DAVITA HEALTHCARE PARTNERS INC.
Form 10-K
February 26, 2015

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-K

For the Fiscal Year Ended December 31, 2014

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, 2014, the number of shares of the Registrant's common stock outstanding was approximately 214.8 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 $15.5 billion.

As of January 30, 2015, the number of shares of the Registrant's common stock outstanding was approximately 215.8 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 $16.2 billion.

Documents incorporated by reference

Portions of the Registrant's proxy statement for its 2015 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 support costs. 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 health care delivery and management company with nearly three 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, 2014, we provided dialysis and administrative services in the U.S. through a network of 2,179 outpatient dialysis centers in 46 states and the District of Columbia, serving a total of approximately 173,000 patients. We also provide acute inpatient dialysis services in approximately 1,000 hospitals and related laboratory services throughout the U.S. Our U.S. dialysis and related lab services business accounted for approximately 64% of our 2014 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 451,000 ESRD dialysis patients in the U.S. in 2012. The underlying ESRD dialysis patient population has grown at an approximate compound rate of 4.0% from 2000 to 2012, 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 health care 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, 2014, approximately 90% of our total dialysis patients were covered under some form of government-based programs, with approximately 78% 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, 2014, we operated or provided administrative services through a network of 2,179 outpatient dialysis centers in the U.S. that are designed specifically for outpatient hemodialysis. In 2014, our overall network of U.S. outpatient dialysis centers increased by 105 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 5.1% from 2013.

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 2014 and 26% in 2013. However, in 2014, the overall number of patients to whom we provided services in the U.S. increased by approximately 6% from 2013, primarily from the opening of new dialysis centers and acquisitions, continued growth within the industry and lower mortality rates.

Hospital inpatient hemodialysis services

As of December 31, 2014, we provided hospital inpatient hemodialysis services, excluding physician services, to patients in approximately 1,000 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 2014, hospital inpatient hemodialysis services accounted for approximately 4.5% 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 to 29 outpatient dialysis centers located in the U.S. in which we either own a minority equity investment or are wholly-owned by third parties. These services are provided pursuant to management and administrative services agreements. 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 250 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 eleven 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 seven physicians with extensive experience in clinical practice in addition to the members of OCMO and currently eight Group Medical Directors.

Sources of revenue—concentrations and risks

Our U.S. dialysis and related lab services business net revenues represent approximately 64% of our consolidated net revenues for the year ended December 31, 2014. Our U.S. dialysis and related lab services revenues are derived primarily from our core business of providing kidney 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 and related lab services revenues by source for the year ended December 31, 2014:

	Revenue percentages	
Medicare and Medicare-assigned plans	58	%
Medicaid and Medicaid-assigned plans	6	%
Other government-based programs	3	%
Total government-based programs	67	%
Commercial (including hospital inpatient dialysis services)	33	%
Total dialysis and related lab services revenues	100	%

The following table summarizes our U.S. dialysis and related lab services revenues by modality for the year ended December 31, 2014:

	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

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 that were historically separately reimbursed to the dialysis providers, 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 that used to be paid directly to laboratories are also included in the bundled payment. The bundled payment rate is also adjusted for certain patient characteristics, a geographic usage index and certain other factors.

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. The Center 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” which will reduce our market basket inflation adjustment by – 1.25% in 2016 and 2017, and 1% in 2018. CMS also recently issued the 2015 final rule for the ESRD PPS, which would increase payments to dialysis facilities modestly in 2015 by 0.3% to 0.5%, although rural facilities would receive a decrease of 0.5%.

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 across-the-board spending cuts pursuant to the sequester have affected and will continue to adversely affect our revenues, earnings and cash flows.

The CMS 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 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 health care 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 seeking to participate in the Comprehensive ESRD Care Model with the CMS Innovation Center. Even if we do not participate in this or other programs, some of our patients may be assigned to a program, in which case the quality and cost of care that we furnish will be included in an ACO’s or other programs’ calculations. As new models of care emerge 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 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 2015 that will outpace any 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 a three month waiting period, or earlier if the patient's commercial insurance plan coverage terminates. When Medicare becomes the primary payor, the payment rate we receive for that patient shifts from the commercial insurance plan rate to the Medicare payment rate.

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. 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 contract payment rates. In 2014, 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 rate reductions in excess of our commercial 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 health care insurance exchanges, we could experience a decrease in the number of patients covered under commercial insurance plans.

Approximately 33% of our dialysis and related lab services revenues and approximately 10% of our dialysis patients were associated with commercial payors for the year ended December 31, 2014. Commercial patients as a percentage of our total dialysis patients remained approximately 10% in 2014 and 2013. 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, 2014.

The health care reform legislation introduced health care insurance exchanges which provide a marketplace for eligible individuals and small employers to purchase health care insurance. Although we cannot predict the long term effects of these exchanges, we believe the health care insurance exchanges could result in a reduction in patients covered by commercial insurance or an increase of patients covered through the exchanges under more restrictive commercial plans with lower reimbursement rates. To

the extent that the implementation of such exchanges results in a reduction in patients covered by commercial insurance or a reduction in reimbursement rates for our services from commercial and/or government payors, our operating results could be adversely affected.

Revenue from other pharmaceuticals and EPO

The percentage of revenue that we generate from separately billable pharmaceuticals as a result of operating under Medicare's single bundled payment rate system continues to decline, since pharmaceuticals, including EPO, are included in the ESRD single bundled payment. In addition, a significant percentage of our payor contracts covering commercial patients continue to pay us under a single bundled rate for all dialysis services provided to these patients. Approximately 3% of our total dialysis and related lab services revenues for the year ended December 31, 2014, as compared to 5% in 2013, are associated with the administration of separately-billable physician-prescribed pharmaceuticals.

EPO is an erythropoiesis-stimulating agent (ESA), a genetically-engineered form of a naturally occurring protein that stimulates the production of red blood cells. EPO is used in connection with all forms of dialysis to treat anemia, a medical complication most ESRD patients experience. The administration of EPO that was separately billable, accounted for approximately 2% of our dialysis and related lab services revenues for the year ended December 31, 2014. EPO is produced by a single manufacturer, Amgen. Any interruption of supply or product cost increases could adversely affect our operations.

Evaluations on the utilization and reimbursement for ESAs, which have occurred in the past and may occur in the future, and related actions by the U.S. Congress and federal agencies, could result in further restrictions on the utilization and reimbursement for ESAs. Additionally, commercial payors have 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, 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, or further decreases in reimbursement for EPO and other pharmaceuticals that are not 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, as described below, we also have agreed not to enforce investment non-compete restrictions relating to dialysis clinics or programs that were formed by 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 formed by 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;
- Fines, damages and monetary penalties for anti-kickback law violations, Stark Law violations, submission of false claims, civil or criminal liability based on violations of law or other failures to meet regulatory requirements;
- Claims for monetary damages from patients who believe their protected health information (PHI) 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 health care 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 our Medicaid certifications. 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 imposes criminal and civil sanctions on persons who knowingly and willfully solicit or receive in return for, or knowingly and willfully offer or pay to induce the enumerated list of prohibitions:

- The referral of a patient covered by Medicare, Medicaid or similar federal and state programs;

- The ordering or purchasing of items or services that are paid for in whole or in part by Medicare, Medicaid or similar federal and state programs; or
- Arranging for or recommending the ordering or purchasing of such items.

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 Medicare and Medicaid programs. 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 also held that the statute is violated whenever one of the purposes 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 (The 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 claims under the False Claims Act.

Regulations issued by the U.S. Department of Health and Human Services (HHS) create exceptions or “safe harbors” for some business transactions and arrangements. Transactions and arrangements structured within these safe harbors are deemed to not violate the federal anti-kickback statute. A business transaction or arrangement must satisfy every element of a safe harbor to be protected by that safe harbor. Transactions and arrangements that do not satisfy all elements of a relevant safe harbor do not necessarily violate the statute, but can be subject to greater scrutiny by enforcement agencies.

Our medical directors refer patients to our dialysis centers, and these arrangements, by which we pay them for their medical director services, must be in compliance with the federal anti-kickback statute in order to avoid scrutiny under the statute. Among the available safe harbors is one for personal services furnished for fair market value. However, most of our agreements with our medical directors do not satisfy all seven of the requirements of the personal services safe harbor. We believe that because of the nature of our medical directors’ duties, it is impossible to satisfy the anti-kickback safe-harbor requirement that services provided under an agreement on a part-time basis must specify the schedule of intervals of service, and their precise length and the exact charge for such intervals. Accordingly, while we believe that our agreements with our medical directors for our dialysis centers satisfy many of the elements of this safe harbor as we believe is reasonably possible, our arrangements do not qualify for safe harbor protection, as precise scheduling is not possible. We also note that there is little guidance available as to what constitutes fair market value for medical director services. We believe that our agreements do not violate the federal anti-kickback statute; however, since the arrangements do not satisfy all of the requirements for safe harbor protection, these arrangements could be challenged.

We own a controlling interest in numerous U.S. dialysis related joint ventures. For the year ended December 31, 2014, these joint ventures represented approximately 22% 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 must comply with a federal anti-kickback statute safe harbor in order to avoid scrutiny under the statute. Although there is a safe harbor for certain investment interests in small entities, our joint ventures do not satisfy all of the requirements for safe harbor protection. 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 anti-kickback statute scrutiny on a case-by-case basis. 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.

We have structured our joint ventures to satisfy as many safe harbor requirements 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 for safe harbor protection, 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 and the Office of the Inspector General 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 False Claims Act. In October 2014, we entered into the Settlement Agreement with the United States and relator David Barbetta to resolve the 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 health care programs, we have entered into a five-year Corporate Integrity (CIA) Agreement with the OIG.

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 260 of our dialysis centers as of December 31, 2014. These arrangements must comply with a federal anti-kickback statute safe harbor in order to avoid scrutiny under the statute. We believe that

we meet the elements of the safe harbor for space rentals in all material respects. Therefore, we believe that our physician lease arrangements should not be subject to scrutiny or challenge under the federal anti-kickback statute.

Some medical directors and other referring physicians may own our common stock. We believe that these interests materially satisfy the requirements of the safe harbor for investments in large publicly traded companies for the federal anti-kickback statute. Therefore, we believe that these investment arrangements should not be subject to scrutiny or challenge under the federal anti-kickback statute.

