services and a decrease in costs due to the planned non-renewal of some plans due to unfavorable economics in certain markets.

HCP's patient care costs for 2014 increased by approximately $391 million from 2013. The increase was primarily attributable to increases in medical claim expenses and hospital expenses due to increases in senior and Medicaid memberships from acquisitions, non-acquired growth, Medicaid expansion, and an increase in utilization. The increase was also driven by an increase in clinic support costs due to acquisitions.

General and administrative expenses. HCP's general and administrative costs for 2015 increased $90 million from 2014. The increase was primarily attributable to an increase in corporate administrative support costs related to growth initiatives, professional fees, recognition of additional compensation expense, and travel costs.

HCP's general and administrative costs for 2014 increased $61 million from 2013. The increase was primarily attributable to an increase in corporate administrative support departments to accommodate additional acquisitions during 2014, an increase in utilization of professional services related to IT infrastructure projects and management bonuses related to retention of key personnel.

Depreciation and amortization. HCP's depreciation and amortization for 2015 increased $4 million from 2014. The increase is primarily attributable to depreciation and amortization of assets associated with acquisitions.

HCP's depreciation and amortization for 2014 increased $11 million from 2013. The increase is primarily attributable to depreciation and amortization of assets associated with acquisitions.

Goodwill and other intangible asset impairment charges. During the quarter ended December 31, 2015, we determined that circumstances indicated it had become more likely than not that the goodwill and an indefinite-lived intangible

asset of certain HCP reporting units had become impaired. These circumstances included underperformance of the business in recent quarters, as well as changes in other market conditions, including government reimbursement cuts and our expected ability to mitigate them. We are performing the required valuation of these reporting units and have estimated the fair value of their net assets and implied goodwill with the assistance of a third-party valuation firm. Based on the current assessments, we recorded an estimated $206 million in goodwill and other intangible asset impairment charges. The final amount of these impairment charges will depend upon the final outcome of this valuation work, which we expect will be completed in the first quarter of 2016.

Equity investment income. HCP's share of equity investment income from our unconsolidated joint venture relationships for 2015 decreased $6 million from 2014. The decrease in equity income is primarily attributable to our share of expenses from a certain newly formed joint venture that provides integrated healthcare and reduced commercial risk pool performance.

HCP's share of equity investment income from our joint venture relationships for 2014 decreased $13 million from 2013. The decrease in equity income is primarily attributable to our share of initial expenses of a newly formed joint venture and increased professional capitation costs related to our other joint venture.

Segment operating income

HCP's operating income for 2015 decreased $181 million, including estimated goodwill and other intangible asset impairment charges of $206 million in 2015 related to certain reporting units. Excluding the impairment charges from 2015, adjusted HCP operating income for the year ended December 31, 2015 would have increased by approximately $25 million, or 11.6%. The increase in adjusted HCP operating income was primarily attributable to an increase in FFS revenue from acquisitions and non-acquired growth, an increase in Medicaid members due to Medicaid expansion, the timing of recognition of additional Medicare risk share revenue and a reduction of claims expense due to the planned non-renewal of some plans due to unfavorable economics in certain markets. This increase was partially offset by a decrease in commercial members, and higher general and administrative costs.

HCP's operating income for 2014 decreased $170 million. The decrease was primarily attributable to a decrease in Medicare Advantage rates, a decrease in commercial memberships and higher medical expenses, partially offset by an increase in Medicare and Medicaid revenues due to increases in senior capitated members from acquisitions and Medicaid expansion.

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, 2015, these consisted primarily of pharmacy services, disease management services, vascular access services, clinical research programs, physician services, direct primary care and our international dialysis operations. The ancillary services and strategic initiatives generated approximately $1.382 billion of net revenues in 2015, representing approximately 10% of our consolidated net revenues. We currently expect to continue to invest in our ancillary services and strategic initiatives including our continued expansion into certain international markets as we work to develop successful new business operations. However, any significant change in market conditions, business performance or in the regulatory environment may impact the economic viability of any of these strategic initiatives. Any unfavorable changes in these strategic initiatives could result in a write-off or an impairment of some or all of our investments, including goodwill, and could also result in significant termination costs if we were to exit a certain line of business or one or more of our international markets.

As of December 31, 2015, we provided dialysis and administrative services to a total of 118 outpatient dialysis centers located in ten countries outside of the U.S., and we owned a minority equity investment in a primary care and multi-specialty chain in India. Our international dialysis operations are still in an early phase of development as we primarily commenced operations during the fourth quarter of 2011. The total net revenues generated from our international operations, as reflected below, were approximately 1% of our 2015 consolidated net revenues.

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

	Year ended December 31,		
	2015	2014	2013
	(dollar amounts rounded to nearest million)		
U.S. revenues			

Net patient service revenues	$26	$20	$15
Other revenues	1,144	941	703
Capitated revenues	72	70	67
Total	1,242	1,031	785
International revenues			
Net patient service revenues	134	102	61
Other revenues	6	6	6
Total	140	108	67
Total net revenues	$1,382	$1,139	$852
Total segment operating loss	$(104)	$(25)	$(39)

Net revenues

The ancillary services and strategic initiatives net revenues for 2015 increased by approximately $243 million, or 21.3%, as compared to 2014. The increase was primarily related to an increase in pharmacy services volume and pharmaceutical rates, as well as an increase in net revenues from growth in our international business and other strategic initiatives. These increases were partially offset by an increase in reserves for refunds of prior period pharmacy reimbursements.

The ancillary services and strategic initiatives net revenues for 2014 increased by approximately $287 million, or 33.7%, as compared to 2013, primarily from growth in prescriptions dispensed, increases in other pharmacy services revenue and growth in our international operations.

Operating expenses

Ancillary services and strategic initiatives operating expenses for 2015 increased by approximately $322 million from 2014 which includes an estimated accrual for damages and liabilities associated with our pharmacy business of $22 million, as well as a goodwill impairment charge of $4 million related to one of our international reporting units during the second quarter of 2015. Excluding these items from 2015, the ancillary services and strategic initiatives adjusted operating expenses would have increased by $296 million. The increase in adjusted operating expenses was primarily due to an increase in prescription dispensing volume, higher pharmaceutical costs, higher labor costs and related payroll taxes and benefit costs, additional expenses associated with our international dialysis expansion, and an increase in costs associated with the right to use intellectual property and general and administrative and corporate administrative support expenses.

Ancillary services and strategic initiatives operating expenses for 2014 increased by approximately $273 million from 2013. The increase in operating expenses was primarily due to an increase in prescription dispensing volume and costs in our pharmacy business, an increase in expenses associated with our international dialysis expansion into Europe, Middle East, South America and Asia Pacific, higher labor costs and related payroll taxes, an increase in benefit costs and an increase in business related licensing and the right to use newly developed intellectual property and corporate administrative support expenses.

Operating loss

Ancillary services and strategic initiatives operating losses for 2015 increased by approximately $79 million from 2014 which includes an estimated accrual for damages and liabilities of $22 million, as well as a goodwill impairment charge of $4 million related to our international operations during the second quarter of 2015. Excluding these items from 2015, the ancillary services and strategic initiatives adjusted operating losses would have increased by $53 million. This increase in adjusted operating losses was primarily due to an increase in drug prescription costs associated with our pharmacy business, higher labor costs, increases in expenses related to our international expansion, an increase in costs associated with the right to use intellectual property and an increase in general and administrative costs. The increase in adjusted operating losses was partially offset by an increase in net revenue in our pharmacy business, primarily from additional volume and increases in pharmaceutical rates.

Ancillary services and strategic initiatives operating losses for 2014 decreased by approximately $14 million from 2013. This decrease in operating losses was primarily due to improved operating performance of our pharmacy business related to increased prescriptions dispensed and pharmacy services rendered, partially offset by an increase in labor costs and related payroll taxes, an increase in benefit costs and an increase in costs associated with international dialysis expansion.

Corporate level charges

Debt expense. Debt expense for 2015, 2014, and 2013 consisted of interest expense of approximately $390 million, $386 million, and $401 million, respectively, and the amortization and accretion of debt discounts and premiums, the amortization of deferred financing costs and the amortization of interest rate cap agreements of approximately $18 million in 2015, $25 million in 2014 and $29 million in 2013. The increase in debt expense in 2015 as compared to 2014, was primarily related to an increase in weighted average outstanding principal balances offset by lower weighted average interest rates as a result of the issuance of our 5.0% Senior Notes in April 2015, as well as the entry

into a new credit agreement and the issuance of senior notes in June 2014, as discussed below. Our overall weighted average effective interest rate in 2015 was 4.42% as compared to 4.68% in 2014.

The decrease in debt expense in 2014 as compared to 2013 was primarily related to our credit agreement issued in June 2014, as well as the issuance of our 5 % Senior Notes that were entered into in the second quarter of 2014 that contain lower weighted average interest rates and from lower average interest rates associated with the unhedged portion of Term Loan A. Our overall weighted average effective interest rate in 2014 was 4.68% as compared to 4.84% in 2013.

Other income. Other income was approximately $9 million, $2 million, and $5 million in 2015, 2014, and 2013, respectively, and consisted principally of interest income. Other income increased in 2015 as compared to 2014 due to an increase in short-term investment interest income and a decrease in foreign currency transaction losses. Other income in 2014 decreased from 2013, primarily as a result of the impact of certain foreign currency transactions, partially offset by an increase in short-term investment interest income.

