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

FORM 10-Q

For the Quarterly Period Ended March 31, 2013

QUARTERLY 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, CO 80202
Telephone number (303) 405-2100

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

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

Indicate by check mark whether the registrant has submitted electronically 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 ☒ 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.

Large accelerated filer	☒	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 ☒

As of April 30, 2013, the number of shares of the Registrant's common stock outstanding was approximately 105.8 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 $12.5 billion.

DAVITA HEALTHCARE PARTNERS INC.
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Note: Items 3, 4 and 5 of Part II are omitted because they are not applicable.

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DAVITA HEALTHCARE PARTNERS INC.

CONSOLIDATED STATEMENTS OF INCOME
(unaudited)
(dollars in thousands, except per share data)

	Three months ended March 31,	
	2013	2012
Patient service revenues	$ 1,979,873	$ 1,765,482
Less: Provision for uncollectible accounts	(70,057)	(53,008)
Net patient service revenues	1,909,816	1,712,474
HCP capitated revenues	746,071	—
Other revenues	173,695	137,059
Total net revenues	2,829,582	1,849,533
Operating expenses and charges:		
Patient care costs	1,953,929	1,249,395
General and administrative	291,372	205,401
Depreciation and amortization	125,909	75,381
Provision for uncollectible accounts	878	1,106
Equity investment income	(9,367)	(2,632)
Loss contingency reserve	300,000	—
Total operating expenses and charges	2,662,721	1,528,651
Operating income	166,861	320,882
Debt expense	(105,817)	(61,381)
Other income	598	1,039
Income from continuing operations before income taxes	61,642	260,540
Income tax expense	15,144	95,556
Income from continuing operations	46,498	164,984
Discontinued operations:		
Loss from operations of discontinued operations, net of tax	(139)	(101)
Gain on disposal of discontinued operations, net of tax	13,375	—
Net income	59,734	164,883
Less: Net income attributable to noncontrolling interests	(29,570)	(24,763)
Net income attributable to DaVita HealthCare Partners Inc.	$ 30,164	$ 140,120
Earnings per share:		
Basic income from continuing operations per share attributable to DaVita HealthCare Partners Inc.	$ 0.16	$ 1.50
Basic net income per share attributable to DaVita HealthCare Partners Inc.	$ 0.29	$ 1.49
Diluted income from continuing operations per share attributable to DaVita HealthCare Partners Inc.	$ 0.16	$ 1.46
Diluted net income per share attributable to DaVita HealthCare Partners Inc.	$ 0.28	$ 1.46
Weighted average shares for earnings per share:		
Basic	104,484,476	93,769,092
Diluted	107,063,633	95,729,105
Amounts attributable to DaVita HealthCare Partners Inc.:		
Income from continuing operations	$ 16,915	$ 140,220
Discontinued operations	13,249	(100)
Net income	$ 30,164	$ 140,120

See notes to condensed consolidated financial statements.

DAVITA HEALTHCARE PARTNERS INC.

CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME
(unaudited)
(dollars in thousands, except per share data)

	Three months ended March 31,	
	2013	2012
Net income	$ 59,734	$ 164,883
Other comprehensive (loss) income, net of tax:		
Unrealized losses on interest rate swap and cap agreements:		
Unrealized losses on interest rate swap and cap agreements	(2,369)	(2,261)
Less: Reclassifications of net swap and cap agreements realized losses into net income	2,507	2,520
Unrealized gains on investments:		
Unrealized gains on investments	618	1,146
Less: Reclassification of net investment realized gains into net income	(94)	(75)
Foreign currency translation adjustments	(2,106)	(619)
Other comprehensive (loss) income	(1,444)	711
Total comprehensive income	58,290	165,594
Less: Comprehensive income attributable to the noncontrolling interests	(29,570)	(24,763)
Comprehensive income attributable to DaVita HealthCare Partners Inc.	$ 28,720	$ 140,831

See notes to condensed consolidated financial statements.

DAVITA HEALTHCARE PARTNERS INC.

CONSOLIDATED BALANCE SHEETS
(unaudited)
(dollars in thousands, except per share data)

	March 31, 2013	December 31, 2012
ASSETS		
Cash and cash equivalents	$ 699,671	$ 533,748
Short-term investments	7,142	7,138
Accounts receivable, less allowance of $239,669 and $245,122	1,516,642	1,424,303
Inventories	76,582	78,126
Other receivables	298,871	265,671
Other current assets	150,432	201,572
Income tax receivable	—	55,454
Deferred income taxes	441,828	315,782
Total current assets	3,191,168	2,881,794
Property and equipment, net of accumulated depreciation of $1,546,266 and $1,522,183	1,915,453	1,872,370
Intangibles, net of accumulated amortization of $349,332 and $304,323	2,104,044	2,128,118
Equity investments	37,520	35,150
Long-term investments	63,451	59,341
Other long-term assets	86,806	79,854
Goodwill	9,015,035	8,947,736
	$ 16,413,477	$ 16,004,363
LIABILITIES AND EQUITY		
Accounts payable	$ 330,247	$ 414,143
Other liabilities	565,262	563,365
Accrued compensation and benefits	565,206	566,911
Medical payables	298,322	238,964
Loss contingency reserve	300,000	—
Current portion of long-term debt	228,219	227,791
Income tax payable	37,983	—
Total current liabilities	2,325,239	2,011,174
Long-term debt	8,277,259	8,326,534
Other long-term liabilities	497,708	443,743
Alliance and product supply agreement, net	13,325	14,657
Deferred income taxes	737,521	710,638
Total liabilities	11,851,052	11,506,746
Commitments and contingencies		
Noncontrolling interests subject to put provisions	605,894	580,692
Equity:		
Preferred stock ($0.001 par value, 5,000,000 shares authorized; none issued)		
Common stock ($0.001 par value, 450,000,000 shares authorized; 134,862,283 shares issued; 105,702,448 and 105,498,575 shares outstanding)	135	135
Additional paid-in capital	1,208,315	1,208,800
Retained earnings	3,761,999	3,731,835
Treasury stock, at cost (29,159,835 and 29,363,708 shares)	(1,154,266)	(1,162,336)
Accumulated other comprehensive loss	(16,741)	(15,297)
Total DaVita HealthCare Partners Inc. shareholders' equity	3,799,442	3,763,137
Noncontrolling interests not subject to put provisions	157,089	153,788
Total equity	3,956,531	3,916,925
	$ 16,413,477	$ 16,004,363

See notes to condensed consolidated financial statements.

DAVITA HEALTHCARE PARTNERS INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS
(unaudited)
(dollars in thousands)

	Three months ended March 31,	
	2013	2012
Cash flows from operating activities:		
Net income	$ 59,734	$ 164,883
Adjustments to reconcile net income to cash provided by operating activities:		
Loss contingency reserve	300,000	—
Depreciation and amortization	125,756	75,975
Stock-based compensation expense	16,021	12,550
Tax benefits from stock award exercises	9,368	10,890
Excess tax benefits from stock award exercises	(6,957)	(6,101)
Deferred income taxes	(111,331)	(13,335)
Equity investment income, net	(2,486)	483
Other non-cash charges and (gain) loss on disposal of assets	(11,396)	7,125
Changes in operating assets and liabilities, other than from acquisitions and divestitures:		
Accounts receivable	(92,339)	(71,706)
Inventories	2,162	4,851
Other receivables and other current assets	(32,281)	56,452
Other long-term assets	(9,865)	3,742
Accounts payable	(83,896)	(20,624)
Accrued compensation and benefits	(3,790)	41,623
Other current liabilities	79,277	17,462
Income taxes	93,401	43,072
Other long-term liabilities	47,829	4,532
Net cash provided by operating activities	379,207	331,874
Cash flows from investing activities:		
Additions of property and equipment, net	(116,724)	(112,459)
Acquisitions	(91,498)	(132,699)
Proceeds from asset and business sales	62,357	825
Purchase of investments available for sale	(1,212)	(489)
Purchase of investments held-to-maturity	(4)	(3,212)
Proceeds from sale of investments available for sale	1,091	6,791
Proceeds from maturities of investments held-to-maturity	—	7,551
Purchase of intangible assets	(137)	—
Distributions received on equity investments	116	2
Net cash used in investing activities	(146,011)	(233,690)
Cash flows from financing activities:		
Borrowings	16,797,510	8,634,603
Payments on long-term debt	(16,860,949)	(8,658,001)
Interest rate cap premiums and other deferred financing costs	(248)	3
Distributions to noncontrolling interests	(34,926)	(26,405)
Stock award exercises and other share issuances, net	5,833	1,663
Excess tax benefits from stock award exercises	6,957	6,101
Contributions from noncontrolling interests	14,257	3,651
Proceeds from sales of additional noncontrolling interests	4,174	100
Purchases from noncontrolling interests	—	(4,372)
Net cash used in financing activities	(67,392)	(42,657)
Effect of exchange rate changes on cash and cash equivalents	119	11
Net increase in cash and cash equivalents	165,923	55,538
Cash and cash equivalents at beginning of period	533,748	393,752
Cash and cash equivalents at end of period	$ 699,671	$ 449,290

See notes to condensed consolidated financial statements.

DAVITA HEALTHCARE PARTNERS INC.

CONSOLIDATED STATEMENTS OF EQUITY
(unaudited)
(dollars and shares in thousands)

		DaVita HealthCare Partners Inc. Shareholders' Equity								
	Non-controlling interests subject to put provisions	Common stock		Additional paid-in capital	Retained earnings	Treasury stock		Accumulated other comprehensive income (loss)	Total	Non-controlling interests not subject to put provisions
Balance at December 31, 2011	$ 478,216	134,862	$135	$ 596,300	$3,195,818	(41,221)	$ (1,631,694)	$ (19,484)	$2,141,075	$ 127,050
Comprehensive income:										
Net income	66,456				536,017				536,017	38,764
Other comprehensive income								4,187	4,187	
Stock purchase shares issued				4,311		101	4,011		8,322	
Stock unit shares issued				(8,303)		210	8,303			
Stock options and SSARs exercised				(83,558)		2,166	85,733		2,175	
Stock-based compensation expense				45,384					45,384	
Excess tax benefits from stock awards exercised				62,036					62,036	
Issuance of common stock associated with the HCP acquisition				684,161		9,380	371,311		1,055,472	
Assumption of noncontrolling interests associated with the HCP acquisition										29,850
Distributions to noncontrolling interests	(70,133)									(43,371)
Contributions from noncontrolling interests	26,371									11,024
Sales and assumptions of additional noncontrolling interests	20,124			1,064					1,064	2,432
Purchases from noncontrolling interests	(5,229)			(20,694)					(20,694)	(838)
Changes in fair value of noncontrolling interests	71,901			(71,901)					(71,901)	
Held for sale reclassification	(7,014)									
Purchase accounting adjustments										(11,123)
Balance at December 31, 2012	$ 580,692	134,862	$135	$1,208,800	$3,731,835	(29,364)	$(1,162,336)	$ (15,297)	$ 3,763,137	$ 153,788
Comprehensive income:										
Net income	18,643				30,164				30,164	10,927
Other comprehensive income								(1,444)	(1,444)	
Stock unit shares issued				(1,085)		27	1,085			
Stock-settled SARs exercised				(6,985)		177	6,985			
Stock-based compensation expense				16,021					16,021	
Excess tax benefits from stock awards exercised				6,957					6,957	
Distributions to noncontrolling interests	(19,822)									(15,104)
Contributions from noncontrolling interests	8,281									5,976
Sales and assumptions of additional noncontrolling interests	4,030			(809)					(809)	988
Expiration of put option	(889)			375					375	514
Changes in fair value of noncontrolling interests	14,959			(14,959)					(14,959)	
Balance at March 31, 2013	$ 605,894	134,862	$135	$1,208,315	$ 3,761,999	(29,160)	$(1,154,266)	$ (16,741)	$ 3,799,442	$ 157,089

See notes to condensed consolidated financial statements.

DAVITA HEALTHCARE PARTNERS INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

(unaudited)

(dollars and shares in thousands, except per share data)

Unless otherwise indicated in this Quarterly Report on Form 10-Q "the Company", "we", "us", "our" and similar terms refer to DaVita HealthCare Partners Inc. and its consolidated subsidiaries.

1. Condensed consolidated interim financial statements

The condensed consolidated interim financial statements included in this report are prepared by the Company without audit. In the opinion of management, all adjustments necessary for a fair presentation of the results of operations are reflected in these consolidated interim financial statements. All significant intercompany accounts and transactions have been eliminated. The preparation of these financial statements requires management to make estimates and assumptions that affect the reported amounts of assets, liabilities, revenues and expenses. The most significant estimates and assumptions underlying these financial statements and accompanying notes generally involve the accrual of an estimated loss contingency reserve and its impact on the Company's income taxes, revenue recognition and accounts receivable, impairments of long-lived assets, fair value estimates, accounting for income taxes, variable compensation accruals, consolidation of variable interest entities, purchase accounting valuation estimates, stock-based compensation and medical liability claims. The results of operations for the three months ended March 31, 2013 are not necessarily indicative of the operating results for the full year. The consolidated interim financial statements should be read in conjunction with the audited consolidated financial statements and notes thereto included in the Company's Annual Report on Form 10-K for the year ended December 31, 2012. Prior year balances and amounts have been reclassified to conform to the current year presentation and retrospectively revised to reflect purchase accounting entries. The Company has evaluated subsequent events through the date these condensed consolidated financial statements were issued and has included all necessary disclosures.

2. Earnings per share

Basic net income per share is calculated by dividing net income attributable to the Company, net of any (increase) decrease in noncontrolling interests redemption rights in excess of fair value, by the weighted average number of common shares and vested stock units outstanding. Diluted net income per share includes the dilutive effect of outstanding stock-settled stock appreciation rights, stock options and unvested stock units (under the treasury stock method).

DAVITA HEALTHCARE PARTNERS INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS—(continued)

(unaudited)

(dollars and shares in thousands, except per share data)

The reconciliations of the numerators and denominators used to calculate basic and diluted earnings per share are as follows:

	Three months ended March 31,	
	2013	2012
Basic:		
Income from continuing operations attributable to DaVita HealthCare Partners Inc.	$ 16,915	$140,220
Discontinued operations attributable to DaVita HealthCare Partners Inc.	13,249	(100)
Net income attributable to DaVita HealthCare Partners Inc. for basic earnings per share calculation	$ 30,164	$140,120
Weighted average shares outstanding during the period	105,578	93,766
Vested stock units	3	3
Contingently returnable shares held in escrow for the DaVita HealthCare Partners merger	(1,097)	—
Weighted average shares for basic earnings per share calculation	104,484	93,769
Basic income from continuing operations per share attributable to DaVita HealthCare Partners Inc.	$ 0.16	$ 1.50
Basic income from discontinued operations per share attributable to DaVita HealthCare Partners Inc.	$ 0.13	$ (0.01)
Basic net income per share attributable to DaVita HealthCare Partners Inc.	$ 0.29	$ 1.49
Diluted:		
Income from continuing operations attributable to DaVita HealthCare Partners Inc.	$ 16,915	$140,220
Discontinued operations attributable to DaVita HealthCare Partners Inc.	13,249	(100)
Net income attributable to DaVita HealthCare Partners Inc. for diluted earnings per share calculation	$ 30,164	$140,120
Weighted average shares outstanding during the period	105,578	93,766
Vested stock units	3	3
Assumed incremental shares from stock plans	1,483	1,960
Weighted average shares for diluted earnings per share calculation	107,064	95,729
Diluted income from continuing operations per share attributable to DaVita HealthCare Partners Inc.	$ 0.16	$ 1.46
Diluted income from discontinued operations per share attributable to DaVita HealthCare Partners Inc.	$ 0.12	$ —
Diluted net income per share attributable to DaVita HealthCare Partners Inc.	$ 0.28	$ 1.46
Anti-dilutive stock-settled awards excluded from calculation [(1)]	1,093	2,309

(1) Shares associated with stock-settled stock appreciation rights and stock options that are excluded from the diluted denominator calculation because they are anti-dilutive under the treasury stock method.

DAVITA HEALTHCARE PARTNERS INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS—(continued)

(unaudited)

(dollars and shares in thousands, except per share data)

3. Stock-based compensation and other common stock transactions

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

During the three months ended March 31, 2013, the Company granted 1,330 stock-settled stock appreciation rights with an aggregate grant-date fair value of $36,024 and a weighted-average expected life of approximately 4.3 years, and also granted 10 stock units with an aggregate grant-date fair value of $1,163 and a weighted-average expected life of approximately 2.7 years.

For the three months ended March 31, 2013 and 2012, the Company recognized $16,021 and $12,550, respectively, in stock-based compensation expense for stock appreciation rights, stock units and discounted employee stock plan purchases, which are primarily included in general and administrative expenses. The estimated tax benefits recorded for stock-based compensation through March 31, 2013 and 2012 was $6,088 and $4,723, respectively. As of March 31, 2013, there was $123,372 of total estimated unrecognized compensation cost related to unvested stock-based compensation arrangements under the Company's equity compensation and stock purchase plans. The Company expects to recognize this cost over a weighted average remaining period of 1.5 years.

The Company did not receive any cash proceeds from stock option exercises for the first quarter of 2013. During the three months ended March 31, 2012, the Company received $1,391 in cash proceeds from stock option exercises. In addition, for the three months ended March 31, 2013 and 2012 the Company received $9,368 and $10,890, respectively, in actual tax benefits upon the exercise of stock awards.

4. Accounts receivable

Accounts receivable are reduced by an allowance for doubtful accounts. In evaluating the ultimate collectability of the Company's accounts receivable, the Company analyzes its historical cash collection experience and trends for each of its government payors and commercial payors to estimate the adequacy of the allowance for doubtful accounts and the amount of the provision for uncollectible accounts. Management regularly updates its analysis based upon the most recent information available to determine its current provision for uncollectible accounts and the adequacy of its allowance for doubtful accounts. For receivables associated with dialysis patient services covered by government payors, primarily Medicare, the Company receives 80% of the payment directly from Medicare as established under the governments bundled payment system and determines an appropriate allowance for doubtful accounts and provision for uncollectible accounts on the remaining balance due depending upon the Company's estimate of the amounts ultimately collectible from other secondary coverage sources or from the patients. For receivables associated with services to patients covered by commercial payors that are either based upon contractual terms or for non-contracted health plan coverage, the Company provides an allowance for doubtful accounts by recording a provision for uncollectible accounts based upon its historical collection experience, potential inefficiencies in its billing processes and for which collectability is determined to be unlikely. Approximately 3% of the Company's net accounts receivable are associated with patient pay and it is the Company's policy with respect to its dialysis operations to reserve 100% of these outstanding accounts receivable balances when the amounts due are outstanding for more than four months.

DAVITA HEALTHCARE PARTNERS INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS—(continued)

(unaudited)

(dollars and shares in thousands, except per share data)

During the three months ended March 31, 2013, the Company's allowance for doubtful accounts decreased by approximately $5,453. This was primarily due to continued higher non-covered Medicare write-offs during the period in the Company's U.S. dialysis business. There were no unusual transactions impacting the allowance for doubtful accounts.

5. Goodwill

Changes in the value of goodwill by reportable segments were as follows:

	Three months ended March 31, 2013			
	U.S. dialysis and related lab services	HCP	Other-ancillary services and strategic initiatives	Consolidated total
Balance at January 1, 2013	$ 5,309,152	$3,501,557	$ 137,027	$ 8,947,736
Acquisitions	56,338	9,511	4,022	69,871
Divestitures	(1,234)	—	—	(1,234)
Other adjustments	12	163	(1,513)	(1,338)
Balance at March 31, 2013	$ 5,364,268	$ 3,511,231	$ 139,536	$ 9,015,035

	Year ended December 31, 2012			
	U.S. dialysis and related lab services	HCP	Other-ancillary services and strategic initiatives	Consolidated total
Balance at January 1, 2012	$ 4,865,864	$ —	$ 81,112	$ 4,946,976
Acquisitions	443,997	3,518,790	88,611	4,051,398
Divestitures	(709)	—	—	(709)
Held for sale	—	—	(31,853)	(31,853)
Other adjustments	—	—	(843)	(843)
Balance at December 31, 2012 as previously reported	$ 5,309,152	$ 3,518,790	$ 137,027	$ 8,964,969
HCP purchase accounting adjustments	—	(17,233)	—	(17,233)
Balance at December 31, 2012 as adjusted	$ 5,309,152	$3,501,557	$ 137,027	$ 8,947,736

Each of the Company's operating segments described in Note 13 to these condensed consolidated financial statements represents an individual reporting unit for goodwill impairment testing purposes, except that HCP is comprised of four reporting units, our direct primary care segment is comprised of two reporting units and each sovereign jurisdiction within our international operations segment is considered a separate reporting unit.

Within the U.S. dialysis and related lab services operating segment, the Company considers each of its dialysis centers to constitute an individual business for which discrete financial information is available. However, since these dialysis centers have similar operating and economic characteristics, and since resource allocation and significant investment decisions concerning these businesses are highly centralized and the benefits broadly distributed, the Company has aggregated these centers and deemed them to constitute a single reporting unit.

DAVITA HEALTHCARE PARTNERS INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS—(continued)
(unaudited)
(dollars and shares in thousands, except per share data)

The Company has applied a similar aggregation to the HCP practice management operations in each region, to the vascular access service centers in its vascular access services reporting unit, and to the physician practices in its physician services reporting unit. For the Company's additional operating segments, no component below the level of the operating segment is considered a discrete business and therefore these operating segments directly constitute individual reporting units.

During the first quarter of 2013, the Company did not record any goodwill impairment charges and, as of March 31, 2013, none of the goodwill associated with the Company's various reporting units was considered at risk of impairment. Since the date of the Company's last annual goodwill impairment test, there have been no material developments, events, changes in operating performance or other changes in circumstances that would cause management to believe it is more likely than not that the fair value of any of its reporting units would be less than its carrying amount.