Because we are purchasing and selling items and services in the operation of our dialysis centers that may be paid for, in whole or in part, by Medicare, Medicaid or other federal or state healthcare program and because we acquire certain items and services at a discount, we must structure these arrangements in compliance with a federal anti-kickback statute safe harbor in order to avoid scrutiny under the statute. Subject to certain requirements and limitations, discounts representing reductions in the amounts we are charged for items or services based on arm's-length transactions can qualify for safe harbor protection if we fully and accurately report the discounts in the applicable Medicare cost reports. While some of the safe harbor criteria are subject to interpretation, we believe that our vendor contracts with discount provisions are in compliance with the federal anti-kickback statute discount safe harbor. Therefore, we believe that our discounted vendor contracts should not be subject to scrutiny or challenge under the federal anti-kickback statute.

Stark Law

A federal 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. Stark Law DHS include 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, 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. Stark Law violations also can form the basis for False Claims Act liability. 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.

CMS has adopted implementing regulations under the Stark Law, (collectively, known as the Stark Regulations). CMS has not yet adopted implementing regulations regarding application of the Stark Law to Medicaid, but has indicated that it anticipates issuing additional regulations regarding the application of the Stark Law to Medicaid referrals.

The definition of DHS under the Stark Law excludes services paid under a composite rate, even if some of the components bundled in the composite rate are DHS. Although the 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. The definition of DHS 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 Regulations 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. We believe that the compensation arrangements under 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, which are the result of arm's length negotiations, 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. If the 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.

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.

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.

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 cannot 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.

If any of the business transactions or arrangements, including those described above, were found to violate the federal anti-kickback statute of Stark Law, 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.

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 be interpreted 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 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 False Claims Act (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. 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. These amendments could subject our procedures for identifying and processing overpayments to greater scrutiny. We have made significant investments in additional resources to accelerate the time it takes 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 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. 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 a violation of the federal anti-kickback statute can form the basis for liability under 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.

The Health Insurance Portability and Accountability Act of 1996

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), requires us to provide certain protections to patients and their health information under the Protected Health Information, or PHI. HIPAA requires us to afford patients certain rights regarding their PHI, and to limit uses and disclosure of their PHI existing in any media form (electronic and hardcopy). HIPAA also requires us to implement administrative, physical, and technical safeguards with respect to electronic PHI. We believe our HIPAA Privacy and Security Program sufficiently address HIPAA requirements. 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, if PHI of 500 or more individuals is improperly used or disclosed, we would be required to report the improper use or disclosure to the Department of Health and Human Services, which would post the violation on its website. If there were improper use or disclosure of PHI of more than 500 individuals in the same jurisdiction, we would be required to report the improper use or disclosure to the media. Improper use or disclosure could result in significant fines and reputational damage.

Healthcare reform

In March 2010, broad health care 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 may be modified before being implemented, 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 state exchanges, cover essential health benefits (EHBs) in ten general categories. The scope of the benefits are intended to equal the scope of benefits under a typical employer plan.

In December 2011, the 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 requires states to define an EHB benchmark plan that must be covered by plans in the state. States that do not define an EHB benchmark plan must use the small group plan with the largest enrollment in the state.

On February 25, 2013, HHS issued the final rule governing the standards applicable to EHB Bulletins, 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.

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 $2.7 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.

	2014	2013	2012	2011	2010
Number of centers at beginning of year	2,074	1,954	1,809	1,612	1,530
Acquired centers	18	26	93	170 (1)	41
Developed centers	105	98	70	65	65
Net change in centers with management and administrative services agreements*	—	4	(8)	1	—
Sold and closed centers**	(2)	(5)	(1)	(32) (1)	(10)
Closed centers***	(16)	(3)	(9)	(7)	(14)

Number of centers at end of year	2,179	2,074	1,954	1,809	1,612

(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, 2014, we operated or provided administrative services to a total of 2,179 U.S. outpatient dialysis centers. A total of 2,150 of such centers are consolidated in our financial statements. Of the remaining 29 unconsolidated U.S. outpatient dialysis centers, we own a minority equity investment in 22 centers and provide management and administrative services to seven centers that are wholly-owned by third parties. The locations of the 2,150 U.S. outpatient dialysis centers consolidated in our financial statements at December 31, 2014 were as follows:

State	Centers	State	Centers	State	Centers
California	257	Minnesota	47	Nebraska	15
Texas	195	New Jersey	47	Massachusetts	13
Florida	164	Colorado	38	Mississippi	11
Georgia	122	Wisconsin	38	District of Columbia	10
Ohio	112	Oklahoma	35	Idaho	9
Pennsylvania	96	Kentucky	34	West Virginia	7
Illinois	84	Arkansas	33	Utah	4
Michigan	75	South Carolina	33	New Mexico	4
North Carolina	66	Washington	30	New Hampshire	4
Virginia	60	Louisiana	29	Maine	3
Indiana	58	Arizona	25	South Dakota	3
Maryland	57	Iowa	25	North Dakota	2
Alabama	55	Kansas	25	Rhode Island	1
Missouri	54	Connecticut	23	Montana	1
Tennessee	54	Oregon	23		
New York	49	Nevada	20		

Ancillary services and strategic initiatives businesses, including our international operations

As of December 31, 2014, 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 8.9% of our consolidated net revenues for the year ended December 31, 2014, 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, 2014:

- Pharmacy services. DaVita Rx is a specialty pharmacy that provides 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 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. Through a combination of clinical coordination, medical claims analysis and information technology, we endeavor to assist our customers and patients in obtaining superior renal health care 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 2014, VillageHealth also operated a Medicare Advantage ESRD Special Needs Plan in partnership with a payor that works with CMS to

provide ESRD patients full service health care. We are at risk for all medical costs of the program in excess of the capitation payments.

- Vascular access services. Lifeline provides management and administrative services to physician-owned vascular access clinics that provide surgical and interventional radiology services for dialysis patients. Lifeline also is the majority-owner of six 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 clinic that is majority-owned are recognized in the period when physician 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 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, 2014, we operated or provided administrative services to a total of 91 outpatient dialysis centers located in ten countries outside of the U.S., serving approximately 7,200 patients. Our international dialysis operations continue to steadily grow and expand as a result of developing and acquiring outpatient dialysis centers in various strategic markets, since the commencement of our international operations during the fourth quarter of 2011. However, our overall net revenues generated from our international operations were less than 1% of our consolidated net revenues during 2014. 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.

	2014	2013	2012
Number of centers at beginning of year	73	36	11
Acquired centers	7	37	13
Developed and hospital operated centers	11	2	8
Managed centers, net	2	1	4
Closed centers	(2)	(3)	—
Number of centers at end of year	91	73	36

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

Malaysia	24
Colombia	15
Germany	14
India	13

Poland	8
Portugal	5
Taiwan	4
Saudi Arabia	4
China	2
Singapore	2
	91

Corporate Support Costs

Corporate support costs consist primarily of labor, benefits and long-term incentive compensation costs for departments which provide support to all of our different operating lines of business. In addition, the 2013 amounts also included the adjustment to reduce a tax asset associated with the HCP acquisition escrow provisions of approximately $8 million. Corporate support costs were approximately $13 million in 2014, $53 million in 2013 and $46 million in 2012. These expenses are included in our consolidated general and administrative expenses. The decrease in corporate support costs in 2014 as compared to 2013 was due to an additional allocation of management fees.

HealthCare Partners Division

HealthCare Partners business overview

HCP is a patient- and physician-focused integrated health care delivery and management company with nearly three decades of experience providing coordinated, outcomes-based medical care in a cost-effective manner. As of December 31, 2014, HCP had approximately 837,300 members under its care in southern California, 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 310,500 individuals were patients enrolled in Medicare Advantage, and the remaining approximately 526,800 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 independent practice associations (IPAs) benefit from an integrated approach to medical care that places the physician at the center of patient care. As of December 31, 2014, HCP delivered services to its members via a network of over 3,300 associated group and other network primary care physicians, 228 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 2013, CMS reported that health care accounted for 17.4% of the U.S. economy and healthcare spending increased 3.6% to reach $2.9 trillion. Medicare spending grew 3.4% to $585.7 billion in 2013 or 20% of National Health Expenditures, according to CMS. Medicare outlays accounted for 14% of the Federal Budget in 2013 according to the Congressional Budget Office. Medicare is frequently the focus of discussions on how to moderate the growth of both federal spending and health care spending in the U.S.

Growth in Medicare spending is expected to continue due to population demographics. According to the U.S. Census Bureau, from 1970 through 2013, the overall U.S. population grew 55% while the number of Medicare enrollees grew by more than 150% over that time period. 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 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 typically 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, under federal Medicare benefits or through state Medicaid programs. 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 CMS, in 2014, Medicare Advantage represents only 30% 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 32 million uninsured individuals by 2019, while potentially increasing Medicaid coverage by up to 16 million individuals and net commercial coverage by 16 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 2013 report to Congress, the Medicare Payment Advisory Commission (MedPAC) estimated that 2014 Medicare Advantage benchmarks, bids, and payments would average 112%, 98%, and 106% 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, HMOs as a group bid an average of 95% of FFS spending, yet 2014 payments for HMO enrollees are estimated to average 105% of FFS spending because the benchmarks, including the quality bonuses, average 112% 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 as compared to 112% of fee for-service today. 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 health care 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 health care 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 health care 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 health care 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. This is particularly the case for Medicare Advantage members for whom revenue to a system can be substantial given the higher expected morbidity and cost associated with a Medicare Advantage member.

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. The Health Reform Acts are considered by some to be the most dramatic change to the U.S. healthcare system in decades. The 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 current Medicaid program. This legislation made significant changes to the Medicare program and to the health insurance market overall. The Health Reform Acts reflect sweeping legislation that, once fully implemented, may have a significant impact on the U.S. health care system generally and the operations of HCP's business. There are numerous steps required to implement the Health Reform Acts, and Congress may seek to alter or eliminate some of their provisions.

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. HCP recently entered into an agreement with CMS to participate in the Medicare Shared Savings Program in California, Florida and Nevada beginning in 2014. Under this program, HCP will strive to attain improved clinical outcomes to its Medicare fee for service 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 a $583 billion program in 2013, covering approximately 52 million Americans and, based on the growing number of eligible beneficiaries and increases in the cost of health care, Congressional Budget Office (CBO) projects that Net Medicare Spending will increase from $512 billion in 2014 to $858 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, health care provider or facility certified by Medicare. CMS reimburses providers, based on a fee schedule, if Medicare covers the service and CMS considers it medically necessary.