Provision for income taxes. The provision for income taxes for 2015 represented an effective annualized tax rate of 40.9%, compared with 34.1% and 33.9% of income from continuing operations in 2014 and 2013, respectively. The effective tax rate in 2015 was higher primarily due to the impairment of goodwill in 2015.

Noncontrolling interests

Net income attributable to noncontrolling interests for 2015, 2014 and 2013 was approximately $158 million, $140 million and $124 million, respectively. The increases in noncontrolling interests in 2015 and 2014 were primarily due to increases in the number of new joint ventures and increases in the profitability of our dialysis-related joint ventures. The percentage of U.S. dialysis and related lab services net revenues generated from dialysis-related joint ventures was approximately 23%, 22% and 21% in 2015, 2014 and 2013, respectively.

Accounts receivable

Our U.S. dialysis and related lab services accounts receivable balances at December 31, 2015 and December 31, 2014 were $1.255 billion and $1.157 billion, respectively, representing approximately 53 days and 50 days of revenue, respectively, net of bad debt provision. The increase in day sales outstanding (DSO) for the U.S. dialysis and related lab services business, was primarily the result of the continued rollout of our billing system in 2015, as well as improved cash collection performance in 2014 that positively impacted the DSO in 2014 which we did not experience in 2015. Our DSO calculation is based on the current quarter’s average revenues per day.

As of December 31, 2015 and 2014, our dialysis and related lab services unreserved accounts receivable balances that were more than six months old were approximately $233 million and $152 million, respectively, representing approximately 18% and 13% of our dialysis accounts receivable balances, respectively. There were no significant unreserved balances over one year old. Less than 1% of our revenues are classified as patient pay. Substantially all revenue realized is from government and commercial payors, as discussed above.

Amounts pending approval from third-party payors as of December 31, 2015 and 2014, other than the standard monthly billing, consisted of approximately $106 million in 2015 and $119 million in 2014, associated with Medicare bad debt claims, classified as other receivables. Currently, a significant portion of our Medicare bad debt claims are typically paid to us before the Medicare fiscal intermediary audits the claims. However, the payment received from Medicare is subject to adjustment based upon the actual results of the audits. Such audits typically occur one to four years after the claims are filed. As a kidney dialysis provider, our revenue is not subject to cost report settlements, except for potentially limiting the collectability of these Medicare bad debt claims.

Liquidity and capital resources

Available liquidity. As of December 31, 2015, our cash balance was $1.5 billion and we also had approximately $408 million in short-term investments. We also had an undrawn revolving line of credit under our Senior Secured Credit Facilities totaling $1.0 billion, of which approximately $92.2 million was committed for outstanding letters of credit. In addition, HCP has an outstanding letter of credit of approximately $1.3 million that is secured by a certificate of deposit. We believe that we will have sufficient liquidity, operating cash flows and access to borrowings to fund our scheduled debt service payments and other obligations for the foreseeable future. Our primary sources of liquidity are cash from operations and cash from borrowings.

Cash flow from operations during 2015 amounted to $1.6 billion, compared with $1.5 billion for 2014. The increase in our operating cash flows in 2015 as compared to 2014 was primarily due to the timing of other working capital items, a decrease in our income tax payments and a reduction in our net settlement payments and charges, offset by an increase in our cash interest payments. Cash flow from operations in 2015 included cash interest payments of

approximately $405 million and cash tax payments of $156 million. Cash flow from operations in 2014 included cash interest payments of approximately $352 million and cash tax payments of $239 million.

Non-operating cash outflows in 2015 included $708 million for capital asset expenditures, including $381 million for new center developments and relocations, and $327 million for maintenance and information technology. We also spent an additional $97 million for acquisitions. During 2015, we also received $1.6 billion from the maturity and sale of investments. However, some of these proceeds were either used to repurchase other investments or were used to fund distributions from our deferred compensation plans. In addition, during 2015, we received $54 million associated with stock option exercises and other share issuances and the related excess tax benefits. We also made distributions to noncontrolling interests of $175 million, and received contributions from noncontrolling interests of $55 million associated with new joint ventures and from additional equity contributions. We also repurchased a total of 7,779,958 shares of our common stock for $575 million, or an average price of $73.96 per share, of which $25 million was unsettled at December 31, 2015.

Non-operating cash outflows in 2014 included $641 million for capital asset expenditures, including $376 million for new center developments and relocations, and $265 million for maintenance and information technology. We also spent an additional $272 million for acquisitions. During 2014, we also received $144 million from the maturity and sale of investments. However, some of these proceeds were either used to repurchase other investments or were used to fund distributions from our deferred compensation plans. In addition, during 2014, we received $65 million associated with stock option exercises and other share issuances and the related excess tax benefits. We also made distributions to noncontrolling interests of $149 million, and received contributions from noncontrolling interests of $65 million associated with new joint ventures and from additional equity contributions. We did not repurchase any shares of our common stock in 2014.

On August 17, 2015, we entered into a definitive agreement to acquire Colorado-based Renal Ventures Limited, LLC (Renal Ventures), including a 100% interest in all dialysis centers owned by Renal Ventures, for approximately $415 million in cash, subject to, among other things, adjustments for certain items such as working capital. Renal Ventures currently operates 36 dialysis clinics in six states serving approximately 2,400 patients, and also operates other ancillary businesses. The transaction is subject to approval by the Federal Trade Commission (FTC) including Hart-Scott-Rodino antitrust clearance. We anticipate that we will be required by the FTC to divest a certain number of outpatient dialysis centers as a condition of the transaction. We currently expect this transaction to close in 2016.

On November 23, 2015, we entered into a definitive merger agreement to acquire The Everett Clinic Medical Group (TEC), a Washington state physician group, for approximately $385 million in cash, subject to, among other things, adjustments for certain items such as working capital. TEC has 500 providers in primary and specialty care locations throughout Snohomish County, Washington who care for more than 315,000 patients. We currently expect this transaction to close in early 2016.

During 2015, we opened 72 new U.S. dialysis centers, acquired a total of six U.S. dialysis centers, sold one center, merged five centers, added two centers in which we operate under a management and administrative services agreement and closed two centers. Outside the U.S., we acquired 21 dialysis centers, opened seven new dialysis and hospital operated centers, and terminated one management and administration services agreement.

During 2015, our HCP business acquired three family practices, one management services organization, two primary care practices, and six private medical practices.

During the year ended December 31, 2015, we made mandatory principal payments under our Senior Secured Credit Facilities totaling $50 million on the Term Loan A and $35 million on the Term Loan B.

During 2014, we opened 105 new U.S. dialysis centers, acquired a total of 18 U.S. dialysis centers, sold one center, merged 16 centers and closed one center. Outside the U.S., we acquired seven dialysis centers, opened 11 new dialysis and hospital operated centers, closed two dialysis centers and added a net two centers in which we operate under management and administration services agreements. During 2014, our HCP business acquired a family practice, a management services organization, two primary care practices, and eight private medical practices.

Debt transactions

In April 2015, we issued $1.5 billion 5.0% Senior Notes due 2025 (5.0% Senior Notes). The 5.0% Senior Notes pay interest on May 1 and November 1 of each year beginning November 1, 2015. The 5.0% Senior Notes are unsecured senior obligations and rank equally in right of payment with our existing and future unsecured senior indebtedness. The 5.0% Senior Notes are guaranteed by certain of our domestic subsidiaries. We may redeem up to 35% of the 5.0% Senior Notes at any time prior to May 1, 2018 at a certain specified price from the proceeds of one or more equity offerings. In addition, we may redeem some or all of the 5.0% Senior Notes at any time prior to May 1, 2020 at make

whole redemption rates and on or after such date at certain specified redemption prices. The net proceeds from the 5.0% Senior Notes offering were used to repurchase all of the outstanding $775 million aggregate principal amount of 6 % Senior Notes due 2020 (6 % Senior Notes) through a combination of a tender offer and a redemption process and to pay fees and expenses. The remaining net offering proceeds will be used for general corporate purposes, future acquisitions and share repurchases. As a result of these transactions, we incurred $48 million in debt redemption charges consisting of tender and redemption premiums as well as the write-off of deferred financing fees associated with the repurchase of the 6 % Senior Notes.

Interest rate swap and cap agreements

As of December 31, 2015, we maintain several interest rate swap agreements that were entered into in March 2013 with amortizing notional amounts of these swap agreements totaling $760 million. These agreements have the economic effect of modifying the LIBOR variable component of our interest rate on an equivalent amount of our Term Loan A to fixed rates ranging from 0.49% to 0.52%, resulting in an overall weighted average effective interest rate of 2.26%, including the Term Loan A margin of 1.75%. The overall weighted average effective interest rate also includes the effects of $165 million of unhedged Term Loan A debt that bears interest at LIBOR plus an interest rate margin of 1.75%. The swap agreements expire on September 30, 2016 and require monthly interest payments. During the year ended December 31, 2015, we recognized debt expense of $2.7 million from these swaps. As of December 31, 2015, the total fair value of these swap agreements was a net asset of approximately $0.5 million. During the year ended December 31, 2015, we recorded a loss of $4.0 million in other comprehensive income due to a decrease in the unrealized fair value of these swap agreements. We estimate that approximately $0.5 million of existing unrealized pre-tax gains in other comprehensive income at December 31, 2015 will be reclassified into income over the next twelve months.

