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

# FORM 10-Q

**For the Quarterly Period Ended June 30, 2017**

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

**Commission File Number: 1-14106**

# DAVITA 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 | ☐ |
| Emerging growth company | ☐ | | |

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

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

As of July 28, 2017, the number of shares of the Registrant's common stock outstanding was approximately 191.2 million shares.

**DAVITA INC.**
**INDEX**



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

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

| | Three months ended June 30, | | Six months ended June 30, | |
|---|---|---|---|---|
| | 2017 | 2016 | 2017 | 2016 |
| Patient service revenues | $ 2,682,467 | $ 2,583,514 | $ 5,283,845 | $ 5,065,448 |
| Less: Provision for uncollectible accounts | (115,485) | (111,428) | (228,468) | (220,633) |
| Net patient service revenues | 2,566,982 | 2,472,086 | 5,055,377 | 4,844,815 |
| Capitated revenues | 1,022,078 | 899,985 | 1,940,114 | 1,787,993 |
| Other revenues | 288,417 | 345,580 | 579,269 | 665,979 |
| Total net revenues | 3,877,477 | 3,717,651 | 7,574,760 | 7,298,787 |
| Operating expenses and charges: | | | | |
| Patient care costs and other costs | 2,859,911 | 2,671,025 | 5,582,731 | 5,253,358 |
| General and administrative | 382,315 | 386,895 | 774,095 | 773,324 |
| Depreciation and amortization | 200,038 | 180,381 | 390,244 | 349,736 |
| Provision for uncollectible accounts | (606) | 3,566 | 1,304 | 6,083 |
| Equity investment (income) loss | (3,614) | 505 | (7,549) | (882) |
| Goodwill and asset impairment charges | 61,117 | 176,000 | 100,483 | 253,000 |
| Gain on changes in ownership interests, net | — | (29,791) | (6,273) | (29,791) |
| Gain on settlement, net | — | — | (526,827) | — |
| Total operating expenses and charges | 3,499,161 | 3,388,581 | 6,308,208 | 6,604,828 |
| Operating income | 378,316 | 329,070 | 1,266,552 | 693,959 |
| Debt expense | (107,962) | (102,894) | (212,391) | (205,778) |
| Other income, net | 5,253 | 3,215 | 9,496 | 6,191 |
| Income before income taxes | 275,607 | 229,391 | 1,063,657 | 494,372 |
| Income tax expense | 113,982 | 134,888 | 401,747 | 261,710 |
| Net income | 161,625 | 94,503 | 661,910 | 232,662 |
| Less: Net income attributable to noncontrolling interests | (34,624) | (41,121) | (87,212) | (81,846) |
| Net income attributable to DaVita Inc. | $ 127,001 | $ 53,382 | $ 574,698 | $ 150,816 |
| **Earnings per share:** | | | | |
| Basic net income per share attributable to DaVita Inc. | $ 0.66 | $ 0.26 | $ 3.00 | $ 0.74 |
| Diluted net income per share attributable to DaVita Inc. | $ 0.65 | $ 0.26 | $ 2.95 | $ 0.73 |
| **Weighted average shares for earnings per share:** | | | | |
| Basic | 191,088,216 | 204,497,970 | 191,728,913 | 204,432,315 |
| Diluted | 193,987,983 | 208,047,172 | 194,630,936 | 207,987,530 |

See notes to condensed consolidated financial statements.

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

| | Three months ended June 30, | | Six months ended June 30, | |
|---|---|---|---|---|
| | 2017 | 2016 | 2017 | 2016 |
| Net income | $ 161,625 | $ 94,503 | $ 661,910 | $ 232,662 |
| Other comprehensive income (loss), net of tax: | | | | |
| Unrealized losses on interest rate cap and swap agreements: | | | | |
| Unrealized losses on interest rate cap and swap agreements | (1,815) | (2,616) | (5,002) | (8,085) |
| Reclassifications of net rate cap and swap agreements realized losses into net income | 1,265 | 448 | 2,529 | 913 |
| Unrealized gains on investments: | | | | |
| Unrealized gains on investments | 1,057 | 638 | 2,614 | 867 |
| Reclassification of net investment realized gains into net income | (71) | — | (211) | (93) |
| Unrealized gains on foreign currency translation: | | | | |
| Foreign currency translation adjustments | 49,142 | (4,844) | 62,403 | 6,337 |
| Other comprehensive income (loss) | 49,578 | (6,374) | 62,333 | (61) |
| Total comprehensive income | 211,203 | 88,129 | 724,243 | 232,601 |
| Less: Comprehensive income attributable to noncontrolling interests | (34,624) | (41,270) | (87,210) | (81,995) |
| Comprehensive income attributable to DaVita Inc. | $ 176,579 | $ 46,859 | $ 637,033 | $ 150,606 |

See notes to condensed consolidated financial statements.