FFS Medicare is paid according to a physician fee schedule (PFS) set each year by CMS in accordance with formulas mandated by Congress. CMS is required to limit the growth in spending under the PFS by a predetermined sustained growth rate (SGR). If implemented as mandated, the SGR would result in significant payment reductions under the PFS. CMS announced that the estimated PFS update for 2015 would be reduced by 21.2% due to the SGR formula. Every year since 2003, Congress has delayed application of the SGR but we cannot predict whether they will continue to do so. Congress most recently delayed application of the SGR in the Pathway for SGR Reform Act (SGR Act) which was signed by President Obama on December 26, 2013. Pursuant to the SGR Act, the negative impact of the SGR is further delayed for a temporary 3-month period which began on January 1, 2014. The SGR Act gives

physicians a 0.5% reimbursement increase during the 3 month delay period. However, the SGR Act also extends a 2% Medicare sequestration cut mandated by the Budget Control Act of 2011 and the Sequestration Transparency Act of 2012 for an additional two years beyond the original expiration date of 2021.

There is pressure for Congress to implement a permanent solution to the SGR reductions. The House Committee on Ways and Means and the Senate Committee of Finance released SGR repeal proposals in early November 2013, and the two committees have since met to revise their respective bills. Although the original proposals each called for a 10-year freeze on Medicare physician payments, the most recent incarnation of the House bill provides a 0.5% update for 2014-2016. The current form of the Senate bill, however, retains the full 10-year payment freeze. We cannot predict whether the SGR will be repealed or if another formula would be substituted and what form that might take. Repeal of the SGR could be offset by further reductions in Medicare payments.

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 in 2013. In particular, a 2% reduction in Medicare payments took effect on April 1, 2013. The across-the-board spending cuts pursuant to the sequestration have adversely affected HCP and will continue to adversely affect their 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. See "—Governmental regulation" below.

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 30% in 2014 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, beginning in 2014, health plans offering Medicare Advantage will be 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 (Knox-Keene entity) it is not subject to the 85% MLR requirement. 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 health care 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 health care services, including preventative care, and to control health care 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 health care services by contracting with a network of medical providers, such as HCP. HCP has entered into capitation agreements with health plans to manage approximately 139,000 Medicaid managed care members in its southern California and Florida markets.

Commercial payors

According to a survey conducted from January through May 2014 by the Kaiser Family Foundation and the Health Research and Education Trust, approximately 62% of non-elderly U.S. citizens received their health care benefits through their employers, which contracted with health plans to administer these health care 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 149 million in 2014, according to the survey conducted by the Kaiser Family Foundation and the percentage of workers covered statistically remains unchanged at 62% from 2013. Under the Health Reform Acts, beginning in 2014, many uninsured individuals and many individuals who receive their health insurance benefits through small employers may purchase their health care 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 health care 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' health care 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 health care 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 only professional services.

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 health care service plan 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 is currently in the process of obtaining such license. 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. As indicated above, HCP only assumed financial responsibility for professional services in New Mexico.

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), 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 the Knox-Keene licensee. 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 Office of Inspector General (OIG), the U.S. Department of Justice, 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 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 electronic PHI may subject HCP to sanctions and penalties under the federal HIPAA of 1996 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 health care 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. Some 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 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 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 HealthCare Partners Affiliates Medical Group and HealthCare Partners Associates Medical Group, Inc. (collectively 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 independent practice association 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 an Arizona professional entity (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 and Nevada management services agreements, which might include a modification of the management fee, and/or establishing an alternative structure. For example, 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 the HCP-owned licensed entity 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) such as health plans 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 health care expenditures (except those paid on a capitated basis or managed hospital payment basis) plus 4% of the annualized health care 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 health care services contract in which a downstream contracting entity agrees to provide both professional (e.g., medical group) services and institutional (e.g., 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.

One of HCP's subsidiaries (the Plan) 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 the Plan 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 the Knox-Keene Act and its regulations. Under its restricted Knox-Keene license, the Plan is prohibited from declaring or paying any dividends or making any distribution of cash or property to the Plan's parent, affiliates, or shareholders, if such a distribution would cause the Plan 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 health care services. In addition, the Plan is subject to DMHC oversight and must seek approval before incurring any debt or guaranteeing any debt relating to the Plan's parent, affiliates, or shareholders. The Plan must also submit proposed global capitation contracts to DMHC for approval.

HCP services

Approximately 91% of HCP's operating revenues for the year ended December 31, 2014 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 health care 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, 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, 2014, HCP's total consolidated operating revenues were $3.5 billion and total care dollars under management were $4.5 billion.

HCP provides complete medical care through a network of participating physicians and other health care professionals. Through its group model, HCP employs, directly (where permitted by state law) and through its associated physician groups, approximately 470 associated group full-time primary care physicians. Through its IPA model, HCP contracts with approximately 3,300 additional network primary care physicians who provide care for HCP's members in an independent office setting. These physicians are complemented by a network of several thousand specialists and ancillary providers and 228 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.

A typical FFS primary care physician might treat up to 30 to 40 patients per day. In contrast, HCP group physicians typically see 18 to 20 patients per day, which we believe is a more 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 health care 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 health care). 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 health care. 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 health care 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. health care 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 nearly three 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, 2014.

Locations of HCP clinics

As of December 31, 2014, HCP managed a total of 212 medical clinics, of which 65 clinics were located in California, 81 clinics were located in Florida, 49 clinics were located in Nevada and 17 clinics were located in New Mexico. 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. 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.

The two largest dialysis companies, Fresenius Medical Care (FMC) and our company, account for approximately 71% of outpatient dialysis patients in the U.S. with our company serving approximately 35% of the total outpatient dialysis patients. Approximately 46% 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 their ability to manufacture their 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 an agreement with FMC to purchase a certain amount of dialysis equipment, parts and supplies from FMC through 2013. This agreement was subsequently amended to extend our commitment through 2015. In addition, in August 2006 in connection with the DVA Renal Healthcare acquisition, we entered into a product supply agreement with Gambro Renal Products, Inc. (Gambro) that requires us to purchase a certain amount of our hemodialysis non-equipment product supplies, such as dialyzers, at fixed prices through 2015. Our purchases of products in these categories generally offered by both FMC and Gambro represent approximately 4% of our total U.S. dialysis operating expenses. In 2014, we purchased hemodialysis products and supplies from both FMC and Gambro that each represented approximately 2% of our total U.S. dialysis operating expenses.

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 Corporate Integrity Agreement (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, annual certifications from senior executives that evidence compliance with federal healthcare laws and regulations, internal compliance policies, the CIA, an executive recoupment program and quarterly and annual reports to the OIG;
- requires the formal allocation of certain oversight responsibility to the Board's 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 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,
  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; and
- requires that we engage an Independent Monitor who will provide additional oversight and reporting to the OIG for the term of the CIA.

The costs associated with compliance with the CIA 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 health care programs. 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 in which HCP owns a 67% equity interest.

Teammates

As of December 31, 2014, we employed approximately 57,900 teammates, including our international teammates:

· Licensed professional staff (physicians, nurses and other healthcare professionals)	24,000
· Other patient care and center support staff and laboratory personnel	23,600
· Corporate, billing and regional administrative staff	10,300

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 33% of our dialysis and related lab services revenues for the year ended December 31, 2014, were generated from patients who have commercial payors as their primary payor. The majority of these patients have insurance policies that pay us on terms and at rates that are generally significantly higher than Medicare rates. The payments we receive from commercial payors generate nearly all of our profit and all of our nonacute dialysis profits come from commercial payors. We continue to experience downward pressure on some of our commercial payment rates as a result of general conditions in the market, recent and future consolidations among commercial payors, increased focus on dialysis services and other factors. There is no guarantee that commercial payment rates will not be materially lower in the future.

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

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

Our revenue levels are sensitive to the percentage of our patients with higher-paying commercial insurance coverage. A patient's insurance coverage may change for a number of reasons, including changes in the patient's or a family member's employment status. Currently, for a patient covered by an employer group health plan, Medicare generally

becomes the primary payor after 33 months, or earlier, if the patient's employer group health plan coverage terminates. When Medicare becomes the primary payor, the payment rate we receive for that patient decreases from the employer group health plan rate to the lower Medicare payment rate. We have seen an increase in the number of patients who have government-based programs as their primary payors which we believe is largely a result of improved mortality and recent economic conditions which have a negative impact on the percentage of patients covered under commercial insurance plans. To the extent there are sustained or increased job losses in the U.S., independent of whether general economic conditions might be improving, we could experience a continued decrease in the number of patients covered under commercial plans. We could also experience a further decrease if changes to the healthcare regulatory system result in fewer patients covered under commercial plans or an increase of patients covered under more restrictive commercial plans with lower reimbursement rates. In addition, our continuous process of negotiations with commercial payors under existing or potentially new agreements could result in a decrease in the number of patients under commercial plans to the extent that we cannot reach agreement with commercial payors on rates and other terms, resulting in termination or non-renewals of existing agreements or our inability to enter into new ones. If there is a significant reduction in the number of patients under higher-paying commercial plans relative to government-based programs that pay at lower rates, it would have a material adverse effect on our revenues, earnings and cash flows.

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

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

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

- Risk that our rates are reduced by CMS. Uncertainty about future payment rates remains a material risk to our business. CMS issued the 2014 final rule for the ESRD prospective payment system (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” which will reduce our market basket inflation adjustment by - 1.25% in 2016 and 2017, and 1% in 2018. CMS also recently issued the 2015 final rule for the ESRD PPS, which will increase payments to dialysis facilities modestly by 0.3% to 0.5%, although rural facilities will receive a decrease of 0.5%.
- 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 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 across-the-board spending cuts pursuant to the sequester have affected and will continue to adversely affect our revenues, earnings and cash flows.
- Risk that 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 additional details regarding the risks we face for failing to adhere to our Medicare and Medicaid regulatory compliance obligations, see the risk factor below under the heading “If we fail to adhere to all of the complex government regulations that apply to our business, we could suffer severe consequences that would substantially reduce our revenues, earnings, cash flows and stock price”.

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

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

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

flows could be adversely affected.

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

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

The CMS Center for Medicare & Medicaid Innovation (Innovation Center) is currently working with various healthcare providers to develop, 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, Comprehensive ESRD Care Model (which includes the development of ESCOs), the Comprehensive Primary Care Initiative, the Duals Demonstration, and other models, will impact the health care 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 seeking to participate in the Comprehensive ESRD Care Model with the Innovation Center. Even if we do not participate in this or other programs, some of our patients may be assigned to a program, in which case the quality and cost of care that we furnish will be included in an ACO's or other programs' calculations. As new models of care emerge 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. The enacted reforms as well as future legislative changes could have a material adverse effect on our results of operations, including lowering our reimbursement rates and increasing our expenses.