As of December 31, 2015, we maintain several forward interest rate cap agreements that were entered into in October 2015 with notional amounts totaling $3.5 billion. These forward cap agreements will be effective June 29, 2018 and will 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. These cap agreements expire on June 30, 2020. As of December 31, 2015, the total fair value of these cap agreements was an asset of approximately $13.8 million. During the year ended December 31, 2015, we recorded a loss of $3.5 million in other comprehensive income due to a decrease in the unrealized fair value of these cap agreements.

As of December 31, 2015, we maintain several forward interest rate cap agreements that were entered into in November 2014 with notional amounts totaling $3.5 billion. These forward cap agreements will be effective September 30, 2016 and will 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. The cap agreements expire on June 30, 2018. As of December 31, 2015, the total fair value of these cap agreements was an asset of approximately $1.3 million. During the year ended December 31, 2015, we recorded a loss of $11.0 million in other comprehensive income due to a decrease in the unrealized fair value of these cap agreements.

As of December 31, 2015, we maintain several interest rate cap agreements that were entered into in March 2013 with notional amounts totaling $2.7 billion on our Term Loan B debt. These agreements have the economic effect of capping the LIBOR variable component of our interest rate at a maximum of 2.50% on an equivalent amount of our Term Loan B. During the year ended December 31, 2015, we recognized debt expense of $2.4 million from these caps. The cap agreements expire on September 30, 2016. As of December 31, 2015, the total fair value of these cap agreements was immaterial. During the year ended December 31, 2015, we recorded a loss of $1.6 million in other comprehensive income due to a decrease in the unrealized fair value of these cap agreements.

Other items

As a result of an embedded LIBOR floor on the Term Loan B debt agreement and the swap and cap agreements, our overall weighted average effective interest rate on the Senior Secured Credit Facilities was 3.46%, based on the current margins in effect of 1.75% for the Term Loan A and 2.75% for the Term Loan B, as of December 31, 2015.

As of December 31, 2015, the interest rate on our Term Loan B debt is effectively fixed subject to an embedded LIBOR floor which is higher than actual LIBOR as of such date and the Term Loan B is also subject to an interest rate cap if LIBOR should rise above 2.50%. Interest rates on our senior notes are fixed by their terms. The LIBOR variable

component of our interest rate on the majority of our Term Loan A is economically fixed as a result of interest rate swaps.

Our overall weighted average effective interest rate during the year ended December 31, 2015 was 4.42% and as of December 31, 2015 was 4.39%.

As of December 31, 2015, we had undrawn revolving credit facilities totaling $1.0 billion of which approximately $92.2 million was committed for outstanding letters of credit. The remaining amount is unencumbered. In addition, HCP has an outstanding letter of credit of approximately $1.3 million that is secured by a certificate of deposit.

Goodwill and indefinite-lived intangible assets

During the quarter ended December 31, 2015, we determined that circumstances indicated it had become more likely than not that the goodwill and an indefinite-lived intangible asset of certain HCP reporting units had become impaired.

These circumstances included underperformance of the business in recent quarters, as well as changes in other market conditions, including government reimbursement cuts and our expected ability to mitigate them. We are performing the required

valuation of certain HCP reporting units and have estimated the fair value of their net assets and implied goodwill with the assistance of a third-party valuation firm. Based on our current assessments, we recorded an estimated $206 million in non-cash goodwill and other intangible asset impairment charges of certain HCP reporting units. The final amount of these impairment charges will depend upon the final outcome of this valuation work, which we expect will be completed in the first quarter of 2016.

Our HCP Nevada, HCP Florida, HCP Colorado and Kidney Care Malaysia reporting units remain at risk of further goodwill impairment. As of December 31, 2015, these reporting units have goodwill amounts of $424,468, $530,075, $16,897, and $13,329, respectively. As of December 31, 2015, the estimated fair values of the HCP Nevada, HCP Florida, HCP Colorado and Kidney Care Malaysia reporting units exceeded (fell short of) from their total carrying amounts by approximately (3.4)%, 0.7%, 9.5% and 11.2%, respectively.

For our at-risk HCP reporting units, further reductions in reimbursement rates or other significant adverse changes in expected future cash flows or valuation assumptions could result in further goodwill impairment charges in the future. For example, a sustained, long-term reduction of 3% in operating income for HCP Nevada or HCP Florida could reduce their estimated fair values by up to 2.0% and 1.6%, respectively. Separately, an increase in their respective discount rates of 100 basis points could reduce the estimated fair values of HCP Nevada and HCP Florida by up to 2.9% and 2.8%, respectively.

In addition, we recorded a $4 million impairment charge related to one of our international reporting units.

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 the dialysis and related lab services business, the HCP business, corporate administrative support, and the ancillary services and strategic initiatives.

Our stock-based compensation awards are measured at their estimated fair values on the date of grant if settled in shares or at their estimated fair values at the end of each reporting period if settled in cash. The value of stock-based awards so measured is recognized as compensation expense on a cumulative straight-line basis over the vesting terms of the awards, adjusted for expected forfeitures.

During 2015, we granted approximately 994 thousand stock-settled stock appreciation rights (SSARs) with an aggregate grant-date fair value of $17.9 million and a weighted-average expected life of approximately 4.1 years and approximately 279 thousand stock units with an aggregate grant-date fair value of $22.4 million and a weighted-average expected life of approximately 3.1 years.

Long-term incentive compensation costs of $130.7 million for the year ended December 31, 2015 increased by approximately $11.7 million as compared to 2014. The increase in long-term incentive compensation was primarily due to an increase in the value of LTIP awards that contributed expense during this period and LTIP award forfeitures realized at a lower rate than previously expected.

Long-term incentive compensation costs in 2014 increased by approximately $34.1 million as compared to 2013, primarily due to an increase in the value of LTIP awards that contributed expense during this period and LTIP award forfeitures realized at a lower rate than previously expected.

As of December 31, 2015, there was $124.0 million in total estimated but unrecognized long-term incentive compensation costs for LTIP awards outstanding, including $63.6 million relating to stock-based awards under our equity compensation plans. We expect to recognize the performance-based cash component of these LTIP costs over a weighted average remaining period of 1.0 years and the stock-based component of these LTIP costs over a weighted average remaining period of 1.3 years.

For the years ended December 31, 2015, 2014 and 2013, we received $45.7 million, $59.1 million and $46.9 million, respectively, in actual tax benefits upon the exercise of stock awards. As a result of issuing SSARs, beginning in 2013 we no longer have stock options outstanding and did not receive cash proceeds from stock option exercises during the years ended December 31, 2015, 2014 and 2013.

Stock repurchases

In 2015, we repurchased a total of 7,779,958 shares of our common stock for $575 million, or an average price of $73.96 per share. We also repurchased a total of 3,689,738 shares of our common stock for $249 million, or an average price of $67.61 per share, during January 2016.

On April 14, 2015, our Board of Directors approved additional share repurchases in the amount of $726 million. These approved share repurchases are in addition to the $274 million remaining at that time under our Board of Directors’ prior share repurchase

approval announced in November 2010. As a result of the above transactions, there was approximately $259 million available under our current Board authorizations for additional share repurchases as of January 31, 2016. Our share repurchase authorizations have no expiration dates. However, we are subject to share repurchase limitations under the terms of our Senior Secured Credit Facility 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, non-owned and minority-owned entities. These obligations are in the form of put provisions and 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' noncontrolling interests at either the appraised fair market value or a predetermined multiple of earnings or cash flow attributable to the noncontrolling 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 the noncontrolling interests subject to put provisions is 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' noncontrolling 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 centers in which we own a minority equity investment as well as to physician-owned vascular access clinics or medical practices that we operate under management and administrative services agreements. We have certain other potential commitments related to service agreements of approximately $5.6 million.

The following is a summary of these contractual obligations and commitments as of December 31, 2015 (in millions):

	Less Than 1 year	2-3 years	4-5 years	After 5 years	Total
Scheduled payments under contractual obligations:					
Long-term debt	$113	$284	$765	$7,781	$8,943
Interest payments on the senior notes	237	473	473	840	2,023
Interest payments on the Term Loan B[(1)]	122	240	235	58	655

Interest payments on the Term Loan A[2]	20	35	7	—	62
Capital lease obligations	16	35	41	191	283
Operating leases	432	791	615	1,084	2,922
	$940	$1,858	$2,136	$9,954	$14,888
Potential cash requirements under existing commitments:					
Letters of credit	$94	$—	$—	$—	$94
Noncontrolling interests subject to put provisions	501	126	128	109	864
Non-owned and minority owned put provisions	47	—	—	—	47
Operating capital advances	6	—	—	—	6
	$648	$126	$128	$109	$1,011

(1) Assuming no changes to LIBOR-based interest rates as the Term Loan B currently bears interest at LIBOR (floor of 0.75%) plus an interest rate margin of 2.75%.

(2) Based upon current LIBOR-based interest rates in effect at December 31, 2015 plus an interest rate margin of 1.75% for the Term Loan A.