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

| | June 30, 2017 | December 31, 2016 |
|---|---|---|
| **ASSETS** | | |
| Cash and cash equivalents | $ 711,997 | $ 913,187 |
| Short-term investments | 211,436 | 310,198 |
| Accounts receivable, less allowance of $240,918 and $252,056 | 2,053,812 | 1,917,302 |
| Inventories | 199,304 | 164,858 |
| Other receivables | 644,755 | 453,483 |
| Prepaid and other current assets | 202,464 | 210,604 |
| Income taxes receivable | — | 10,596 |
| Total current assets | 4,023,768 | 3,980,228 |
| Property and equipment, net of accumulated depreciation of $3,130,797 and $2,832,160 | 3,248,030 | 3,175,367 |
| Intangible assets, net of accumulated amortization of $1,035,664 and $940,731 | 1,462,894 | 1,527,767 |
| Equity method and other investments | 542,468 | 502,389 |
| Long-term investments | 114,693 | 103,679 |
| Other long-term assets | 60,140 | 44,510 |
| Goodwill | 9,889,791 | 9,407,317 |
| | $ 19,341,784 | $ 18,741,257 |
| **LIABILITIES AND EQUITY** | | |
| Accounts payable | $ 439,741 | $ 522,415 |
| Other liabilities | 885,274 | 856,847 |
| Accrued compensation and benefits | 760,284 | 815,761 |
| Medical payables | 390,387 | 336,381 |
| Current portion of long-term debt | 182,323 | 165,041 |
| Income tax payable | 115,316 | — |
| Total current liabilities | 2,773,325 | 2,696,445 |
| Long-term debt | 8,910,814 | 8,947,327 |
| Other long-term liabilities | 520,886 | 465,358 |
| Deferred income taxes | 855,159 | 809,128 |
| Total liabilities | 13,060,184 | 12,918,258 |
| Commitments and contingencies: | | |
| Noncontrolling interests subject to put provisions | 1,009,704 | 973,258 |
| 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; 194,774,810 and 194,554,491 shares issued and 191,200,237 and 194,554,491 shares outstanding, respectively) | 195 | 195 |
| Additional paid-in capital | 1,058,090 | 1,027,182 |
| Retained earnings | 4,285,011 | 3,710,313 |
| Treasury stock (3,574,573 shares at June 30, 2017) | (231,674) | — |
| Accumulated other comprehensive loss | (27,308) | (89,643) |
| Total DaVita Inc. shareholders' equity | 5,084,314 | 4,648,047 |
| Noncontrolling interests not subject to put provisions | 187,582 | 201,694 |
| Total equity | 5,271,896 | 4,849,741 |
| | $ 19,341,784 | $ 18,741,257 |

See notes to condensed consolidated financial statements.

**DAVITA INC.**
**CONSOLIDATED STATEMENTS OF CASH FLOWS**
**(unaudited)**
**(dollars in thousands)**

| | Six months ended June 30, | |
|---|---|---|
| | **2017** | **2016** |
| **Cash flows from operating activities:** | | |
| Net income | $ 661,910 | $ 232,662 |
| Adjustments to reconcile net income to net cash provided by operating activities: | | |
| Depreciation and amortization | 390,244 | 349,736 |
| Goodwill and asset impairment charges | 100,483 | 253,000 |
| Stock-based compensation expense | 17,504 | 23,717 |
| Deferred income taxes | 40,938 | 19,952 |
| Equity investment income, net | 9,367 | 14,275 |
| Gain on sales of business interests, net | (6,273) | (29,791) |
| Other non-cash charges | 28,615 | 23,120 |
| Changes in operating assets and liabilities, other than from acquisitions and divestitures: | | |
| Accounts receivable | (113,208) | (104,005) |
| Inventories | (31,067) | (9,213) |
| Other receivables and other current assets | (112,469) | (107,610) |
| Other long-term assets | (12,124) | (431) |
| Accounts payable | (55,897) | 22,809 |
| Accrued compensation and benefits | (63,727) | 41,098 |
| Other current liabilities | 13,991 | 112,825 |
| Income taxes | 123,637 | 135,026 |
| Other long-term liabilities | 19,520 | (31,531) |
| Net cash provided by operating activities | 1,011,444 | 945,639 |
| **Cash flows from investing activities:** | | |
| Additions of property and equipment | (398,940) | (358,627) |
| Acquisitions | (619,839) | (473,314) |
| Proceeds from asset and business sales | 70,236 | 17,393 |
| Purchase of investments available for sale | (6,812) | (7,873) |
| Purchase of investments held-to-maturity | (220,632) | (518,965) |
| Proceeds from sale of investments available for sale | 5,049 | 5,337 |
| Proceeds from investments held-to-maturity | 320,484 | 545,685 |
| Purchase of equity investments | (1,194) | (8,785) |
| Proceeds from sale of equity investments | — | 40,920 |
| Net cash used in investing activities | (851,648) | (758,229) |
| **Cash flows from financing activities:** | | |
| Borrowings | 25,529,555 | 26,134,952 |
| Payments on long-term debt and other financing costs | (25,593,587) | (26,196,373) |
| Purchase of treasury stock | (231,674) | (274,926) |
| Distributions to noncontrolling interests | (116,075) | (94,153) |
| Stock award exercises and other share issuances, net | 8,163 | 9,465 |
| Contributions from noncontrolling interests | 39,872 | 13,117 |
| Purchase of noncontrolling interests | (1,432) | (6,240) |
| Other | — | 10,604 |
| Net cash used in financing activities | (365,178) | (403,554) |
| Effect of exchange rate changes on cash and cash equivalents | 4,192 | 444 |
| Net decrease in cash and cash equivalents | (201,190) | (215,700) |
| Cash and cash equivalents at beginning of the year | 913,187 | 1,499,116 |
| Cash and cash equivalents at end of the period | $ 711,997 | $ 1,283,416 |

See notes to condensed consolidated financial statements.