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

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

The VA 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 and related lab services revenues for the year ended December 31, 2014 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 prospective payment system such that dosing variations do not change the amount paid to a dialysis facility. Although some Medicaid programs and other payors suggest movement towards a bundled payment system inclusive of EPO, some non-Medicare payors continue to pay for EPO separately from the treatment rate. The administration of EPO and other pharmaceuticals that are separately billable accounted for approximately 3% of our dialysis and related lab services revenues for the year ended December 31, 2014, with EPO alone accounting for approximately 2% of our dialysis and related lab services revenues during that period. Changes in physician clinical practices that result in further decreased utilization of prescribed pharmaceuticals or changes in payment rates for those pharmaceuticals could reduce our revenues, earnings and cash flows.

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

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

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

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

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

We are the subject of a number of investigations by the federal government. We have received subpoenas or other requests for documents from the federal government in connection with the Vainer private civil suit, the Swoben private civil suit, the 2011 U.S. Attorney Medicaid investigation and the 2015 U.S. Attorney Transportation Investigation.

In each of the Vainer and Swoben private civil suits, a relator filed a complaint against us in federal court under the qui tam provisions of the False Claims Act (FCA) (and in the Swoben matter, provisions of the California False Claims Act, as well) and pursued the claims independently after the government declined to intervene. With regard to the Vanier private civil suit, the parties are engaged in active litigation, and in August 2014, the court reopened fact discovery. With regard to the Swoben private civil suit, in July 2013, the court granted HCP's motion and dismissed with prejudice all of the claims in the Third Amended Complaint, and in October 2013 the plaintiff filed an appeal of the dismissal, which is currently pending. (See Note 17 to the consolidated financial statements of this report for additional details regarding these matters).

If we fail to comply with our Corporate Integrity Agreement, we could be subject to substantial penalties and exclusion from participation in federal health care programs that may adversely impact our revenues, earnings and cash flows.

In October 2014, we entered into the Settlement Agreement with the United States and relator David Barbetta to resolve the pending 2010 and 2011 U.S. Attorney Physician Relationship Investigations. 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 health care programs, we have entered into the five-year Corporate Integrity Agreement (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, reporting, certification, records retention and training obligations, the formal allocation of certain oversight responsibility to the Board's Compliance Committee, the creation of a Management Compliance Committee and the retention of an independent compliance advisor to the Board, and (iv) contains certain business restrictions related to a subset of our joint venture arrangements, including our agreeing to: (1) unwind 11 joint venture transactions that were created through partial divestitures to or partial acquisitions from nephrologists and that cover 26 of our 2,119 clinics that existed at the time we entered into the Settlement Agreement; (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. 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, or could be excluded from participation in federal health care programs. The costs associated with compliance with the CIA, or any liability or consequences associated with its breach, could have an adverse effect on our revenues, earnings and cash flows.

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

Our dialysis operations are subject to extensive federal, state and local government regulations, including Medicare and Medicaid payment rules and regulations, federal and state anti-kickback laws, the physician self-referral law (Stark Law) and analogous state self-referral prohibition statutes, Federal Acquisition Regulations, the FCA and federal and state laws regarding the collection, use and disclosure of patient health information and the storage, handling and administration of pharmaceuticals. The Medicare and Medicaid reimbursement rules related to claims

submission, enrollment and licensing requirements, cost reporting, and payment processes impose complex and extensive requirements upon dialysis providers as well. A violation or departure from any of these legal requirements may result in government audits, lower reimbursements, significant fines and penalties, the potential loss of certification, recoupment efforts or voluntary repayments.

We endeavor to comply with all legal requirements, however, there is no guarantee that we will be able to adhere to all of the complex government regulations that apply to our business. We further endeavor to structure all of our relationships with physicians to comply with state and federal anti-kickback and physician self-referral laws. We utilize considerable resources to monitor the laws and implement necessary changes. However, the laws and regulations in these areas are complex and often subject to varying interpretations. For example, if an enforcement agency were to challenge the level of compensation that we pay our medical directors or the number of medical directors whom we engage, we could be required to change our practices, face criminal or civil penalties, pay substantial fines or otherwise experience a material adverse effect as a result of a challenge to these arrangements. In addition, amendments to the FCA impose severe penalties for the knowing and improper retention of overpayments collected from government payors. These amendments could subject our procedures for identifying and processing overpayments to greater scrutiny. We have made significant investments in new resources to decrease the time it takes to identify and process overpayments and we may be required to make additional investments in the future. An acceleration in our ability to identify and process overpayments could result in us refunding overpayments to government and other payors more rapidly than we have in the past which could have a material adverse effect on our operating cash flows. Additionally, amendments to the federal anti-kickback statute in the health reform law make anti-kickback violations subject to FCA prosecution, including qui tam or whistleblower suits.

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

- Suspension or termination of our participation in government payment programs;
- Refunds of amounts received in violation of law or applicable payment program requirements;
- Loss of required government certifications or exclusion from government payment programs;
- Loss of licenses required to operate health care facilities or administer pharmaceuticals in some of the states in which we operate;
- Reductions in payment rates or coverage for dialysis and ancillary services and related pharmaceuticals;
- Fines, damages or monetary penalties for anti-kickback law violations, Stark Law violations, FCA violations, civil or criminal liability based on violations of law, or other failures to meet regulatory requirements;
- Enforcement actions by governmental agencies and/or state claims for monetary damages by patients who believe their protected health information has been used, disclosed or not properly safeguarded in violation of federal or state patient privacy laws, including Health Insurance Portability and Accountability Act (HIPAA) of 1996;
- Mandated changes to our practices or procedures that significantly increase operating expenses;
- Imposition of and compliance with corporate integrity agreements that could subject us to ongoing audits and reporting requirements as well as increased scrutiny of our billing and business practices which could lead to potential fines;
- Termination of relationships with medical directors; and
- Harm to our reputation which could impact our business relationships, affect our ability to obtain financing and decrease access to new business opportunities.

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

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

cause us to incur write-offs of investments or accelerate the recognition of lease obligations in the event we have to close centers or our centers' operating performance deteriorates, and it could have an adverse effect on our revenues, earnings and cash flows.

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

As of December 31, 2014, we owned a controlling interest in numerous dialysis-related joint ventures, which represented approximately 22% of our U.S. dialysis and related lab services revenues for the year ended December 31, 2014. In addition, we also owned minority equity investments in several other dialysis related joint ventures. We may continue to increase the number of our joint ventures. Many of our joint ventures with physicians or physician groups also have certain physician owners providing medical director services to centers we own and operate. Because our relationships with physicians are governed by the federal and state anti-kickback statutes, we have sought to structure our joint venture arrangements to satisfy as many federal safe harbor requirements as we believe are commercially reasonable. However, if 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 the Settlement Agreement with the United States and relator David Barbetta to resolve the then pending 2010 and 2011 U.S. Attorney Physician Relationship Investigations. 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 health care 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 173,000 U.S. patients at any point in time, together with the changes in patient coverage that occur each month, requires complex, resource-intensive processes. Errors in determining the correct coordination of benefits may result in refunds to payors. Revenues associated with Medicare and Medicaid programs are also subject to estimating risk related to the amounts not paid by the primary government payor that will ultimately be collectible from other government programs paying secondary coverage, the patient’s commercial health plan secondary coverage or the patient. Collections, refunds and payor retractions typically continue to occur for up to three years and longer after services are provided. We generally expect our range of U.S. dialysis and related lab services revenues estimating risk to be within 1% of net revenues for the segment, which represents approximately 5% of dialysis 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, 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 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 as well as further disruptions in the financial markets could have a material adverse effect on our revenues, earnings and cash flows and otherwise adversely affect our financial condition.

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. Increasing job losses or slow improvement in the unemployment rate 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 health care providers. This nursing shortage may limit our ability to expand our operations. In addition, changes in certification requirements or increases in the required staffing levels for skilled clinical personnel can impact our ability to maintain sufficient staff levels to the extent our teammates are not able to meet new requirements or we experience a higher than normal turnover rate due to increased competition for qualified clinical personnel. If we are unable to hire skilled clinical personnel when needed, or if we experience a higher than normal turnover rate for our skilled clinical personnel, our operations and

treatment growth will be negatively impacted, which would result in reduced revenues, earnings and cash flows.

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

Our business is labor intensive, and our results are subject to variations in labor-related costs, productivity and the number of pending or potential claims against us related to labor and employment practices. If political 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 migration to a new billing and collections system could have a material adverse effect on our revenues, cash flows and operating results.

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

Risk factors related to HCP:

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

As a participant in the healthcare industry, HCP is subject to many of the same risks to which our dialysis business is subject to as described in the risk factors set forth above in this Part II, 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 is derived from fixed Per Member Per Month (PMPM) fees paid by health plans under capitation agreements with HCP or its associated physician groups. While there are variations specific to each arrangement, HCP, through DaVita HealthCare Partners Plan, Inc., a subsidiary of HealthCare Partners Holdings, LLC and a restricted Knox-Keene licensed entity (DaVita HealthCare Partners Plan), 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 HCP's and DaVita's future revenues and profitability.

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

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

In California and Nevada, HCP operates by maintaining long-term contracts with its associated physician groups which are each owned and operated by physicians and which employ or contract with additional physicians to provide physician services. Under these arrangements, HCP provides management services 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 California and Nevada physician groups through succession agreements and other arrangements with their physician equity holders. However, such equity interests cannot be transferred to or held by HCP or by any non-professional organization. Accordingly, neither HCP nor HCP's subsidiaries directly own any equity interests in any physician groups in California and Nevada. In the event that any of these associated physician groups fails to comply with the management arrangement or any management arrangement is terminated and/or HCP is unable to enforce its contractual rights over the orderly transfer of equity interests in its associated physician groups, such events could have a material adverse effect on HCP's business, financial condition or results of operations.

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

physician groups. Such a determination could force a restructuring of HCP's management arrangements with associated physician groups in California and/or Nevada, which might include revisions of the management services agreements, including a modification of the management fee and/or establishing an alternative structure, which would permit HCP to contract with a physician network without violating the corporate practice of medicine prohibition. There can be no assurance that such a restructuring would be feasible, or that it could be accomplished within a reasonable time frame without a material adverse effect on HCP's operations and financial results. In December 2013, DaVita HealthCare Partners Plan obtained a restricted Knox-Keene license in California pursuant to the California Knox-Keene Health Care Service Plan Act of 1975 (the Knox-Keene Act), which permits DaVita HealthCare Partners Plan to contract with health plans in California to accept global risk without violating the corporate practice of medicine prohibition. However, HCP's Nevada associated physician groups and HCP, as well as those physician equity holders of associated physician groups who are subject to succession agreements with HCP, could be subject to criminal or civil penalties or an injunction for practicing medicine without a license or aiding and abetting the unlicensed practice of medicine.