The pay-fixed swap's obligations represent the estimated fair market values of our interest rate swap agreements that are based upon valuation models utilizing the income approach and commonly accepted valuation techniques that use inputs from closing prices for similar assets and liabilities in active markets as well as other relevant observable market inputs and other current market conditions that existed as of December 31, 2015. Currently all of our swaps are in an asset position. However, we could have a potential obligation that we would be required to pay based upon the estimated future settlement of each specific tranche over the term of the swap agreements, assuming no future changes in the forward yield curve if we were required to pay an amount in excess of what we would receive. The actual amount of our obligation associated with these swaps in the future will depend upon changes in the LIBOR-based interest rates that can fluctuate significantly depending upon market conditions, and other relevant factors that can affect the fair market value of these swap agreements.

We are committed to purchase a certain amount of our hemodialysis non-equipment product supplies, such as dialyzers, from Baxter at fixed prices through 2018.

In January 2010, we entered into and subsequently extended an agreement with FMC to purchase a certain amount of dialysis equipment, parts and supplies from FMC through February 29, 2016. We are currently renegotiating this agreement to extend the period of the agreement and to finalize the costs of our dialysis products. Our total expenditures for the year ended December 31, 2015 on such products were approximately 2% of our total U.S. operating expenses. 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.

In November 2011, we entered into a seven year Sourcing and Supply Agreement with Amgen that expires on December 31, 2018. Under the terms of the agreement we will purchase EPO in amounts necessary to meet no less than 90% of our requirements for ESAs. The actual amount of EPO that we will purchase from Amgen 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 $51 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 that, 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.

As of December 31, 2015, if these physician groups were not consolidated in our financial statements, our consolidated indebtedness would have been approximately $9.226 billion, our consolidated other liabilities (excluding indebtedness) would have been approximately $3.056 billion and our consolidated assets would have been approximately $17.956 billion. If these physician groups were not consolidated in our financial statements for the year ended December 31, 2015, our consolidated total net revenues (including approximately $650 million of management fees payable to us), consolidated operating income and consolidated net income would be reduced by approximately $1.132 billion, $82 million, and $52 million, respectively.

In addition, we own a 67% equity interest in CMGI, which is an Unrestricted Subsidiary as defined in the indentures governing our outstanding senior notes, and does not guarantee those senior notes. Our 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 as equity investment income.

For the year ended December 31, 2015, excluding our equity investment income attributable to CMGI, our consolidated operating income and consolidated net income would be decreased by approximately $13 thousand and $8 thousand, respectively. See Note 29 to the consolidated financial statements for further details.

Contingencies

The information in Note 17 to the consolidated financial statements of 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. 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 or other long-lived assets, accounting for income taxes, quarterly and annual variable compensation accruals, consolidation of variable interest entities, purchase accounting valuation estimates, fair value estimates, stock-based compensation and medical liability claims 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. Effective January 1, 2011, our dialysis related reimbursements from Medicare became subject to certain variations under Medicare’s new 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 new single bundled payment rate system, our revenue recognition is now 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 180,000 U.S. patients at any point in time, together with the changes in patient coverage’s 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 our range of dialysis and related lab services revenues estimating risk to be within 1% of its revenue, which can represent as much as 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.

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

HCP revenue recognition. HCP revenues consist primarily of fees for medical services provided under capitated contracts with various health plans and under risk-sharing programs. Revenues with respect to both professional and institutional capitation are recognized in the month in which enrollees are entitled to receive healthcare and are based on the number of enrollees selecting an HCP associated group physician employed or affiliated with one of HCP's medical group entities as their primary healthcare provider. Capitation payments received for enrollees under Medicare Advantage plans are subject to retroactive adjustment depending upon certain clinical and demographic factors. We estimate the amount of current year adjustments in revenues during the first and second quarters of any given year and adjust our estimates during the third quarter upon receipt of payments from CMS related to prior year. Any difference between actual contract settlements and estimated revenues are recorded in the year of final settlement.

In addition, as compensation under HCP's various managed care-related agreements with hospitals, we are entitled to receive a percentage of the amount by which the institutional capitation revenue received from health plans exceeds institutional expenses, and any such risk-share amount to which we are entitled is recorded as HCP revenues. In addition, pursuant to such managed care-related agreements, HCP agrees to be responsible should the third party incur a deficit as a result of institutional expenses being in excess of institutional capitation revenue. As with global capitation, revenue with respect to professional capitation is reported in the month in which enrollees are entitled to receive healthcare. However, risk-share revenues (that is, the portion of the excess of institutional capitation revenue to which HCP is entitled less institutional expenses), in contrast, are based on the number of enrollees and significant estimating risk relating to institutional utilization and associated costs incurred by assigned health plan enrollees. The medical groups also receive other incentive payments from health plans based on specified performance and quality criteria and the amounts accrued when earned can be reasonably estimated. Differences between actual contract settlements and estimated receivables and payables are recorded in the year of final settlement. In 2013, HCP obtained a restricted Knox-Keene license in California, which now permits HCP to enter into contracts with health plans allowing it to recognize revenue under global capitation arrangements for both professional and institutional services.

Impairments of long-lived assets. We account for impairments of long-lived assets, which include property and equipment, equity investments in non-consolidated businesses, amortizable intangible assets, indefinite-lived intangible assets and goodwill, in accordance with the provisions of applicable accounting guidance. Goodwill is not amortized, but is assessed for valuation impairment as circumstances warrant and at least annually. An impairment charge would be recorded to the extent that the carrying amount of a reporting unit's goodwill exceeds its implied fair value. Impairment reviews on other long-lived assets are also performed at least annually and whenever a change in condition occurs which indicates that the carrying amounts of assets may not be recoverable.

Such changes include changes in our business strategies and plans, changes in the quality or structure of our relationships with our partners, changes in reimbursement rates, deteriorating operating performance of individual dialysis centers or other operations. We use a variety of factors to assess the realizable value of assets depending on their nature and use. Such assessments are primarily based upon the sum of expected future undiscounted net cash flows over the expected period the asset will be utilized, as well as market values and conditions. The computation of expected future undiscounted net cash flows can be complex and involves a number of subjective assumptions. Any changes in these factors or assumptions could impact the assessed value of an asset and result in an impairment charge equal to the amount by which its carrying value exceeds its actual or estimated fair value.

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. Significant judgments and estimates are required in determining the 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, and results of recent operations, assumptions about the amount of future state, federal, and foreign pre-tax operating income adjusted for items that do not have tax consequences. The assumptions about future taxable income require significant judgment and are consistent with the plans and estimates we are using 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.

Variable compensation accruals. We estimate variable compensation accruals quarterly based upon the amounts expected to be earned and paid out resulting from the achievement of certain teammate-specific and/or corporate

financial and operating goals. Our estimates, which include compensation incentives for bonuses and other awards, including long-term incentive programs, are updated periodically based on changes in our economic condition or cash flows that could ultimately impact the actual final award. Actual results reflected in each fiscal quarter may vary due to the subjectivity involved in anticipating fulfillment of specific and/or corporate goals, as well as the final determination and approval of amounts by our Board of Directors, as applicable.

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 significant 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.

Purchase accounting valuation estimates. We make various assumptions and estimates regarding the valuation of tangible and intangible assets, liabilities, contingent earn-out consideration, noncontrolling interests and contractual as well as non-contractual contingencies associated with our acquisitions. These assumptions can have a material effect on our balance sheet valuations and the related amount of depreciation and amortization expense and any contingent earn-out adjustments that will be recognized in the future.

Fair value estimates. We have recorded certain assets, liabilities and noncontrolling interests (temporary equity) subject to put provisions at fair value. The FASB defines fair value which is measured based upon certain valuation techniques that include inputs and assumptions that market participants would use in pricing assets, liabilities and noncontrolling interests subject to put provisions. We have measured the fair values of our applicable assets, liabilities and noncontrolling interests subject to put provisions based upon certain market inputs and assumptions that are either observable or unobservable in determining fair values and have also classified these assets, liabilities and noncontrolling interests subject to put provisions into the appropriate fair value hierarchy levels. The fair value of our investments available for sale are based upon quoted market prices from active markets and the fair value of our swap and cap agreements were based upon valuation models utilizing the income approach and commonly accepted valuation techniques that use inputs from closing prices for similar assets and liabilities in active markets as well as other relevant observable market inputs at quoted intervals such as current interest rates, forward yield curves, implied volatility and credit default swap pricing. The fair value of funds on deposit with third parties are based primarily on quoted close or bid market prices of the same or similar assets. The fair value of our contingent earn-out considerations were primarily based upon unobservable inputs including projected EBITDA, the estimated probabilities of achieving other performance targets and the estimated probability of the earn-out payments being made by using option pricing techniques and simulation models of expected EBITDA and operating income and other performance targets. For our noncontrolling interests subject to put provisions we have estimated the fair values of these based upon either the higher of 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 estimate of the fair values of the noncontrolling interests subject to put provisions 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 the noncontrolling interests subject to put provisions can also fluctuate and the implicit multiple of earnings at which these noncontrolling interests obligations may be settled will vary 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' noncontrolling interests.