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

| | Non-controlling interests subject to put provisions | DaVita Inc. Shareholders' Equity | | | | | | | | Non-controlling interests not subject to put provisions |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Common stock | | Additional paid-in capital | Retained earnings | Treasury stock | | Accumulated other comprehensive loss | Total | |
| | | Shares | Amount | | | Shares | Amount | | | |
| Balance at December 31, 2015 | $ 864,066 | 217,120 | $ 217 | $ 1,118,326 | $ 4,356,835 | (7,366) | $ (544,772) | $ (59,826) | $ 4,870,780 | $ 213,392 |
| Comprehensive income: | | | | | | | | | | |
| Net income | 99,834 | | | | 879,874 | | | | 879,874 | 53,374 |
| Other comprehensive loss | | | | | | | | (29,817) | (29,817) | 190 |
| Stock purchase shares issued | | 438 | 1 | 23,902 | | — | | | 23,903 | |
| Stock unit shares issued | | 4 | — | (19,815) | | 276 | 19,815 | | — | |
| Stock-settled SAR shares issued | | 218 | — | (36,685) | | 513 | 36,685 | | — | |
| Stock-settled stock-based compensation expense | | | | 37,970 | | | | | 37,970 | |
| Excess tax benefits from stock awards exercised | | | | 13,251 | | | | | 13,251 | |
| Changes in noncontrolling interest from: | | | | | | | | | | |
| Distributions | (111,092) | | | | | | | | | (81,309) |
| Contributions | 33,517 | | | | | | | | | 14,073 |
| Acquisitions and divestitures | 28,874 | | | 3,423 | | | | | 3,423 | 2,585 |
| Partial purchases | (6,660) | | | (13,105) | | | | | (13,105) | (1,747) |
| Fair value | 65,855 | | | (65,855) | | | | | (65,855) | |
| Reclassifications and expirations of puts | (1,136) | | | | | | | | | 1,136 |
| Purchase of treasury stock | | | | | | (16,649) | (1,072,377) | | (1,072,377) | |
| Retirement of treasury stock | | (23,226) | (23) | (34,230) | (1,526,396) | 23,226 | 1,560,649 | | — | |
| Balance at December 31, 2016 | $ 973,258 | 194,554 | $ 195 | $ 1,027,182 | $ 3,710,313 | — | $ — | $ (89,643) | $ 4,648,047 | $ 201,694 |
| Comprehensive income: | | | | | | | | | | |
| Net income | 56,721 | | | | 574,698 | | | | 574,698 | 30,491 |
| Other comprehensive income | | | | | | | | 62,335 | 62,335 | (2) |
| Stock unit shares issued | | 105 | — | — | | — | — | | — | |
| Stock-settled SAR shares issued | | 116 | — | — | | — | — | | — | |
| Stock-settled stock-based compensation expense | | | | 17,468 | | | | | 17,468 | |
| Changes in noncontrolling interest from: | | | | | | | | | | |
| Distributions | (72,636) | | | — | | | | | — | (43,439) |
| Contributions | 31,368 | | | — | | | | | — | 8,504 |
| Acquisitions and divestitures | 34,365 | | | (709) | | | | | (709) | (7,457) |
| Partial purchases | (1,544) | | | 195 | | | | | 195 | (83) |
| Fair value | (13,954) | | | 13,954 | | | | | 13,954 | |
| Reclassifications and expirations of puts | 2,126 | | | | | | | | | (2,126) |
| Purchase of treasury stock | | | | | | (3,575) | (231,674) | | (231,674) | |
| Balance at June 30, 2017 | $ 1,009,704 | 194,775 | $ 195 | $ 1,058,090 | $ 4,285,011 | (3,575) | $ (231,674) | $ (27,308) | $ 5,084,314 | $ 187,582 |

See notes to condensed consolidated financial statements

(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 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 condensed 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 revenue recognition and accounts receivable, contingencies, impairments of goodwill and other long-lived assets, fair value estimates, accounting for income taxes, variable compensation accruals, consolidation of variable interest entities, purchase accounting valuation estimates, long-term incentive program compensation and medical liability claims. The results of operations for the six months ended June 30, 2017 are not necessarily indicative of the operating results for the full year. The condensed 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, 2016. Prior year balances and amounts have been reclassified to conform to the current year presentation. The Company has evaluated subsequent events through the date these condensed consolidated financial statements were issued and has included all necessary adjustments and disclosures.

## 2. Earnings per share

Basic net income per share is calculated by dividing net income attributable to the Company, adjusted for any change in noncontrolling interests redemption rights in excess of fair value, by the weighted average number of common shares and vested stock units outstanding, net of shares held in escrow from the DaVita HealthCare Partners merger that under certain circumstances may be returned to the Company.

Diluted net income per share includes the dilutive effect of outstanding stock-settled stock appreciation rights and unvested stock units (under the treasury stock method) as well as contingently returnable shares held in escrow.

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

| | Three months ended June 30, | | Six months ended June 30, | |
|---|---|---|---|---|
| | 2017 | 2016 | 2017 | 2016 |
| **Basic:** | | | | |
| Net income attributable to DaVita Inc. | $ 127,001 | $ 53,382 | $ 574,698 | $ 150,816 |
| Weighted average shares outstanding during the period | 193,282 | 206,692 | 193,923 | 206,626 |
| Contingently returnable shares held in escrow from the DaVita HealthCare Partners merger | (2,194) | (2,194) | (2,194) | (2,194) |
| Weighted average shares for basic earnings per share calculation | 191,088 | 204,498 | 191,729 | 204,432 |
| **Basic net income per share attributable to DaVita Inc.** | $ 0.66 | $ 0.26 | $ 3.00 | $ 0.74 |
| **Diluted:** | | | | |
| Net income attributable to DaVita Inc. | $ 127,001 | $ 53,382 | $ 574,698 | $ 150,816 |
| Weighted average shares outstanding during the period | 193,282 | 206,692 | 193,923 | 206,626 |
| Assumed incremental shares from stock plans | 706 | 1,355 | 708 | 1,362 |
| Weighted average shares for diluted earnings per share calculation | 193,988 | 208,047 | 194,631 | 207,988 |
| **Diluted net income per share attributable to DaVita Inc.** | $ 0.65 | $ 0.26 | $ 2.95 | $ 0.73 |
| Anti-dilutive potential common shares excluded from calculation[(1)] | 3,780 | 1,811 | 3,603 | 2,042 |

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

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

## 3. Accounts receivable

Accounts receivable are reduced by an allowance for doubtful accounts. In evaluating the ultimate collectability of 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 Medicare, the Company receives 80% of the payment directly from Medicare as established under the government's 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.

For receivables associated with the Company's capitated health plans, the balances remain on the balance sheet for as long as the respective plan years are open, which varies by health plan but is generally two years in length, with collections occurring on a periodic basis throughout the duration of the corresponding plan year.