6. Long-term debt

Long-term debt was comprised of the following:

	March 31, 2013	December 31, 2012
Senior Secured Credit Facilities:		
Term Loan A	$ 875,000	$ 900,000
Term Loan A-3	1,333,125	1,350,000
Term Loan B	1,710,625	1,715,000
Term Loan B-2	1,645,875	1,650,000
Senior notes	2,800,000	2,800,000
Acquisition obligations and other notes payable	52,206	64,276
Capital lease obligations	109,221	96,594
Total debt principal outstanding	8,526,052	8,575,870
Discount on long-term debt	(20,574)	(21,545)
	8,505,478	8,554,325
Less current portion	(228,219)	(227,791)
	$8,277,259	$ 8,326,534

Scheduled maturities of long-term debt at March 31, 2013 were as follows:

2013	162,723
2014	264,212
2015	842,548
2016	1,892,176
2017	908,853
2018	801,824
Thereafter	3,653,716

During the first three months of 2013, the Company made mandatory principal payments under its Senior Secured Credit Facilities totaling $25,000 on the Term Loan A, $16,875 on the Term Loan A-3, $4,375 on the Term Loan B and $4,125 on the Term Loan B-2.

DAVITA HEALTHCARE PARTNERS INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS—(continued)

(unaudited)

(dollars and shares in thousands, except per share data)

The Company has entered into several interest rate swap agreements as a means of hedging its exposure to and volatility from variable-based interest rate changes as part of its overall interest rate risk management strategy. These agreements are not held for trading or speculative purposes and have the economic effect of converting the LIBOR variable component of the Company's interest rate to a fixed rate. These swap agreements are designated as cash flow hedges, and as a result, hedge-effective gains or losses resulting from changes in the fair values of these swaps are reported in other comprehensive income until such time as each specific swap tranche is realized, at which time the amounts are reclassified into net income. Net amounts paid or received for each specific swap tranche that have settled have been reflected as adjustments to debt expense. In addition, the Company has entered into several interest rate cap agreements that have the economic effect of capping the Company's maximum exposure to LIBOR variable interest rate changes on specific portions of the Company's Term Loan B debt and Term Loan B-2 debt, as described below. These cap agreements are also designated as cash flow hedges and, as a result, changes in the fair values of these cap agreements are reported in other comprehensive income. The amortization of the original cap premium is recognized as a component of debt expense on a straight line basis over the term of the cap agreements. The swap and cap agreements do not contain credit-risk contingent features.

In March 2013, the Company entered into several new interest rate swap agreements. As of March 31, 2013, the amortizing notional amounts of these swap agreements totaled $1,333,125. These agreements have the economic effect of modifying the LIBOR variable component of the Company's interest rate on an equivalent amount of the Company's Term Loan A-3 to fixed rates ranging from 0.49% to 0.52%, resulting in an overall weighted average effective interest rate of 3.01%, including the Term Loan A-3 margin of 2.50%. The swap agreements expire by September 30, 2016 and require monthly interest payments. During the three months ended March 31, 2013 the Company accrued net charges of $45 from these swaps which are included in debt expense. As of March 31, 2013, the total fair value of these swap agreements was a liability of $384. The Company estimates that approximately $2,734 of existing unrealized pre-tax losses in other comprehensive income at March 31, 2013 will be reclassified into income in 2013.

In addition, in March 2013, the Company entered into several interest rate forward swap agreements with amortizing notional amounts totaling $600,000. These forward swap agreements will be effective September 30, 2014 and will have the economic effect of modifying the LIBOR variable component of the Company's interest rate on an equivalent amount of the Company's outstanding debt to fixed rates ranging from 0.72% to 0.75%. These swap agreements expire on September 30, 2016 and will require quarterly interest payments beginning in October 2014. Any unrealized gains or losses resulting from changes in the fair value of these swaps will be recorded in other comprehensive income. As of March 31, 2013, the total fair value of these swap agreements was a liability of $344.

During March 2013, the Company entered into several interest rate cap agreements with notional amounts totaling $1,250,000 on the Company's Term Loan B debt and $1,485,000 on the Company's Term Loan B-2 debt. These agreements have the economic effect of capping the LIBOR variable component of the Company's interest rate at a maximum of 2.50% on an equivalent amount of the Company's Term Loan B and Term Loan B-2 debt. The cap agreements expire on September 30, 2016. As of March 31, 2013, the total fair value of these cap agreements was an asset of $5,626. During the three months ended March 31, 2013, the Company recorded a loss of $2,910 in other comprehensive income due to a decrease in the unrealized fair value of these cap agreements.

As of March 31, 2013, the Company also maintains a total of nine other interest rate swap agreements with amortizing notional amounts totaling $875,000. These agreements had the economic effect of modifying the

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LIBOR variable component of the Company's interest rate on an equivalent amount of our Term Loan A to fixed rates ranging from 1.59% to 1.64%, resulting in an overall weighted average effective interest rate of 4.11%, including the Term Loan A margin of 2.50%. The swap agreements expire by September 30, 2014 and require monthly interest payments. During the three months ended March 31, 2013, the Company accrued net charges of $3,162 from these swaps which are included in debt expense. As of March 31, 2013, the total fair value of these swap agreements was a liability of $16,023. The Company estimates that approximately $8,943 of existing unrealized pre-tax losses in other comprehensive income at March 31, 2013 will be reclassified into income in 2013.

As of March 31, 2013, the Company also maintains five interest rate cap agreements with notional amounts totaling $1,250,000. These agreements have the economic effect of capping the LIBOR variable component of our interest rate at a maximum of 4.00% on an equivalent amount of our Term Loan B debt. However, as a result of the new interest rate cap agreements that were entered into in March 2013, as described above, these interest rate cap agreements became ineffective cash flow hedges and as a result any changes in the fair value associated with these interest rate cap agreements will be charged to income. During the three months ended March 31, 2013, the Company accrued net charges of $897 from these caps which are included in debt expense. The cap agreements expire on September 30, 2014. As of March 31, 2013, the total fair value of these cap agreements was an asset of $63. During the three months ended March 31, 2013, the Company recorded a loss of $3 in other comprehensive income due to a decrease in the unrealized fair value of these cap agreements.

The following table summarizes the Company's derivative instruments as of March 31, 2013 and December 31, 2012:

	March 31, 2013		December 31, 2012	
Derivatives designated as hedging instruments	**Balance sheet location**	**Fair value**	**Balance sheet location**	**Fair value**
Interest rate swap agreements	Other long-term liabilities	$16,751	Other long-term liabilities	$18,994
Interest rate cap agreements	Other long-term assets	$ 5,689	Other long-term assets	$ 65

The following table summarizes the effects of the Company's interest rate swap and cap agreements for the three months ended March 31, 2013 and 2012:

	Amount of gains (losses) recognized in OCI on interest rate swap and cap agreements			Amount of gains (losses) reclassified from accumulated OCI into income	
	Three months ended March 31,			Three months ended March 31,	
Derivatives designated as cash flow hedges	**2013**	**2012**	**Location of gains (losses) reclassified from accumulated OCI into income**	**2013**	**2012**
Interest rate swap agreements	$ (964)	$ (3,276)	Debt expense	$ (3,207)	$ (3,225)
Interest rate cap agreements	(2,913)	(424)	Debt expense	(897)	(897)
Tax benefit	1,508	1,439		1,597	1,602
Total	$ (2,369)	$ (2,261)		$ (2,507)	$ (2,520)

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As of March 31, 2013, interest rates on the Company's Term Loan B and Term Loan B-2 debt are effectively fixed because of an embedded LIBOR floor which is higher than actual LIBOR as of such date. Furthermore, interest rates on $1,250,000 of the Company's Term Loan B and $1,485,000 of the Company's Term Loan B-2 are subject to interest rate caps if LIBOR should rise above 2.50%. Interest rates on the Company's senior notes are fixed by their terms. The LIBOR variable component of the Company's interest rates on the Company's Term Loan A and the Term Loan A-3 are economically fixed as a result of interests rate swaps.

As a result of embedded LIBOR floors in some of the Company's debt agreements and the swap and cap agreements, the Company's overall weighted average effective interest rate on the Senior Secured Credit Facilities was 4.09%, based upon the current margins in effect of 2.50% for both the Term Loan A and for the Term Loan A-3, and 3.00% for both the Term Loan B and for the Term Loan B-2, as of March 31, 2013. Effective April 2, 2013, the interest rate margin on the Term Loan A increased to 2.75%

The Company's overall weighted average effective interest rate during the first quarter of 2013 was 4.76% and as of March 31, 2013 was 4.79%.

As of March 31, 2013, the Company had undrawn revolving credit facilities totaling $350,000 of which approximately $114,456 was committed for outstanding letters of credit.

7. Contingencies

The majority of the Company's revenues are from government programs and may be subject to adjustment as a result of: (i) examination by government agencies or contractors, for which the resolution of any matters raised may take extended periods of time to finalize; (ii) differing interpretations of government regulations by different Medicare contractors or regulatory authorities; (iii) differing opinions regarding a patient's medical diagnosis or the medical necessity of services provided; and (iv) retroactive applications or interpretations of governmental requirements. In addition, the Company's revenues from commercial payors may be subject to adjustment as a result of potential claims for refunds, as a result of government actions or as a result of other claims by commercial payors.

Inquiries by the Federal Government and Certain Related Civil Proceedings

Vainer Private Civil Suit: In December 2008, the Company received a subpoena for documents from the OIG relating to the pharmaceutical products Zemplar, Hectorol, Venofer, Ferrlecit and EPO, as well as other related matters. The subpoena covered the period from January 2003 to December 2008. The Company was in contact with the U.S. Attorney's Office for the Northern District of Georgia and the U.S. Department of Justice in Washington, DC since November 2008 relating to this matter, and was advised that this was a civil inquiry. On June 17, 2009, the Company 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 U.S. 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 complaint in the U.S. District Court for the Northern District of Georgia, purportedly on behalf of the federal government. The allegations in the complaint relate to the Company's drug administration practices for the Company's dialysis operations for Vitamin D and iron

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agents for a period from 2003 through 2010. The complaint seeks monetary damages and civil penalties as well as costs and expenses. The Company is vigorously defending this matter and intends to continue to do so. The Company can make no assurances as to the time or resources that will be needed to devote to this litigation or its final outcome.

2010 U.S. Attorney Physician Relationship Investigation : In May 2010, the Company received a subpoena from the OIG's office in Dallas, Texas. The civil subpoena covers the period from January 1, 2005 to May 2010, and seeks production of a wide range of documents relating to the Company's dialysis operations, including documents related to, among other things, 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. The Company has been advised by the attorneys conducting this civil investigation that they believe that some or all of the Company's joint ventures do not comply with the anti-kickback statute and the False Claims Act. The Company disagrees that its joint venture structure generally, which the Company believes is widely used in the dialysis industry and other segments of the healthcare industry substantially in the form that the Company uses it, violates the federal anti-kickback statute or the False Claims Act. As to individual transactions, the Company made significant effort to ensure that its joint venture structures and process complied with the rules, but the Company is talking with the government about addressing its concerns. The focus of this investigation overlaps substantially with the 2011 U.S. Attorney Physician Relationship Investigation described below. The Company is engaged in good faith discussions with the attorneys from 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 in an effort to find a mutually acceptable resolution to this matter and the 2011 U.S. Attorney Physician Relationship Investigation. Discussions have advanced to a point where the Company believes it is appropriate to accrue an estimated loss contingency reserve of $300,000 in the first quarter of 2013 in connection with an offer to settle the related civil, administrative and criminal matters. However, the discussions are ongoing, and until concluded, there can be no certainty about the timing or likelihood of a definitive resolution or the scope of any potential restrictions that may be agreed upon in connection with a settlement. As these discussions proceed and additional information becomes available to us, the amount of the estimated loss contingency reserve may need to be increased or decreased to reflect this new information. This matter will continue to require management's attention and significant legal expense, and the Company can make no assurances as to the final outcome.

2011 U.S. Attorney Physician Relationship Investigation : In August 2011, the Company announced it had learned that the U.S. Attorney's Office for the District of Colorado would be investigating certain activities of its dialysis business in connection with information being provided to a grand jury. This investigation relates to the Company's relationships with physicians, including its joint ventures, and whether those relationships and joint ventures comply with the federal anti-kickback statute, and overlaps substantially, with the 2010 U.S. Attorney Physician Relationship Investigation described above. The Company has received a number of subpoenas for documents covering the period from January 2006 to November 2012, and the Company has produced documents in response to those subpoenas and other requests. In addition, certain current and former members of the Board, executives and other teammates have received subpoenas to testify before the grand jury. It is possible that criminal proceedings may be initiated against the Company in connection with this investigation. As noted above, the Company is engaged in good faith discussions in an effort to find a mutually acceptable resolution of both this matter and the 2010 U.S. Attorney Physician Relationship Investigation. As also noted above, the discussions are ongoing, and until concluded, there can be no certainty about the timing or likelihood of a definitive resolution. This matter will continue to require management's attention and significant legal expense, and the Company can make no assurances as to the final outcome.

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2011 U.S. Attorney Medicaid Investigation: In October 2011, the Company announced that it would be receiving a request for documents, which could include an administrative subpoena from the Office of Inspector General for the U.S. Department of Health and Human Services. Subsequent to the Company's announcement of this 2011 U.S. Attorney Medicaid Investigation, the Company 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. The Company believes this inquiry is civil in nature. The Company does not know the time period or scope. The Company understands that certain other providers that operate dialysis clinics in New York may be receiving or have received a similar request for documents. The Company is cooperating with the government and is producing the requested documents.

Turner-Hooks Private Civil Suit: In January 2013, the Company was served with a civil complaint filed by a former patient, Laura Turner-Hooks, and brought pursuant to the *qui tam* provisions of the federal False Claims Act purportedly on behalf of the federal government. On November 13, 2012, the U.S. District Court for the Eastern District of Michigan 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 U.S. would not be intervening and not pursuing the relator's allegation in litigation. The relator's complaint, originally filed in July 2011, stated that she was a patient at a single dialysis facility in Michigan and that the Company allegedly violated the federal False Claims Act by providing treatments at the facility that failed to comply with the standard of care required under federal healthcare programs. The complaint asked the court to order the Company to cease committing the alleged violations and seeks monetary damages and civil penalties as well as costs and expenses. On March 29, 2013, the Company filed a motion to dismiss the case, arguing that the allegations were meritless. After reviewing the Company's motion, on April 29, 2013, the U.S. District Court dismissed the case with prejudice as to the relator. There was no finding of wrongdoing by the Company, nor was the Company assessed or required to pay, any fines, penalties or other amounts in connection with the relator's complaint or dismissal of the case.

Swoben Private Civil Suit: In April 2013, the Company's Health Care 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 that are referred to collectively in the complaint as the HMOs. The allegations in the complaint relate to patient diagnosis coding. The complaint seeks monetary damages and civil penalties as well as costs and expenses. The Company believes and is in the process of evaluating the extent to which it might have indemnification from the sellers in connection with the Company's merger with HCP on November 1, 2012 for all or a portion of any liabilities it might incur related to this matter. The Company intends to vigorously defend this action.

Except for the private civil complaints filed by the relators as described above, to the Company's knowledge, no proceedings have been initiated against the Company at this time in connection with any of the

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inquiries by the federal government. Although the Company 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 the Company, exclusion from future participation in the Medicare and Medicaid programs and, to the extent criminal proceedings may be initiated against the Company, possible criminal penalties. At this time, the Company cannot predict the ultimate outcome of these inquiries, or the potential outcome of the relators' claims (except as described above), or the potential range of damages, if any.

Other

The Company has 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. The Company has 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, the Company intends to defend against them vigorously; however, the Company may not be successful and these claims may lead to litigation and any such litigation may be resolved unfavorably. At this time, the Company 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 the Company in the Superior Court of California. The Company was served with the complaint in this lawsuit in April 2008, and it has been amended since that time. The lawsuit, as amended, alleges that the Company 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. The Company intends to continue to vigorously defend against these claims. Any potential settlement of these claims is not anticipated to be material to the Company's consolidated financial statements.

In October 2007, the Company was contacted by the Attorney General's Office for the State of Nevada. The Attorney General's Office informed the Company that it was conducting a civil and criminal investigation of the Company's operations in Nevada and that the investigation related to the billing of pharmaceuticals by our dialysis business, including EPO. In February 2008, the Attorney General's Office informed the Company that the civil and criminal investigation had been discontinued. The Attorney General's Office further advised the Company that Nevada Medicaid intended to conduct audits of ESRD dialysis providers in Nevada and that such audits would relate to the issues that were the subjects of the investigation. To the Company's knowledge, no court proceedings have been initiated against the Company at this time. Any negative audit findings could result in a substantial repayment by the Company. At this time, the Company cannot predict the ultimate outcome of this matter or the potential range of damages, if any.

In addition to the foregoing, the Company is 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

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government entities, in the ordinary course of business. The Company believes 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.

8. Investments in debt and equity securities

Based on the Company's intentions and strategy involving investments in debt securities, the Company classifies certain debt securities as held-to-maturity and records them at amortized cost. Equity securities that have readily determinable fair values, including those of mutual funds, as well as other debt securities, are classified as available for sale and recorded at fair value.

The Company's investments in securities consist of the following:

	March 31, 2013			December 31, 2012		
	Held to maturity	Available for sale	Total	Held to maturity	Available for sale	Total
Certificates of deposit and money market funds due within one year	$5,942	$ —	$ 5,942	$5,938	$ —	$ 5,938
Investments in mutual funds	—	16,317	16,317	—	15,185	15,185
	$5,942	$16,317	$22,259	$5,938	$15,185	$ 21,123
Short-term investments	$5,942	$ 1,200	$ 7,142	$5,938	$ 1,200	$ 7,138
Long-term investments	—	15,117	15,117	—	13,985	13,985
	$5,942	$16,317	$22,259	$5,938	$15,185	$ 21,123

The cost of the certificates of deposit and money market funds at March 31, 2013 approximates their fair value. As of March 31, 2013 and December 31, 2012, the available for sale investments include $3,002 and $2,146 of gross pre-tax unrealized gains, respectively. During the three months ended March 31, 2013, the Company recorded gross pre-tax unrealized gains of $1,011, or $618 after tax, in other comprehensive income associated with changes in the fair value of these investments. During the three months ended March 31, 2013, the Company sold investments in mutual funds for net proceeds of $1,091 and recognized a pre-tax gain of $155, or $94 after-tax, which was previously recorded in other comprehensive income. During the three months ended March 31, 2012, the Company sold investments in mutual funds for net proceeds of $6,791, and recognized a pre-tax gain of $123, or $75 after tax, that was previously recorded in other comprehensive income.

The investments in mutual funds classified as available for sale are held within a trust to fund existing obligations associated with several of the Company's non-qualified deferred compensation plans.

9. Fair value of financial instruments

The Company measures the fair value of certain assets, liabilities and noncontrolling interests subject to put provisions (temporary equity) based upon certain valuation techniques that include observable or unobservable inputs and assumptions that market participants would use in pricing these assets, liabilities, temporary equity and commitments. The Company also has classified certain assets, liabilities and temporary equity that are measured at fair value into the appropriate fair value hierarchy levels as defined by FASB.

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The following table summarizes the Company's assets, liabilities and temporary equity measured at fair value on a recurring basis as of March 31, 2013:

	Total	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Assets				
Available for sale securities	$ 16,317	$ 16,317	$ —	$ —
Interest rate cap agreements	$ 5,689	$ —	$ 5,689	$ —
Funds on deposit with third parties	$ 72,303	$ 15,548	$ 56,755	$ —
Liabilities				
Interest rate swap agreements	$ 16,751	$ —	$ 16,751	$ —
Contingent earn-out obligations	$ 294,079	$ —	$ —	$ 294,079
Temporary equity				
Noncontrolling interests subject to put provisions	$ 605,894	$ —	$ —	$ 605,894

The available for sale securities represent investments in various open-ended registered investment companies, or mutual funds, and are recorded at fair value based upon quoted prices reported by each mutual fund. See Note 8 to the condensed consolidated financial statements for further discussion.

The interest rate swap and cap agreements are recorded at fair value based upon valuation models utilizing the income approach and commonly accepted valuation techniques that use inputs from closing prices for similar assets and liabilities in active markets as well as other relevant observable market inputs at quoted intervals such as current interest rates, forward yield curves, implied volatility and credit default swap pricing. The Company does not believe the ultimate amount that could be realized upon settlement of these interest rate swap and cap agreements would be materially different from the fair values as currently reported. See Note 6 to the condensed consolidated financial statements for further discussion.

The funds on deposit with third parties represent funds held with various third parties as required by regulation or contract and invested by those parties in various investments, which are measured at estimated fair value based primarily on quoted close or bid market prices of the same or similar assets.

The estimated fair value measurements of contingent earn-out obligations are primarily based on unobservable inputs including projected EBITDA of acquired businesses, estimated probabilities of achieving gross margin of certain medical procedures and the estimated probability of earn-out payments being made using an option pricing technique and a simulation model for expected EBITDA. In addition, a probability-adjusted model was used to estimate the fair values of the quality results amounts. The estimated fair value of these contingent earn-out obligations will be remeasured as of each reporting date and could fluctuate based upon any significant changes in key assumptions, such as changes in the Company credit risk-adjusted rate that is used to discount obligations to present value.

See Note 10 to the condensed consolidated financial statements for a discussion of the Company's methodology for estimating the fair value of noncontrolling interests subject to put provisions.

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Other financial instruments consist primarily of cash, accounts receivable, life insurance contracts, accounts payable, other accrued liabilities, and debt. The balances of the non-debt financial instruments are presented in the condensed consolidated financial statements at March 31, 2013 at their approximate fair values due to the short-term nature of their settlements. The carrying amount of the Company's Senior Secured Credit Facilities totaled $5,564,625 as of March 31, 2013, and the fair value was $5,598,190 based upon quoted market prices. The fair value of the Company's senior notes was approximately $2,965,243 at March 31, 2013, based upon quoted market prices, as compared to the carrying amount of $2,800,000.