Stock-based compensation. Stock-based compensation awards are measured at their estimated fair values on the date of grant if settled in shares or at their estimated fair values at the end of each reporting period if settled in cash. The value of stock-based awards so measured is recognized as compensation expense on a cumulative straight-line basis over the vesting terms of the awards, adjusted for expected forfeitures. We estimate the fair value of stock awards using complex option pricing models that rely heavily on estimates from us about uncertain future events, including the expected term of the awards, the expected future volatility of our stock price, and expected future risk-free interest rates.

Medical liability claims associated with HCP. The medical groups are responsible for the medical services that associated physicians and contracted hospitals provide to assigned HMO enrollees. We provide medical services to health plan enrollees through a network of contracted providers under sub-capitation and FFS arrangements, company-operated clinics and staff physicians. Medical costs for professional and institutional services rendered by contracted providers are recorded as medical expenses and hospital expenses, respectively, in the consolidated statements of income. Costs for operating medical clinics, including the salaries of medical and non-medical personnel and support costs, are recorded in clinic support and other operating costs.

An estimate of amounts due to contracted physicians, hospitals, and other professional providers is included in medical payables in the accompanying consolidated balance sheets. Medical claims payable include claims reported as of the balance sheet date and estimates of IBNR. Such estimates are developed using actuarial methods and are based on many variables, including the utilization of healthcare services, historical payment patterns, cost trends, product mix, seasonality, changes in membership, and other factors. The estimation methods and the resulting reserves are continually reviewed and updated. Many of the medical contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of various services. We engage a third-party actuary to assist in the evaluation of the estimated IBNR reserves. Such differing interpretations may not come to light until a substantial period of time has passed following the contract implementation. Any adjustments to reserves are reflected in current operations.

Significant new accounting standards

New accounting standards

We elected to early adopt Accounting Standards Update (ASU) No. 2015-03, Interest - Imputation of Interest (Subtopic 835-30): Simplifying the Presentation of Debt Issuance Costs, retrospectively effective as of January 1, 2014. The amendments in this ASU require that debt issuance costs related to a recognized debt liability be presented in the balance sheet as a direct deduction from

the carrying amount of that debt liability, consistent with debt discounts. In August 2015, the FASB issued ASU 2015-15, Interest – Imputation of Interest (Subtopic 835-30) – Presentation and Subsequent Measurement of Debt Issuance Costs Associated with Line-of-Credit Arrangements, which clarifies that the treatment of debt issuance costs related to a line-of-credit may continue to be deferred in an asset position and subsequently amortized over the term of the line-of-credit arrangement, regardless of whether there are any outstanding borrowings on the line-of-credit arrangement. The recognition and measurement guidance for debt issuance costs are not affected by the amendments in this ASU. Adoption of this standard did not have a material impact on our consolidated financial statements.

We elected to early adopt ASU No. 2015-17, Income Taxes (ASC 740): Balance Sheet Classification of Deferred Taxes, retrospectively effective as of January 1, 2014. The amendments in this ASU serve to simplify the presentation of deferred income taxes. The update requires that deferred tax liabilities and assets be classified as noncurrent in a classified statement of financial position. Adoption of this standard did not have a material impact on our consolidated financial statements.

In February 2016, the FASB issued ASU No. 2016-02, Leases (Topic 842). The amendments in this ASU revise the accounting related to lessee accounting. Under the new guidance, lessees will be required to recognize a lease liability and a right-of-use asset for all leases. The new lease guidance also simplified the accounting for sale and leaseback transactions primarily because lessees must recognize lease assets and lease liabilities. The amendments in this ASU are effective for us beginning on January 1, 2019 and should be applied through a modified retrospective transition approach for leases existing at, or entered into after, the beginning of the earliest comparative period presented in the financial statements. Early adoption is permitted. We have not yet determined what the effects of adopting this ASU will be on our consolidated financial statements.

In January 2016, the FASB issued ASU No. 2016-01, Financial Statements – Overall (Subtopic 825-10): Recognition and Measurement of Financial Assets and Financial Liabilities. The amendments in this ASU revise the 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 amendments in this ASU are effective for us beginning on January 1, 2018 and should be applied through a cumulative-effect adjustment to the statement of financial position. Early adoption is permitted under certain circumstances. The adoption of this standard is not expected to have a material impact on our consolidated financial statements.

In September 2015, the FASB issued ASU No. 2015-16, Business Combinations (Topic 805): Simplifying the Accounting for Measurement-Period Adjustments. The amendments in this ASU allow an acquirer to recognize adjustments to provisional amounts that are identified during the measurement period in the reporting period in which the adjustment amounts are determined. This will be inclusive of the effect on earnings of changes in depreciation, amortization, or other income effects as a result of the change to provisional amounts, calculated as if the accounting had been completed at the acquisition date. The amendments in this ASU became effective for us on January 1, 2016, and are applied prospectively. Early adoption was permitted. The adoption of this standard is not expected to have a material impact on our consolidated financial statements.

In July 2015, the FASB issued ASU No. 2015-11, Inventory (Topic 330): Simplifying the Measurement of Inventory. The amendments in this ASU apply to all inventory with the exception of inventory measured using last-in, first-out or the retail inventory method. This ASU simplifies the measurement of inventory. Under this new standard, inventory should be measured using the lower of cost and net realizable value. Net realizable value is the estimated selling price in the ordinary course of business, less reasonably predictable costs of completion, disposal and transportation. The amendments in this ASU are effective for us beginning January 1, 2017 and should be applied prospectively. Early adoption is permitted. The adoption of this standard is not expected to have a material impact on our consolidated financial statements.

In April 2015, the FASB issued ASU No. 2015-05, Customer's Accounting for Fees Paid in a Cloud Computing Arrangement, which amends ASC 350-40, Intangibles-Goodwill and Other-Internal-Use Software. This ASU provides guidance to customers about whether a cloud computing arrangement includes a software license. If an arrangement includes a software license, the accounting for the license will be consistent with licenses of other intangible assets. If the arrangement does not include a license, the arrangement will be accounted for as a service contract. The amendments in this ASU are effective for us beginning January 1, 2016 and can be adopted prospectively or retrospectively. We are currently assessing the effects of adopting this ASU on our consolidated financial statements, however, the adoption is not expected to have a material impact on our consolidated financial statements.

In February 2015, the FASB issued ASU No. 2015-02, Consolidation (Topic 810): Amendments to the Consolidation Analysis. The amendments in the ASU clarify consolidation of VIEs regarding which reporting entity consolidates the legal entity. The amendments in the ASU became effective for us on January 1, 2016. The adoption of this standard is not expected to have a material impact on our consolidated financial statements.

In May 2014, the FASB issued ASU No. 2014-09, Revenue from Contracts with Customers, 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. The ASU will replace most existing revenue recognition guidance in U.S. GAAP when it becomes effective. The new standard as issued

was to be effective for us on January 1, 2017. In July 2015, the FASB issued ASU 2015-14, Revenue from Contracts with Customers (Topic 606): Deferral of Effective Date. This guidance approves a one-year deferral of the effective date of ASU 2014-09. The final ASU now requires us to adopt this standard on January 1, 2018. Early application is permitted as of the initial effective date of January 1, 2017, but not prior to that date. The standard permits the use of either the retrospective or cumulative effect transition method. We have assembled an internal revenue task force that meets regularly to discuss and evaluate the overall impact this guidance will have on the various revenue streams in the consolidated financial statements and related disclosures, as well as the expected timing and method of adoption. We have not yet selected a transition method nor have we determined the effect of the standard on our ongoing financial reporting.

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, 2015. 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, 2015. The Term Loan A margin in effect is 1.75% at December 31, 2015, 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. The Term Loan B currently bears interest at LIBOR (floor of 0.75%) plus an interest rate margin of 2.75%.

	Expected maturity date							Average interest		
	2016	2017	2018	2019	2020	Thereafter	Total	rate		Fair value
	(dollars in millions)									
Long term debt:										
Fixed rate	$65	$ 61	$61	$61	$ 61	$ 7,967	$8,276	4.64	%	$ 8,240
Variable rate	$64	$ 92	$105	$680	$ 4	$ 5	$950	2.19	%	$ 948

	Notional amount	Contract maturity date					Pay fixed	Receive variable	Fair value
		2016	2017	2018	2019	2020			
		(dollars in millions)							
Swaps:									
Pay-fixed rate	$ 760	$760	$ —	$—	$ —	$—	0.49% to 0.52%	LIBOR	$ 0.5
Cap agreements	$ 9,735	$2,735	$ —	$3,500	$ —	$3,500		LIBOR above 2.5% and 3.5%	$ 15.1

Our Senior Secured Credit Facilities, which include the Term Loan A 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 the Term Loan A, 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. However, the LIBOR variable component of the interest rate for the majority of the Term Loan A is economically fixed as a result of our swap agreements, as described below.

The Term Loan B is subject to a LIBOR floor of 0.75%. Because actual LIBOR, as of December 31, 2015, was lower than this embedded LIBOR floors, the interest rate on the Term Loan B is treated as “effectively fixed” for purposes of the table above. We have included the Term Loan B in the fixed rate totals in the table above until such time as the actual LIBOR-based variable component of our interest rate exceeds 0.75% on the Term Loan B. At such time, we will then be subject to LIBOR-based interest rate volatility on the LIBOR variable component of our interest rate for the Term Loan B, but limited to a maximum LIBOR rate of 2.50% on $2.7 billion of outstanding principal debt on the Term Loan B as a result of the interest rate cap agreements, as described below. The remaining $712.5 million outstanding principal balance of the Term Loan B is subject to LIBOR-based interest rate volatility above a floor of 0.75%.