Approximately 1% of the Company's net accounts receivable are associated with patient pay. The Company's policy is to reserve 100% of the outstanding accounts receivable balances for dialysis services when those amounts due have been outstanding for more than three months and to reserve 100% of the outstanding accounts receivable balances for services of DaVita Medical Group (DMG, formerly known as HealthCare Partners or HCP) when those amounts due have been outstanding for more than twelve months and when the amount is not subject to a payment plan.

During the six months ended June 30, 2017, the Company's allowance for doubtful accounts decreased by $11,138. This was primarily due to an increase in write-offs of aged balances and timing of adjustments related to the U.S. dialysis and related lab business. There were no unusual transactions impacting the allowance for doubtful accounts.

## 4. Investments in debt and equity securities

The Company classifies certain debt securities as held-to-maturity and records them at amortized cost based on the Company's intentions and strategy concerning those investments. Equity securities that have readily determinable fair values, and certain other financial instruments that have readily determinable fair values or redemption values, are classified as available-for-sale and recorded at fair value.

The Company's investments in these securities and certain other financial instruments consist of the following:

| | June 30, 2017 | | | December 31, 2016 | | |
|---|---|---|---|---|---|---|
| | Held to maturity | Available for sale | Total | Held to maturity | Available for sale | Total |
| Certificates of deposit, commercial paper and money market funds due within one year | $ 210,236 | $ — | $ 210,236 | $ 256,827 | $ — | $ 256,827 |
| Investments in mutual funds and common stock | — | 53,209 | 53,209 | 50,000 | 47,404 | 97,404 |
| Cash surrender value of life insurance policies | — | 62,684 | 62,684 | — | 59,646 | 59,646 |
| | $ 210,236 | $ 115,893 | $ 326,129 | $ 306,827 | $ 107,050 | $ 413,877 |
| Short-term investments | $ 210,236 | $ 1,200 | $ 211,436 | $ 306,827 | $ 3,371 | $ 310,198 |
| Long-term investments | — | 114,693 | 114,693 | — | 103,679 | 103,679 |
| | $ 210,236 | $ 115,893 | $ 326,129 | $ 306,827 | $ 107,050 | $ 413,877 |

The cost of the certificates of deposit, commercial paper and money market funds at June 30, 2017 and December 31, 2016 approximates their fair value. As of June 30, 2017 and December 31, 2016, the available-for-sale investments included $6,783 and $3,701 of gross pre-tax unrealized gains, respectively. During the six months ended June 30, 2017, the Company recorded gross pre-tax unrealized gains of $3,428, or $2,616 after tax, in other comprehensive income associated with changes in the fair value of these investments. During the six months ended June 30, 2017, the Company sold investments in mutual funds and debt securities for net proceeds of $5,049 and recognized a pre-tax gain of $346, or $211 after-tax, which was previously recorded in other comprehensive income. During the six months ended June 30, 2016, the Company sold investments in mutual funds for net proceeds of $1,347 and recognized a pre-tax gain of $152, or $93 after-tax, which 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.

Investments in life insurance policies are carried at their cash surrender value, are held within trusts to fund existing obligations associated with certain of the Company's non-qualified deferred compensation plans, and are principally classified as long-term to correspond with the long-term classification of the related plan liabilities.

Certain DMG legal entities are required to maintain minimum cash balances in order to comply with regulatory requirements in conjunction with medical claim reserves. As of June 30, 2017, this minimum cash balance was approximately $56,717.

**5. Equity method and other investments**

Equity investments that do not have readily determinable fair values are carried on the cost or equity method, as applicable. The Company maintains equity method investments in nonconsolidated investees in both its DaVita Kidney Care (Kidney Care) and DMG lines of business, as well as minor cost method investments in private securities of certain other healthcare businesses. The Company classifies its non-marketable cost- and equity method investments as equity method and other investments on its balance sheet.

Equity method and other investments in nonconsolidated businesses were $542,468 and $502,389 at June 30, 2017 and December 31, 2016, respectively. The increase in these equity investments was primarily due to foreign exchange valuation changes, which caused an increase in our investment in the APAC JV (described below). During the six months ended June 30, 2017 and 2016, the Company recognized equity investment income of $7,549 and $882, respectively, from equity method investments in nonconsolidated businesses.

Effective as of August 1, 2016, the Company deconsolidated its Asia Pacific dialysis business held by DaVita Care Pte. Ltd. (the "APAC JV"), adjusted its retained investment in the APAC JV to estimated fair value at that time, and has accounted for this retained investment on the equity method since August 1, 2016.

The Company holds a 60% voting interest and an 86.7% current economic interest in DaVita Care Pte. Ltd., an entity which was previously a wholly-owned subsidiary of the Company. Based on the governance structure and voting rights established for the APAC JV, certain key decisions affecting the joint venture's operations are no longer at the unilateral discretion of the Company, but rather are shared with other noncontrolling investors.

These other noncontrolling investors collectively hold a 40% voting interest and a 13.3% current economic interest in the APAC JV. The economic interests of these other noncontrolling investors are expected to increase to match their voting interests in the APAC JV as they make additional subscribed capital contributions through August 1, 2019. Each of these other noncontrolling investors also holds reserved approval rights over certain key decisions affecting the joint venture's operations. As a result, the Company has no longer consolidated the APAC JV since its formation on August 1, 2016.