10. Noncontrolling interests subject to put provisions and other commitments

The Company has potential obligations to purchase the noncontrolling interests held by third parties in several of its joint ventures, non-owned and minority-owned entities and non-wholly-owned subsidiaries. These obligations are in the form of put provisions and are exercisable at the third-party owners' discretion within specified periods as outlined in each specific put provision. If these put provisions were exercised, the Company would be required to purchase the third-party owners' noncontrolling interests at either the appraised fair market value or a predetermined multiple of earnings or cash flow attributable to the noncontrolling interests put to the Company, which is intended to approximate fair value. The methodology the Company uses to estimate the fair values of noncontrolling interests subject to put provisions assumes either the higher of a liquidation value of net assets or an average multiple of earnings, based on historical earnings, patient mix and other performance indicators, as well as other factors. The estimated fair values of the noncontrolling interests subject to put provisions can fluctuate and the implicit multiple of earnings at which these noncontrolling interests obligations may be settled will vary significantly depending upon market conditions including potential purchasers' access to the capital markets, which can impact the level of competition for dialysis and non-dialysis related businesses, the economic performance of these businesses and the restricted marketability of the third-party owners' noncontrolling interests. The amount of noncontrolling interests subject to put provisions that contractually employ a predetermined multiple of earnings rather than fair value are immaterial.

Additionally, the Company has certain other potential commitments to provide operating capital to several dialysis centers that are wholly-owned by third parties or centers in which the Company owns a minority equity investment as well as to physician-owned vascular access clinics that the Company operates under management and administrative services agreements of approximately $3,000.

Certain consolidated joint ventures are contractually scheduled to dissolve after terms ranging from ten to fifty years. Accordingly, the noncontrolling interests in these joint ventures are considered mandatorily redeemable instruments for which the classification and measurement requirements have been indefinitely deferred. Future distributions upon dissolution rather than sale of these entities would be valued below the related noncontrolling interests carrying balances in the condensed consolidated balance sheet.

11. Income taxes

As of March 31, 2013, the Company's total liability for unrecognized tax benefits relating to tax positions that do not meet the more-likely-than-not threshold is $67,131, of which $41,291 would impact the Company's effective tax rate if recognized. This balance represents a decrease of $415 from the December 31, 2012 balance of $67,546 due to the reduction of 2012 liabilities.

The Company recognizes accrued interest and penalties related to unrecognized tax benefits in its income tax expense. At March 31, 2013 and December 31, 2012, the Company had approximately $12,425 and $12,073, respectively, accrued for interest and penalties related to unrecognized tax benefits, net of federal tax benefits.

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12. Acquisitions and discontinued operations

Dialysis and other acquisitions

During the first three months of 2013, the Company acquired dialysis businesses and one other business consisting of eight dialysis centers located in the U.S. and one hospice care business for a total of $91,498 in cash and deferred purchase price obligations totaling $3,514. The assets and liabilities for all acquisitions were recorded at their estimated fair values at the dates of the acquisitions and are included in the Company's condensed consolidated financial statements and operating results from the designated effective dates of the acquisitions.

The following table summarizes the assets acquired in these transactions and recognized at their acquisition dates at estimated fair values:

	Three months ended March 31, 2013
Tangible assets, principally leasehold improvements and equipment	$ 3,874
Intangible and other long-term assets	21,267
Goodwill	69,871
	$ 95,012

Amortizable intangible assets acquired during the first three months of 2013 had weighted-average estimated useful lives of 10.3 years. The total amount of goodwill deductible for tax purposes associated with these acquisitions is approximately $69,871.

HCP acquisition

The initial allocations of the purchase price at the time of the acquisition of HCP on November 1, 2012 were recorded at the estimated fair values of assets acquired and liabilities assumed based upon the best information available to management at that time and will be finalized when certain information arranged to be obtained has been received. Certain income tax amounts are pending issuance of final tax refunds and the evaluation and quantification of certain pre-acquisition tax contingencies. Valuation of medical claims reserves and certain noncontrolling interest amounts are pending final issuance and acceptance of third party actuarial reports.

The following is a summary of HCP's purchase accounting adjustments recorded in the first quarter of 2013 applied retrospectively to the December 31, 2012 balance sheet and primarily relates to adjustments to medical claims reserves and noncontrolling interests:

	Adjustments to the December 31, 2012 balance sheet
Accounts receivable	$ 3,000
Medical payables	$ 7,000
Noncontrolling interest	$ 11,123
Goodwill	$ (17,233)
Deferred income taxes	$ (3,890)

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(dollars and shares in thousands, except per share data)

Discontinued operations

Divestiture of HomeChoice Partners, Inc.

On February 1, 2013, the Company completed the sale of HomeChoice Partners Inc. (HomeChoice) to BioScrip, Inc. pursuant to a stock purchase agreement dated December 12, 2012 for $70,000 in cash, subject to various post-closing adjustments, of which the Company receives approximately 90% of the proceeds. The stock purchase agreement also provides that as additional consideration the Company may earn up to a total of 90% of $20,000 if certain performance amounts exceed certain thresholds over the next two years. As of February 1, 2013, the Company has assigned no value to this contingent receivable and will recognize any estimated realizable value of this receivable only when it becomes probable and reasonably estimable. The Company recorded a gain of approximately $13,375, net of tax, during the three months ended March 31, 2013 related to this divestiture.

HomeChoice is a regional provider of home infusion services that provides specialized pharmacy, nursing and nutritional services to patients in their homes.

The operating results of HomeChoice have been reported as discontinued operations for all periods presented.

The results from discontinued operations related to HomeChoice were as follows:

	Three months ended March 31,	
	2013	2012
Net revenues	$ 6,351	$ 17,102
Loss before income taxes	(223)	(162)
Income tax benefit	(84)	(61)
Loss from discontinued operations	$ (139)	$ (101)

Net assets of discontinued operations related to HomeChoice as of February 1, 2013, were as follows:

Current assets	$ 17,039
Property and equipment, net	2,963
Long-term assets	28
Goodwill	31,853
Liabilities and noncontrolling interests	(8,998)
Net assets of discontinued operations	$42,885

Contingent earn-out obligations

As a result of HCP achieving certain financial performance targets in 2012, the Company made earn-out payments of $136,954 on April 1, 2013, to the common unit holders of HCP. In addition, HCP's prior owners can still earn as further consideration $137,500 if HCP's earn-out EBITDA for 2013 is equal to or greater than $600,000. As of March 31, 2013, the Company estimated the fair value of the total contingent earn-out obligation to be $260,000. After the payment for the 2012 contingent earn-out obligation, the Company has estimated the fair value of the 2013 contingent earn-out obligation to be approximately $123,000.

DAVITA HEALTHCARE PARTNERS INC.

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The Company also has several other contingent earn-out obligations associated with other acquisitions that could result in the Company paying the former shareholders of those acquired companies up to $95,100 if certain EBITDA performance targets and quality margins are met over the next three years and earn-out obligations based on 20% of operating income over the next five years. As of March 31, 2013, the Company has measured the fair value of these contingent earn-out obligations to be $34,079.

Contingent earn-out obligations will subsequently be remeasured to fair value at each reporting date until the contingencies are resolved with changes in the liability due to the re-measurement recorded in earnings. See Note 9 to the condensed consolidated financial statements for further details. Of the total contingent earn-out obligations of $294,079 recognized at March 31, 2013, a total of $141,244 is included in other accrued liabilities and the remaining $152,835 is included in other long-term liabilities on our consolidated balance sheet.

13. Segment reporting

The Company primarily operates two major lines of business, the largest being its U.S. dialysis and related lab services business and the other being HCP. The Company also operates various other ancillary services and strategic initiatives.

As of March 31, 2013, the ancillary services and strategic initiatives consisted primarily of pharmacy services, disease management services, vascular access services, ESRD clinical research programs, physician services, direct primary care and the Company's international dialysis operations. For internal management reporting the U.S. dialysis and related lab services business, HCP's practice management operations in each region, and each of the ancillary services and strategic initiatives have been defined as separate operating segments by management since separate financial information is regularly produced and reviewed by the Company's chief operating decision maker in making decisions about allocating resources and assessing financial results. The chief operating decision maker for the Company's U.S. dialysis business and its ancillary services and strategic initiatives is its Chief Executive Officer. The chief operating decision maker for the HCP business is the HCP Chief Executive Officer. The U.S. dialysis and related lab services business and the HCP business each qualify as separately reportable segments and all of the other ancillary services and strategic initiatives operating segments have been combined and disclosed in the other segments category.

The Company's operating segment financial information is prepared on an internal management reporting basis that the Chief Executive Officer uses to allocate resources and analyze the performance of the operating segments. For internal management reporting, segment operations include direct segment operating expenses but exclude (i) corporate support, which consists primarily of indirect labor, benefits and long-term incentive based compensation of departments which provide support to all of the Company's operating lines of business, and (ii) transaction expenses for the three months ended March 31, 2012 associated with the acquisition of HCP.

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The following is a summary of segment revenues, segment operating margin (loss), and a reconciliation of segment operating margin to consolidated income before income taxes:

	Three months ended March 31,	
	2013	2012
Segment net revenues:		
U.S. dialysis and related lab services		
Patient service revenues:		
External sources	$ 1,908,783	$ 1,762,578
Intersegment revenues	7,511	4,059
Total dialysis and related lab services revenues	1,916,294	1,766,637
Less: Provision for uncollectible accounts	(67,071)	(53,008)
Net dialysis and related lab services patient service revenues	1,849,223	1,713,629
Other revenues [1]	2,895	2,885
Total net dialysis and related lab services revenues	1,852,118	1,716,514
HCP		
HCP revenues:		
Capitated revenues	746,071	—
Net patient service revenues	53,602	—
Other revenues [2]	4,086	—
Total revenues	803,759	—
Other—Ancillary services and strategic initiatives		
Net patient service revenues (U.S. and international)	$ 14,502	$ 2,905
Other external sources	166,714	134,173
Intersegment revenues	2,779	2,044
Total ancillary services and strategic initiatives revenues	183,995	139,122
Total net segment revenues	2,839,872	1,855,636
Elimination of intersegment revenues	(10,290)	(6,103)
Consolidated net revenues	$2,829,582	$ 1,849,533
Segment operating margin (loss):		
U.S. dialysis and related lab services	$ 87,292	$ 359,090
HCP	110,231	—
Other—Ancillary services and strategic initiatives	(15,014)	(18,260)
Total segment margin	182,509	340,830
Reconciliation of segment operating margin to consolidated income from continuing operations before income taxes:		
Corporate support costs	(15,648)	(13,895)
Transaction expenses	—	(6,053)
Consolidated operating income	166,861	320,882
Debt expense	(105,817)	(61,381)
Other income	598	1,039
Consolidated income from continuing operations before income taxes	$ 61,642	$ 260,540

[1] Includes management fees for providing management and administrative services to dialysis centers that are wholly-owned by third parties or centers in which the Company owns a minority equity investment.

DAVITA HEALTHCARE PARTNERS INC.

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(2) Includes payments received for medical consulting services and management fees for providing management and administrative services to an unconsolidated joint venture that provides medical services in which the Company owns a 50% interest.

For the three months ended March 31, 2013, depreciation and amortization expense for the dialysis and related lab services, HCP and the ancillary services and strategic initiatives was $84,936, $38,017 and $2,956, respectively.

For the three months ended March 31, 2012, depreciation and amortization expense for the dialysis and related lab services and for the ancillary services and strategic initiatives was $73,727 and $1,654, respectively.

Summary of assets by segment is as follows:

	March 31, 2013	December 31, 2012
Segment assets		
U.S. dialysis and related lab services	$ 9,609,466	$ 9,351,075
HCP	6,399,107	6,218,133
Other—Ancillary services and strategic initiatives	404,904	435,155
Consolidated assets	$16,413,477	$16,004,363

For the three months ended March 31, 2013, the total amount of expenditures for property and equipment, excluding capital leases for U.S. dialysis and related lab services, were $102,076, $6,539 for HCP and were $8,109 for the ancillary services and strategic initiatives.

For the three months ended March 31, 2012, the total amount of expenditures for property and equipment, excluding capital leases for U.S. dialysis and related lab services, were $106,802 and were $5,657 for the ancillary services and strategic initiatives.

DAVITA HEALTHCARE PARTNERS INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS—(continued)
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14. Changes in DaVita HealthCare Partners Inc.'s ownership interest in consolidated subsidiaries

The effects of changes in DaVita HealthCare Partners Inc.'s ownership interest on the Company's equity are as follows:

	Three months ended March 31, 2013	
	2013	2012
Net income attributable to DaVita HealthCare Partners Inc.	$ 30,164	$ 140,120
(Decrease) increase in paid-in capital for sales of noncontrolling interests	(809)	5
Decrease in paid-in capital for the purchase of noncontrolling interests	—	(897)
Net transfer to noncontrolling interests	(809)	(892)
Change from net income attributable to DaVita HealthCare Partners Inc. and transfers to noncontrolling interests	$29,355	$139,228

15. Variable interest entities

The Company relies on the operating activities of certain entities that it does not directly own or control, but over which it has indirect influence and of which it is considered the primary beneficiary. These entities are subject to the consolidation guidance applicable to variable interest entities (VIEs).

Under U.S. GAAP, variable interest entities typically include those for which the entity's equity is not sufficient to finance its activities without additional subordinated financial support; those for which the equity holders as a group lack the power to direct the activities that most significantly influence the entity's economic performance, the obligation to absorb the entity's expected losses, or the right to receive the entities expected returns; or those for which the voting rights of some investors are not proportional to their obligations to absorb the entity's losses.

Under U.S. GAAP, the Company has determined that substantially all of the entities it is associated with that qualify as variable interest entities must be included in its consolidated financial statements. The Company manages these entities and provides operating and capital funding as necessary for the entities to accomplish their operational and strategic objectives. A number of these entities are subject to nominee share ownership or share transfer restriction agreements that effectively transfer the majority of the economic risks and rewards of their ownership to the Company. In other cases the Company's management agreements with these entities include both financial terms and protective and participating rights to the entity's operating, strategic and non-clinical governance decisions which transfer substantial powers over and economic responsibility for the entity to the Company. In some cases such entities are subject to broad exclusivity or noncompetition restrictions that benefit the Company. Further, in some cases the Company has contractual arrangements with its related party nominee owners that effectively indemnify these parties from the economic losses from, or entitle the Company to the economic benefits of, these entities.

DAVITA HEALTHCARE PARTNERS INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS—(continued)
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The analyses upon which these consolidation determinations rest are complex, involve uncertainties, and require significant judgment on various matters, some of which could be subject to different interpretations. At March 31, 2013, these consolidated financial statements include total assets of variable interest entities of $477,771 and total liabilities and noncontrolling interests of variable interest entities to third parties of $323,627.

The Company also sponsors certain deferred compensation plans whose trusts qualify as variable interest entities and as their primary beneficiary the Company consolidates each of these plans. The assets of these plans are recorded in short-term or long-term investments with matching offsetting liabilities recorded in accrued compensation and benefits and other long-term liabilities. See Note 8 for disclosures on the assets of these consolidate non-qualified deferred compensation plans.

16. Health care costs payable

The health care costs shown in the following table include estimates for the cost of professional medical services provided by non-employed physicians and other providers, as well as inpatient and other ancillary costs for all markets, other than California, where state regulation allows for the assumption of global risk. Health care costs payable are included in medical payables.

The following table shows the components of changes in the health care costs payable for the three months ended March 31, 2013:

	Three months ended March 31, 2013
Health care costs payable, beginning of the period	$ 119,512
Acquisitions and other adjustments	19,267
Add: Components of incurred health care costs	
Current year	329,374
Prior years	(2,145)
Total incurred health care costs	327,229
Less: Claims paid	
Current year	187,950
Prior years	107,713
Total claims paid	295,663
Health care costs payable, end of the period	$ 170,345

Our prior year estimates of health care costs payable decreased by $2,145 resulting from certain medical claims being settled for amounts less than originally estimated. These reductions were primarily the result of lower than expected utilization trends. When significant decreases (increases) in prior-year health care cost estimates occur that we believe significantly impact our current year operating results, we disclose that amount as favorable (unfavorable) development of prior-year's health care cost estimates. Actual claim payments for prior year services have not been materially different from our year-end estimates.

DAVITA HEALTHCARE PARTNERS INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS—(continued)

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17. Comprehensive income

On January 1, 2013, the Company adopted FASB's ASU No. 2013-02 *Comprehensive Income*. This standard requires an entity to provide information about the amounts reclassified out of accumulated other comprehensive income by component. In addition, an entity is required to present, either on the face of the statement where net income is presented or in the notes, significant amounts reclassified out of accumulated other comprehensive income by the respective line items of net income but only if the amount reclassified is required under U.S. GAAP to be reclassified to net income in its entirety in the same reporting period. For other amounts that are not required under U.S. GAAP to be reclassified in their entirety to net income, an entity is required to cross reference to other disclosures required under U.S. GAAP that provide additional detail about those amounts.

	For the three months ended March 31, 2013				For the three months ended March 31, 2012			
	Interest rate swap and cap agreements	Investment securities	Foreign currency translation adjustments	Accumulated other comprehensive income (loss)	Interest rate swap and cap agreements	Investment securities	Foreign currency translation adjustments	Accumulated other comprehensive income (loss)
Beginning balance	$ (15,402)	$ 1,310	$ (1,205)	$ (15,297)	$ (19,328)	$ (156)	$ —	$ (19,484)
Unrealized (losses) gains	(3,877)	1,011	(2,106)	(4,972)	(3,700)	1,877	(619)	(2,442)
Related income tax benefit (expense)	1,508	(393)	—	1,115	1,439	(731)	—	708
	(2,369)	618	(2,106)	(3,857)	(2,261)	1,146	(619)	(1,734)
Reclassification from accumulated other comprehensive income into net income	4,104	(155)	—	3,949	4,122	(123)	—	3,999
Related tax	(1,597)	61	—	(1,536)	(1,602)	48	—	(1,554)
	2,507	(94)	—	2,413	2,520	(75)	—	2,445
Ending balance	$ (15,264)	$ 1,834	$ (3,311)	$ (16,741)	$ (19,069)	$ 915	$ (619)	$ (18,773)

The reclassification of net swap and cap realized losses into income are recorded as debt expense in the corresponding condensed consolidated statements of income. See Note 6 to the condensed consolidated financial statements for further details.

The reclassification of net investment realized gains into income are recorded in other income in the corresponding condensed consolidated statements of income. See Note 8 to the condensed consolidated financial statements for further details.

DAVITA HEALTHCARE PARTNERS INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS—(continued)

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18. Condensed consolidating financial statements

The following information is presented in accordance with Rule 3-10 of Regulation S-X. The operating and investing activities of the separate legal entities included in the Company's consolidated financial statements are fully interdependent and integrated. Revenues and operating expenses of the separate legal entities include intercompany charges for management and other administrative services. The Company's senior notes are guaranteed by substantially all of its domestic wholly-owned subsidiaries. Each of the guarantor subsidiaries has guaranteed the notes on a joint and several basis. However, the guarantor subsidiaries can be released from their obligations in the event of a sale or other disposition of all or substantially all of the assets of such subsidiary, including by merger or consolidation or the sale of all equity interests in such subsidiary owned by the Company, if such subsidiary guarantor is designated as an unrestricted subsidiary or otherwise ceases to be a restricted subsidiary, and if such subsidiary guarantor no longer guaranties any other indebtedness of the Company. Non-wholly-owned subsidiaries, certain wholly-owned subsidiaries, foreign subsidiaries, joint ventures, partnerships, non-owned entities and third parties are not guarantors of these obligations.

Condensed Consolidating Statements of Income

For the three months ended March 31, 2013	DaVita HealthCare Partners Inc.	Guarantor subsidiaries	Non-Guarantor subsidiaries	Consolidating adjustments	Consolidated total
Dialysis patient service revenues	$ —	$1,452,220	$536,658	$ (9,005)	$1,979,873
Less: Provision for uncollectible accounts	—	(63,857)	(6,200)	—	(70,057)
Net patient service revenues	—	1,388,363	530,458	(9,005)	1,909,816
HCP capitated revenue	—	343,480	403,675	(1,084)	746,071
Other revenues	135,375	375,001	17,657	(354,338)	173,695
Total net revenues	135,375	2,106,844	951,790	(364,427)	2,829,582
Operating expenses	420,504	1,781,223	825,421	(364,427)	2,662,721
Operating (loss) income	(285,129)	325,621	126,369	—	166,861
Debt (expense)	(105,331)	(94,715)	(10,723)	104,952	(105,817)
Other income (expense)	100,221	5,967	(638)	(104,952)	598
Income tax (benefit) expense	(136,703)	138,088	13,759	—	15,144
Equity earnings in subsidiaries	183,700	66,077	—	(249,777)	—
Income from continuing operations	30,164	164,862	101,249	(249,777)	46,498
Discontinued operations	—	—	13,236	—	13,236
Net income	30,164	164,862	114,485	(249,777)	59,734
Less: Net income attributable to noncontrolling interests	—	—	—	(29,570)	(29,570)
Net income attributable to DaVita HealthCare Partners Inc.	$ 30,164	$ 164,862	$ 114,485	$ (279,347)	$ 30,164

DAVITA HEALTHCARE PARTNERS INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS—(continued)

(unaudited)

(dollars and shares in thousands, except per share data)

For the three months ended March 31, 2012	DaVita HealthCare Partners Inc.	Guarantor subsidiaries	Non-Guarantor subsidiaries	Consolidating adjustments	Consolidated total
Dialysis patient service revenues	$ —	$1,315,992	$ 463,090	$ (13,600)	$ 1,765,482
Less: Provision for uncollectible accounts	—	(38,846)	(14,162)	—	(53,008)
Net patient service revenues	—	1,277,146	448,928	(13,600)	1,712,474
Other revenues	123,593	146,965	4,153	(137,652)	137,059
Total net revenues	123,593	1,424,111	453,081	(151,252)	1,849,533
Operating expenses	93,158	1,230,436	356,309	(151,252)	1,528,651
Operating income	30,435	193,675	96,772	—	320,882
Debt (expense)	(62,181)	(51,218)	(6,366)	58,384	(61,381)
Other income	58,346	632	445	(58,384)	1,039
Income tax expense	10,773	78,112	6,671	—	95,556
Equity earnings in subsidiaries	124,293	59,540	—	(183,833)	—
Income from continuing operations	140,120	124,517	84,180	(183,833)	164,984
Discontinued operations	—	—	(101)	—	(101)
Net income	140,120	124,517	84,079	(183,833)	164,883
Less: Net income attributable to noncontrolling interests	—	—	—	(24,763)	(24,763)
Net income attributable to DaVita HealthCare Partners Inc.	$ 140,120	$ 124,517	$ 84,079	$(208,596)	$ 140,120

DAVITA HEALTHCARE PARTNERS INC.