As of December 31, 2015, we maintain several interest rate swap agreements that were entered into in March 2013 with amortizing notional amounts totaling $760 million. These agreements have the economic effect of modifying the LIBOR variable component of our interest rate on an equivalent amount of our Term Loan A to fixed rates ranging from 0.49% to 0.52%, resulting in an overall weighted average effective interest rate of 2.26%, including the Term Loan A margin of 1.75%. The overall weighted

average effective interest rate also includes the effects of $165 million of unhedged Term Loan A debt that bears interest at LIBOR plus an interest rate margin of 1.75%. The swap agreements expire on September 30, 2016 and require monthly interest payments. During the year ended December 31, 2015, we recognized debt expense of $2.7 million from these swaps. As of December 31, 2015, the total fair value of these swap agreements was a net asset of approximately $0.5 million. During the year ended December 31, 2015, we recorded a loss of $4.0 million in other comprehensive income due to a decrease in the unrealized fair value of these swap agreements. We estimate that approximately $0.5 million of existing unrealized pre-tax gains in other comprehensive income at December 31, 2015 will be reclassified into income over the next twelve months.

As of December 31, 2015, we maintain several forward interest rate cap agreements that were entered into in October 2015 with notional amounts totaling $3.5 billion. These forward cap agreements will be effective June 29, 2018 and will 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. These cap agreements expire on June 30, 2020. As of December 31, 2015, the total fair value of these cap agreements was an asset of approximately $13.8 million. During the year ended December 31, 2015, we recorded a loss of $3.5 million in other comprehensive income due to a decrease in the unrealized fair value of these cap agreements.

As of December 31, 2015, we maintain several forward interest rate cap agreements that were entered into in November 2014 with notional amounts totaling $3.5 billion. These forward cap agreements will be effective September 30, 2016 and will 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. The cap agreements expire on June 30, 2018. As of December 31, 2015, the total fair value of these cap agreements was an asset of approximately $1.3 million. During the year ended December 31, 2015, we recorded a loss of $11.0 million in other comprehensive income due to a decrease in the unrealized fair value of these cap agreements.

As of December 31, 2015, we maintain several interest rate cap agreements that were entered into in March 2013 with notional amounts totaling $2.7 billion on our Term Loan B debt. These agreements have the economic effect of capping the LIBOR variable component of our interest rate at a maximum of 2.50% on an equivalent amount of our Term Loan B. During the year ended December 31, 2015, we recognized debt expense of $2.4 million from these caps. The cap agreements expire on September 30, 2016. As of December 31, 2015, the total fair value of these cap agreements was immaterial. During the year ended December 31, 2015, we recorded a loss of $1.6 million in other comprehensive income due to a decrease in the unrealized fair value of these cap agreements.

As a result of an embedded LIBOR floor on the Term Loan B debt agreement and the swap and cap agreements, our overall weighted average effective interest rate on the Senior Secured Credit Facilities was 3.46%, based on the current margins in effect of 1.75% for the Term Loan A and 2.75% for the Term Loan B, as of December 31, 2015.

As of December 31, 2015, the interest rate on our Term Loan B debt is effectively fixed subject to an embedded LIBOR floor which is higher than actual LIBOR as of such date. The Term Loan B is also subject to interest rate caps if LIBOR should rise above 2.50%. Interest rates on our senior notes are fixed by their terms. The LIBOR variable component of our interest rate on the majority of our Term Loan A is economically fixed as a result of interest rate swaps.

Our overall weighted average effective interest rate during the year ended December 31, 2015 was 4.42% and as of December 31, 2015 was 4.39%.

As of December 31, 2015, we had undrawn revolving credit facilities totaling $1.0 billion of which approximately $92.2 million was committed for outstanding letters of credit. The remaining amount is unencumbered. In addition, HCP has an outstanding letter of credit of approximately $1.3 million which is secured by a certificate of deposit.

We believe that we will have sufficient liquidity and will generate significant operating cash flows to fund our scheduled debt service and other obligations and working capital needs for the foreseeable future, including the next 12 months, under the terms of our debt agreements. Our primary sources of liquidity are cash from operations and cash from borrowings.

One mean 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 $6.3 million, $5.7 million, and $4.0 million, net of tax, for the years ended December 31, 2015, 2014, and 2013, respectively.

Exchange rate sensitivity

We are currently not exposed to any significant foreign currency exchange rate risk.

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.

There has not been any 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.

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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. 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, 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 No. 1. Election of Directors", "Corporate Governance", and "Security Ownership of Certain Beneficial Owners and Management" included in our definitive proxy statement relating to our 2016 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" and "Compensation Committee Interlocks and Insider Participations" included in our definitive proxy statement relating to our 2016 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 2016 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, 2015, 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 (a)	Weighted average exercise price of outstanding options, warrants and rights (b)	Number of shares remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a)) (c)	Total of shares reflected in columns (a) and (c) (d)
Equity compensation plans approved by shareholders	9,298,621	$ 54.19	32,906,935	42,205,556
Equity compensation plans not requiring shareholder approval	—	—	—	—
Total	9,298,621	$ 54.19	32,906,935	42,205,556

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 2016 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 2016 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 "Ratification of Appointment of Independent Registered Public Accounting Firm" included in our definitive proxy statement relating to our 2016 annual stockholder meeting.

PART IV

Item 15. Exhibits, Financial Statement Schedules.
(a) Documents filed as part of this Report:

(1) Index to Financial Statements:

(2) Index to Financial Statement Schedules:

(1) Exhibits:

2.1 Agreement and Plan of Merger, dated as of May 20, 2012, by and among DaVita Inc., Seismic Acquisition LLC, HealthCare Partners Holdings, LLC, and the Member Representative.(36)

2.2 Amendment, dated as of July 6, 2012, to the Agreement and Plan of Merger, dated as of May 20, 2012, by and among DaVita Inc., Seismic Acquisition LLC, HealthCare Partners Holdings, LLC, and the Member Representative.(37)

3.1 Amended and Restated Certificate of Incorporation of Total Renal Care Holdings, Inc. (TRCH), dated December 4, 1995.(1)

3.2 Certificate of Amendment of Certificate of Incorporation of TRCH, dated February 26, 1998.(2)

3.3 Certificate of Amendment of Certificate of Incorporation of DaVita Inc. (formerly Total Renal Care Holdings, Inc.), dated October 5, 2000.(3)

3.4 Certificate of Amendment of Amended and Restated Certificate of Incorporation of DaVita Inc., as amended dated May 30, 2007.(16)

3.5 Certificate of Ownership and Merger Merging DaVita Name Change, Inc. with and into DaVita Inc., as filed with Secretary of State of the State of Delaware on November 1, 2012.(40)

3.6 Amended and Restated Bylaws for DaVita Inc. dated as of March 10, 2011.(17)

4.1 Indenture, dated August 28, 2012, by and among DaVita Inc., the Guarantors named therein and The Bank of New York Mellon Trust Company, N.A., as Trustee.(38)

4.2 Form of 5.750% Senior Notes due 2022 and related Guarantee (included in Exhibit 4.1).(38)

4.3 Indenture, dated June 13, 2014, by and among DaVita HealthCare Partners Inc., the Guarantors named therein and The Bank of New York Mellon Trust Company, N.A., as Trustee. (44)

4.4 Form of 5.125% Senior Notes due 2024 and related Guarantee (included in Exhibit 4.3). (44)

4.5 Second Supplemental Indenture for the 5.750% Senior Notes due 2022, dated June 13, 2014, by and among DaVita HealthCare Partners Inc., the guarantors named therein and The Bank of New York Mellon Trust Company, N.A., as Trustee. (45)

4.6 Indenture for the 5.000% Senior Notes due 2025, dated April 17, 2015, by and among DaVita HealthCare Partners Inc., the Guarantors named therein and The Bank of New York Mellon Trust Company, N.A., as Trustee. (28)

4.7 Form of 5.000% Senior Notes due 2025 and related Guarantee (included in Exhibit 4.6). (28)

10.1 Employment Agreement, dated as of October 19, 2009, by and between DaVita Inc. and Kim M. Rivera.(29)*

10.2 Employment Agreement, dated as of October 31, 2005, effective October 24, 2005, by and between DaVita Inc. and Dennis Kogod.(8)*