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

## 6. Goodwill

Changes in goodwill by reportable segments were as follows:

| | U.S. dialysis and related lab services | DMG | Other-ancillary services and strategic initiatives | Consolidated total |
|---|---|---|---|---|
| Balance at January 1, 2016 | $ 5,629,183 | $ 3,398,264 | $ 267,032 | $ 9,294,479 |
| Acquisitions | 75,295 | 248,901 | 123,632 | 447,828 |
| Divestitures | (12,891) | (2,223) | (29,645) | (44,759) |
| Goodwill impairment charges | — | (253,000) | (28,415) | (281,415) |
| Foreign currency and other adjustments | — | — | (8,816) | (8,816) |
| Balance at December 31, 2016 | $ 5,691,587 | $ 3,391,942 | $ 323,788 | $ 9,407,317 |
| Acquisitions | 427,299 | 31,796 | 113,669 | 572,764 |
| Divestitures | (32,260) | (29) | (54) | (32,343) |
| Goodwill impairment charges | — | (50,619) | (34,696) | (85,315) |
| Foreign currency and other adjustments | — | — | 27,368 | 27,368 |
| Balance at June 30, 2017 | $ 6,086,626 | $ 3,373,090 | $ 430,075 | $ 9,889,791 |
| | | | | |
| Balance at June 30, 2017: | | | | |
| Goodwill | $ 6,086,626 | $ 3,865,478 | $ 499,095 | $ 10,451,199 |
| Accumulated impairment charges | — | (492,388) | (69,020) | (561,408) |
| | $ 6,086,626 | $ 3,373,090 | $ 430,075 | $ 9,889,791 |

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

Each of the Company's operating segments described in Note 18 to these condensed consolidated financial statements represents an individual reporting unit for goodwill impairment testing purposes, except that each sovereign jurisdiction within the Company's international operating segments 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 the allocation of resources and significant investment decisions concerning these businesses are highly centralized and the benefits broadly distributed, the Company has aggregated these centers and deemed them to constitute a single reporting unit.

The Company has applied a similar aggregation to the DMG operations in each region, to the vascular access service centers in its vascular access reporting unit, to the physician practices in its physician services and direct primary care reporting units, and to the dialysis centers within each international reporting unit. For the Company's other operating segments, discrete business components below the operating segment level constitute individual reporting units.

Based on continuing developments at the Company's DMG and vascular access reporting units during the second quarter of 2017, the Company performed impairment assessments for certain at-risk reporting units.

As a result of the assessments performed during the three months ended June 30, 2017, the Company recognized goodwill impairment charges of $49,946 at its DMG Florida reporting unit and $673 at its DMG New Mexico reporting unit. These charges resulted primarily from changes in expectations concerning government reimbursement, including the effect of Medicare Advantage final benchmark payment rates for 2018 announced on April 3, 2017 and the Company's expected ability to mitigate them, as well as medical cost and utilization trends.

During the three months ended June 30, 2017, the Company also recognized an incremental goodwill impairment charge

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

of $10,498 at its vascular access reporting unit. This additional charge resulted primarily from continuing changes in the Company's outlook as the Company's partners and operators have continued to evaluate and make decisions concerning changes in operations, including termination of their management services agreements and center closures as a result of the Centers for Medicare and Medicaid Services (CMS) 2017 Physician Fee Schedule Final Rule and the Ambulatory Surgical Center Payment Final Rule released November 2, 2016, which introduced significant changes in reimbursement structure for this business unit. As of June 30, 2017, there was no goodwill remaining at the Company's vascular access reporting unit.

For the three and six months ended June 30, 2017, the Company has recognized total goodwill impairment charges of $61,117 and $85,315, respectively.

During the three months ended June 30, 2016, the Company recognized goodwill impairment charges of $97,000 at its DMG Florida reporting unit and $79,000 at its DMG Nevada reporting unit. These charges resulted primarily from changes in expectations concerning government reimbursement and the Company's expected ability to mitigate them, as well as medical cost trends and other market conditions.

For the three and six months ended June 30, 2016, the Company recognized total goodwill impairment charges of $176,000 and $253,000, respectively.

Further reductions in reimbursement rates, increases in medical cost or utilization trends, or other significant adverse changes in expected future cash flows or valuation assumptions could result in goodwill impairment charges in the future for the following reporting units, which remain at risk of goodwill impairment:

| Reporting unit | Goodwill balance as of June 30, 2017 | Carrying amount coverage[1] | Sensitivities | |
|---|---|---|---|---|
| | | | Operating income[2] | Discount rate[3] |
| DMG Nevada | $ 275,914 | 17.0% | (2.4)% | (3.8)% |
| DMG Florida | $ 397,127 | —% | (1.6)% | (2.8)% |
| DMG New Mexico | $ 70,253 | —% | (1.6)% | (2.4)% |
| DMG Washington | $ 247,552 | 9.3% | (1.7)% | (3.6)% |

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

Except as described above, none of the Company's various other reporting units was considered at risk of goodwill impairment as of June 30, 2017. Since the dates of their last annual goodwill impairment tests, there have been certain developments, events, changes in operating performance and other changes in key circumstances that have affected these other businesses. However, except as further described above, these changes did not cause management to believe it is more likely than not that the fair value of any of its reporting units would be less than their respective carrying amounts.

## 7. Medical payables

The following table includes estimates for the cost of professional medical services provided by non-employed physicians and other providers, as well as inpatient and other ancillary costs, other than California's non-global risk contracts. The Company does not include inpatient and other ancillary costs for non-global risk contracts held in California, as state regulation does not allow medical group entities to assume risk for inpatient services. Healthcare costs payable are included in medical payables in the condensed consolidated balance sheet.

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

The following table shows the components of changes in health care costs payable for the six months ended June 30, 2017:

| | Six months ended June 30, 2017 |
|---|---|
| Healthcare costs payable, beginning of the period | $ 214,275 |
| Add: Components of incurred health care costs | |
| Current year | 991,818 |
| Prior years | (6,838) |
| Total incurred health care costs | 984,980 |
| Less: Claims paid | |
| Current year | 727,814 |
| Prior years | 186,623 |
| Total claims paid | 914,437 |
| Healthcare costs payable, end of the period | $ 284,818 |

The Company's prior year estimates of healthcare costs payable resulted in medical claims being settled for different amounts than originally estimated. When significant increases (decreases) in prior-year health care cost estimates occur that the Company believes significantly impact its current year operating results, the Company discloses that amount as unfavorable (favorable) development of prior-year's health care cost estimates. Actual claim payments for prior year services have not been materially different from the Company's year-end estimates.