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Condensed Consolidating Statements of Comprehensive Income

For the three months ended March 31, 2013	DaVita HealthCare Partners Inc.	Guarantor subsidiaries	Non-Guarantor subsidiaries	Consolidating adjustments	Consolidated total
Net income	$ 30,164	$164,862	$114,485	$ (249,777)	$ 59,734
Other comprehensive loss	(1,444)	—	—	—	(1,444)
Total comprehensive income	28,720	164,862	114,485	(249,777)	58,290
Less: comprehensive income attributable to the noncontrolling interests	—	—	—	(29,570)	(29,570)
Comprehensive income attributable to DaVita HealthCare Partners Inc.	$ 28,720	$164,862	$114,485	$ (279,347)	$ 28,720
For the three months ended March 31, 2012					
Net income	$140,120	$ 124,517	$ 84,079	$ (183,833)	$ 164,883
Other comprehensive income	711	—	—	—	711
Total comprehensive income	140,831	124,517	84,079	(183,833)	165,594
Less: comprehensive income attributable to the noncontrolling interests	—	—	—	(24,763)	(24,763)
Comprehensive income attributable to DaVita HealthCare Partners Inc.	$140,831	$ 124,517	$ 84,079	$(208,596)	$ 140,831

DAVITA HEALTHCARE PARTNERS INC.

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Condensed Consolidating Balance Sheets

As of March 31, 2013	DaVita HealthCare Partners Inc.	Guarantor subsidiaries	Non-Guarantor subsidiaries	Consolidating adjustments	Consolidated total
Cash and cash equivalents	$ 303,829	$ 222,548	$ 173,294	$ —	$ 699,671
Accounts receivable, net	—	979,782	536,860	—	1,516,642
Other current assets	141,748	743,622	89,485	—	974,855
Total current assets	445,577	1,945,952	799,639	—	3,191,168
Property and equipment, net	158,570	1,239,950	516,933	—	1,915,453
Amortizable intangibles, net	92,172	1,974,157	37,715	—	2,104,044
Investments in subsidiaries	7,739,790	1,335,279	—	(9,075,069)	—
Intercompany receivables	4,433,541	160,955	423,295	(5,017,791)	—
Other long-term assets and investments	59,701	71,056	57,020	—	187,777
Goodwill	—	7,760,863	1,254,172	—	9,015,035
Total assets	$12,929,351	$ 14,488,212	$ 3,088,774	(14,092,860)	$16,413,477
Current liabilities	$ 486,690	$ 1,489,523	$ 349,026	$ —	$ 2,325,239
Intercompany payables	—	4,161,191	856,600	(5,017,791)	—
Long-term debt and other long-term liabilities	8,258,157	1,097,708	169,948	—	9,525,813
Noncontrolling interests subject to put provisions	385,062	—	—	220,832	605,894
Total DaVita HealthCare Partners Inc. shareholders' equity	3,799,442	7,739,790	1,335,279	(9,075,069)	3,799,442
Noncontrolling interests not subject to put provisions	—	—	377,921	(220,832)	157,089
Total equity	3,799,442	7,739,790	1,713,200	(9,295,901)	3,956,531
Total liabilities and equity	$12,929,351	$ 14,488,212	$ 3,088,774	$(14,092,860)	$16,413,477

As of December 31, 2012					
Cash and cash equivalents	$ 195,037	$ 166,107	$ 172,604	$ —	$ 533,748
Accounts receivable, net	—	966,854	457,449	—	1,424,303
Other current assets	13,928	775,595	134,220	—	923,743
Total current assets	208,965	1,908,556	764,273	—	2,881,794
Property and equipment, net	143,684	1,237,166	491,520	—	1,872,370
Amortizable intangibles, net	96,472	1,995,372	36,274	—	2,128,118
Investments in subsidiaries	7,444,676	1,337,414	—	(8,782,090)	—
Intercompany receivables	4,866,059	—	423,626	(5,289,685)	—
Other long-term assets and investments	52,787	67,000	54,558	—	174,345
Goodwill	—	7,705,119	1,242,617	—	8,947,736
Total assets	$ 12,812,643	$14,250,627	$ 3,012,868	$(14,071,775)	$ 16,004,363
Current liabilities	$ 357,476	$ 1,274,305	$ 379,393	$ —	$ 2,011,174
Intercompany payables	—	4,593,709	695,976	(5,289,685)	—
Long-term debt and other long-term liabilities	8,326,266	993,331	175,975	—	9,495,572
Noncontrolling interests subject to put provisions	365,764	—	—	214,928	580,692
Total DaVita HealthCare Partners Inc. shareholders' equity	3,763,137	7,389,282	1,392,808	(8,782,090)	3,763,137
Noncontrolling interests not subject to put provisions	—	—	368,716	(214,928)	153,788
Total equity	3,763,137	7,389,282	1,761,524	(8,997,018)	3,916,925
Total liabilities and equity	$ 12,812,643	$14,250,627	$ 3,012,868	$(14,071,775)	$ 16,004,363

DAVITA HEALTHCARE PARTNERS INC.

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Condensed Consolidating Statements of Cash Flows

For the three months ended March 31, 2013	DaVita HealthCare Partners Inc.	Guarantor subsidiaries	Non-Guarantor subsidiaries	Consolidating adjustments	Consolidated total
Cash flows from operating activities:					
Net income	$ 30,164	$ 164,862	$ 114,485	$(249,777)	$ 59,734
Changes in operating assets and liabilities and non-cash items included in net income	105,835	11,971	(48,110)	249,777	319,473
Net cash provided by operating activities	135,999	176,833	66,375	—	379,207
Cash flows from investing activities:					
Additions of property and equipment, net	(19,582)	(51,574)	(45,568)	—	(116,724)
Acquisitions	—	(81,505)	(9,993)	—	(91,498)
Proceeds from asset and business sales	60,650	1,707	—	—	62,357
Purchases/proceeds from investment sales and other items	(125)	(21)	—	—	(146)
Net cash provided by (used in) investing activities	40,943	(131,393)	(55,561)	—	(146,011)
Cash flows from financing activities:					
Long-term debt and related financing costs, net	(50,725)	(3,907)	(9,055)	—	(63,687)
Intercompany borrowing	(30,215)	10,734	19,481	—	—
Other items	12,790	4,174	(20,669)	—	(3,705)
Net cash (used in) provided by financing activities	(68,150)	11,001	(10,243)	—	(67,392)
Effect of exchange rate changes on cash	—	—	119	—	119
Net increase in cash and cash equivalents	108,792	56,441	690	—	165,923
Cash and cash equivalents at beginning of period	195,037	166,107	172,604	—	533,748
Cash and cash equivalents at end of period	$ 303,829	$ 222,548	$ 173,294	$ —	$ 699,671
For the three months ended March 31, 2012					
Cash flows from operating activities:					
Net income	$ 140,120	$ 124,517	$ 84,079	$ (183,833)	$ 164,883
Changes in operating assets and liabilities and non-cash items included in net income	(49,986)	60,253	(27,109)	183,833	166,991
Net cash provided by operating activities	90,134	184,770	56,970	—	331,874
Cash flows from investing activities:					
Additions of property and equipment, net	(18,640)	(58,812)	(35,007)	—	(112,459)
Acquisitions	—	(116,269)	(16,430)	—	(132,699)
Proceeds from asset sales	—	825	—	—	825
Purchases of investments and other items	6,302	4,341	—	—	10,643
Net cash used in investing activities	(12,338)	(169,915)	(51,437)	—	(233,690)
Cash flows from financing activities:					
Long-term debt and related financing costs, net	(17,158)	(10,678)	4,437	—	(23,399)
Intercompany borrowing	(11,910)	95	11,815	—	—
Other items	7,768	(4,272)	(22,754)	—	(19,258)
Net cash used in financing activities	(21,300)	(14,855)	(6,502)	—	(42,657)
Effect of exchange rate changes on cash	—	—	11	—	11
Net increase (decrease) in cash and cash equivalents	56,496	—	(958)	—	55,538
Cash and cash equivalents at beginning of period	365,276	—	28,476	—	393,752
Cash and cash equivalents at end of period	$ 421,772	$ —	$ 27,518	$ —	$ 449,290

Item 2. *Management's Discussion and Analysis of Financial Condition and Results of Operations.*

Forward-looking statements

This Management's Discussion and Analysis of Financial Condition and Results of Operations contain statements that are forward-looking statements within the meaning of the federal securities laws. This Quarterly Report on Form 10-Q contains 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, including earnings per share, and incorporation of HCP's operating results into the Company's consolidated operating results. 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 the continued downward pressure on average realized payment rates from, and a reduction in the number of patients under, higher-paying commercial payor plans, which may result in the loss of revenues or patients, a reduction in government payment rates under the Medicare ESRD program or other government-based programs, the impact of health care reform legislation that was enacted in the U.S. in March 2010, 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, including risks relating to the resolution of the 2010 and 2011 U.S. Attorney Physician Relationship Investigations, 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 any 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, 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 fact that HCP faces certain competitive threats that could reduce its profitability, 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 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 Quarterly Report on Form 10-Q. 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 condensed consolidated financial statements.

Consolidated results of operations

We primarily operate two major lines of business and, to a lesser extent, various other ancillary services and strategic initiatives, which includes our international dialysis operations. Our largest line of business is our U.S. dialysis and related lab services 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 other major line of business is HealthCare Partners (HCP), which 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.

Following is a summary of our consolidated operating results for the first quarter of 2013 compared with the prior sequential quarter and the same quarter of 2012 for reference in the discussion that follows. The operating results of HCP are included in our operating results effective November 1, 2012.

	Three months ended					
	March 31, 2013		December 31, 2012		March 31, 2012	
	(dollar amounts rounded to nearest million)					
Net revenues:						
Patient service revenues	$ 1,980		$ 1,930		$ 1,766	
Less: Provision for uncollectible accounts	(70)		(68)		(53)	
Net patient service revenues	1,910		1,862		1,713	
HCP capitated revenues	746		419		—	
Other revenues	174		197		137	
Total consolidated net revenues	2,830	100%	2,478	100%	1,850	100%
Operating expenses and charges:						
Patient care costs	1,954	69%	1,703	69%	1,250	68%
General and administrative	291	10%	278	11%	206	11%
Depreciation and amortization	126	4%	109	4%	75	4%
Provision for uncollectible accounts	1	—	1	—	1	—
Equity investment income	(9)	—	(8)	—	(3)	—
Loss contingency reserve and other legal settlement expenses	300	11%	7	—	—	—
Total operating expenses and charges	2,663	94%[1]	2,090	84%	1,529	83%
Operating income	$ 167	6%	$ 388	16%	$ 321	17%

The following table summarizes consolidated net revenues for our U.S. dialysis and related lab services segment, HCP and our other ancillary services and strategic initiatives:

	Three months ended		
	March 31, 2013	December 31, 2012	March 31, 2012
	(dollar amounts rounded to nearest million)		
Net revenues:			
Dialysis and related lab services patient service revenues	$ 1,916	$ 1,894	$ 1,767
Less: Provision for uncollectible accounts	(67)	(66)	(53)
Dialysis and related lab services net patient service revenues	$ 1,849	$ 1,828	$ 1,714
Other revenues	3	3	3
Total net dialysis and related lab services revenues	1,852	1,831	1,717
HCP capitated revenues	746	419	—
HCP net patient service revenues (less provision for uncollectible accounts of $3 and $2)	54	34	—
Other revenues	4	24	—
Total net HCP revenues	804	477	—
Other—Ancillary services and strategic initiatives revenues	169	173	136
Other—Ancillary services and strategic initiatives net patient service revenues	15	5	3
Total net other-ancillary services and strategic initiatives revenues	184	178	139
Total net segment revenues	2,840	2,486	1,856
Elimination of intersegment revenues	(10)	(8)	(6)
Consolidated net revenues	$ 2,830	$ 2,478	$ 1,850

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

	Three months ended		
	March 31, 2013	December 31, 2012	March 31, 2012
	(dollar amounts rounded to nearest million)		
Dialysis and related lab services	$ 87	$ 362	$ 359
HCP services	110	67	—
Other—Ancillary services and strategic initiatives loss	(15)	(15)	(18)
Total segment operating income	182	414	341
Reconciling items:			
Corporate support costs	(15)	(13)	(14)
Transaction expenses	—	(13)	(6)
Consolidated operating income	167	388	321
Reconciliation of non-GAAP measure:			
Add:			
Loss contingency reserve and other legal settlement expenses	300	7	—
Transaction expenses	—	13	6
Adjusted consolidated operating income [1]	$ 467	$ 408	$ 327

[1] For the three months ended March 31, 2013, we have excluded $300 million of expenses related to an estimated loss contingency reserve and for the three months ended December 31, 2012, we have excluded $7 million of expenses related to a legal settlement, from operating expenses and operating income. In addition, for the three months ended December 31, 2012 and March 31, 2012, we have excluded $13 million and $6 million, respectively, 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 an estimated $300 million loss contingency reserve related to the 2010 and 2011 U.S. Attorney Physician Relationship Investigations (see note 7 to the condensed consolidated financial statements), $7 million of expenses relating to a settlement we reached in the second quarter of 2012 with the U.S. District Court in the Eastern District of Texas to resolve federal program claims regarding EPO that were or could have been raised in the complaint relating to historical EPO practices dating back to 1997, and an unusual amount of transaction expenses totaling $13 million and $6 million for the three months ended December 31, 2012 and March 31, 2012, respectively, that resulted from the acquisition of HCP. These adjusted consolidated operating income amounts are therefore considered meaningful and comparable to our prior period results.

Consolidated net revenues

Consolidated net revenues for the first quarter of 2013 increased by approximately $352 million, or approximately 14.2%, as compared to the fourth quarter of 2012. The increase in consolidated net revenues was primarily due to an increase of approximately $327 million associated with HCP as a result of HCP's operations being included for the full first quarter in 2013 as compared to two months in 2012. HCP's net revenues in the first quarter of 2013 benefited from an increase in new members and growth through acquisitions. In addition, consolidated net revenues increased as a result of an increase in the dialysis and related lab services net revenues of approximately $21 million, principally due to an increase in our average dialysis revenue per treatment of

approximately $10 in the first quarter of 2013 and volume growth from additional treatments from non-acquired growth and acquisitions. However, consolidated net revenues were negatively impacted by three fewer treatment days in the first quarter of 2013.

Consolidated net revenues for the first quarter of 2013 increased by approximately $980 million, or approximately 53.0%, as compared to the first quarter of 2012. The increase in consolidated net revenues was primarily due to the acquisition of HCP which generated approximately $804 million in net revenues, an increase of $135 million in the dialysis and related lab services net revenues, primarily due to an increase in our average dialysis revenue per treatment of approximately $8 and strong volume growth from additional treatments from non-acquired treatment growth in existing and new centers, and growth through acquisitions partially offset by one and a half fewer treatment days in the first quarter of 2013. In addition, the increase in consolidated net revenues was also due to an increase of approximately $45 million in our ancillary services and strategic initiatives, primarily from growth in our pharmacy services and in our international operations.

Consolidated operating income

Consolidated operating income for the first quarter of 2013 decreased by approximately $221 million, or approximately 57.0%, as compared to the fourth quarter of 2012, including the estimated loss contingency reserve of $300 million in the first quarter of 2013 and including other legal settlement expenses of approximately $7 million and the transaction expenses of $13 million associated with acquisition of HCP in the fourth quarter of 2012. Excluding these items from the respective periods, adjusted consolidated operating income would have increased by $59 million. The increase in the adjusted consolidated operating income was primarily due to HCP's operating results being included for the full first quarter in 2013, compared to two months in 2012. HCP's operating results benefited from an increase in new members. In addition, adjusted consolidated operating income increased as a result of an increase in our average dialysis revenue per treatment of approximately $10, volume growth in the number of treatments, lower benefit costs and a decrease in the EPO unit costs. Adjusted consolidated operating income was negatively impacted by three fewer treatment days in the first quarter of 2013, higher labor costs and related payroll taxes and a decline in productivity.

Consolidated operating income for the first quarter of 2013 decreased by approximately $154 million, or approximately 48.0%, as compared to the first quarter of 2012 including the estimated loss contingency reserve of $300 million in the first quarter of 2013 and including transaction expenses of $6 million associated with the acquisition of HCP in the first quarter of 2012. Excluding these items from their respective periods, adjusted consolidated operating income would have increased by $140 million. The increase in adjusted operating income was primarily due to the acquisition of HCP, which generated $110 million in operating income, an increase of approximately $8 in our average dialysis revenue per treatment, strong volume growth in the number of treatments, lower professional fees for legal and compliance matters, lower transaction and integration costs associated with the acquisition of DSI and a decrease in the EPO unit costs. Adjusted consolidated operating income was negatively impacted by one and a half fewer treatment days in the first quarter of 2013, higher labor costs and related payroll taxes, a decline in productivity and a decline in the intensities of physician-prescribed pharmaceuticals.

U.S. dialysis and related lab services business

Results of Operations

	Three months ended		
	March 31, 2013	December 31, 2012	March 31, 2012
	(dollar amounts rounded to nearest million, except per treatment data)		
Net revenues:			
Dialysis and related lab services patient service revenues	$ 1,916	$ 1,894	$ 1,767
Less: Provision for uncollectible accounts	(67)	(66)	(53)
Dialysis and related lab services net patient service revenues	$ 1,849	$ 1,828	$ 1,714
Other revenues	3	3	3
Total net dialysis and related lab services revenues	$ 1,852	$ 1,831	$ 1,717
Operating expenses and charges:			
Patient care costs	1,216	1,219	1,129
General and administrative	167	163	158
Depreciation and amortization	85	83	74
Loss contingency reserve and other legal settlement expenses	300	7	—
Equity investment income	(3)	(3)	(3)
Total operating expenses and charges	1,765	1,469	1,358
Operating income	$ 87	$ 362	$ 359
Dialysis treatments	5,628,799	5,736,776	5,314,275
Average dialysis treatments per treatment day	73,579	72,161	68,132
Average dialysis and related lab services revenue per treatment	$ 340	$ 330	$ 332

Net revenues

Dialysis and related lab services' net revenues for the first quarter of 2013 increased by approximately $21 million, or approximately 1.1%, as compared to the fourth quarter of 2012. The increase in net revenues was primarily due to an increase of approximately $10 in the average dialysis revenue per treatment, primarily due to an increase in our Medicare reimbursements, an increase in some of our commercial payment rates and a slight increase in our commercial patient mix. The increase in dialysis and related lab services' net revenues was also due to an increase in the number of treatments per day as a result of non-acquired treatment growth in existing and new centers and growth through acquisitions, partially offset by a reduction in the overall number of treatments as a result of three fewer treatment days in the quarter.

Dialysis and related lab services' net revenues for the first quarter of 2013 increased by approximately $135 million, or approximately 7.9%, as compared to the first quarter of 2012. The increase in net revenues in the first quarter of 2013 was principally due to strong volume growth from additional treatments, even with one and a half fewer treatment days in the first quarter of 2013. Dialysis and related services' net revenues also increased as a result of an increase in the average dialysis revenue per treatment of approximately $8. The increase in the number of treatments was primarily attributable to non-acquired treatment growth at existing and new centers

and growth through acquisitions. The increase in the average dialysis revenue per treatment was primarily due to an increase in our Medicare reimbursements and an increase in some of our commercial payment rates, partially offset by a slight decline in our commercial mix and a decline in the intensities of physician-prescribed pharmaceuticals.

Under the American Taxpayer Relief Act of 2012, the sequester was postponed until March 1, 2013. However, since Congress failed to act by that date, the sequestration became effective on April 1, 2013 and as a result, our dialysis Medicare reimbursements were reduced by 2% effective at that time which represents a reduction of approximately $20 million per quarter.

Operating expenses and charges

Patient care costs. Dialysis and related lab services' patient care costs on a per treatment basis for the first quarter of 2013 increased by approximately $4 per treatment as compared to the fourth quarter of 2012. The increase in the dialysis and related lab services' patient care costs per treatment was primarily due to higher labor costs and related payroll taxes and a decline in productivity, partially offset by a decrease in our benefit costs and a decrease in the EPO unit cost.

Dialysis and related lab services' patient care costs on a per treatment basis for the first quarter of 2013 increased by approximately $4 as compared to the first quarter of 2012. The increase was primarily attributable to higher labor costs and related payroll taxes, a decline in productivity and an increase in our other direct operating expenses associated with our dialysis centers, partially offset by lower pharmaceutical costs mainly from a decline in the intensities of physician prescribed pharmaceuticals and a decrease in the EPO unit cost.

General and administrative expenses. Dialysis and related lab services' general and administrative expenses of approximately $167 million increased by approximately $4 million in the first quarter of 2013 as compared to the fourth quarter of 2012. The increase was primarily due to higher labor costs and related payroll taxes, higher long-term incentive compensation and an increase in our professional fees for legal and compliance matters, partially offset by lower benefit costs and lower costs related to leadership meetings and related travel costs.