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

HCP's financial statements are consolidated 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 DaVita HealthCare Partners Plan, Inc. is not able to satisfy financial solvency or other regulatory requirements, DaVita HealthCare Partners Plan, Inc. could become subject to sanctions and its license to do business in California could be limited, suspended or terminated.

The Knox-Keene Act requires health care service plans operating in California to comply with financial solvency and other requirements overseen by the California Department of Managed Health Care (DMHC). Under the Knox-Keene Act, DaVita HealthCare Partners Plan, Inc. is required to, among other things:

- Maintain, at all times, a minimum tangible net equity;
- 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, Inc.'s operations and compliance with the Knox-Keene Act.

In the event that DaVita HealthCare Partners Plan, Inc. is not in compliance with the provisions of the Knox-Keene Act, 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 Department of Managed Health Care's financial solvency requirements, HCP's associated physician group could become subject to sanctions and HCP's ability to do business in California could be limited or terminated.

The California 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 the Knox-Keene Act requirements related to claims payment

timeliness had maintained positive tangible net equity (i.e., at least $1.00), and had maintained positive working capital (i.e., at least $1.00).

In the event that 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, including those recently approved and effective in 2014, such as reductions in or limitations of reimbursement amounts or rates under programs, reductions in funding of programs, expansion of benefits without adequate funding, elimination of coverage for certain benefits, or elimination of coverage for certain individuals or treatments under programs, could have a material adverse effect on HCP's revenues, earnings and cash flows. On April 7, 2014 CMS issued final guidance for 2015 Medicare Advantage rates, which incorporated a re-blending of the risk adjustment models that CMS utilizes to determine risk acuity scores of Medicare Advantage patients. In 2014, CMS blended the risk scores calculated using the 2013 CMS-HCC model and the 2014 CMS-HCC model by weighting the scores from the 2013 model by 25% and the scores from the 2014 model by 75%. In 2015, CMS will blend the scores by 67% and 33%, respectively. Although we estimate that the final cumulative impact of the 2015 rate structure represents an increase of up to approximately 0.5% of HCP's average Medicare Advantage revenues as compared to 2014, there is no guarantee that CMS's risk acuity adjustment models and the resulting Medicare Advantage rates will, in the future, increase HCP's Medicare Advantage revenues.

On February 20, 2015, CMS issued its Advance Notice detailing preliminary 2016 Medicare Advantage benchmark payment rates (the Advance Notice). CMS has invited public comment on these preliminary rates before releasing final rates on April 6, 2015.

Based upon our preliminary analysis, we estimate that if rates in the Advance Notice were implemented as proposed it would lead to a reduction in Medicare Advantage rates to HCP of approximately 4%, or a net impact of approximately $100 million to 2016 operating income. This compares to an industry average rate cut of approximately 0.95% as indicated by CMS in the Advance Notice.

This more significant decline in Medicare Advantage rates for us is driven by a larger-than-average decline associated with CMS's adjustment to the risk model calculation. The proposed move to the 2014 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.

The Advance Notice is a preliminary rule and benchmark rates may be different in the final rule expected to be announced on April 6, 2015. Furthermore, the impact to specific geographies will not be known until the final rate announcement; historically, county-level changes have varied from national rate changes – and may vary in the final rule.

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. Failure to meet these revised benchmarks may have a significant negative impact on HCP's revenues, earnings and cash flows.

- Rebates received by Medicare Advantage plans that underbid based on payment benchmarks will be reduced, with larger reductions for plans failing to receive certain quality ratings.
- The Secretary of the HHS has been granted the explicit authority to deny Medicare Advantage plan bids that propose significant increases in cost sharing or decreases in benefits. If the bids submitted by plans contracted with HCP are denied, this would have a significant negative impact on HCP's revenues, earnings and cash flows.
- 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. 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 in 2014, which reduced 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 proposed 2015 budget proposed nearly $400 billion in cuts to Medicare, Medicaid and other programs run by HHS over the next decade. Although the majority of the cuts are not targeted at Medicare Advantage plans, the broad cuts could signal further downward pressure on reimbursement to Medicare providers and Medicare Advantage plans, which would have a negative impact on HCP's revenues, earnings and cash flows. The final 2015 budget did not contain significant changes to Medicare funding, but cuts in future budgets 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 Congressional Budget Office (CBO) predicted in 2012 that Medicare Advantage participation would drop precipitously by 2020, in 2013 the CBO reversed its prediction and instead predicted that enrollment in Medicare Advantage could increase by up to 50% in the next decade. 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 proposed in February 2014. On February 20, 2015, CMS announced its proposed 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.

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, 2014, 64% 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 and New Mexico, and may not be able to successfully establish a presence in new geographic regions.

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

To expand the operations of its network outside of the Existing Geographic Regions, HCP must devote resources to identifying and exploring such perceived opportunities. Thereafter, HCP must, among other things, recruit and retain qualified personnel, develop new offices, establish potentially new relationships with one or more health plans, and establish new relationships with physicians and other healthcare providers. The ability to establish such new relationships may be significantly inhibited by competition for such relationships and personnel in the health care marketplace in the targeted new geographic regions. Additionally, HCP may face the risk that a substantial portion of the patients served in a new geographic area may be enrolled in a Medicare FFS program and will not desire to transition to a Medicare Advantage program, such as those offered through the health plans that HCP serves, or they may enroll with other health plans with whom HCP does not contract to 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, or RAF, scores attributable to members. These RAF scores determine, in part, the revenue to which the health plans and, in turn, HCP is entitled for the provision of medical care to such members. The data submitted to CMS by each health plan is based, in part, on medical charts and diagnosis codes prepared and submitted by HCP. Each health plan generally relies on HCP to appropriately document and support such RAF data in HCP's medical records. Each health plan also relies on HCP to appropriately code claims for medical services provided to members. HCP may periodically review medical records and may find inaccurate or unsupportable coding or otherwise inaccurate records. Erroneous claims and erroneous encounter records and submissions could result in inaccurate PMPM fee revenue and risk adjustment payments, which may be subject to correction or retroactive adjustment in later periods. This corrected or adjusted information may be reflected in financial statements for periods subsequent to the period in which the revenue was recorded. HCP might also need to refund a portion of the revenue that it received,

which refund, depending on its magnitude, could damage its relationship with the applicable health plan and could have a material adverse effect on HCP's results of operations, financial condition or cash flows.

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

CMS has indicated that 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. Since the CMS rules, regulations, and statements regarding this audit program are still not well defined and, in some cases, have not been published in final form, there is also a risk that CMS may adopt new rules and regulations that are inconsistent with their existing rules, regulations, and statements.

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

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

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

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

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

- As a result of the direct and indirect impacts of the Health Reform Acts, many Medicare beneficiaries may decide that an original FFS Medicare program is more attractive than a Medicare Advantage plan. As a result, enrollment in the health plans HCP serves may decrease.
- Managed care companies offer alternative products such as regional preferred provider organizations (PPOs) and private FFS plans. Medicare PPOs and private FFS plans allow their patients more flexibility in selecting physicians

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

- The payments for the local and regional Medicare Advantage plans are based on a competitive bidding process that may indirectly cause a decrease in the amount of the PMPM fee or result in an increase in benefits offered.
- The annual enrollment process and subsequent lock-in provisions of the Health Reform Acts may adversely affect HCP's level of revenue growth as it will limit the ability of a health plan to market to and enroll new Medicare beneficiaries in its established service areas outside of the annual enrollment period.

- 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 its subsidiary 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.

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

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

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

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

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

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 health care regulatory developments.

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

CMS has mandated the use of new patient codes for reporting medical diagnosis and inpatient procedures, referred to as ICD-10, 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 the date that CMS sets must use ICD-10 for medical diagnosis and inpatient procedures or they will not be paid. We anticipate that if our services, processes or information systems or those of our payors do not comply with ICD-10 requirements at any future date, it could potentially delay or even reduce reimbursement payments to us. These delays or reductions could negatively impact our revenues, earnings and cash flows.

While Congress voted to delay the ICD-10 implementation deadline until no earlier than October 1, 2015, CMS has the authority to delay implementation even further, which leads to uncertainty about when ICD-10 will be mandated. Such uncertainty could lead to additional costs of running both ICD-9 and ICD-10 systems, which 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 protected health information (PHI), including HIPAA and its implementing privacy and security regulations, as amended by the federal HITECH Act and collectively referred to as HIPAA. 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; 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 protected health information, 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.

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, Fresenius, our largest competitor, manufactures a full line of dialysis supplies and equipment in addition to owning and operating dialysis centers. This may give it cost advantages over us because of its ability to manufacture its own products. If we are not able to continue to make acquisitions, continue to maintain acceptable levels of non-acquired growth, or if we face significant patient attrition to our competitors or a reduction in the number of our medical directors or associated physicians, it could adversely affect our business.

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

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

If we fail to successfully maintain an effective internal control over financial reporting, 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. The high level of our indebtedness, among other things, 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.

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 related to our historical billing practices and the historical billing practices of the centers acquired from Gambro Healthcare and other matters related to their settlement agreement with the Department of Justice. Although the ultimate outcome of these claims cannot be predicted, an adverse result with respect to one or more of these claims could have a material adverse effect on our financial condition, results of operations, and cash flows. We currently maintain insurance coverage for those risks we deem are appropriate to insure against and make determinations about whether to self-insure as to other risks or layers of coverage. However, a successful claim, including a professional liability, malpractice or negligence claim which is in excess of any applicable insurance coverage, or that is subject to our self-insurance retentions, could have a material adverse effect on our earnings and cash flows.