**8. Income taxes**

As of June 30, 2017, the Company's total liability for unrecognized tax benefits relating to tax positions that do not meet the more-likely-than-not threshold was $25,926, all of which would impact the Company's effective tax rate if recognized. This balance represents an increase of $1,860 from the December 31, 2016 balance of $24,066.

The Company recognizes accrued interest and penalties related to unrecognized tax benefits in its income tax expense. At June 30, 2017 and December 31, 2016, the Company had approximately $3,891 and $2,595, respectively, accrued for interest and penalties related to unrecognized tax benefits, net of federal tax benefits.

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

## 9. Long-term debt

Long-term debt was comprised of the following:

| | June 30, 2017 | December 31, 2016 |
|---|---|---|
| Senior secured credit facilities: | | |
| Term Loan A | $ 825,000 | $ 862,500 |
| Term Loan B | 3,395,000 | 3,412,500 |
| Senior notes | 4,500,000 | 4,500,000 |
| Acquisition obligations and other notes payable | 139,371 | 117,547 |
| Capital lease obligations | 305,643 | 299,682 |
| Total debt principal outstanding | 9,165,014 | 9,192,229 |
| Discount and deferred financing costs | (71,877) | (79,861) |
| | 9,093,137 | 9,112,368 |
| Less current portion | (182,323) | (165,041) |
| | $ 8,910,814 | $ 8,947,327 |

Scheduled maturities of long-term debt at June 30, 2017 were as follows:

| | |
|---|---|
| 2017 (remainder of the year) | 96,454 |
| 2018 | 172,318 |
| 2019 | 746,464 |
| 2020 | 71,432 |
| 2021 | 3,303,146 |
| 2022 | 1,280,031 |
| Thereafter | 3,495,169 |

During the first six months of 2017, the Company made mandatory principal payments under its senior secured credit facilities totaling $37,500 on Term Loan A and $17,500 on Term Loan B.

As of June 30, 2017, the Company maintains several active and forward 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 floating rate debt, as described below. The cap agreements are 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 cap agreements do not contain credit-risk contingent features.

As of June 30, 2017, the Company maintains several interest rate cap agreements that were entered into in November 2014 with notional amounts totaling $3,500,000. These cap agreements became effective September 30, 2016 and have the economic effect of capping the LIBOR variable component of the Company’s interest rate at a maximum of 3.50% on an equivalent amount of the Company’s debt. The cap agreements expire on June 30, 2018. As of June 30, 2017, the total fair value of these cap agreements was an asset of approximately $1. During the six months ended June 30, 2017, the Company recognized debt expense of $4,139 from these caps. During the six months ended June 30, 2017, the Company recorded a loss of $115 in other comprehensive income due to a decrease in unrealized fair value of these cap agreements.

As of June 30, 2017, the Company also maintains several forward interest rate cap agreements that were entered into in October 2015 with notional amounts totaling $3,500,000. These forward cap agreements will become effective June 29, 2018 and will have the economic effect of capping the LIBOR variable component of the Company’s interest rate at a maximum of 3.50% on an equivalent amount of its debt. These cap agreements expire on June 30, 2020. As of June 30, 2017, the total fair value of these cap agreements was an asset of approximately $1,742. During the six months ended June 30, 2017, the Company recorded a loss of $8,071 in other comprehensive income due to a decrease in the unrealized fair value of these forward cap agreements.

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

The following table summarizes the Company's derivative instruments as of June 30, 2017 and December 31, 2016:

| | June 30, 2017 | | December 31, 2016 | |
|---|---|---|---|---|
| **Derivatives designated as hedging instruments** | **Balance sheet location** | **Fair value** | **Balance sheet location** | **Fair value** |
| Interest rate cap agreements | Other long-term assets | $ 1,743 | Other long-term assets | $ 9,929 |

The following table summarizes the effects of the Company's interest rate cap and swap agreements for the three and six months ended June 30, 2017 and 2016:

| | Amount of losses recognized in OCI on interest rate cap and swap agreements | | | | | Amount of losses reclassified from accumulated OCI into income | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Three months ended June 30, | | Six months ended June 30, | | Location of losses reclassified from accumulated OCI into income | Three months ended June 30, | | Six months ended June 30, | |
| **Derivatives designated as cash flow hedges** | **2017** | **2016** | **2017** | **2016** | | **2017** | **2016** | **2017** | **2016** |
| Interest rate swap agreements | $ — | $ (168) | $ — | $ (860) | Debt expense | $ — | $ 123 | $ — | $ 274 |
| Interest rate cap agreements | (2,969) | (4,115) | (8,186) | (12,374) | Debt expense | 2,070 | 610 | 4,139 | 1,220 |
| Tax benefit | 1,154 | 1,667 | 3,184 | 5,149 | Tax expense | (805) | (285) | (1,610) | (581) |
| Total | $ (1,815) | $ (2,616) | $ (5,002) | $ (8,085) | | $ 1,265 | $ 448 | $ 2,529 | $ 913 |

As of June 30, 2017, the interest rate on the Company's Term Loan B debt bears interest at LIBOR plus an interest rate margin of 2.75%. Term Loan B is subject to interest rate caps if LIBOR should rise above 3.50%. Term Loan A bears interest at LIBOR plus an interest rate margin of 2.00%. The capped portion of Term Loan A is $105,000 if LIBOR should rise above 3.50%. In addition, the uncapped portion of Term Loan A, which is subject to the variability of LIBOR, is $720,000. Interest rates on the Company's senior notes are fixed by their terms.