Dialysis and related lab services' general and administrative expenses for the first quarter of 2013 increased by approximately $9 million as compared to the first quarter of 2012. The increase was primarily due to higher labor costs and related payroll taxes, and higher long-term incentive compensation, partially offset by lower professional fees in conjunction with legal and compliance matters and lower transaction and integration costs associated with the acquisition of DSI.

Depreciation and amortization. Depreciation and amortization for dialysis and related lab services was approximately $85 million for the first quarter of 2013, $83 million for the fourth quarter of 2012 and $74 million for the first quarter of 2012. The increases in depreciation and amortization in the first quarter of 2013, as compared to both the fourth quarter of 2012 and the first quarter of 2012, was primarily due to growth in newly developed centers and from acquired centers. In addition, the increase in depreciation and amortization in the first quarter of 2013 compared to the first quarter of 2012 was also due to additional depreciation expense associated with the opening of our new corporate headquarters in August 2012.

Provision for uncollectible accounts. The provision for uncollectible accounts receivable for dialysis and related lab services was 3.5% for the first quarter of 2013, 3.5% for the fourth quarter of 2012, and 3.0% for the first quarter of 2012. The increase in the provision for uncollectible accounts in the first quarter of 2013 as compared to the first quarter of 2012 was primarily due to higher non-covered Medicare charges that continue to result in additional write-offs. We assess our level of the provision for uncollectible accounts based upon our historical cash collection experience and trends, and have and will continue to adjust the provision as necessary as a result of changes in our cash collections.

Loss contingency reserve and other legal settlement expenses. We are engaged in good faith discussions with the attorneys from 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 in an effort to find a mutually acceptable resolution to the 2010 and 2011 U.S. Attorney Physician Relationship Investigations. Discussions have advanced to a point where we believe it is appropriate to accrue an estimated loss contingency reserve of $300 million in the first quarter of 2013 in connection with an offer to settle the related civil, administrative and criminal matters. However, the discussions are ongoing, and until concluded, there can be no certainty about the timing or likelihood of a definitive resolution or the scope of any potential restrictions that may be agreed upon in connection with a settlement. As these discussions proceed, and additional information becomes available to us, the amount of the estimated loss contingency reserve may need to be increased or decreased to reflect this new information. In the fourth quarter of 2012, we incurred $7.0 million of expenses relating to a settlement we reached in the second quarter of 2012 with the U.S. District Court in the Eastern District of Texas to resolve federal program claims regarding EPO that were or could have been raised in the complaint relating to historical EPO practices dating back to 1997.

Equity investment income. Equity investment income was approximately $3.3 million for the first quarter of 2013, as compared to $3.1 million for the fourth quarter of 2012 and $2.6 million for the first quarter of 2012. The increases in equity income in the first quarter of 2013, as compared to both the fourth quarter of 2012 and the first quarter of 2012 were primarily due to improvements in the operating performance of certain joint ventures.

Segment operating income

Dialysis and related lab services' operating income for the first quarter of 2013 decreased by approximately $275 million, or approximately 76.0%, as compared to the fourth quarter of 2012, including the estimated loss contingency reserve of $300 million and including other legal settlement expenses of $7 million in the fourth quarter of 2012, as discussed above. Excluding these items from their respective periods, the dialysis and related lab services adjusted operating income would have increased by approximately $18 million. The increase in adjusted operating income was primarily due to an increase of approximately $10 in our average dialysis revenue per treatment, strong volume growth even with three fewer treatment days in the quarter, lower benefit costs and a decrease in our EPO unit cost, partially offset by a higher labor costs and related payroll taxes, a decline in productivity and higher long-term incentive compensation costs.

Dialysis and related lab services' operating income for the first quarter of 2013 decreased by approximately $272 million, or approximately 75.8%, as compared to the first quarter of 2012 including the estimated loss contingency reserve of $300 million in the first quarter of 2013. Excluding this item, the dialysis and related lab services adjusted operating income would have increased by approximately $28 million. The increase in adjusted operating income was primarily attributable to strong volume growth in revenues from additional treatments as a result of non-acquired treatment growth and growth through acquisitions, even with one and a half fewer treatment days in the first quarter of 2013. Dialysis and related lab services' operating income also increased as a result of an increase in the average dialysis revenue per treatment of approximately $8, as described above, lower professional fees for legal and compliance matters, lower transaction and integration costs associated with the acquisition of DSI and lower EPO unit cost. However, dialysis and related lab services operating income was negatively impacted by higher labor costs and related payroll taxes, higher benefit costs and a decline in productivity, and a decline in the intensities of physician-prescribed pharmaceuticals.

HCP business

Results of Operations

HCP consolidated operating results for the quarter ended March 31, 2013 and December 31, 2012 were as follows:

	Three months ended March 31, 2013		For the period November 1, 2012 through December 31, 2012	
	(dollar amounts rounded to nearest millions)			
Net revenues:				
HCP capitated revenue	$ 746	93%	$ 419	88%
Patient service revenue	57		36	
Less: Provision for uncollectible accounts	(3)		(2)	
Net patient service revenue	54	7%	34	7%
Other revenues	4	—	24	5%
Total net revenues	$ 804	100%	$ 477	100%
Operating expense:				
Patient care costs	$ 588	73%	$ 339	71%
General and administrative expense	74	9%	52	11%
Depreciation and amortization	38	5%	24	5%
Equity investment income	(6)	(1)%	(5)	(1)%
Total expenses	694	86%	410	86%
Operating income	$ 110	14%	$ 67	14%

Capitated membership information

The following table provides (i) the total number of capitated members to whom HCP provided healthcare services as of March 31, 2013 and December 31, 2012, and (ii) the aggregate member months for the three months ended March 31, 2013 and two months ended December 31, 2012. Member months represent the aggregate number of months of healthcare services HCP has provided to capitated members during a period of time:

	Members at March 31, 2013	Member months for the three months ended March 31, 2013	Members at December 31, 2012	Member months for the period November 1, 2012 through December 31, 2012
Total	742,000	2,239,400	724,000	1,422,600

In addition to the members above, HCP provided healthcare services to members of Magan joint venture, an unconsolidated entity that is accounted for as an equity investment. The Magan joint venture provided care for approximately 47,400 members as of March 31, 2013 and for approximately 143,900 member months for the quarter ended March 31, 2013.

Revenues

The following table provides HCP's sources of revenues:

	Three months ended March 31, 2013		For the period November 1, 2012 through December 31, 2012	
	(dollar amounts rounded to nearest millions)			
HCP revenues:				
Commercial revenues	$ 182	22%	$ 112	24%
Senior revenues	552	69%	298	62%
Medicaid revenues	12	2%	9	2%
Total capitated revenues	$ 746	93%	$ 419	88%
Patient service revenue, net of provision for uncollectible accounts	54	7%	34	7%
Other revenues	4	— %	24	5%
Total net revenues	$ 804	100%	$ 477	100%

Net revenues

HCP's net revenue for the first quarter of 2013 increased by $327 million, or 69%, as only two months of HCP's operations were included in our results for the fourth quarter of 2012. HCP's net revenues for the first quarter of 2013 would have increased by approximately $88 million, or approximately 12.2%, as compared to the fourth quarter of 2012, on a pro-forma basis as if HCP operations were included for the entire fourth quarter of 2012. The increase in revenue was primarily attributable to an increase in the number of senior capitated members to whom HCP provided health care services, increases in average premiums for our commercial and senior capitated members, offset in part by a decrease in other income resulting from a decline in non-patient care related revenues.

In addition, on April 1, 2013, the Center for Medicare and Medicaid Services (CMS) announced its final 2014 Medicare Advantage benchmark rate structure. While these rates were generally improved from the preliminary rates which were announced in February of this year, the rates still represent a significant decline in what HCP will realize as average revenues for its senior capitated members in 2014 relative to 2013 due to recalibration of patient risk coding. We estimate that the final cumulative impact of the 2014 rate structure represents a reduction of approximately 6% to 9% of HCP's average revenues it manages on behalf of its senior capitated members. We expect to be able to offset approximately 10% of this rate reduction through contractual pass-throughs to our provider network. Additionally, there is potential that up to half of the remaining rate reductions can be offset through benefit design changes that our health plan partners can make. We expect to offset some of the remaining rate reductions, but are unable to quantify the amount at this time.

Operating expenses

HCP's patient care costs of approximately $588 million would have increased by approximately $79 million, or approximately 15.4%, as compared to the fourth quarter of 2012 on a pro-forma basis. The increase in patient care costs was primarily attributable to an increase in the number of senior managed care members to whom HCP provided health care services.

HCP's general and administrative costs were approximately $74 million, or approximately 9.2%, for the quarter ended March 31, 2013.

HCP's depreciation and amortization of approximately $38 million for the quarter ended March 31, 2013 reflects the expense based upon the fair value of equipment, leasehold improvements and intangible assets we recognized in the HCP acquisition.

Segment operating income

HCP's operating income for the first quarter of 2013 would have increased by approximately $10 million, or approximately 9.8%, as compared to the fourth quarter of 2012 on a pro-forma basis. The increase was primarily due to an increase in senior membership growth and premium increases for our senior and commercial capitated members in excess of medical cost increases, partially offset by a decline in other income.

Other—Ancillary services and strategic initiatives business

Our other operations include ancillary services and strategic initiatives which are primarily aligned with our core business of providing dialysis services to our network of patients. As of March 31, 2013 these consisted primarily of pharmacy services, disease management services, vascular access services, ESRD clinical research programs, physician services, direct primary care and our international dialysis operations. The ancillary services and strategic initiatives generated approximately $184 million of net revenues for the three months ended March 31, 2013, representing approximately 7% of our consolidated net revenues. We currently expect to continue to invest in our ancillary services and strategic initiatives including our continued expansion into certain international markets as we work to develop successful new business operations in the U.S. as well as outside the U.S. However, any significant change in market conditions, business performance or in the regulatory environment may impact the economic viability of any of these strategic initiatives. Any unfavorable changes in these strategic initiatives could result in a write-off or an impairment of some or all of our investments, including goodwill, which occurred in 2011 when we recorded a non-cash goodwill impairment charge relating to our infusion therapy business, and could also result in significant termination costs if we were to exit a certain line of business.

As of March 31, 2013, we provided dialysis and administrative services to a total of 41 outpatient dialysis centers located in nine countries outside of the U.S. The total net revenues generated from our international operations are reflected below.

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

	Three months ended		
	March 31, 2013	December 31, 2012	March 31, 2012
	(dollar amounts rounded to nearest in millions)		
U.S. revenues			
Net patient service revenues	$ 4	$ 2	$ 2
Other revenues	168	172	134
Total	172	174	136
International revenues			
Net patient service revenues	11	3	1
Other revenues	1	1	2
Total	12	4	3
Total net revenues	$ 184	$ 178	$ 139
Segment operating loss	$ (15)	$ (15)	$ (18)

Net revenues

The ancillary services and strategic initiatives net revenues for the first quarter of 2013 increased by approximately $6 million or 3.4% as compared to the fourth quarter of 2012. The increase was primarily from growth in our international operations, mainly from acquisitions.

The ancillary services and strategic initiatives net revenues for the first quarter of 2013 increased by approximately $45 million, or 32.4%, as compared to the first quarter of 2012. The increase was primarily from growth in pharmacy services, an increase in our Special Needs Plan and an increase in our international operations.

Operating expenses

Ancillary services and strategic initiatives operating expenses for the first quarter of 2013 increased by approximately $6 million as compared to the fourth quarter of 2012. The increase in operating expenses was primarily due to an increase in volume in our pharmacy business and an increase in labor and benefit costs, partially offset by a decrease in our professional fees in our international operations.

Ancillary services and strategic initiatives operating expenses for the first quarter of 2013 increased by approximately $42 million as compared to the first quarter of 2012. The increase in operating expenses was primarily due to an increase in volume in our pharmacy business, an increase in expenses associated with our international dialysis expansion and an increase in labor and benefit costs.

Ancillary services and strategic initiatives operating losses

Ancillary services and strategic initiatives operating losses for the first quarter of 2013 were flat from the fourth quarter of 2012.

Ancillary services and strategic initiatives operating losses for the first quarter of 2013 decreased by approximately $3 million from the first quarter of 2012. The decrease in operating losses was primarily due to improved operating performance of our pharmacy business and in our vascular access services, partially offset by a decrease in the operating performance of our direct primary care business.

Corporate-level charges

Debt expense. Debt expense of $105.8 million increased by approximately $7.8 million in the first quarter of 2013 as compared to the fourth quarter of 2012 and increased by $44.4 million as compared to the first quarter of 2012. The increase in debt expense in the first quarter of 2013 as compared to both the fourth quarter of 2012 and the first quarter of 2012 was primarily due to the issuance of our new term loans for $3,000 million under our amended Senior Secured Credit Facilities that we entered into on November 1, 2012. In addition, the increase in debt expense in the first quarter of 2013 as compared to the first quarter of 2012 was also due to the issuance of our new senior notes for $1,250 million on August 28, 2012. Our overall weighted average effective interest rate for the first quarter of 2013 was 4.76% and for the fourth quarter of 2012 was 4.93%, compared to 5.27% for the first quarter of 2012.

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 operating lines of business and were approximately $15 million in the first quarter of 2013, $13 million in the fourth quarter of 2012 and $14 million in first quarter of 2012. These expenses are included in our consolidated general and administrative expenses. The increase in these costs in the first quarter of 2013 compared to both the fourth quarter of 2012 and the first quarter of 2012 was primarily due to higher labor and benefit costs and an increase in our long-term incentive compensation.

Transaction expenses. In the fourth quarter of 2012 and the first quarter of 2012, we incurred approximately $13 million and $6 million, respectively, of transaction expenses associated with the acquisition of HCP, which are included in our consolidated general and administrative expenses.

Other income. Other income for the first quarter of 2013 was slightly lower as compared to the fourth quarter of 2012 and to the first quarter of 2012.

Noncontrolling interests

Net income attributable to noncontrolling interests. Net income attributable to noncontrolling interests was $29.6 million for the first quarter of 2013 as compared to $28.0 million for the fourth quarter of 2012 and $24.8 million for the first quarter of 2012. The increases in net income attributable to noncontrolling interests in the first quarter of 2013 as compared to both the fourth quarter of 2012 and the first quarter of 2012 were primarily due to an increase in the overall number of joint ventures and an increase in the overall profitability of certain of our dialysis joint ventures.

Accounts receivable

Our U.S. dialysis and related lab services accounts receivable balances at March 31, 2013 and December 31, 2012 were $1,164 million and $1,169 million, respectively, which represented approximately 57 days and 59 days of revenue, respectively, which is net of bad debt provision. The decrease in day sales outstanding (DSO), was primarily the result of improved cash collections from Medicare. Our DSO calculation is based on the current quarter's average revenues per day. There were no significant changes during the first quarter of 2013 from the fourth quarter of 2012 in the amount of unreserved accounts receivable over one year old or the amounts pending approval from third-party payors.

Outlook

We are updating our consolidated operating income guidance for 2013 to now be in the range of $1,800 million to $1,900 million. Our previous consolidated operating income guidance was expected to be in the range of $1,750 million to $1,900 million. In addition, we are also updating our operating income guidance for our dialysis services and related ancillary businesses for 2013 to now be in the range of $1,400 million to $1,450 million. Our previous dialysis services and related ancillary businesses guidance was expected to be in the range of $1,350 million to $1,450 million. Operating income guidance for HCP for 2013 is still expected to be in the range of $400 million to $450 million. Consolidated operating cash flows for 2013 are still expected to be in the range of $1,350 million to $1,500 million.

The consolidated and dialysis services and related ancillary businesses operating income guidance amounts exclude the estimated loss contingency reserve of $300 million.

These projections and the underlying assumptions involve significant risks and uncertainties, and actual results may vary significantly from these current projections. These risks and uncertainties, among others, include those relating to the concentration of profits generated by the continued downward pressure on average realized payment rates from, and a reduction in the number of patients under higher-paying commercial payor plans, which may result in the loss of revenues or patients, a reduction in government payment rates under the Medicare ESRD program or other government-based programs, the impact of health care reform legislation that was enacted in the United States in March 2010, 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, including risks relating to the resolution of the 2010 and 2011 U.S. Attorney Physician Relationship Investigations, 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 any 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, 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 fact that HCP faces certain competitive threats that could reduce its profitability, 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 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. See "Risk Factors" in Part II, Item 1A. in this Quarterly Report on Form 10-Q and the cautionary language contained in the forward looking statements and associated risks as discussed under "Forward-looking statements" on page 33 for more information about these and other potential risks. We undertake no obligation to update or revise these projections, whether as a result of changes in underlying factors, new information, future events or otherwise.

Liquidity and capital resources

Liquidity and capital resources. Cash flow from operations during the first quarter of 2013 was $379 million, compared to $332 million during the first quarter of 2012. Cash flow from operations in the first quarter of 2013 increased as a result of improved cash earnings, partially offset by the timing of certain working capital items. Non-operating cash outflows for the first quarter of 2013 included capital asset expenditures of $117 million, including $72 million for new center developments and relocations and $45 million for maintenance and information technology. In addition, we spent $91 million for acquisitions. We paid distributions to noncontrolling interests of $35 million. Non-operating cash outflows for the first quarter of 2012 included capital asset expenditures of $112 million, including $57 million for new center developments and relocations and $55 million for maintenance and information technology. We spent an additional $133 million for acquisitions. We paid distributions to noncontrolling interests of $26 million.

During the first quarter of 2013, we acquired a total of eight dialysis centers, opened 27 dialysis centers, merged one center into other existing centers and provided management and administrative services to three additional centers located in the U.S. In addition, we also opened a total of one center and provided management and administrative services to four additional centers outside of the U.S. in which we consolidate under the applicable accounting standards. During the first quarter of 2012, we acquired a total of 28 dialysis centers and opened 13 dialysis centers located in the United States. We previously provided management and administrative services to nine of the acquired centers. In addition, we also opened a total of four centers outside of the United States.

During the first three months of 2013, we made mandatory principal payments under our Senior Secured Credit Facilities totaling $25.0 million on the Term Loan A, $16.9 million on the Term Loan A-3, $4.4 million on the Term Loan B and $4.1 million on the Term Loan B-2.

In March 2013, we entered into several new interest rate swap agreements. As of March 31, 2013, the amortizing notional amounts of these swap agreements totaled $1,333 million. These agreements have the economic effect of modifying the LIBOR variable component of our interest rate on an equivalent amount of our Term Loan A-3 to fixed rates ranging from 0.49% to 0.52%, resulting in an overall weighted average effective interest rate of 3.01%, including the Term Loan A-3 margin of 2.50%. The swap agreements expire by September 30, 2016 and require monthly interest payments. During the three months ended March 31, 2013 we accrued net charges of $0.04 million from these swaps which are included in debt expense. As of March 31, 2013, the total fair value of these swap agreements was a liability of $0.4 million. We estimate that approximately $2.7 million of existing unrealized pre-tax losses in other comprehensive income at March 31, 2013 will be reclassified into income in 2013.

In addition, in March 2013, we entered into several interest rate forward swap agreements with amortizing notional amounts totaling $600 million. These forward swap agreements will be effective September 30, 2014 and will have the economic effect of modifying the LIBOR variable component of our interest rate on an equivalent amount of our outstanding debt to fixed rates ranging from 0.72% to 0.75%. These swap agreements expire on September 30, 2016 and will require quarterly interest payments beginning in October 2014. Any unrealized gains or losses resulting from changes in the fair value of these swaps will be recorded in other comprehensive income. As of March 31, 2013, the total fair value of these swap agreements was a liability of $0.3 million.

During March 2013, we entered into several interest rate cap agreements with notional amounts totaling $1,250 million on our Term Loan B debt and $1,485 million on our Term Loan B-2 debt. These agreements have the economic effect of capping the LIBOR variable component of our interest rate at a maximum of 2.50% on an equivalent amount of our Term Loan B and Term Loan B-2 debt. The cap agreements expire on September 30, 2016. As of March 31, 2013, the total fair value of these cap agreements was an asset of $5.6 million. During the three months ended March 31, 2013, we recorded a loss of $2.9 million in other comprehensive income due to a decrease in the unrealized fair value of these cap agreements.

As of March 31, 2013, we also maintained a total of nine other interest rate swap agreements with amortizing notional amounts totaling $875 million. These agreements had the economic effect of modifying the LIBOR variable component of our interest rate on an equivalent amount of our Term Loan A to fixed rates ranging from 1.59% to 1.64%, resulting in an overall weighted average effective interest rate of 4.11%, including the Term Loan A margin of 2.50%. The swap agreements expire by September 30, 2014 and require monthly interest payments. During the three months ended March 31, 2013, we accrued net charges of $3.2 million from these swaps which are included in debt expense. As of March 31, 2013, the total fair value of these swap agreements was a liability of $16.0 million. We estimate that approximately $8.9 million of existing unrealized pre-tax losses in other comprehensive income at March 31, 2013 will be reclassified into income in 2013.

As of March 31, 2013, we also maintained five interest rate cap agreements with notional amounts totaling $1,250 million. These agreements have the economic effect of capping the LIBOR variable component of our interest rate at a maximum of 4.00% on an equivalent amount of our Term Loan B debt. However, as a result of the new interest rate cap agreements that were entered into in March 2013, as described above, these interest rate cap agreements became ineffective cash flow hedges and as a result any changes in the fair value associated with these interest rate cap agreements will be charged to income. During the three months ended March 31, 2013, we accrued net charges of $0.9 million from these caps which are included in debt expense. The cap agreements expire on September 30, 2014. As of March 31, 2013, the total fair value of these cap agreements was an asset of $0.06 million. During the three months ended March 31, 2013, we recorded a loss of $0.003 million in other comprehensive income due to a decrease in the unrealized fair value of these cap agreements.