10.3 Amendment to Mr. Kogod’s Employment Agreement, effective December 12, 2008.(23)*

10.4 Second Amendment to Mr. Kogod’s Employment Agreement, effective December 31, 2012.(23)*

10.5 Employment Agreement, effective September 22, 2005, by and between DaVita Inc. and James Hilger.(10)*

10.6 Amendment to Mr. Hilger’s Employment Agreement, effective December 12, 2008.(23)*

10.7 Second Amendment to Mr. Hilger’s Employment Agreement, effective December 27, 2012.(42)*

10.8 Employment Agreement, effective July 25, 2008, between DaVita Inc. and Kent J. Thiry.(20)*

10.9 Employment Agreement, effective August 1, 2008, between DaVita Inc. and Allen Nissenson.(21)*

10.10 Employment Agreement, effective March 3, 2008, between DaVita Inc. and David Shapiro.(23)*

10.11 Amendment to Mr. Shapiro’s Employment Agreement, effective December 4, 2008.(23)*

10.12 Employment Agreement, effective March 17, 2010, by and between DaVita Inc. and Javier Rodriguez.(25)*

10.13 Memorandum Relating to Bonus Structure for Kent J. Thiry.(26)*

10.14 Memorandum Relating to Bonus Structure for Dennis L. Kogod.(26)*

10.15 Form of Indemnity Agreement.(15)*

10.16 Form of Indemnity Agreement.(9)*

10.17 Executive Incentive Plan (as Amended and Restated effective January 1, 2009).(24)*

10.18 Executive Retirement Plan.(23)*

10.19 DaVita Voluntary Deferral Plan.(7)*

10.20 Deferred Bonus Plan (Prosperity Plan).(22)*

10.21 Amendment No. 1 to Deferred Bonus Plan (Prosperity Plan).(23)*

10.22 Amended and Restated Employee Stock Purchase Plan.(18)*

10.23 Amended and Restated DaVita Healthcare Partners Inc. Severance Plan.(42)*

10.24 Change in Control Bonus Program.(23)*

10.25 Non-Management Director Compensation Philosophy and Plan.(19)*

10.26 Amended and Restated 2002 Equity Compensation Plan.(6)*

10.27 Amended and Restated 2002 Equity Compensation Plan.(14)*

10.28 Amended and Restated 2002 Equity Compensation Plan.(18)*

10.29 Amended and Restated 2002 Equity Compensation Plan.(23)*

10.30 DaVita Inc. 2002 Equity Compensation Plan.(27)*

10.31 Form of Non-Qualified Stock Option Agreement—Employee (DaVita Inc. 1999 Non-Executive Officer and Non-Director Equity Compensation Plan.(13)*

10.32 Form of Non-Qualified Stock Option Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(4)*

10.33 Form of Non-Qualified Stock Option Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(11)*

10.34 Form of Non-Qualified Stock Option Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(13)*

10.35 Form of Restricted Stock Units Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(4)*

10.36 Form of Restricted Stock Units Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(11)*

10.37 Form of Restricted Stock Units Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(13)*

10.38 Form of Restricted Stock Units Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(23)*

10.39 Form of Stock Appreciation Rights Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(11)*

10.40 Form of Stock Appreciation Rights Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(13)*

10.41 Form of Stock Appreciation Rights Agreement—Board (DaVita Inc. 2002 Equity Compensation Plan).(21)*

10.42 Form of Stock Appreciation Rights Agreement—Board members (DaVita Inc. 2011 Incentive Award Plan).(32)*

10.43 Form of Restricted Stock Units Agreement—Board (DaVita Inc. 2002 Equity Compensation Plan).(21)*

10.44 Form of Restricted Stock Units Agreement—Board members (DaVita Inc. 2011 Incentive Award Plan).(32)*

10.45 Form of Non-Qualified Stock Option Agreement—Board (DaVita Inc. 2002 Equity Compensation Plan).(21)*

10.46 Form of Stock Appreciation Rights Agreement—Executives (DaVita Inc. 2011 Incentive Award Plan).(32)*

10.47 Form of Restricted Stock Units Agreement—Executives (DaVita Inc. 2011 Incentive Award Plan).(32)*

10.48 Form of Restricted Stock Units Agreement (DaVita Inc. 2011 Incentive Award Plan). (42)*

10.49 Form of Stock Appreciation Rights Agreement (DaVita Inc. 2011 Incentive Award Plan). (42)*

10.50 Form of Long-Term Incentive Program Award Agreement (For 162(m) designated teammates) (DaVita Inc. 2011 Incentive Award Plan).(42)*

10.51 Form of Long-Term Incentive Program Award Agreement (DaVita Inc. 2011 Incentive Award Plan). (42)*

10.52 Credit Agreement, dated as of June 24, 2014, by and among DaVita Healthcare Partners Inc., the guarantors the guarantors party thereto, the lenders party thereto, JPMorgan Chase Bank, N.A., as Administrative Agent and Collateral Agent, Barclays Bank PLC, and Wells Fargo Bank, National Association as Co-Syndication Agents, Bank of America, N.A., Credit Suisse AG, Goldman Sachs Bank USA, JPMorgan Chase Bank, N.A., Morgan Stanley Senior Funding, Inc., and SunTrust Bank, as Co-Documentation Agents, Barclays Bank PLC, Wells Fargo Securities, LLC, Credit Suisse Securities (USA) LLC, Goldman Sachs Bank USA, J.P. Morgan

Securities, LLC, Bank of America, N.A., Morgan Stanley Senior Funding, Inc., and SunTrust Robinson Humphrey, Inc. as Joint Lead Arrangers and Joint Bookrunners, The Bank of Nova Scotia, Credit Agricole Securities (USA) Inc., The Bank of Tokyo-Mitsubishi UFJ, Ltd., and Sumitomo Mitsui Banking Corporation, as Senior Managing Agents, HSBC Securities (USA) Inc., Fifth Third Bank, and Compass Bank as Managing Agents. (45)

10.53 Perfection Certificate executed as of October 20, 2010 and delivered in connection with the closing of the Credit Agreement filed as Exhibit 10.68.(34)**

10.54 Dialysis Organization Agreement between DaVita Inc. and Amgen USA Inc. dated December 20, 2007.(22)**

10.55 Dialysis Organization Agreement between DaVita Inc. and Amgen USA Inc. dated December 17, 2010.(30)**

10.56 Amended and Restated DaVita HealthCare Partners Inc. 2011 Incentive Award Plan.(45)*

10.57 Amendment No. 2 to Dialysis Organization Agreement between DaVita Inc. and Amgen USA Inc. effective as of July 1, 2011.(33)**

10.58 Sourcing and Supply Agreement between DaVita Inc. and Amgen USA Inc. effective as of January 1, 2012.(35)**

10.59 Amendment No. 1 to Sourcing and Supply Agreement between DaVita HealthCare Partners Inc. and Amgen USA Inc. effective as of January 1, 2013. (42)**

10.60 Voting Agreement, dated as of May 20, 2012, by and among DaVita Inc., HealthCare Partners Holdings, LLC, and HealthCare Partners Medical Group.(36)

10.61 Support Agreement, dated as of May 20, 2012, by and among DaVita Inc., HealthCare Partners Holdings, LLC, and Dr. Robert Margolis.(36)

10.62 Support Agreement, dated as of May 20, 2012, by and among DaVita Inc., HealthCare Partners Holdings, LLC, and Dr. William Chin.(36)

10.63 Support Agreement, dated as of May 20, 2012, by and among DaVita Inc., HealthCare Partners Holdings, LLC, and Matthew Mazdyasni.(36)

10.64 Support Agreement, dated as of May 20, 2012, by and among DaVita Inc., HealthCare Partners Holdings, LLC, and Dr. Thomas Paulsen.(36)

10.65 Form of Non-Competition and Non-Solicitation Agreement, dated as of May 20, 2012, between DaVita Inc. and Dr. Robert Margolis, Dr. William Chin, Dr. Thomas Paulsen, Mr. Zan Calhoun, and Ms. Lori Glisson.(36)

10.66 Form of Non-Competition and Non-Solicitation Agreement, dated as of May 20, 2012, between DaVita Inc. and Mr. Matthew Mazdyasni, Dr. Sherif Abdou, and Dr. Amir Bacchus.(36)

10.67 Escrow Agreement, dated as of August 28, 2012, by and among DaVita Inc., The Bank of New York Mellon Trust Company, N.A., as trustee, The Bank of New York Mellon Trust Company, N.A., as escrow agent and The Bank of New York Mellon Trust Company, N.A., as bank and securities intermediary.(38)

10.68 Employment Agreement, dated as of May 20, 2012, effective as of the November 1, 2012, by and among Dr. Robert Margolis, DaVita Inc. and HealthCare Partners Holdings, LLC.(39)*

10.69 Amendment to Dr. Margolis' Employment Agreement, effective December 31, 2012. (42)*

10.70 Employment Agreement, effective July 5, 2013, between DaVita HealthCare Partners Inc. and Garry E. Menzel.(41)*

10.71 Form of 2014 Long Term Incentive Program Cash Performance Award Agreement under the DaVita HealthCare Partners Inc. 2011 Incentive Award Plan and Long-Term Incentive Program (for 162(m) designated teammates). (46) * **

10.72 Form of 2014 Long Term Incentive Program Cash Performance Award Agreement under the DaVita HealthCare Partners Inc. 2011 Incentive Award Plan and Long-Term Incentive Program. (46)* **

10.73 Form of 2014 Long Term Incentive Program Performance Stock Units Agreement under the DaVita HealthCare Partners Inc. 2011 Incentive Award Plan and Long-Term Incentive Program (for 162(m) designated teammates). (46) * **

10.74 Form of 2014 Long Term Incentive Program Restricted Stock Units Agreement under the DaVita HealthCare Partners Inc. 2011 Incentive Award Plan and Long-Term Incentive Program. (46)*