The Company's weighted average effective interest rate on the senior secured credit facilities at end of the quarter was 4.20%, based on the current margins in effect of 2.00% for Term Loan A and 2.75% for Term Loan B, as of June 30, 2017.

The Company's overall weighted average effective interest rate during the quarter ended June 30, 2017 was 4.69% and as of June 30, 2017 was 4.76%.

As of June 30, 2017, the Company's interest rates are fixed on approximately 53.3% of its total debt.

As of June 30, 2017, the Company had undrawn revolving credit facilities totaling $1,000,000, of which approximately $94,623 was committed for outstanding letters of credit. The remaining amount is unencumbered. In addition, the Company has approximately $1,286 of committed letters of credit outstanding related to DMG, which is backed by a certificate of deposit.

## 10. Contingencies

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

The Company operates in a highly regulated industry and is a party to various lawsuits, claims, governmental investigations and audits (including investigations resulting from its obligation to self-report suspected violations of law) and other legal proceedings. The Company records accruals for certain legal proceedings and regulatory matters to the extent that the Company determines an unfavorable outcome is probable and the amount of the loss can be reasonably estimated. As of

June 30, 2017 and December 31, 2016, the Company's total recorded accruals with respect to legal proceedings and regulatory matters, net of anticipated third party recoveries, were approximately $62,000 and $69,000, respectively. While these accruals reflect the Company's best estimate of the probable loss for those matters as of the dates of those accruals, the recorded amounts may differ materially from the actual amount of the losses for those matters, and any anticipated third party recoveries for any such losses may not ultimately be recoverable. Additionally, in some cases, no estimate of the possible loss or range of loss in excess of amounts accrued, if any, can be made because of the inherently unpredictable nature of legal proceedings and regulatory matters, which may be exacerbated by various factors, including that they may involve indeterminate claims for monetary damages or may involve fines, penalties or non-monetary remedies; present novel legal theories or legal uncertainties; involve disputed facts; represent a shift in regulatory policy; are in the early stages of the proceedings; or result in a change of business practices. Further, there may be various levels of judicial review available to the Company in connection with any such proceeding.

The following is a description of certain lawsuits, claims, governmental investigations and audits and other legal proceedings to which the Company is subject.

***Inquiries by the Federal Government and Certain Related Civil Proceedings***

Swoben Private Civil Suit: In April 2013, HealthCare Partners (HCP), now known as the Company's DMG subsidiary, was one of several defendants served with a civil complaint filed by a former employee of SCAN Health Plan (SCAN), an HMO. On July 13, 2009, pursuant to the *qui tam* provisions of the federal False Claims Act (FCA) and the California False Claims Act, James M. Swoben, as relator, filed his initial *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 2009 and 2010, the relator twice amended his complaint and added additional defendants, and in November 2011, he filed his Third Amended Complaint under seal alleging violations of the federal FCA and the California False Claims Act, and added additional defendants, including HCP and certain health insurance companies (the defendant HMOs). The allegations in the complaint against HCP relate to patient diagnosis coding to determine reimbursement in the Medicare Advantage (MA) program, referred to as HCC and RAF scores. The complaint sought monetary damages and civil penalties as well as costs and expenses. The U.S. Department of Justice (DOJ) reviewed these allegations and in January 2013 declined to intervene in the case. HCP and the other defendants filed motions to dismiss the Third Amended Complaint, and the court dismissed with prejudice the claims and judgment was entered in September 2013. Upon the plaintiff's appeal, a panel of the Ninth Circuit overturned the trial court's ruling and vacated the dismissal of the case. The Company, with certain defendants, petitioned the Ninth Circuit for a rehearing, but in December 2016, the Ninth Circuit rejected the petition and determined the relator should be given an opportunity to amend the complaint, and remanded the case back to district court. In March 2017, the relator filed his Fourth Amended Complaint alleging that HCP and certain health insurance companies employed one-way retrospective reviews that were designed only to identify additional diagnoses that would be submitted to CMS for risk adjustment purposes, and thereby drive higher risk scores that would increase the capitated payments made by the federal government under the MA program. In March 2017, the DOJ partially intervened as to certain defendant HMOs, but elected not to intervene with respect to HCP. The Company disputes the allegations and intends to defend accordingly.

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

In addition to the subpoena described above, in June 2015, the Company received a subpoena from the OIG. This civil subpoena covers the period from January 1, 2008 through the present and seeks production of a wide range of documents relating to the Company's and its subsidiaries' (including DMG's and its subsidiary JSA's) provision of services to MA plans

and related patient diagnosis coding and risk adjustment submissions and payments. The Company believes that the request is part of a broader industry investigation into MA patient diagnosis coding and risk adjustment practices and potential overpayments by the government. The information requested includes information relating to patient diagnosis coding practices for a number of conditions, including potentially improper historical DMG coding for a particular condition. With respect to that condition, the guidance related to that coding issue was discontinued following the Company's November 1, 2012 acquisition of DMG, and the Company notified CMS in April 2015 of the coding practice and potential overpayments. In that regard, the Company has identified certain additional coding practices which may have been problematic and is in discussions with the DOJ about the scope and nature of a review of claims relating to those practices. The Company is cooperating with the government and is producing the requested information. In addition, the Company is continuing to review other DMG coding practices to determine whether there were any improper coding issues. In connection with the DMG merger, the Company has certain indemnification rights against the sellers and an escrow was established as security for the indemnification. The Company has submitted an indemnification claim against the sellers secured by the escrow for any and all liabilities incurred relating to these matters and intends to pursue recovery from the escrow. However, the Company can make no assurances that the indemnification and escrow will cover the full amount of the Company's potential losses related to these matters.