As a result of the embedded LIBOR floors in some of our debt agreements and the swap and cap agreements, our overall weighted average effective interest rate on the Senior Secured Credit Facilities was

4.09%, based upon the current margins in effect of 2.50% for both the Term Loan A and for the Term Loan A-3, and 3.00% for both the Term Loan B and the Term Loan B-2, as of March 31, 2013. Effective April 2, 2013, the interest rate margin on the Term Loan A increased to 2.75%.

As of March 31, 2013, interest rates on our Term Loan B and Term Loan B-2 debt are effectively fixed because of an embedded LIBOR floor which is higher than actual LIBOR as of such date. Furthermore, interest rates on $1,250 million of our Term Loan B and $1,485 million of our Term Loan B -2 are subject to interest rate caps if LIBOR should rise above 2.50%. Interest rates on our senior notes are fixed by their terms. The LIBOR variable component of our interest rates on our Term Loan A and our Term Loan A-3 are economically fixed as a result of interest rate swaps.

Our overall weighted average effective interest rate during the first quarter of 2013 was 4.76% and as of March 31, 2013 was 4.79%.

As of March 31, 2013, we had undrawn revolving line of credit totaling $350 million of which approximately $114 million was committed for outstanding letters of credit.

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

Divestiture of HomeChoice Partners, Inc.

On February 1, 2013, we completed the sale of HomeChoice Partners Inc. (HomeChoice) to BioScrip, Inc. pursuant to a stock purchase agreement dated December 12, 2012 for $70 million in cash, subject to various post-closing adjustments of which we receive approximately 90% of the proceeds. The stock purchase agreement also provides that as additional consideration we may earn up to a total of 90% of $20 million if certain performance amounts exceed certain thresholds over the next two years. As of February 1, 2013, we have assigned no value to this contingent receivable and will recognize any estimated realizable value of this receivable only when it becomes probable and reasonably estimable. We recorded a gain of approximately $13 million, net of tax, during the three months ended March 31, 2013 related to this divestiture.

HomeChoice is a regional provider of home infusion services that provides specialized pharmacy, nursing and nutritional services to patients in their homes. HomeChoice generated approximately $68 million in revenues for the year ended December 31, 2012 and approximately $6 million for the period January 1, 2013 to February 1, 2013.

Stock-based compensation awards

Stock-based compensation awards are measured at their estimated fair values on the date of grant if settled in shares, or at their estimated fair values at the end of each reporting period if settled in cash. The value of stock-based awards so measured is recognized as compensation expense on a cumulative straight-line basis over the vesting terms of the awards, adjusted for expected forfeitures. During the three months ended March 31, 2013, we granted 1,329,700 stock-settled stock appreciation rights with an aggregate grant-date fair value of $36.0 million and a weighted-average expected life of approximately 4.3 years and 9,848 stock units with an aggregate grant-date fair value of $1.2 million and a weighted-average expected life of approximately 2.7 years.

Long-term incentive compensation

Long-term incentive program (LTIP) compensation includes both stock-based compensation (principally stock-settled stock appreciation rights and restricted stock units) as well as long-term performance-based cash awards. Long-term incentive compensation expense, which was primarily general and administrative in nature,

was allocated among the dialysis and related lab services business, corporate support costs, and the ancillary services and strategic initiatives. Long-term incentive compensation costs of $18.7 million in the first quarter of 2013 increased by approximately $7.7 million as compared to the fourth quarter of 2012 and increased by approximately $6.1 million as compared to the first quarter of 2012. The increase in long-term incentive compensation in the first quarter of 2013 as compared to both the fourth quarter of 2012 and the first quarter of 2012 was primarily due to a delay in the timing of our normal annual grant cycle during 2012 until late in that year, an increase in the fair value of LTIP awards that contributed expense to these respective periods and LTIP award forfeitures realized at a lower rate than initially expected.

As of March 31, 2013, there was $174.2 million in total estimated but unrecognized long-term incentive compensation for LTIP awards outstanding, including $123.4 million for nonvested stock-based awards under our equity compensation and stock purchase plans. We expect to recognize the performance-based cash component of these LTIP costs over a weighted average remaining period of 1.6 years, and the stock-based component of these LTIP costs over a weighted average remaining period of 1.5 years.

The Company did not receive any cash proceeds from stock option exercises for the first quarter of 2013. During the three months ended March 31, 2012, the Company received $1,391 in cash proceeds from stock option exercises. In addition, for the three months ended March 31, 2013 and 2012 the Company received $9,368 and $10,890, respectively, in actual tax benefits upon the exercise of stock awards.

Off-balance sheet arrangements and aggregate contractual obligations

In addition to the debt obligations reflected on our balance sheet, we have commitments associated with operating leases and letters of credit, as well as potential obligations associated with our equity investments in nonconsolidated businesses and to dialysis centers that are wholly-owned by third parties. Substantially all of our facilities are leased. We have potential acquisition obligations for several joint ventures, non-owned and minority owned entities and for some of our non-wholly-owned subsidiaries. These obligations are in the form of put provisions and are exercisable at the third-party owners' discretion within specified periods as outlined in each specific put provision. If these put provisions were exercised, we would be required to purchase the third-party owners' noncontrolling interests at either the appraised fair market value or a predetermined multiple of earnings or cash flow attributable to the noncontrolling interests put to us, which is intended to approximate fair value. The methodology we use to estimate the fair values of noncontrolling interests subject to put provisions assumes either the higher of a liquidation value of net assets or an average multiple of earnings, based on historical earnings, patient mix and other performance indicators, as well as other factors. The estimated fair values of the noncontrolling interests subject to put provisions is a critical accounting estimate that involves significant judgments and assumptions and may not be indicative of the actual values at which the noncontrolling interests may ultimately be settled, which could vary significantly from our current estimates. The estimated fair values of noncontrolling interests subject to put provisions can fluctuate and the implicit multiple of earnings at which these noncontrolling interests obligations may be settled will vary significantly depending upon market conditions including potential purchasers' access to the capital markets, which can impact the level of competition for dialysis and non-dialysis related businesses, the economic performance of these businesses and the restricted marketability of the third-party owners' noncontrolling interests. The amount of noncontrolling interests subject to put provisions that contractually employ a predetermined multiple of earnings rather than fair value are immaterial. For additional information see Note 10 to the condensed consolidated financial statements.

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

The following is a summary of these contractual obligations and commitments as of March 31, 2013 (in millions):

	Remainder of 2013	1-3 years	4-5 years	After 5 years	Total
Scheduled payments under contractual obligations:					
Long-term debt	$ 159	$2,983	$1,698	$3,577	$ 8,417
Interest payments on the senior notes	137	518	320	390	1,365
Interest payments on the Term Loan B[1]	59	214	—	—	273
Interest payments on the Term Loan B-2[2]	50	196	127	52	425
Capital lease obligations	3	16	13	77	109
Operating leases	260	883	449	644	2,236
	$ 668	$ 4,810	$ 2,607	$ 4,740	$12,825
Potential cash requirements under existing commitments:					
Letters of credit	$ 114	$ —	$ —	$ —	$ 114
Noncontrolling interests subject to put provisions	362	104	55	85	606
Non-owned and minority owned put provisions	11	21	—	—	32
Pay-fixed swaps potential obligations	12	5	—	—	17
Operating capital advances	3	—	—	—	3
	$ 502	$ 130	$ 55	$ 85	$ 772

(1) Assuming no changes to LIBOR-based interest rates as the Term Loan B currently bears interest at LIBOR (floor of 1.50%) plus an interest rate margin of 3.00%.

(2) Assuming no changes to LIBOR-based interest rates as the Term Loan B-2 currently bears interest at LIBOR (floor of 1.00%) plus an interest rate margin of 3.00%

The pay-fixed swap obligations represent the estimated fair market values of our interest rate swap agreements that are based upon valuation models utilizing the income approach and commonly accepted valuation techniques that use inputs from closing prices for similar assets and liabilities in active markets as well as other relevant observable market inputs and other current market conditions that existed as of March 31, 2013. This amount represents the estimated potential obligation that we would be required to pay based upon the estimated future settlement of each specific tranche over the term of the swap agreements, assuming no future changes in the forward yield curve. The actual amount of our obligation associated with these swaps in the future will depend upon changes in the LIBOR-based interest rates that can fluctuate significantly depending upon market conditions, and other relevant factors that can affect the fair market value of these swap agreements.

In addition to the above commitments, we are obligated to purchase a certain amount of our hemodialysis products and supplies at fixed prices through 2015 from Gambro Renal Products, Inc. (Gambro) in connection with a product supply agreement with Gambro. Our total expenditures for the three months ended March 31, 2013 on such products were approximately 2% of our total U.S. dialysis operating costs in each year. In January 2010, we entered into an agreement with Fresenius which committed us to purchase a certain amount of dialysis equipment, parts and supplies from them through 2013. Our total expenditures for the three months ended March 31, 2013 on such products were approximately 2% of our total U.S. operating costs. The actual amount of purchases in future years from Gambro Renal Products and Fresenius will depend upon a number of factors, including the operating requirements of our centers, the number of centers we acquire, growth of our existing centers, and in the case of the Product Supply Agreement, Gambro Renal Products' ability to meet our needs.

In November 2011, we entered into a seven year sourcing and supply agreement with Amgen USA Inc. that expires on December 31, 2018. Under the terms of the agreement, we will purchase EPO in amounts necessary to meet no less than 90% of our requirements for erythropoiesis stimulating agents (ESAs). The actual amount of EPO that we will purchase from Amgen will depend upon the amount of EPO administered during dialysis as

prescribed by physicians and the overall number of patients that we serve. In December 2012 we entered into an amendment to our agreement with Amgen that makes non-material changes to certain terms of the agreement for the period from January 1, 2013 through December 31, 2013. Under the terms of the original agreement before the amendment, we were required to purchase EPO in amounts necessary to meet no less than 90% of our requirements of ESAs and are still required to do so after 2013. In addition, all of the other conditions as specified in the original agreement entered into in November 2011 still apply.

Settlements of approximately $82 million of existing income tax liabilities for unrecognized tax benefits including interest, penalties and other long-term tax liabilities are excluded from the above table as reasonably reliable estimates of their timing cannot be made.

Item 3. *Quantitative and Qualitative Disclosures about Market Risk*

Interest rate sensitivity

The tables below provide information about our financial instruments that are sensitive to changes in interest rates. The table below presents principal repayments and current weighted average interest rates on our debt obligations as of March 31, 2013. The variable rates presented reflect the weighted average LIBOR rates in effect for all debt tranches plus interest rate margins in effect as of March 31, 2013. The Term Loan A and Term Loan A-3 margins in effect are both 2.50% at March 31, 2013, and along with the revolving line of credit are subject to adjustment depending upon changes in certain of our financial ratios including a leverage ratio. Effective April 2, 2013, the interest rate margin on the Term Loan A increased to 2.75%. The Term Loan B currently bears interest at LIBOR (floor of 1.50%) plus an interest rate margin of 3.00% subject to a ratings based step-down to 2.75%. The Term Loan B-2 bears interest at LIBOR (floor of 1.00%) plus an interest rate margin of 3.00%.

	Expected maturity date								
	2013	2014	2015	2016	2017	2018	Thereafter	Total	Average interest rate	Fair value
	(dollars in millions)									
Long term debt:										
Fixed rate	$ 36	$ 45	$ 55	$1,688	$ 31	$801	$3,653	$6,309	5.26%	$6,504
Variable rate	$126	$219	$788	$ 204	$878	$ 1	$ 1	$2,217	2.71%	$2,217

	Notional amount	Contract maturity date					Pay fixed	Receive variable	Fair value
		2013	2014	2015	2016	2017			
	(dollars in millions)								
Swaps:									
Pay-fixed rate	$2,808	$126	$867	$135	$1,680	$—	0.49% to 1.64%	LIBOR	$(16.8)
Cap agreements	$2,735	$—	$—	$—	$2,735	$—		LIBOR above 2.50%	$ 5.7

Our Senior Secured Credit Facilities, which include the Term Loan A, the Term Loan A-3, the Term Loan B and the Term Loan B-2, consist of various individual tranches of debt that can range in maturity from one month to twelve months (currently, all tranches are one month in duration). For the Term Loan A and the Term Loan A-3, each tranche bears interest at a LIBOR rate that is determined by the duration of such tranche plus an interest rate margin. The LIBOR variable component of the interest rate for each tranche is reset as such tranche matures and a new tranche is established. LIBOR can fluctuate significantly depending upon conditions in the credit and capital markets. However, the LIBOR variable component of the interest rate for the Term Loan A and the Term Loan A-3 are economically fixed as a result of our swap agreements, as described below.

The Term Loan B and Term Loan B-2 are subject to LIBOR floors of 1.50% and 1.00%, respectively. Because actual LIBOR, as of March 31, 2013, was lower than either of these embedded LIBOR floors, the interest rates on the Term Loan B and the Term Loan B-2 are treated as “effectively fixed” for purposes of the table above. We have included both of these Term Loans in the fixed rate totals in the table above until such time as the actual LIBOR-based component of our interest rate exceeds 1.50% on the Term Loan B and 1.00% on the

Term Loan B-2. At such time, we will then be subject to LIBOR-based interest rate volatility on the LIBOR variable component of our interest rate for the Term Loan B and the Term Loan B-2, but limited to a maximum rate of 2.50% on $1,250 million of outstanding principal debt on the Term Loan B and $1,485 million of outstanding principal debt on the Term Loan B-2 as a result of the interest rate cap agreements, as described below. The remaining $461 million outstanding principal balance of the Term Loan B is subject to LIBOR-based interest rate volatility above a floor of 1.50%. The remaining $161 million outstanding principal balance of the Term Loan B-2 is subject to LIBOR-based interest rate volatility above a floor of 1.00%.

In March 2013, we entered into several new interest rate swap agreements. As of March 31, 2013, the amortizing notional amounts of these swap agreements totaled $1,333 million. These agreements have the economic effect of modifying the LIBOR variable component of our interest rate on an equivalent amount of our Term Loan A-3 to fixed rates ranging from 0.49% to 0.52%, resulting in an overall weighted average effective interest rate of 3.01%, including the Term Loan A-3 margin of 2.50%. The swap agreements expire by September 30, 2016 and require monthly interest payments. During the three months ended March 31, 2013 we accrued net charges of $0.04 million from these swaps which are included in debt expense. As of March 31, 2013, the total fair value of these swap agreements was a liability of $0.4 million. We estimate that approximately $2.7 million of existing unrealized pre-tax losses in other comprehensive income at March 31, 2013 will be reclassified into income in 2013.

In addition, in March 2013, we entered into several interest rate forward swap agreements with amortization notional amounts totaling $600 million. These forward swap agreements will be effective September 30, 2014 and will have the economic effect of modifying the LIBOR variable component of our interest rate on an equivalent amount of our outstanding debt to fixed rates ranging from 0.72% to 0.75%. These swap agreements expire on September 30, 2016 and will require quarterly interest payments beginning in October 2014. Any unrealized gains or losses resulting from changes in the fair value of these swaps will be recorded in other comprehensive income. As of March 31, 2013, the total fair value of these swap agreements was a liability of $0.3 million.

During March 2013, we entered into several interest rate cap agreements with notional amounts totaling $1,250 million on our Term Loan B debt and $1,485 million on our Term Loan B-2 debt. These agreements have the economic effect of capping the LIBOR variable component of our interest rate at a maximum of 2.50% on an equivalent amount of our Term Loan B and Term Loan B-2 debt. The cap agreements expire on September 30, 2016. As of March 31, 2013, the total fair value of these cap agreements was an asset of $5.6 million. During the three months ended March 31, 2013, we recorded a loss of $2.9 million in other comprehensive income due to a decrease in the unrealized fair value of these cap agreements.

As of March 31, 2013, we also maintained a total of nine other interest rate swap agreements with amortizing notional amounts totaling $875 million. These agreements had the economic effect of modifying the LIBOR variable component of our interest rate on an equivalent amount of our Term Loan A to fixed rates ranging from 1.59% to 1.64%, resulting in an overall weighted average effective interest rate of 4.11%, including the Term Loan A margin of 2.50%. The swap agreements expire by September 30, 2014 and require monthly interest payments. During the three months ended March 31, 2013, we accrued net charges of $3.2 million from these swaps which are included in debt expense. As of March 31, 2013, the total fair value of these swap agreements was a liability of $16.0 million. We estimate that approximately $8.9 million of existing unrealized pre-tax losses in other comprehensive income at March 31, 2013 will be reclassified into income in 2013.

As of March 31, 2013, we also maintained five interest rate cap agreements with notional amounts totaling $1,250 million. These agreements have the economic effect of capping the LIBOR variable component of our interest rate at a maximum of 4.00% on an equivalent amount of our Term Loan B debt. However, as a result of the new interest rate cap agreements that were entered into in March 2013, as described above, these interest rate cap agreements became ineffective cash flow hedges and as a result any changes in the fair value associated with these interest rate cap agreements will be charged to income. During the three months ended March 31, 2013, we

accrued net charges of $0.9 million from these caps which are included in debt expense. The cap agreements expire on September 30, 2014. As of March 31, 2013, the total fair value of these cap agreements was an asset of $0.06 million. During the three months ended March 31, 2013, we recorded a loss of $0.003 million in other comprehensive income due to a decrease in the unrealized fair value of these cap agreements.

As a result of the embedded LIBOR floors in some of our debt agreements and the swap and cap agreements, the overall weighted average effective interest rate on the Senior Secured Credit Facilities was 4.09%, based upon the current margins in effect of 2.50% for both the Term Loan A and the Term Loan A-3, and 3.00% for both the Term Loan B and the Term Loan B-2, as of March 31, 2013. Effective April 2, 2013, the interest rate margin on the Term Loan A increased to 2.75%.

As of March 31, 2013, interest rates on our Term Loan B and Term Loan B-2 debt are effectively fixed because of an embedded LIBOR floor which is higher than actual LIBOR as of such date. Furthermore, interest rates on $1,250 million of our Term Loan B and $1,485 million of our Term Loan B-2 are subject to interest rate caps if LIBOR should rise above 2.50%. Interest rates on our senior notes are fixed by their terms. The LIBOR variable component of our interest rates on our Term Loan A and our Term Loan A-3 are economically fixed as a result of interest rate swaps.

The overall weighted average effective interest rate during the first quarter of 2013 was 4.76% and as of March 31, 2013 was 4.79%.

Item 4. *Controls and Procedures*

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

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

There has not been any change in the Company's internal control over financial reporting during the fiscal quarter covered by this report on Form 10-Q that has materially affected, or is reasonably likely to materially affect, the Company's internal control over financial reporting.

PART II
OTHER INFORMATION

Item 1. *Legal Proceedings*

The information in Note 7 of the Notes to Condensed Consolidated Financial Statements in Part I, Item 1 of this report is incorporated by this reference in response to this item.

Item 1A. *Risk Factors*

A restated description of the risk factors associated with our business is set forth below. This description includes any material changes to and supersedes the description of the risk factors associated with our business previously disclosed in Part I, Item 1A of our Annual Report on Form 10-K for the year ended December 31, 2012. The risks discussed below are not the only ones facing our business. Please read the cautionary notice regarding forward-looking statements under the heading "Management's Discussion and Analysis of Financial Condition and Results of Operations".

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

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

Approximately 34% of our dialysis and related lab services revenues for the quarter ended March 31, 2013, were generated from patients who have commercial payors as the 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 and it is possible that commercial payment rates could be materially lower in the future. The downward pressure on commercial payment rates is a result of general conditions in the market, recent and future consolidations among commercial payors, increased focus on dialysis services and other factors.

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. Some of our contracted rates with commercial payors may decrease or we may 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. In some circumstances for some commercial payors, our centers are designated 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, 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 shifts 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, including the American Taxpayer Relief Act of 2012, the Budget Control Act of 2011 and other healthcare reform initiatives, could substantially reduce our revenues, earnings and cash flows.

Approximately 48% of our dialysis and related lab services revenues for the quarter ended March 31, 2013 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 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, which would have a negative impact on our revenues.
- risk that CMS will inadequately price oral-only ESRD drugs for inclusion in the bundle. Under the ESRD Prospective Payment System (PPS), beginning January 1, 2016, certain oral-only ESRD drugs will be included in the ESRD bundled payment to dialysis facilities. Inadequate pricing could have a significant negative financial impact on our dialysis facilities given the volume and value of these drugs.
- 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 sequester 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. The across-the-board cuts pursuant to the sequester will adversely affect our revenues, earnings and cash flows.
- risk that we may not be able to comply with the CMS rules related to the bundled payment system as processes and systems are modified substantially to capture all required data. To the extent we are not able to adequately bill and collect for certain payment adjustors and are not able to offset the mandated reductions in reimbursement or if we face regulatory enforcement actions and penalties as a result of alleged improper billing of governmental programs, it could have a material adverse effect on our revenues, earnings and cash flows.
- risk that our rates are reduced by CMS. The American Taxpayer Relief Act of 2012 mandates that the CMS Secretary reduce dialysis payments beginning in January 2014 to reflect the Secretary's estimate of changes in patient utilization data from 2007 to 2012 for erythropoiesis stimulating agents (ESAs), other drugs and biologicals that would have been paid for separately under the composite rate system, and laboratory services that would have been paid for separately under the composite rate system. The Secretary must also use the most recently available data on average sales prices and changes in prices for drugs and biologicals reflected in the ESRD market basket percentage increase factor. Any reduction in dialysis payments will negatively impact our revenues, earnings and cash flows.

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.

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.

In March 2012, the HHS issued two final rules related to the establishment of health care insurance exchanges due to be operating by 2014 that will provide a marketplace for eligible individuals to purchase health care insurance. We believe the establishment of 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 revenues, earnings and cash flows could be adversely affected.