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, 2014, these cash bonuses would total approximately $646 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 six other outpatient dialysis centers and the building at one of our Florida labs and we own two separate land parcels and sublease a total of four 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 15 years and typically contain renewal options of five to ten years at the fair rental value at the time of renewal. Our leases are generally subject to periodic consumer price index increases, or contain fixed escalation clauses. Our outpatient dialysis centers range in size from approximately 500 to 33,000 square feet, with an average size of approximately 7,000 square feet. HCP's clinics range in size from approximately 800 to 102,000 square feet, with an average size of approximately 9,000 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 and related Warehouse	Denver, CO	82,000	2018
Administrative Office	Vernon Hills, IL	33,000	2019
Administrative Office	Centennial, CO	29,000	2018
Administrative Office	Washington DC	5,000	2019
Administrative Office	Tempe, AZ	3,000	2016
Business Office	Tacoma, WA	119,000	2015 through 2021
Business Office	Federal Way, WA	187,000	2023
Business Office	Malvern, PA	120,371	2022
Business Office	Brentwood, TN	95,000	2021
Business Office	El Segundo, CA	71,000	2023
Business Office	Irvine, CA	65,000	2015
DaVita Rx	Coppell, TX	135,200	2019
DaVita Rx	Orlando, FL	50,979	2020
DaVita Rx	San Bruno, CA	7,200	2017
Laboratory Warehouse and Offices	DeLand, FL	53,351	2014 through 2016
Laboratory	Ft. Lauderdale, FL	43,000	2019
Laboratory	DeLand, FL	42,620	Owned
Laboratory Office	Miami, FL	1,000	2014
HCP's business:			
Business Office	El Segundo, CA	11,000	2016
Business Office	Chicago, IL	9,000	2015
Business Office	Costa Mesa, CA	5,000	2016
Business Office	Boston, MA	4,000	2017
Business Office	Rochester, NY	4,000	2016
Administrative Office	Torrance, CA	207,000	2015 through 2021
Administrative Office	Albuquerque, NM	135,000	2016
Administrative Office	Los Angeles, CA	46,000	2015 through 2021
Administrative Office	St. Petersburg, FL	43,000	2020
Administrative Office	Las Vegas, NV	37,000	2015 through 2016
Administrative Office	Costa Mesa, CA	27,000	2017
Administrative Office	Arcadia, CA	24,000	2019
Administrative Office	Phoenix, AZ	14,000	2019
Administrative Office	Peoria, AZ	6,000	2016
Administrative Office	Coral Springs, FL	4,000	2018
Administrative Office	Fort Harrison, FL	2,000	2018
Administrative Office	Orlando, FL	2,000	2013
International business:			
Administrative Office	Singapore, Singapore	57,100	2017
Administrative Office	Kuala Lumpur, Malaysia	18,700	2015 through 2016

Administrative Office	Bogota, Colombia	7,500	2023
Administrative Office	Bangalore, India	4,600	2016 through 2021
Administrative Office	Benxi, China	3,600	2015
Administrative Office	Amsterdam, Netherlands	3,300	2016
Administrative Office	Shanghai, China	2,900	2015 through 2016
Administrative Office	Taipei, Taiwan	2,200	2017
Administrative Office	Hamburg, Germany	2,000	2020
Administrative Office	Wroclaw, Poland	1,200	2017
Administrative Office	Carnaxide, Portugal	800	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

Vainer Private Civil Suit: In December 2008, we received a subpoena for documents from the Office of Inspector General (OIG) for HHS relating to the pharmaceutical products Zemplar, Hectorol, Venofer, Ferrlecit and erythropoietin (EPO), as well as other related matters. The subpoena covered the period from January 2003 to December 2008. We were advised by the U.S. Attorney's Office for the Northern District of Georgia and the U.S. Department of Justice in Washington, DC that this was a civil inquiry. On June 17, 2009, we learned that the allegations underlying this inquiry were made as part of a civil complaint filed by individuals and brought pursuant to the qui tam provisions of the federal False Claims Act. On April 1, 2011, the U.S. District Court for the Northern District of Georgia ordered the case to be unsealed. At that time, the Department of Justice and U.S. Attorney's Office filed a notice of declination stating that the federal government would not be intervening and not pursuing the relators' allegation in litigation. On July 25, 2011, the relators, Daniel Barbir and Dr. Alon Vainer, filed their amended civil complaint in the U.S. District Court for the Northern District of Georgia, purportedly on behalf of the federal government. The amended complaint alleges that our drug administration practices for our dialysis operations for Vitamin D and iron agents from 2003 through 2010 fraudulently created unnecessary waste, which was billed to and paid for by the government. The amended complaint seeks monetary damages and civil penalties as well as costs and expenses. The parties completed discovery in early 2014; however, in August 2014, the Court granted relators' motion for sanctions and reopened discovery on a limited basis. We are vigorously defending this matter and intend to continue to do so. We can make no assurances as to the time or resources that will be needed to devote to this litigation. We cannot predict the ultimate outcome of this case, but if the case is resolved in favor of the plaintiffs, its resolution could have a material adverse effect on our earnings and cash flows.

2010 U.S. Attorney Physician Relationship Investigation: As previously disclosed, the U.S. Attorney's Office for the District of Colorado and the OIG investigated, among other things, our financial relationships with physicians and joint ventures, and whether those relationships and joint ventures comply with the federal anti-kickback statute and the False Claims Act. This investigation has been described in our prior Reports on Forms 10-K and 10-Q and referred to as the 2010 U.S. Attorney Physician Relationship Investigation. This investigation overlapped substantially with the investigation described below under the caption 2011 U.S. Attorney Physician Relationship Investigation. We disclosed in early 2014 that we had reached an agreement in principle with the government to resolve these matters.

As described more fully in our current report on Form 8-K filed on October 23, 2014, and as also disclosed in our prior report on Form 10-Q for the quarter ended September 30, 2014 that was filed with the SEC on November 6, 2014, we entered into a final settlement agreement on October 22, 2014 (the Settlement Agreement) with the United States of America, acting through the United States Department of Justice and on behalf of the OIG, the Defense

Health Agency on behalf of TRICARE, through its General Counsel (collectively, the United States) and relator David Barbetta, to resolve the 2010 and 2011 U.S. Attorney Physician Relationship Investigations. In connection with the resolution of these matters, we agreed to pay and have now paid to the United States $350 million plus accrued interest from the date of our agreement in principle with the United States, plus a civil forfeiture of $39 million. In addition, we agreed to and have paid a settlement of certain state Medicaid claims in the amount of $11.5 million plus interest. Under the Settlement Agreement, among other things, the United States agrees to release us from any civil or administrative monetary liability arising from allegations that we caused the submission of claims to the federal health care programs that were ineligible for reimbursement due to certain violations of the anti-kickback statute in connection with certain of its dialysis center joint venture arrangements, and the United States and the relator agree to dismissal of the civil action filed by the relator under the qui tam provisions of the federal False Claims Act. We also have entered into a five-year corporate integrity agreement (the CIA) with the OIG. The CIA, among other things, (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, reporting, certification, records retention and training obligations, the formal allocation of certain oversight responsibility to the Board's Compliance Committee, the creation of a Management Compliance Committee and the retention of an independent compliance advisor to the Board, and (iv) contains certain business restrictions related to a subset of our joint venture arrangements, including our agreeing to: (1) unwind 11 joint venture transactions that were created through partial divestitures to or partial acquisitions from nephrologists and that cover 26 of our 2,119 clinics that existed at the time we entered into the Settlement Agreement; (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. In the event of a breach of the CIA, we could become liable for payment of certain stipulated penalties, or could be excluded from participation in federal health care programs. The costs associated with compliance with the CIA could be substantial and may be greater than we currently anticipate. In 2013, we accrued a loss contingency reserve of $397 million related to this matter. In the third quarter of 2014, we accrued an additional $17 million related to this matter which resulted in an increase in the reserve from $397 million to $414 million.

2011 U.S. Attorney Physician Relationship Investigation: In August 2011, we announced we had learned that the U.S. Attorney's Office for the District of Colorado would be investigating certain activities of our dialysis business in connection with information being provided to a grand jury. This investigation 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 overlapped substantially with the 2010 U.S. Attorney Physician Relationship Investigation described above. As also described above, both the 2010 and 2011 U.S. Attorney Physician Relationship Investigations have now been resolved. The United States has informed us that it has declined to proceed with any criminal charges in connection with this matter.

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 relates 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 that certain other providers that operate dialysis clinics in New York may be receiving or 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 to resolve this matter. The specific terms of a settlement have not been finalized.

Swoben Private Civil Suit: In April 2013, our HealthCare Partners (HCP) subsidiary was served with a civil complaint filed by a former employee of SCAN Health Plan (SCAN), a health maintenance organization (HMO). On July 13, 2009, pursuant to the qui tam provisions of the federal False Claims Act 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 False Claims Act 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 Risk Adjustment Factor (RAF) scores. The complaint sought monetary damages and civil penalties as well as costs and expenses. The United States Department of Justice 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 the Centers of Medicare & Medicaid Services. 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 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 the respective dialysis center. We have been advised by an attorney with the Civil Division of 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 or 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.

Except for the private civil complaints filed by the relators 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, to the extent criminal proceedings may be 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.

Shareholder Derivative Claims

In re DaVita HealthCare Partners Inc. Derivative Litigation: On January 7, 2014, the U.S. District Court for the District of Colorado consolidated the two previously disclosed shareholder derivative lawsuits: the Haverhill Retirement System action filed on May 17, 2013 and the Clark Shareholder action filed on August 7, 2012. The court appointed Haverhill lead plaintiff. The complaints filed against the directors of the Company and against the Company, as nominal defendant allege, among other things, that our directors breached fiduciary duties to the Company relating to the 2010 and 2011 U.S. Attorney Physician Relationship Investigations described above, the Vainer qui tam private civil suit described above and the Woodard qui tam private civil suit for which we previously announced a settlement in July 2012. We have entered into a settlement with the lead plaintiff, subject to court approval. The terms of the settlement, which were described in a court-ordered notice sent to shareholders in late January 2015, include enhancements to our corporate governance practices and provides that we will not oppose the derivative plaintiff's application for an award of fees and expenses, the dollar amount of which is not material to us. On January 8, 2015, the Court entered an order preliminarily approving the settlement, directing that the notice to shareholders be provided as described above and setting a settlement fairness hearing on May 1, 2015.

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 the Company, related to historical Gambro Healthcare billing practices and other matters covered by its 2004 settlement agreement with the Department of Justice and certain agencies of the U.S. government. We have received no further indication that any of these claims are active, and some of them may be barred by applicable statutes of limitations. To the extent any of these claims might proceed, we intend to defend against them vigorously; however, we may not be successful and these claims may lead to litigation and any such litigation may be resolved unfavorably. At this time, we cannot predict the ultimate outcome of these matters or the potential range of damages, if any.