10.75

	Form of 2014 Long Term Incentive Program Stock Appreciation Rights Agreement under the DaVita HealthCare Partners Inc. 2011 Incentive Award Plan and Long-Term Incentive Program. (46)*
10.76	Corporate Integrity Agreement, dated as of October 22, 2014, by and among the Office of Inspector General of The Department of Health and Human Services and DaVita HealthCare Partners, Inc. (47)
12.1	Computation of Ratio of Earnings to Fixed Charges.ü
14.1	DaVita Inc. Corporate Governance Code of Ethics.(5)
21.1	List of our subsidiaries.ü
23.1	Consent of KPMG LLP, independent registered public accounting firm.ü
24.1	Powers of Attorney with respect to DaVita. (Included on Page II-1).
31.1	Certification of the Chief Executive Officer, dated February 26, 2016, pursuant to Rule 13a-14(a) or 15d-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.ü
31.2	Certification of the Chief Financial Officer, dated February 26, 2016, pursuant to Rule 13a-14(a) or 15d-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.ü
32.1	Certification of the Chief Executive Officer, dated February 26, 2016, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.ü

32.2	Certification of the Chief Financial Officer, dated February 26, 2016, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.ü
101.INS	XBRL Instance Document.ü
101.SCH	XBRL Taxonomy Extension Schema Document.ü
101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document.ü
101.DEF	XBRL Taxonomy Extension Definition Linkbase Document.ü
101.LAB	XBRL Taxonomy Extension Label Linkbase Document.ü
101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document.ü

ü Included in this filing.
* Management contract or executive compensation plan or arrangement.
** Portions of this exhibit are subject to a request for confidential treatment and have been redacted and filed separately with the SEC.
(1) Filed on March 18, 1996 as an exhibit to the Company's Transitional Report on Form 10-K for the transition period from June 1, 1995 to December 31, 1995.
(2) Filed on March 31, 1998 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 1997.
(3) Filed on March 20, 2001 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 2000.
(4) Filed on November 8, 2004 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2004.
(5) Filed on February 27, 2004 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 2003.
(6) Filed on May 4, 2005 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2005.
(7) Filed on November 8, 2005 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2005.
(8) Filed on November 4, 2005 as an exhibit to the Company's Current Report on Form 8-K.
(9) Filed on March 3, 2005 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 2004.
(10) Filed on August 7, 2006 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ending June 30, 2006.
(11) Filed on July 6, 2006 as an exhibit to the Company's Current Report on Form 8-K.
(12) Filed on November 3, 2006 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2006.
(13) Filed on October 18, 2006 as an exhibit to the Company's Current Report on Form 8-K.
(14) Filed on July 31, 2006 as an exhibit to the Company's Current Report on Form 8-K.
(15) Filed on December 20, 2006 as an exhibit to the Company's Current Report on Form 8-K.
(16) Filed on August 6, 2007 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2007.
(17) Filed on March 17, 2011 as an exhibit to the Company's Current Report on Form 8-K/A.
(18) Filed on June 4, 2007 as an exhibit to the Company's Current Report on Form 8-K.

(19) Filed on May 8, 2008 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2008.
(20) Filed on July 31, 2008 as an exhibit to the Company's Current Report on Form 8-K.
(21) Filed on November 6, 2008 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2008.
(22) Filed on February 29, 2008 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 2007.
(23) Filed on February 27, 2009 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 2008
(24) Filed on June 18, 2009 as an exhibit to the Company's Current Report on Form 8-K.
(25) Filed on April 14, 2010 as an exhibit to the Company's Current Report on Form 8-K.
(26) Filed on May 3, 2010 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2010.
(27) Filed on April 28, 2010 as Appendix A to the Company's Definitive Proxy Statement on Schedule 14A.
(28) Filed on April 17, 2015 as an exhibit to the Company's Current Report on Form 8-K.
(29) Filed on February 25, 2010 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 2009.
(30) Filed on December 29, 2011 as an exhibit to the Company's Annual Report on Form 10-K/A for the year ended December 31, 2010.
(31) Filed on April 28, 2014 as Appendix A to the Company's Definitive Proxy Statement on Schedule 14A.
(32) Filed on August 4, 2011 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2011.

(33) Filed on December 29, 2011 as an exhibit to the Company's Quarterly Report on Form 10-Q/A for the quarter ended June 30, 2011.
(34) Filed on January 17, 2012 as an exhibit to the Company's Quarterly Report on Form 10-Q/A for the quarter ended March 31, 2011.
(35) Filed on February 24, 2012 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 2011.
(36) Filed on May 21, 2012 as an exhibit to the Company's Current Report on Form 8-K.
(37) Filed on July 9, 2012 as an exhibit to the Company's Current Report on Form 8-K.
(38) Filed on August 28, 2012 as an exhibit to the Company's Current Report on Form 8-K.
(39) Filed on September 18, 2012 as an exhibit to Amendment No. 2 to the Company's Registration Statement on Form S-4.
(40) Filed on November 1, 2012 as an exhibit to the Company's Current Report on Form 8-K.
(41) Filed on August 7, 2013 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2013.
(42) Filed on February 28, 2013 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 2012.
(43) Filed on February 21, 2014 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 2013.
(44) Filed on June 16, 2014 as an exhibit to the Company's Current Report on Form 8-K.
(45) Filed on August 1, 2014 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2014.
(46) Filed on November 6, 2014 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2014.
(47) Filed on October 23, 2014 as an exhibit to the Company's Current Report on Form 8-K.

DAVITA HEALTHCARE PARTNERS 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, 2015.

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

The Board of Directors and Shareholders

DaVita HealthCare Partners Inc.:

We have audited the accompanying consolidated balance sheets of DaVita HealthCare Partners Inc. and subsidiaries as of December 31, 2015 and 2014, and 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, 2015. 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 conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of DaVita HealthCare Partners Inc. and subsidiaries as of December 31, 2015 and 2014, and the results of their operations and their cash flows for each of the years in the three year period ended December 31, 2015, in conformity with U.S. generally accepted accounting principles.

As discussed in Note 1 to the consolidated financial statements, the Company has changed its method of accounting for the presentation of debt issuance costs due to the adoption of ASU No. 2015-03, Simplifying the Presentation of Debt Issuance Costs, and has changed its method of accounting for the presentation of deferred tax liabilities and deferred tax assets due to the adoption of ASU No. 2015-17, Balance Sheet Classification of Deferred Taxes.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), DaVita HealthCare Partners Inc.'s internal control over financial reporting as of December 31, 2015, based on criteria established in Internal Control – Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO), and our report dated February 26, 2016 expressed an unqualified opinion on the effectiveness of the Company's internal control over financial reporting.

/s/ KPMG LLP

Seattle, Washington

February 26, 2016

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Stockholders

DaVita HealthCare Partners Inc.:

We have audited DaVita HealthCare Partners Inc.'s internal control over financial reporting as of December 31, 2015, based on criteria established in Internal Control – Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). DaVita HealthCare Partners, Inc.'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 conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). 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 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.

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.

In our opinion, DaVita HealthCare Partners Inc. maintained, in all material respects, effective internal control over financial reporting as of December 31, 2015, based on criteria established in Internal Control – Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of DaVita HealthCare Partners Inc. and subsidiaries as of December 31, 2015 and 2014, and 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, 2015, and our report dated February 26, 2016 expressed an unqualified opinion on those consolidated financial statements.

/s/ KPMG LLP

Seattle, Washington

February 26, 2016

DAVITA HEALTHCARE PARTNERS INC.

CONSOLIDATED STATEMENTS OF INCOME

(dollars in thousands, except per share data)

	Year ended December 31,		
	2015	2014	2013
Patient service revenues	$9,480,279	$8,868,338	$8,307,195
Less: Provision for uncollectible accounts	(427,860)	(366,884)	(293,546)
Net patient service revenues	9,052,419	8,501,454	8,013,649
Capitated revenues	3,509,095	3,261,288	2,987,315
Other revenues	1,220,323	1,032,364	763,086
Total net revenues	13,781,837	12,795,106	11,764,050
Operating expenses and charges:			
Patient care costs and other costs	9,824,834	9,119,305	8,198,377
General and administrative	1,452,135	1,261,506	1,176,485
Depreciation and amortization	638,024	590,935	528,737
Provision for uncollectible accounts	9,240	14,453	4,852
Equity investment income	(18,325)	(23,234)	(34,558)
Goodwill and other intangible asset impairment charges	210,234	—	—
Settlement charge and loss contingency accrual	495,000	17,000	397,000
Contingent earn-out obligation adjustment	—	—	(56,977)
Total operating expenses and charges	12,611,142	10,979,965	10,213,916
Operating income	1,170,695	1,815,141	1,550,134
Debt expense	(408,380)	(410,294)	(429,943)
Debt redemption and refinancing charges	(48,072)	(97,548)	—
Other income, net	8,893	2,374	4,787
Income from continuing operations before income taxes	723,136	1,309,673	1,124,978
Income tax expense	295,726	446,343	381,013
Income from continuing operations	427,410	863,330	743,965
Discontinued operations:			
Loss from operations of discontinued operations, net of tax	—	—	(139)
Gain on disposal of discontinued operations, net of tax	—	—	13,375