The CMS Center for Innovation (Innovation Center) is in various stages of development in working with various healthcare providers to implement ACOs and other innovative models of care for Medicare and Medicaid beneficiaries. We are currently uncertain of the extent to which these models of care, including ACOs, Bundled Payments for Care Improvement Initiative (which is scheduled to begin in the spring of 2013), Comprehensive ESRD Care Model (which includes the development of ESRD Seamless Care Organizations or ESCOs), the Comprehensive Primary Care Initiative, the Duals Demonstration, or other models, will impact the health care market. 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 program 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 ACOs' or other programs' calculations regardless of our participation in the program. As new models of care emerge, 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. Furthermore, other initiatives in the government or private sector may arise, including the development of models similar to ACOs, IPA's and integrated delivery systems or evolutions of those concepts which could adversely impact our business.

In addition, the health care reform legislation introduced severe penalties for the knowing and improper retention of overpayments collected from government payors. As a result, we made initial 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, which could have a material adverse effect on our operating cash flows. The failure to return identified overpayments within the specified time frame is now a violation of the federal FCA, and therefore any failure to timely identify and return overpayments may result in significant additional penalties, which may have a negative impact on our revenues, earnings and cash flows. Additionally, the American Taxpayer Relief Act of 2012 extended the look-back period for returning overpayments by two years, which increases the number of claims that may need to be refunded, and which could have a negative impact on our revenues, earnings and cash flows.

The health care reform legislation also reduced the timeline to file Medicare claims, which now must be filed with the government within one calendar year after the date of service. To comply with this reduced timeline, we must deploy significant resources and may change our claims processing methods to ensure that our Medicare claims are filed in a timely fashion. Failure to file a claim within the one year window could result in payment denials, adversely affecting our revenues, earnings and cash flows.

Effective March 2011, CMS instituted screening procedures which we expect will delay the Medicare contractor approval process, potentially causing a delay in reimbursement. Ultimately, 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, which 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, or others, depending upon the scope and breadth of the implementing regulations, could adversely impact our revenues, earnings and cash flows.

There is 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.

The health care reform legislation 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.

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

Approximately 18% of our dialysis and related lab services revenues for the quarter ended March 31, 2013 was generated from patients who have state Medicaid or other non-Medicare government-based programs, such as Medicare-assigned plans or the VA, as their primary coverage. As state governments and governmental organizations face increasing budgetary pressure, we may in turn face reductions in payment rates, delays in the

timing of payments, limitations on eligibility or other changes to the applicable programs. For example, some programs, such as certain state Medicaid programs and the VA, have recently considered, proposed or implemented rate reductions.

On December 17, 2010, the Department of Veterans Affairs (VA) published a final rule in which it materially changed the payment methodology and ultimately the amount paid for dialysis services furnished to veterans in non-VA centers such as ours. In the final rule, the VA adopted the bundled payment system implemented by Medicare and estimated a reduction of 39% in payments for dialysis services to veterans at non-VA centers. Approximately 2% of our dialysis and related lab services revenues for the quarter ended March 31, 2013 was generated by the VA. The VA payment methodology will have a significant negative impact on our revenues, earnings and cash flows as a result of the reduction in rates or as a result of the decrease in the number of VA patients we serve. We recently executed contractual agreements with the VA and there is some uncertainty as to when this rule will take effect for the patients covered by these contracts. While at this time the contracts remain in force, these agreements provide for the right of the VA to terminate the agreement without cause on short notice. Further, patients who are not covered by the contractual arrangements will likely be reimbursed at Medicare rates beginning with the date of implementation of the rule. If the VA proceeds with payment rate reductions or fails to renew our existing contracts, 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 could include all drugs (even those oral-only drugs that Medicare will not include in the bundled payment until 2014) 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 timing 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 reduce our revenues, earnings and cash flows.

Historically, Medicare and most Medicaid programs paid for erythropoietin (EPO) outside of the composite rate. This separate payment has long been the subject of discussions regarding appropriate dosing and payment in an effort to reduce escalating expenditures for EPO. Since January 1, 2011, Medicare has bundled EPO into the prospective payment system such that dosing variations will 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 5% of our dialysis and related lab services revenues for the quarter ended March 31, 2013, with EPO alone accounting for approximately 3% of our dialysis and related lab services revenues for the same 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.

Since late 2006, there has been significant media discussion and government scrutiny regarding anemia management practices in the U.S. which has created confusion and concern in the nephrology community. In late 2006, the U.S. House of Representatives Ways and Means Committee held a hearing on the issue of the utilization of ESAs, which include EPO, and in 2007, the FDA required changes to the labeling of EPO and

Aranesp® to include a black box warning, the FDA's strongest form of warning label. In June 2011, the FDA required that the black box warning be slightly revised and also include more conservative dosing recommendations for patients with CKD. In addition, in 2011, CMS opened a national coverage analysis (NCA) for ESAs that could have resulted in a national coverage determination potentially impacting payments for ESAs in anemia treatment. CMS subsequently determined in 2011 not to issue a national coverage determination for ESAs due to a lack of available evidence to establish coverage criteria or limitations. However, we cannot predict whether CMS might open a NCA for ESAs in the future and, if so, what the potential outcome might be.

The forgoing congressional and agency activities and related actions could result in further restrictions on the utilization and reimbursement for ESAs. Commercial payors have also increasingly examined their administration policies for EPO and, in some cases, have modified those policies. Further 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 or 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 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.

In November 2011, we entered into a seven year Sourcing and Supply Agreement with Amgen USA Inc. Under the agreement we committed to purchase EPO in amounts necessary to meet no less than 90% of our requirements for ESAs. The agreement replaces in its entirety the prior one-year supply agreement between us and Amgen that expired on December 31, 2011. As long as we meet certain conditions, the agreement limits Amgen's ability to unilaterally decide to increase the price for EPO. 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. Our agreement with Amgen for EPO provides for discounted pricing and rebates for EPO. 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. In the initial years of the agreement, however, the total rebate opportunity is less than what was provided in the agreement that expired at the end of 2011, however, the opportunity for us to earn discounts and rebates increases over the term of the agreement. 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. In 2012, we experienced an increase in our overall EPO unit costs. In December 2012 we entered into an amendment to our agreement with Amgen that made non-material changes to certain terms of the agreement for the period from January 1, 2013 through December 31, 2013. Under the terms of the original agreement before the amendment, we were required to purchase EPO in amounts necessary to meet no less than 90% of our requirements of ESAs and are still required to do so after 2013. In addition, all of the other conditions as specified in the original agreement entered into in November 2011 still apply.

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, imposition of certain obligations on our practices and procedures, exclusion from future participation in the Medicare and Medicaid programs and, in certain cases, criminal penalties.

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 2010 U.S. Attorney physician relationship investigation, the 2011 U.S. Attorney physician relationship investigation and the 2011 U.S. Attorney Medicaid investigation. Certain current and former members of the Board, executives and other teammates have been subpoenaed to testify before the grand jury in Colorado related to the 2011 U.S. Attorney physician relationship investigation. (See Note 7 to the condensed consolidated financial statements of this report for additional details regarding these matters.)

With respect to the Vainer private civil suit, after investigation, the government did not intervene and is not actively pursuing this private civil suit. Upon initial review of the recently-served Swoben civil suit, we believe that the government did not intervene and is not actively pursuing this private civil suit other than its partial intervention for the purpose of settlement with and dismissal of the initial defendant in this proceeding. (See Note 7 to the condensed consolidated financial statements of this report for additional details regarding these matters.) In each of these private civil suits, a relator filed a complaint against us in federal court under the *qui tam* provisions of the FCA (and, in the case of the Swoben matter, provisions of the California False Claims Act, as well) and pursued the claims independently after the government declined to intervene. The parties are engaged in active litigation in the Vainer private civil suit and the Swoben private civil suit is at an early stage.

We are cooperating with the OIG and those offices of the U.S. Attorney pursuing the matters mentioned above. Although it is uncertain whether or when proceedings might be initiated by the federal government, the scope of such proceedings or when these matters may be resolved, it is not unusual for investigations 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. As noted elsewhere in this report on Form 10-Q, we are engaged in good faith discussions with the attorneys from 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 in an effort to find a mutually acceptable resolution to the 2010 and 2011 U.S. Attorney Physician Relationship Investigations. Discussions have advanced to a point where we believe it is appropriate to accrue an estimated loss contingency reserve of $300 million in the first quarter of 2013 in connection with an offer to settle the related civil, administrative and criminal matters. However, the discussions are ongoing, and until concluded, there can be no certainty about the timing or likelihood of a definitive resolution or the scope of any potential restrictions that may be agreed upon in connection with a settlement. As these discussions proceed and additional information becomes available to us, the amount of the estimated loss contingency reserve may need to be increased or decreased to reflect this new information. Responding to the subpoenas or investigations and defending ourselves in these matters and the private civil suits will continue to require management's attention and significant legal expense. Any negative findings could result in substantial financial penalties or awards against us, imposition of certain obligations on our practices and procedures, exclusion from future participation in the Medicare and Medicaid programs and, in certain cases, criminal penalties. It is possible that criminal proceedings may be initiated against us in connection with investigations by the federal government, including the 2011 U.S. Attorney physician relationship investigation. To our knowledge, no proceedings have been initiated by the federal government against us at this time.

Changes in clinical practices relating to EPO could adversely affect our operating results and financial condition as well as our ability to care for patients.

In response to clinical studies which identified risks in certain patient populations related to the utilization of EPO and other ESAs, i.e., Aranesp ®, and in response to changes in the labeling of EPO and Aranesp®, there has been substantial media attention and government scrutiny resulting in hearings and legislation regarding

pharmaceutical utilization and reimbursement. Although we believe our anemia management practices and other pharmaceutical administration practices have been compliant with existing laws and regulations, as a result of the current high level of scrutiny and controversy, we may be subject to increased inquiries from a variety of governmental bodies and claims by third parties. Additional inquiries from or audits by various agencies and claims by third parties with respect to these issues would continue to require management's attention and significant legal expense and any negative findings could result in substantial financial penalties or repayments, imposition of certain obligations on our practices and procedures and the attendant financial burden on us to comply, 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.

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 Stark Law physician self-referral prohibition and analogous state referral 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. A violation or departure from any of these requirements may result in government audits, lower reimbursements, significant fines and penalties, the potential loss of certification and recoupments or voluntary repayments.

The regulatory scrutiny of healthcare providers, including dialysis providers continues to increase. For example, CMS has indicated that with respect to the Medicare bundled payment system, it will monitor the use of EPO and other pharmaceuticals. In addition, Medicare has increased the frequency and intensity of its certification inspections of dialysis centers. For example, we are required to provide substantial documentation related to the administration of pharmaceuticals, including EPO, and, to the extent that any such documentation is found insufficient, we may be required to refund to government or commercial payors any amounts received for such administration, and be subject to substantial penalties under applicable laws or regulations. In addition, Medicare contractors have increased their prepayment and post-payment reviews.

We endeavor to comply with all of the requirements for receiving Medicare and Medicaid payments, to structure all of our relationships with referring physicians to comply with state and federal anti-kickback laws and physician self-referral law (Stark Law), and for storing, handling and administering pharmaceuticals. However, the laws and regulations in these areas are complex, require considerable resources to monitor and implement and are 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 additional 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 or other payors sooner than we have in the past. A significant acceleration of these refunds could have a material adverse affect 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 claims for monetary damages by patients who believe PHI has been used or disclosed or not properly safeguarded in violation of federal or state patient privacy laws, including the federal 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, reporting, increased scrutiny of our billing and business practices and potential additional fines;
- Termination of relationships with medical directors; and
- Harm to our reputation, which could impact our business relationships, ability to obtain financing and access to new 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 March 31, 2013, we owned a controlling interest in numerous dialysis-related joint ventures, which represented approximately 20% of our U.S. dialysis and related lab services revenues for the quarter ended March 31, 2013. In addition, we also owned minority equity investments in several other dialysis related joint ventures. We anticipate that we will continue to increase the number of our joint ventures. Many of our joint ventures with physicians or physician groups also have the physician owners providing medical director services to those centers or other centers we own and operate. Because our relationships with physicians are governed by

the federal anti-kickback statute, we have sought to structure our joint venture arrangements to satisfy as many safe harbor requirements as we believe are reasonably possible. However, our joint venture arrangements do not satisfy all elements of any safe harbor under the federal anti-kickback statute. Arrangements that do not meet all of the elements of a safe harbor are not automatically prohibited under the federal anti-kickback statute but are susceptible to government scrutiny. We have received subpoenas and related requests for documents from the U.S. Attorney's Office and the OIG related to our joint ventures. We have been advised by the U.S. Department of Justice that it is conducting civil and grand jury investigations into our financial relationships with physicians, including our joint ventures generally. We have been advised by the attorneys conducting the civil investigation that they believe that some or all of our joint ventures do not comply with the anti-kickback statute and the False Claims Act. We disagree that our joint venture structure generally, which we believe is widely used in the dialysis industry and other segments of the healthcare industry substantially in the form that we use it, violates the federal anti-kickback statute or the False Claims Act. As to individual transactions, we made significant effort to ensure that our joint venture structures and process complied with the rules, but we are talking with the government about addressing its concerns. However, if our joint ventures are found to be in violation of the anti-kickback statute, the False Claims Act or the Stark Law provisions, we could be required to restructure the joint ventures or refuse to accept referrals for Designated Health Services (DHS) from the physicians with whom the joint venture centers have a financial relationship.

We also could be required to repay amounts received by the joint ventures from Medicare and certain other payors to the extent that these arrangements are found to give rise to prohibited referrals, and we could be subject to monetary penalties, exclusion from government healthcare programs and, if criminal proceedings are brought against us, criminal penalties. If our joint venture centers are subject to any of these penalties, we could suffer severe consequences that would have a material adverse effect on 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 156,000 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 can represent as much as 5% of dialysis operating income, excluding a loss contingency reserve of $300 million and other legal settlement expenses. 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. For example, during 2011 and 2012, several of our strategic initiatives generated net operating losses and some are expected to generate net operating losses in 2013 and beyond. 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. Neither our current nor former medical directors have an obligation to refer their patients to our centers. If a medical director agreement terminates, whether before or at the end of its term, and a new medical director is appointed, it may negatively impact the former medical director's decision to treat his or her patients at our center. If we are unable to enforce noncompetition provisions contained in the terminated medical director agreements, former medical directors may choose to provide medical director services for competing providers or establish their own dialysis centers in competition with ours. Also, if the quality of service levels at our centers deteriorates, it may negatively impact patient referrals and treatment volumes.

Our medical director contracts are for fixed periods, generally three to 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 there are a number of factors, including 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, that could negatively impact their decisions to extend their agreements with us. 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. These actions also could negatively impact the decision of physicians to extend their medical director agreements with us or to refer their patients to us. 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. If a significant number of physicians were to cease referring patients to our dialysis centers, whether due to regulatory or other reasons, then our revenues, earnings and cash flows would be substantially reduced.

Current 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.

Current 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 current or recent 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 begin to 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 the current 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 competition for qualified individuals increases. 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 were unable to maintain satisfactory relations with our employees or if union organizing activities were to 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.

Upgrades to our billing and collections systems and complications associated with upgrades and other improvements to our billing and collections systems could have a material adverse effect on our revenues, cash flows and operating results.

We are continuously performing upgrades to our billing systems and expect to continue to do so in the near term. In addition, we continuously work to improve our billing and collections performance through process upgrades, organizational changes and other improvements. We may experience difficulties in our ability to successfully bill and collect for services rendered as a result of these changes, including a slow-down of collections, a reduction in the amounts we expect to collect, 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. The failure to successfully implement the upgrades to the billing and collection systems and other improvements 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 Renal Products and Fresenius. 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.

Risks related to HCP:

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

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

- The healthcare business is heavily regulated and changes in laws, regulations, or government programs could have a material impact on HCP;
- Failure to comply with complex governmental regulations could have severe consequences to HCP, including, without limitation, exclusion from governmental payor programs like Medicare and Medicaid;
- HCP could become the subject of governmental investigations, claims, and litigation;
- HCP may be unable to continue to make acquisitions or to 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 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.

Substantially all of HCP's revenue is derived from Per Member Per Month (PMPM) fees paid by health plans under capitation agreements with HCP or its associated physician groups. In Florida and New Mexico, and a significant portion in Nevada, HCP contracts directly with health plans under global capitation arrangements to assume financial responsibility for both professional and institutional services. In California, HCP 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) generally contracts with health plans to receive a PMPM fee for professional services and assumes 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 (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 share a percentage of the amount by which the institutional capitation revenue exceeds institutional expenses; any such risk-share amount to which HCP is entitled is recorded as medical revenues and HCP is also responsible for 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.

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.

Changes in HCP's or its associated physician groups' ratio of medical expense to revenue can create significant changes in 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 associated primary care physicians;
- 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
- plans with declining premiums.

Risk-sharing arrangements that HCP-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 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. To the extent that such non-capitated 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. 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.

Whenever possible, HCP seeks to contractually reduce or eliminate its liability for risk-sharing deficits. Notwithstanding the foregoing, risk-sharing deficits could have a significant impact on future profitability.

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 60 to 90 days written notice. 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, receives a management fee for providing non-medical management 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.

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.

HCP may be required to restructure its relationship with its associated physician groups if HCP's management services agreements with such associated physician groups or HCP's succession agreements

and other related arrangements with equity holders of any such associated physician groups are deemed invalid under prohibitions against the corporate practice of medicine in California and Nevada.

Some of the relevant laws, regulations, and agency interpretations relating to the corporate practice of medicine have been subject to limited judicial and regulatory interpretation. Moreover, state laws are subject to change and regulatory authorities and other parties, including HCP's group physicians, may assert that, despite these arrangements, HCP is engaged in the prohibited corporate practice of medicine.

In light of the above, 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, confer impermissible control over the business and/or medical operations of such associated physician groups, that the management fee payable under such arrangements results in profit sharing or that HCP is the beneficial owner of the associated physician groups' equity interests in violation of the corporate practice of medicine doctrine. If there were a determination that a corporate practice of medicine violation existed or exists, 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. In addition, HCP's California and 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.

A determination that a corporate practice of medicine violation existed could also force a restructuring of HCP's management arrangements with associated physician groups in California and/or Nevada. Such a restructuring might include revisions of the management services agreements, which might include a modification of the management fee, and/or establishing an alternative structure, such as obtaining a California Knox-Keene license (a managed care plan license issued pursuant to the California Knox-Keene Health Care Service Plan Act of 1975 (the Knox-Keene Act)) or its Nevada equivalent, 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.

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 and include the accounts of its majority-owned subsidiaries and certain non-owned HCP-associated and managed physician groups, which consolidation is effectuated in accordance with applicable accounting standards. 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 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 HCP's associated physician groups are not able to satisfy the California Department of Managed Health Care's financial solvency requirements, HCP's associated physicians groups 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. The regulations are intended to provide a formal mechanism for monitoring the financial solvency of capitated physician groups. Under the regulations, HCP's associated physician groups are 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 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 a physician organization is not in compliance with any of the above criteria, the organization would be required to describe in a report submitted to the DMHC the reasons for non-compliance and actions to be taken to bring the organization into compliance. Further, under these regulations, the DMHC can make public some of the information contained in the reports, including, but not limited to, whether or not a particular physician organization met each of the criteria. In the event HCP or its associated physician groups are not able to meet certain of the financial solvency requirements, and fail to meet subsequent corrective action plans, HCP's associated physicians groups could be subject to sanctions, or limitations on, or removal of, its or their ability to do business in California.

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

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

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 current levels to levels that are between 95% and 115% of fee-for-service 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 is granted explicit authority to deny Medicare Advantage plan bids that propose significant increases in cost sharing or decreases in benefits. If HCP plan bids are denied, this would have a significant negative impact on HCP's revenues, earnings and cash flows.
- Beginning in 2014, Medicare Advantage plans with medical loss ratios below 85% will be required to pay a rebate to the Secretary of HHS. 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.

- Since January 1, 2011, cost-sharing for certain services (such as chemotherapy and skilled nursing care) has been limited to the cost-sharing permitted under the original fee-for-service Medicare program, which could reduce HCP's revenues, earnings and cash flows by reducing the amount that enrollees are permitted to pay for such services.
- 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.
- Beginning in 2014, CMS is required to increase coding intensity adjustments for Medicare Advantage plans, which is expected to reduce CMS payments to Medicare Advantage plans, which in turn will likely reduce the amounts payable to HCP and its associated physicians, physician groups, and IPA's under its capitation agreements. President Obama's proposed budget for Fiscal Year 2014 further increases the coding intensity adjustments, which may further reduce HCP's revenues, earnings and cash flows.

On April 1, 2013, CMS published its final 2014 "Call Letter" – CMS's annual notice to health plans regarding the coming year's Medicare Advantage payment methodology and estimated rates. In a reversal of its previous estimates, which called for a 2.2% reduction in the 2014 Medicare Advantage rates, CMS included in its final 2014 Call Letter an estimated 3.3% increase in the 2014 Medicare Advantage rates. This reversal was the result of CMS's new assumption that Congressional action would prospectively fix the Medicare physician fee schedule's sustainable growth rate (SGR) formula. By assuming an imminent solution to the SGR formula's automatic rate reductions, CMS was able to base its 2014 Medicare Advantage estimates on an assumed 0% change in the Medicare physician fee schedule rates for 2014. As noted above, this change in CMS's assumption has a dramatic positive impact on the estimated Medicare Advantage rates for 2014. Although a congressionally-mandated change to the SGR formula, as described above, would potentially have a significant positive impact on HCP's Medicare Advantage revenues and net income, the likelihood of increasing medical costs and the uncertainty of Congressional action mitigate against the positive impact of CMS's recent Medicare Advantage estimates.

Coupled with the risk that Congress will be unable to find a solution to the SGR formula's automatic rate reductions is the risk that both Medicare Advantage plan payments and Medicare Advantage program enrollment will be reduced as a result of the implementation of the Health Reform Acts. Such payment and enrollment reductions would, if realized, reduce HCP's Medicare Advantage and overall revenues and net income. According to the Congressional Budget Office (CBO), after reaching a high of 26% participation in Medicare Advantage plans in 2013, Medicare Advantage participation will decline to 17% in 2020. Notwithstanding the increase in Medicare Advantage rates predicted by the 2014 Call Letter, the CBO predicts that falling Medicare Advantage enrollment, together with other changes under the Health Reform Act, will result in reductions in Medicare Advantage spending by CMS of up to an aggregate of $131.9 billion over 10 years.