A wage and hour claim, which has been styled as a class action, is pending against us in the Superior Court of California. We were served with the complaint in this lawsuit in April 2008, and it has been amended since that time. 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. In September 2011, the court denied the plaintiffs' motion for class certification. Plaintiffs appealed that decision. In January 2013, the Court of Appeals affirmed the trial court's decision on some claims, but remanded the case to the trial court for clarification of its decision on one of the claims. We reached an agreement with the plaintiffs to settle the claim that was remanded to the trial court, and that settlement has been finalized. The amount of the settlement is not material to our consolidated financial statements. We intend to continue to vigorously defend against the remaining claims. Any potential settlement of the remaining claims is not anticipated to be 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 its 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 closing prices for our common stock as reported by the New York Stock Exchange. The closing prices represent the high and low on a post-split basis, which took effect in the third quarter of 2013. All prior closing prices have been adjusted to reflect the effects of the stock split.

	High	Low
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
Year ended December 31, 2013:		
1st quarter	$61.68	$54.15
2nd quarter	65.60	58.66
3rd quarter	60.62	53.76
4th quarter	63.39	55.03

The closing price of our common stock on January 30, 2015 was $75.06 per share. According to Computershare, our registrar and transfer agent, as of January 30, 2015, there were 11,031 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 2014:

Period	Total Number of Shares Purchased	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or	Approximate Dollar Value of Shares that May Yet Be Purchased Under the Plans or Programs

			Programs(1)	(in millions)
Oct 1—Dec 31, 2014	—	—	—	$ 358.2

(1) On November 3, 2010, the Board of Directors authorized $800 million for repurchases of our common stock. This stock repurchase program has no expiration date. 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. 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. 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. 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.

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. During 2013, we paid an additional $5.3 million in cash for post-closing working capital adjustments. In addition, we paid approximately $137 million to the common unit holders of HCP as a result of HCP achieving certain financial performance targets in 2012. In 2013, we also reached an agreement with the representative of the former owners and option holders of HCP to settle certain post-closing adjustments, including the 2013 contingent earn-out obligation for approximately $68.8 million. The operating results of HCP are included in our consolidated results beginning November 1, 2012.

	Year ended December 31,				
	2014	2013	2012	2011	2010
	(in thousands, except share data)				
Income statement data:					
Net revenues	$12,795,106	$11,764,050	$8,186,280	$6,731,806	$6,219,610
Operating expenses and charges(1)	10,979,965	10,213,916	6,889,196	5,577,093	5,225,802
Operating income	1,815,141	1,550,134	1,297,084	1,154,713	993,808
Debt expense	(410,294)	(429,943)	(288,554)	(241,090)	(181,607)
Debt refinancing and redemption charges	(97,548)	—	(10,963)	—	(74,382)
Other income, net	2,374	4,787	3,737	2,982	3,419
Income from continuing operations before income taxes	1,309,673	1,124,978	1,001,304	916,605	741,238
Income tax expense	446,343	381,013	359,845	325,292	258,874
Income from continuing operations	863,330	743,965	641,459	591,313	482,364
Income from operations of discontinued operations, net of tax(2)	—	(139)	(222)	(13,162)	1,855
Loss on disposal of discontinued operations, net of tax(2)	—	13,375	—	(4,756)	—
Net income	$863,330	$757,201	$641,237	573,395	$484,219
Less: Net income attributable to noncontrolling interests	(140,216)	(123,755)	(105,220)	(95,394)	(78,536)
Net income attributable to DaVita HealthCare Partners Inc.	$723,114	$633,446	$536,017	$478,001	$405,683
Basic income from continuing operations per share	$3.41	$2.95	$2.79	$2.62	$1.99

attributable to DaVita HealthCare Partners Inc.(2)(3)					
Diluted income from continuing operations per share attributable to DaVita HealthCare Partners Inc.(2)(3)	$3.33	$2.89	$2.74	$2.57	$1.96
Weighted average shares outstanding:(3)					
Basic	212,302,000	209,939,000	192,036,000	189,316,000	203,009,000
Diluted	216,928,000	214,764,000	195,942,000	193,064,000	206,118,000
Ratio of earnings to fixed charges(4)	3.05:1	2.73:1	3.17:1	3.39:1	3.43:1
Balance sheet data:					
Working capital	$1,788,145	$1,010,229	$870,625	$1,128,492	$1,698,509
Total assets	17,942,715	17,098,877	16,014,633	8,903,808	8,114,424
Long-term debt	8,383,280	8,141,231	8,326,534	4,417,624	4,233,850
Total DaVita HealthCare Partners Inc. shareholders equity(3)	5,170,513	4,432,479	3,763,137	2,141,075	1,978,422

(1) Operating expenses and charges in 2014 include an additional accrual of $17,000 for the loss contingency reserve related to the settlement of the 2010 and 2011 U.S. Attorney Physician Relationship Investigations. Operating expenses and charges in 2013 include an accrual of a loss contingency reserve of $397,000, a contingent earn-out obligation gain adjustment of $56,977 that increased operating income 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.

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

(3) 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 7,589,372 shares of common stock for $323,348 in 2011 and 17,837,520 shares of common stock for $618,496 in 2010. Shares issued in connection with stock awards were 2,179,766 in 2014, 1,928,137 in 2013, 2,375,571 in 2012, 2,520,518 in 2011 and 3,542,768 in 2010.

(4) 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. 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 End Stage Renal Disease program or other government-based programs, the impact of the Center for Medicare and Medicaid Services (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 and current or potential investigations by various government entities and related government or private-party proceedings, and in compliance with the Corporate Integrity Agreement and the related restrictions on our business and operations required by the Corporate Integrity Agreement and other settlement terms, and the financial impact thereof, continued increased competition from large and medium-sized dialysis providers that compete directly with us, our ability to maintain contracts with physician medical directors, changing affiliation models for physicians, and the emergence of new models of care introduced by the government or private sector that may erode our patient base and reimbursement rates such as accountable care organizations (ACOs), independent practice associations (IPAs) and integrated delivery systems, or to businesses outside of dialysis and HCP's business, our ability to complete acquisitions, mergers or dispositions that we might be considering or announce, or to integrate and successfully operate any business we may acquire or have acquired, including HCP, or to expand our operations and services to markets outside the U.S., variability of our cash flows, the risk that we might invest material amounts of capital and incur significant costs in

connection with the growth and development of our international operations, yet we might not be able to operate them profitably anytime soon, if at all, risks arising from the use of accounting estimates, judgments and interpretations in our financial statements, loss of key HCP employees, potential disruption from the HCP transaction making it more difficult to maintain business and operational relationships with customers, partners, associated physicians and physician groups, hospitals and others, the risk that laws regulating the corporate practice of medicine could restrict the manner in which HCP conducts its business, the risk that the cost of providing services under HCP's agreements may exceed our compensation, the risk that reductions in reimbursement rates, including Medicare Advantage rates, and future regulations may negatively impact HCP's business, revenue and profitability, the risk that HCP may not be able to successfully establish a presence in new geographic regions or successfully address competitive threats that could reduce its profitability, the risk that a disruption in HCP's healthcare provider networks could have an adverse effect on HCP's 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, and we undertake no obligation to update or revise any forward-looking statements, whether as a result of changes in underlying factors, new information, future events or otherwise.

The following should be read in conjunction with our consolidated financial statements and "Item 1. Business".

Company overview

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 support costs. 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 health care delivery and management company with nearly three decades of providing coordinated, outcomes-based medical care in a cost-effective manner.

Our overall financial performance was once again strong for 2014, and was characterized by strong treatment volume growth, primarily from acquisitions and non-acquired growth rates, cost control initiatives and productivity improvements in our dialysis business, and solid growth in HCP's senior capitated members. However, HCP experienced a significant reduction in Medicare Advantage reimbursement rates in 2014, which negatively impacted its operating income. In addition, our dialysis segment experienced a large increase in our pharmaceutical costs.

Some of our major accomplishments and financial operating performance indicators in 2014 and year over year were as follows:

- improved clinical outcomes in our U.S. dialysis operations;
- consolidated net revenue growth of approximately 8.8%. A 5.8% revenue growth related to our U.S. dialysis segment operations and an increase of 9.6% in our HCP segment operations;
- an increase of approximately 5.7% in the overall number of U.S. dialysis related treatments;
- normalized non-acquired U.S. dialysis treatment growth of 5.0%;
- consolidated operating income growth of approximately 17.1%;
- an increase of 72,800 in HCP's senior capitated members;
- added a net total of 105 U.S. dialysis centers and added a total of 18 international dialysis centers; and
- strong operating cash flows of $1.459 billion, which have been reduced by approximately $269 million of after-tax payments made in connection with the settlement of the 2010 and 2011 U.S. Attorney Physician Relationship Investigations.

However, we face uncertainty and various challenges in 2015 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 health care reform legislation that was enacted in the U.S. and there is uncertainty around the potential negative impact of healthcare insurance exchanges. 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 continues to deteriorate or if we experience a decrease in our overall commercial rates, our operating results could be adversely affected. HCP also faces uncertainty in Medicare Advantage reimbursement rates as the government continues to modify adjustments to the rates. See HCP's "net revenues section" for further details.

Following is a summary of consolidated operating results for reference in the discussion that follows. The operating results of HCP are included in our operating results effective November 1, 2012.