Finally, although the Health Reform Acts provide for reductions in payments to Medicare Advantage plans, the Health Reform Acts also provide for bonus payments to Medicare Advantage plans rated four or five stars based on quality measures. In November 2011, CMS announced a three-year demonstration project with an alternative bonus structure that awards bonuses to plans with three or more stars. However, the GAO and MedPAC have criticized the demonstration project. Therefore, Congress may act to curb the CMS-initiated bonus structure. If Congress does take such action and successfully curbs the bonus structure, HCP's Medicare Advantage and other revenues and net income would decrease.

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 period January 1, 2013 through March 31, 2013, 67% 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 these and other 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 purchased or announced their intent to purchase provider organizations. If health plans with which HCP contracts make significant purchases, 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 the 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 Florida, California, New Mexico and Nevada. HCP may not be able to successfully establish a presence in new geographic regions.

HCP derives substantially all of its revenue from operations in California, Nevada, New Mexico and Florida (California, Nevada, New Mexico and Florida are 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 fee-for-service program and do not desire to transition to a Medicare Advantage program, such as those offered through health plans that HCP serves, or they may enroll with other health plans with whom HCP does not contract to provide service, which could reduce substantially HCP's perceived opportunity in such geographic area. In addition, if HCP were to seek expansion 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 for 2012 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. None of the plans with which HCP contracts are five star plans. 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 plan 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 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, starting with payment year 2011, 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. Although CMS has described its audit process as plan-year specific and has stated that it will not extrapolate audit results for plan years prior to 2011.

CMS has not specifically stated that payment adjustments as a result of one plan year's audit will not be extrapolated to prior plan years. 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 estimate incurred but not reported medical expense accurately 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 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 fee-for-service 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 fee-for-service plans. Medicare PPOs and private fee-for-service 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 fee-for-service 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.
- Commencing in 2012, CMS will allow 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. None of the plans HCP serves are 5-star rated. 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, HCP's Existing Geographic Regions have become increasingly attractive to health plans that may compete with HCP, including the health plans with which HCP and its associated physicians, physician groups, and IPAs currently compete. 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. Similarly, HCP's Existing Geographic Regions have also become increasingly attractive to HCP's competitors due to the large populations of Medicare beneficiaries. HCP may not be able to continue to compete effectively if additional competitors enter the same regions.

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 IPA's 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.

HCP regularly explores potential acquisitions, which if consummated could affect its financial condition, results of operations or other aspects of its business.

HCP regularly explores potential acquisitions, which if consummated could affect its financial condition, results of operations or other aspects of its business. There can be no assurance that HCP will be able to identify suitable acquisition candidates or that, if identified, HCP would be able to consummate an acquisition on acceptable terms. There can also be no assurance that HCP will be successful in completing any acquisitions that it might be considering, or integrating any acquired business into its overall operations, or that any such acquired business will operate profitably or will not otherwise adversely impact HCP's results of operations.

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

The Health Reform Acts establish a Medicare shared savings program for Accountable Care Organizations (ACOs), which took effect in January 2012. Under the MSSP, the Secretary of HHS may contract with eligible organizations, including group medical practices, to be accountable for the quality, cost and overall care of Medicare beneficiaries assigned to an ACO. Participating ACOs that meet specified quality performance standards will 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. The continued development and expansion of ACOs will have an uncertain impact on HCP's revenue and profitability.

As an initial step in the formation and development of ACOs, CMS has issued contracts for participation in a Pioneer ACO program. HCP, through certain of its subsidiaries, was awarded contracts to participate as a

Pioneer ACO in California, Nevada, and Florida. HCP is in the process of implementing such operations. The Pioneer ACO program provides for three-year participation with opportunities for upside incentives and downside risk liability for an assigned population of Medicare fee-for-service patients. It is the responsibility of HCP's subsidiary ACOs to provide care to, and manage the health of, a patient population in California, Nevada, and Florida drawn from the traditional Medicare fee-for-service program, using a panel of specified physicians and healthcare facilities. The Pioneer ACO program requires participants to report on ACO operations, utilize healthcare information technology, and attempt to improve the quality of patient care.

The ACO programs are new and therefore operational and regulatory guidance is limited. It is possible that the operations of HCP's subsidiary ACOs may not fully comply with current or future regulations and guidelines applicable to ACOs, may not achieve quality targets or cost savings, or may not attract or retain sufficient physicians or patients to allow HCP to meet its objectives. Additionally, poor performance could put the HCP ACOs at financial risk and obligation to CMS. Traditionally, other than fee-for-service 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 ACOs' investment or to avoid financial or regulatory liability. To date, demonstration projects using healthcare delivery models substantially similar to an ACO have not resulted in savings. HCP believes that its historical experience with fully delegated managed care will be applicable to operation of its subsidiary ACOs, but there can be no such assurance.

California hospitals may terminate their agreements with 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's may not be adequate to cover HCP's potential liabilities.

HCP maintains professional liability insurance and other insurance coverage through California Medical Group Insurance Company, Risk Retention Group, an Arizona corporation in which HCP is a majority owner. 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.

HCP derives a substantial portion of its revenue from direct billings to governmental healthcare programs, such as Medicare and Medicaid, and private health insurance companies and/or health plans, including but not limited to those participating in the Medicare Advantage program. As a result, any negative changes in governmental capitation or fee-for-service rates or methods of reimbursement for the services HCP provides could have a significant adverse impact on HCP's revenue and financial results.

Medicare program reimbursements for physician services as well as other services to Medicare beneficiaries who are not enrolled in Medicare Advantage plans are based upon the fee-for-service rates set forth in the Medicare Physician Fee Schedule, which relies, in part, on a target-setting formula system called the SGR. Each year, on January 1st, the Medicare program updates the Medicare Physician Fee Schedule reimbursement rates. Many private payors use the Medicare Physician Fee Schedule to determine their own reimbursement rates. Based on the SGR, the annual fee schedule update is adjusted to reflect the comparison of actual expenditures to target expenditures. Because one of the factors for calculating the SGR is linked to the growth in the U.S. gross domestic product (GDP), the SGR formula may result in a negative payment update if growth in Medicare beneficiaries' use of services exceeds GDP growth, a situation which has occurred every year since 2002 and the reoccurrence of which HCP cannot predict.

CMS determined that, effective January 1, 2013, the SGR formula results in a decrease to the physician Medicare fee schedule reimbursement by 26.5%. Congress, however, enacted the American Taxpayer Relief Act of 2012 (ATRA) which provides, in part, that Medicare physician fee schedule rates for 2012 are extended through December 31, 2013. Therefore, the Medicare fee schedule rates for 2013 are neither subject to the 26.5% SGR formula-driven reduction nor are they subject to any increase over and above the 2012 fee schedule rates.

While Congress has repeatedly intervened to mitigate the negative reimbursement impact associated with the SGR formula, there is no guarantee that Congress will continue to do so in the future. Moreover, the existing methodology may result in significant yearly fluctuations in the Medicare Physician Fee Schedule amounts, which may be unrelated to changes in the actual costs of providing physician services. Unless Congress enacts a change to the SGR methodology, the uncertainty regarding reimbursement rates and fluctuation will continue to exist. Moreover, if Congress does change the SGR methodology or substitute a new system for physician fee-for-service payments, it may require reductions in other Medicare programs including Medicare Advantage to offset such additional costs.

Another provision that affects physician payments under the Medicare Physician Fee Schedule is an adjustment under the Medicare statute to reflect the geographic variation in the cost of delivering physician services, by comparing those costs to the national average. Medicare payments to physicians under the Medicare Physician Fee Schedule are geographically adjusted to reflect the varying cost of delivering physician services across areas. The adjustments are made by indices, known as the Geographic Practice Cost Indices (GPCI) that reflect how each geographic area compares to the national average. In 2003, Congress established that for three years there would be a floor of 1.0 on the work component of the Medicare Physician Fee Schedule formula used to determine physician payments, which meant that physician payments would not be reduced in a geographic area just because the relative cost of physician work in that area fell below the national average. Congress extended the GPCI work floor several times since its enactment in 2003. The ATRA provides another extension through December 31, 2013. Although Congress has extended the GPCI work floor several times, there is no guarantee that Congress will block the adjustment in the future, which could result in a decrease in payments HCP receives for physician services.

In addition, CMS announced on January 31, 2013 a call for applications to participate in a new Comprehensive ESRD Care model, under which health care providers, including dialysis facilities, nephrologists, and other Medicare providers and suppliers, will be clinically and financially responsible for all care offered to a group of matched beneficiaries, not only dialysis care or care related to ESRD. Participating providers will have an opportunity to share in Medicare savings with CMS, but could also suffer reduced profitability if participating providers are unable to contain the cost of care for such beneficiaries. Although participation in the Comprehensive ESRD Care model is voluntary, it signals CMS's desire to shift the risk of rising health care costs to providers, and mandatory adoption of similar models in the future could adversely affect HCP's revenues from Medicare.

Congress has a strong interest in reducing the federal debt, which may lead to new proposals designed to achieve savings by altering payment policies. The BCA established a Joint Select Committee on Deficit

Reduction, which had the goal of achieving a reduction in the federal debt level of at least $1.2 trillion. As a result of the Joint Select Committee's failure to draft a proposal by the BCA's deadline, automatic cuts in various federal programs (excluding cuts to Medicaid but including cuts to Medicare provider reimbursement in an amount not to exceed 2%) commenced on March 1, 2013, and a 2% cut to Medicare payments began on April 1, 2013, which may have a negative impact on our revenues. In addition, certain Congressional members have stated that the automatic federal spending cuts under the BCA are insufficient to achieve the BCA's goals of reducing federal spending and, in turn, the federal deficit. Such members have said that the way to achieve these additional cuts is to implement changes to federal entitlement programs, such as Medicare. Therefore it is not possible at this time to estimate what further impact, if any, other federal Medicare provider reimbursement cuts will have on our integrated care business or results of operations.

Because 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 as a result of budgetary constraints, cost containment pressures and other reasons. 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 developments.

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 be unable to enhance its existing management information systems or implement new management information systems where necessary. Additionally, HCP may experience unanticipated delays, complications, or expenses in implementing, integrating, and operating its systems. HCP's management information systems may require modifications, improvements, or replacements that may require both substantial expenditures as well as interruptions in operations. HCP's ability to implement these systems is subject to the availability of information technology and skilled personnel to assist HCP in creating and implementing 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 received (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 the Health Insurance Portability and Accountability Act of 1996, or HIPAA, possible penalties and fines as a result of this lack of compliance could have a material adverse effect on HCP's financial condition, and results of operations.

Federal and state privacy and information security laws are complex and HCP may be subject to government or private actions due to privacy and security breaches.

HCP must comply with numerous federal and state laws and regulations governing the collection, dissemination, access, use, security and privacy of PHI, including HIPAA and its implementing privacy and

security regulations, as amended by the federal HITECH Act and collectively referred to as HIPAA. In the event that HCP's non-compliance with existing or new laws and regulations related to PHI results in privacy or security breaches, HCP could be subject to monetary fines, civil suits, civil penalties or criminal sanctions and requirements to disclose the breach publicly.

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 or the uninsured may result in a reduction in the rates of reimbursement 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 or the number of uninsured patients. Even for those patients who remain with private insurance, changes in those programs could increase patient responsibility amounts, resulting in a greater risk for 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, or 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.

Risks related to our overall business and ownership of our common stock:
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.

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. 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 might be considering or announce, or integrating any acquired business into our overall operations or operate them 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.

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 integrate HCP into our internal control over financial reporting or if the internal control of HCP over financial reporting were found to be ineffective, the integrity of our, and/or HCP's, financial reporting could be compromised which could result in a material adverse effect on our reported financial results.

As a private company, HCP has not been subject to the requirements of the Securities Exchange Act of 1934, as amended, with respect to internal control over financial reporting, and for a period of time after the consummation of the HCP transaction our management evaluation and auditor attestation regarding the effectiveness of our internal control over financial reporting will be permitted to exclude the operations of HCP. 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. If we fail to successfully integrate these operations into our internal control over financial reporting, our internal control over financial reporting may not be effective. Failure to achieve and 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. In addition, if HCP's internal control over financial reporting were found to be ineffective, the integrity of HCP's past financial reporting could be adversely impacted.

Under accounting standards applicable to the contingent consideration obligations, we must estimate the fair value of such obligations on a quarterly basis and record any changes in our financial statements. Any increases in the fair value of the contingent consideration obligations will be recorded as an expense and may have an adverse impact on our earnings and our ability to predict the amount of earnings.

A portion of the consideration for the HCP transaction is contingent upon HCP's performance for the calendar years ending December 31, 2012 and 2013. The accounting standards applicable to contingent consideration require that we estimate the fair value of this contingent consideration on a quarterly basis. To the extent that the fair value estimate in any quarter exceeds the prior quarter's estimate, we will be required to record the increase in fair value as an expense in our financial statements. Any such expense will reduce our net income in the quarter in which it is recognized. These requirements will also limit our ability to predict our earnings in the quarters in which we must assess the fair value of the contingent consideration, and projections of such changes have not been included in any of our existing earnings guidance.

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.

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.

If businesses we acquire, including HCP, have liabilities that we are not aware of, we could suffer severe consequences that would substantially reduce our earnings and cash flows or otherwise materially and adversely affect our business.

Our business strategy includes growth through acquisitions of dialysis centers and other businesses. Businesses we acquire, including HCP, may have unknown or contingent liabilities or liabilities that are in excess of the amounts that we originally estimated, which liabilities become consolidated into the Company's. Businesses we acquire, including HCP, may have other issues, including those related to internal controls over financial reporting or issues that could affect our ability to comply with other applicable laws, including healthcare laws and regulations. As a result, we cannot make any assurances that the acquisitions we consummate, including the HCP transaction, will be successful or will not, in fact, harm our business.

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. We have limited indemnification rights in connection with matters affecting HCP. 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.

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;
- 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 guarantors' assets.

Increases in interest rates may increase our interest expense and adversely affect our earnings and cash flow and our ability to service our indebtedness.

A portion of our outstanding debt bears interest at variable rates. We are subject to LIBOR-based interest rate volatility from a floor of 1.50% to a cap of 2.50% on $1,250 million notional amounts of our Term Loan B outstanding debt as a result of several interest rate cap agreements that were entered into in March 2013. The remaining $461 million of outstanding debt on the Term Loan B is subject to LIBOR-based interest rate volatility above a floor of 1.50%. At March 31, 2013, we were also subject to LIBOR-based interest rate volatility above a floor of 1.00% to a cap of 2.50% on $1,485 million of outstanding debt associated with our Term Loan B-2. The remaining $161 million of outstanding debt on the Term Loan B-2 is subject to LIBOR-based interest rate volatility above a floor of 1.00%. At March 31, 2013, we were also subject to LIBOR-based interest rate volatility on Term Loan A-3 and Term Loan A but as a result of our swap agreements the LIBOR-based variable component of our interest rate is economically fixed at March 31, 2013.

We also have approximately $350 million of additional borrowings available of which approximately $113 million was committed for outstanding letters of credit, under our Senior Secured Credit Facilities that are subject to LIBOR-based interest rate volatility and $1 million committed for our outstanding letter of credit related to HCP. We may also incur additional variable rate debt in the future. Increases in interest rates would increase our interest expense of the variable portion of our indebtedness, which could negatively impact our earnings and cash flow and our ability to service our indebtedness which would be particularly significant in the event of rapid and substantial increases in interest rates.

At March 31, 2013, if interest rates were to hypothetically increase by 100 basis points it would increase our interest expense by approximately $3.5 million, which increase relates to our Term Loan B-2 that is subject to LIBOR-based interest rate volatility above a floor of 1.00%. See "Item 3—Quantitative and Qualitative Disclosures about Market Risk" for more information.

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; and
- 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 March 31, 2013, these cash bonuses would total approximately $494 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 2. *Unregistered Sales of Equity Securities and Use of Proceeds*

(c) Stock repurchases

The following table summarizes the Company's repurchases of its common stock during the first quarter of 2013:

Period	Total number of shares purchased	Average price paid per share	Total number of shares purchased as part of publicly announced plans or programs	Approximate dollar value of shares that may yet be purchased under the plans or programs (in millions)
January 1-31, 2013	—	$ —	—	$ 358.2
February 1-28, 2013	—	—	—	358.2
March 1-31, 2013	—	—	—	358.2
Total	—	$ —	—	

In November 2010, our Board of Directors authorized repurchases of our common stock in an aggregate amount of up to $800 million. 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.

Items 3, 4 and 5 are not applicable

Item 6. *Exhibits*

(a) Exhibits

Exhibit Number	
12.1	Ratio of earnings to fixed charges. ✓
31.1	Certification of the Chief Executive Officer, dated May 9, 2013, pursuant to Rule 13a-14(a) or 15d-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002. ✓
31.2	Certification of the Chief Financial Officer, dated May 9, 2013, pursuant to Rule 13a-14(a) or 15d-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002. ✓
32.1	Certification of the Chief Executive Officer, dated May 9, 2013, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002. ✓
32.2	Certification of the Chief Financial Officer, dated May 9, 2013, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002. ✓
101.INS	XBRL Instance Document.
101.SCH	XBRL Taxonomy Extension Schema Document.
101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document.
101.DEF	XBRL Taxonomy Extension Definition Linkbase Document.
101.LAB	XBRL Taxonomy Extension Label Linkbase Document.
101.PRE	XBRL Taxonomy Extension Presentation, Linkbase Document.

✓ Filed herewith.

SIGNATURE

Pursuant to the requirements of the Securities Exchange Act of 1934, the Registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

DAVITA HEALTHCARE PARTNERS INC.

BY: /S/ JAMES K. HILGER

James K. Hilger
Interim Chief Financial Officer and
Chief Accounting Officer*

Date: May 9, 2013

* Mr. Hilger has signed both on behalf of the Registrant as a duly authorized officer and as the Registrant's principal accounting officer.

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INDEX TO EXHIBITS

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101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document.
101.DEF	XBRL Taxonomy Extension Definition Linkbase Document.
101.LAB	XBRL Taxonomy Extension Label Linkbase Document.
101.PRE	XBRL Taxonomy Extension Presentation, Linkbase Document.

✓ Filed herewith.

EXHIBIT 12.1

DAVITA HEALTHCARE PARTNERS INC.
RATIO OF EARNINGS TO FIXED CHARGES

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

	Three months ended March 31, 2013	Year ended December 31,				
		2012	2011	2010	2009	2008
	(dollars in thousands)					
Earnings adjusted for fixed charges:						
Income from continuing operations before income taxes	$ 61,642	$ 1,001,304	$ 916,605	$ 741,238	$ 752,632	$ 654,497
Add:						
Debt expense	105,817	288,554	241,090	181,607	185,755	224,716
Interest portion of rent expense	33,392	112,424	95,919	86,656	80,710	72,236
Less: Noncontrolling interests	(29,651)	(105,891)	(95,899)	(79,048)	(57,285)	(47,023)
	109,558	295,087	241,110	189,215	209,180	249,929
	$ 171,200	$ 1,296,391	$ 1,157,715	$ 930,453	$ 961,812	$ 904,426
Fixed charges:						
Debt expense	$ 105,817	$ 288,554	$ 241,090	$ 181,607	$ 185,755	$ 224,716
Interest portion of rent expense	33,392	112,424	95,919	86,656	80,710	72,236
Capitalized interest	1,509	8,127	4,887	2,621	3,627	4,189
	$ 140,718	$ 409,105	$ 341,896	$ 270,884	$ 270,092	$ 301,141
Ratio of earnings to fixed charges	1.22	3.17	3.39	3.43	3.56	3.00

EXHIBIT 31.1

SECTION 302 CERTIFICATION

I, Kent J. Thiry, certify that:

1. I have reviewed this quarterly report on Form 10-Q of DaVita HealthCare Partners Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   (d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

/S/ KENT J. THIRY

Kent J. Thiry
Chief Executive Officer

Date: May 9, 2013

EXHIBIT 31.2

SECTION 302 CERTIFICATION

I, James K. Hilger, certify that:

1. I have reviewed this quarterly report on Form 10-Q of DaVita HealthCare Partners Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   (d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

/S/ JAMES K. HILGER

James K. Hilger
Interim Chief Financial Officer and
Chief Accounting Officer

Date: May 9, 2013

EXHIBIT 32.1

CERTIFICATION OF CHIEF EXECUTIVE OFFICER
PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Quarterly Report of DaVita HealthCare Partners Inc. (the "Company") on Form 10-Q for the quarter ended March 31, 2013 as filed with the Securities and Exchange Commission on the date hereof (the "Periodic Report"), I, Kent J. Thiry, Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, that:

1. The Periodic Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and
2. The information contained in the Periodic Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/S/ KENT J. THIRY

Kent J. Thiry
Chief Executive Officer
May 9, 2013

A signed original of this written statement required by Section 906 has been provided to the Company and will be retained by the Company and furnished to the Securities and Exchange Commission or its staff upon request.

EXHIBIT 32.2

CERTIFICATION OF CHIEF FINANCIAL OFFICER
PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Quarterly Report of DaVita HealthCare Partners Inc. (the "Company") on Form 10-Q for the quarter ended March 31, 2013 as filed with the Securities and Exchange Commission on the date hereof (the "Periodic Report"), I, James K. Hilger, Interim Chief Financial Officer and Chief Accounting Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, that:

1. The Periodic Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and
2. The information contained in the Periodic Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/S/ JAMES K. HILGER

James K. Hilger
Interim Chief Financial Officer and
Chief Accounting Officer
May 9, 2013

A signed original of this written statement required by Section 906 has been provided to the Company and will be retained by the Company and furnished to the Securities and Exchange Commission or its staff upon request.