	Year ended December 31,					
	2014		2013		2012	
	(dollar amounts rounded to nearest million)					
Net revenues:						
Patient service revenues	$8,869		$8,307		$7,352	
Less: Provision for uncollectible accounts	(367)		(293)		(235)	
Net patient service revenues	8,502		8,014		7,117	
Capitated revenues	3,261		2,987		481	
Other revenues	1,032		763		588	
Total net consolidated revenues	$12,795	100%	$11,764	100%	$8,186	100%
Operating expenses and charges:						
Patient care costs	$9,119	71 %	$8,198	70 %	$5,584	68 %
General and administrative	1,262	10 %	1,177	10 %	889	11 %
Depreciation and amortization	591	5 %	529	4 %	342	4 %
Provision for uncollectible accounts	14	—	5	—	4	—
Equity investment income	(23)	—	(35)	—	(16)	—
Loss contingency reserve and other legal settlements	17	—	397	3 %	86	1 %
Contingent earn-out obligation adjustment	—	—	(57)	—	—	—
Total operating expenses and charges	10,980	86 %	10,214	87 %	6,889	84 %
Operating income	$1,815	14 %	$1,550	13 %	$1,297	16 %

The following table summarizes consolidated net revenues:

	Year ended December 31,		
	2014	2013	2012
	(dollar amounts rounded to nearest million)		
Net revenues:			
Dialysis and related lab services patient service revenues	$8,551	$8,033	$7,317
Less: Provision for uncollectible accounts	(353)	(281)	(234)
Dialysis and related lab services net patient service revenues	8,198	7,752	7,083
Other revenues	13	12	12
Total net dialysis and related lab services revenues	8,211	7,764	7,095
HCP capitated revenues	3,191	2,920	419
HCP net patient service revenues (less provision for uncollectible accounts of $13, $12 and $2, respectively)	219	220	34
Other revenue	92	56	24
Total net HCP revenues	3,502	3,196	477

Other-ancillary services and strategic initiatives revenues	947	709	563
Other-capitated revenues	70	67	62
Other-ancillary services and strategic initiatives net patient service revenues (less provision for uncollectible accounts)	122	76	17
Total net other-ancillary services and strategic initiatives revenues	1,139	852	642
Total net segment revenues	12,852	11,812	8,214
Elimination of intersegment revenues	(57)	(48)	(28)
Consolidated net revenues	$12,795	$11,764	$8,186

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

	Year ended		
	2014	2013	2012
	(dollar amounts rounded to nearest million)		
Dialysis and related lab services	$1,638	$1,200	$1,372
HCP services	215	385	67
Other— — ancillary services and strategic initiatives loss	(25)	(39)	(65)
Total segment operating income	1,828	1,546	1,374
Reconciling corporate items:			
Contingent earn-out obligations	—	57	—
Corporate support costs	(13)	(45)	(46)
Adjustment to reduce a tax asset associated with HCP acquisition escrow provisions	—	(8)	—
Transaction expenses	—	—	(31)
Consolidated operating income	1,815	1,550	1,297
Reconciliation of non-GAAP measure:			
Add:			
Loss contingency reserve and other legal settlements	17	397	86
Contingent earn-out obligation adjustment	—	(57)	—
Adjustment to reduce a tax asset associated with HCP acquisition escrow provisions	—	8	—
Transaction expenses	—	—	31
Adjusted consolidated operating income[(1)]	$1,832	$1,898	$1,414

(1) For the years ended December 31, 2014 and 2013, we have excluded $17 million and $397 million, respectively, of accruals related to a loss contingency reserve 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. For the year ended December 31, 2012, we have excluded $86 million of expenses related to a legal settlement and we have also excluded $31 million of transaction expenses associated with the acquisition of HCP from operating expenses and operating income. 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 of these amounts allows for comparison to our normal prior period results.

Consolidated net revenues

Consolidated net revenues for 2014 increased by approximately $1.031 billion or approximately 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 net revenues for 2013 increased by approximately $3.578 billion or approximately 43.7% from 2012. This increase in consolidated net revenues was due to an increase in dialysis and related lab services net revenues of approximately $669 million, principally due to strong volume growth from additional treatments from non-acquired growth and dialysis center acquisitions and from an increase of $8 in the average dialysis revenue per treatment, primarily from an increase in our Medicare reimbursements, net of the impact of sequestration and an increase in some of our average commercial payment rates, partially offset by a decline in the intensities of physician-prescribed pharmaceuticals that are billed separately. Consolidated net revenues also increased by $2.719 billion as a result of the inclusion of a full year of operations for HCP, which benefited from an increase in its senior capitated members. In addition, revenue increased by approximately $210 million for our ancillary services and strategic initiatives driven primarily from growth in our pharmacy services and from our international operations.

Consolidated operating income

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 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. 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.

Consolidated operating income of $1.550 billion for 2013 increased by approximately $253 million, or 19.5% from 2012, which includes the estimated loss contingency reserve of $397 million, 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 in 2013, and 2012 also includes the $86 million legal settlement and related expenses and the $31 million of transaction expenses associated with the acquisition of HCP. Excluding these items from their respective periods, adjusted consolidated operating income would have increased by $484 million, or 34.2%, primarily as a result of a full year of operations of HCP which generated $385 million in operating income in 2013 as compared to $67 million in 2012, an increase in the dialysis and related lab services net revenues as a result of strong volume growth in revenue from additional treatments due to non-acquired growth and acquisitions, and from an increase in our average dialysis revenue per treatment of approximately $8, partially offset by an increase in our dialysis provision for uncollectible accounts of $47 million. Adjusted consolidated operating income also increased as a result of lower operating losses associated with our ancillary services and strategic initiatives including our international operations and an overall decline in pharmaceutical costs mainly from a decline in the intensities of physician-prescribed pharmaceuticals and lower pharmaceutical unit costs. However, consolidated operating income was negatively impacted by higher labor and benefit costs, an increase in our professional fees for compliance and legal initiatives and for information technology matters, an increase in our dialysis center level impairments, the write-off of certain obsolete software costs, an increase in long-term incentive compensation and a slight decline in productivity.

U.S. dialysis and related lab services business

Our U.S. dialysis and related lab service businesses is a leading provider of kidney dialysis services through a network of 2,179 outpatient dialysis centers in 46 states and the District of Columbia, serving a total of approximately 173,000 patients. We also provide acute inpatient dialysis services in approximately 1,000 hospitals. We estimate that we have approximately a 35% market share in the U.S. based upon the number of patients that we serve. In 2014, our overall network of U.S. outpatient dialysis centers net increased by 105 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 5.9% as compared to 2013. 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 2013. 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 2014 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 and referring physicians, as well as qualified medical directors, 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 patients care and certain costs while still maintaining strong legal and compliance programs.

Approximately 64% of our 2014 consolidated net revenues were derived directly from our dialysis and related lab services business. Approximately 79% of our 2014 dialysis and related lab services revenues were derived from outpatient hemodialysis services in the 2,150 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. These services collectively accounted for the balance of our 2014 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 4.0% 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 that cover certain patients.

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 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 and can also 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 contracted plans. In 2014, the growth of our government-based patients continued to slightly outpace the growth of our commercial patients, which has been a trend that we have experienced for the past several years. We believe the growth in our government-based patients is driven primarily by improved mortality and the current economic environment that has resulted in a decrease in the percent of individuals that are covered under commercial contracted plans. This trend has negatively impacted our average dialysis revenue per treatment over the last several years as a result of receiving a larger proportion of our revenue from government-based payors, such as Medicare, that reimburse us at lower payment rates as compared to commercial payment rates.

The following table summarizes our U.S. dialysis and related lab services revenues by source for the year ended December 31, 2014:

	Revenue

	percentages	
Medicare and Medicare-assigned plans	58	%
Medicaid and Medicaid-assigned plans	6	%
Other government-based programs	3	%
Total government-based programs	67	%
Commercial (including hospital inpatient dialysis services)	33	%
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 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 to the patient or additional services performed. There are also other provisions that will impact the payments including an outlier pool and a low volume facility adjustment.

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 Prospective Payment System base rate (PPS). Absent action by Congress, the PPS base rate is automatically updated annually by a formulaic inflation adjustment.

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" which will reduce our market basket inflation adjustment by –1.25% in 2016 and 2017, and 1% in 2018. CMS also recently issued the 2015 final rule for the ESRD PPS, which would increase payments to dialysis facilities modestly by 0.3% to 0.5%, although rural facilities would receive a decrease of 0.5%.

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

The CMS Center for Medicare & Medicaid Innovation (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, Comprehensive ESRD Care Model (which includes the development of ESCOs), the Comprehensive Primary Care Initiative, the Duals Demonstration, or other models, will impact the health care market 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 seeking to participate in the Comprehensive ESRD Care Model with the Innovation Center. Even if we do not participate in this or other programs, some of our patients may be assigned to a program, in which case the quality and cost of care that we furnish will be included in an ACO's or other programs' calculations. As new models of care emerge 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 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 2015 that will outpace any Medicare rate increases that we may receive, which could significantly impact our operating results. 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 contract rates. In 2014,

we were successful in increasing some of our commercial payment rates which contributed to an increase in our average dialysis revenue per treatment. In 2014, we continued 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. We are continuously in the process of negotiating agreements with our commercial payors, and payors are aggressive in their negotiations. If our negotiations result in overall commercial rate reductions in excess of overall commercial rate increases, this would have a material adverse effect on our operating results. In addition, if there are job losses in the U.S. as a result of a downturn in the economy, or depending upon changes to the healthcare regulatory system, including the impact of health care insurance exchanges, we could experience a decrease in the number of patients covered under commercial plans.

Approximately 3% of our dialysis and related lab services revenues for the year ended December 31, 2014, were from physician-prescribed pharmaceuticals that are separately billable, with EPO accounting for approximately 2% 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 from prior years primarily as a result of Medicare's single bundled payment system, 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 2014, we continued to upgrade our

information technology systems and implemented process changes. We are currently upgrading our billing and other systems and modifying 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 $342, $340 and $332 for 2014, 2013 and 2012, respectively. 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. In 2013, the average dialysis and related lab services revenue per treatment increased by approximately $8 per treatment primarily due to an increase in our Medicare reimbursements, net of the impact of sequestration, and an increase in some of our commercial payment rates, partially offset by changes in the commercial payor mix, and a decline in the intensities of physician-prescribed pharmaceuticals that are billed separately.

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 and pharmaceuticals under Medicare's bundled payment rate system, including our ability to capture certain patient characteristics; changes in the mix of government and commercial patients, including the number of commercial patients that are either covered under commercial contracts or are out of network; and changes in the mix and intensities of physician-prescribed pharmaceuticals that are billed separately.

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 2014 improved slightly compared to 2013, 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 2014, which we believe negatively affected productivity levels. In 2014 and 2013, we experienced an increase in our clinical labor rates of approximately 1.5% and 2.0%, 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 2014, we experienced a significant increase in our pharmaceutical unit costs and additional costs from an increase in pharmaceutical utilization. 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 2014, we continued to implement certain cost control initiatives to manage our overall operating costs, including labor rates.

Our dialysis and related lab services general and administrative expenses represented 8.3% and 9.1% of our dialysis and related lab services net revenues in 2014 and 2013, respectively. The decrease was primarily due to a decrease in professional fees for compliance matters and information technology initiatives, a decrease in labor costs and related payroll taxes, lower travel expenses, and the write-off of certain obsolete software costs that occurred in 2013, partially offset by higher 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 in 2015 will continue 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,		
	2014	2013	2012
	(dollar amounts rounded to nearest million)		
Dialysis and related lab services patient service revenues	$8,551	$8,033	$7,317
Less: Provision for uncollectible accounts	(353)	(281)	(234)
Dialysis and related lab services net patient service revenues	8,198		