2016 U.S. Attorney Prescription Drug Investigation: In early February 2016, the Company announced that its pharmacy services' wholly-owned subsidiary, DaVita Rx, received a CID from the U.S. Attorney's Office for the Northern District of Texas. The government is conducting an FCA investigation concerning allegations that DaVita Rx presented or caused to be presented false claims for payment to the government for prescription medications, as well as into the Company's relationship with pharmaceutical manufacturers. The CID covers the period from January 1, 2006 through the present. In the spring of 2015, the Company initiated an internal compliance review of DaVita Rx during which it identified potential billing and operational issues, including potential write-offs and discounts of patient co-payment obligations, and credits to payors for returns of prescription drugs related to DaVita Rx. The Company notified the government in September 2015 that it was conducting this review of DaVita Rx and began providing regular updates of its review. Upon completion of its review, the Company filed a self-disclosure with the OIG in February 2016 and has been working to address and update the practices it identified in the self-disclosure, some of which overlap with information requested by the U.S. Attorney's Office. The OIG informed the Company in February 2016 that its submission was not accepted. They indicated that the OIG is not expressing an opinion regarding the conduct disclosed or the Company's legal positions. The Company is cooperating with the government.

Solari Post-Acquisition Matter: In 2016, HCP Nevada disclosed to the OIG for the HHS that proper procedures for clinical and eligibility determinations may not have been followed by Las Vegas Solari Hospice (Solari), which was acquired in March 2013 and sold in September 2016 by HCP Nevada. In June 2016, the Company was notified by the OIG that the disclosure submission had been accepted into the OIG's Self Disclosure Protocol. HCP Nevada had previously made a disclosure and repayment of overpayments to National Government Services (NGS), the Medicare Administrative Contractor for HCP Nevada, for claims submitted by Solari to the federal government prior to DMG's acquisition of Solari and claims made to the government post-acquisition for which the sellers had certain responsibilities pursuant to a management services agreement. The Company is cooperating with the government in this matter.

2017 U.S. Attorney American Kidney Fund Investigation: On January 4, 2017, the Company was served with an administrative subpoena for records by the United States Attorney's Office, District of Massachusetts, relating to an investigation into possible federal health care offenses. The subpoena covers the period from January 1, 2007 through the present, and seeks documents relevant to charitable patient assistance organizations, particularly the American Kidney Fund, including documents related to efforts to provide patients with information concerning the availability of charitable assistance. The Company is cooperating with the government and is producing the requested information.

Although the Company cannot predict whether or when proceedings might be initiated or when these matters may be resolved (other than as described above), it is not unusual for inquiries such as these to continue for a considerable period of time through the various phases of document and witness requests and on-going discussions with regulators. In addition to the inquiries and proceedings specifically identified above, the Company is frequently subject to other inquiries by state or federal government agencies and/or private civil *qui tam* complaints filed by relators. Negative findings or terms and conditions that the Company might agree to accept as part of a negotiated resolution of pending or future government inquiries or relator proceedings could result in, among other things, substantial financial penalties or awards against the Company, substantial payments made by the Company, harm to the Company's reputation, required changes to the Company's business practices, exclusion from future participation in the Medicare, Medicaid and other federal health care programs and, if criminal

proceedings were initiated against the Company, possible criminal penalties, any of which could have a material adverse effect on the Company.

***Shareholder Claims***

Peace Officers' Annuity and Benefit Fund of Georgia Securities Class Action Civil Suit: On February 1, 2017, the Peace Officers' Annuity and Benefit Fund of Georgia filed a putative federal securities class action complaint in the U.S. District Court for the District of Colorado against the Company and certain executives. The complaint covers the time period of August 2015 to October 2016 and alleges, generally, that the Company and its executives violated federal securities laws concerning the Company's financial results and revenue derived from patients who received charitable premium assistance from an industry-funded non-profit organization. The complaint further alleges that the process by which patients obtained commercial insurance and received charitable premium assistance was improper and "created a false impression of DaVita's business and operational status and future growth prospects." The Company disputes these allegations and intends to defend this action accordingly.

Blackburn Shareholder Derivative Civil Suit: On February 10, 2017, Charles Blackburn filed a derivative shareholder lawsuit in the U.S. District Court for the District of Delaware against the Company, as nominal defendant, the Board of Directors and certain executives. The complaint covers the time period from 2015 to present and alleges, generally, breach of fiduciary duty, unjust enrichment and misrepresentations and/or failures to disclose certain information in violation of the federal securities laws in connection with an alleged practice to direct patients with government-subsidized health insurance into private health insurance plans to maximize the Company's profits. The Company disputes these allegations and intends to defend this action accordingly.

Gabilondo Shareholder Derivative Civil Suit: On May 30, 2017, Antonio Gabilondo filed a derivative shareholder lawsuit in the U.S. District Court for the District of Delaware against the Company, as nominal defendant, the Board of Directors and certain executives. The complaint covers the time period from 2015 to present and alleges, generally, breach of fiduciary duty, unjust enrichment, abuse of control, gross mismanagement, corporate waste, and misrepresentations and/or failures to disclose certain information in violation of the federal securities laws in connection with an alleged practice to direct patients with government-subsidized health insurance into private health insurance plans to maximize the Company's profits. The Company disputes these allegations and intends to defend this action accordingly.

City of Warren Police and Fire Retirement System Shareholder Derivative Civil Suit: On June 9, 2017, the City of Warren Police and Fire Retirement System filed a derivative shareholder lawsuit in the U.S. District Court for the District of Delaware against the Company, as nominal defendant, the Board of Directors, and certain executives. The complaint covers the time period of 2015 to the present and alleges, generally, a breach of fiduciary duty, corporate waste, unjust enrichment, and misrepresentations and/or failures to disclose certain information in violation of the federal securities laws in connection with an alleged practice to direct patients with government-subsidized health insurance into private health insurance plans to maximize the Company's profits. The Company disputes these allegations and intends to defend this action accordingly.

***Other Proceedings***

In addition to the foregoing, from time to time the Company is subject to other lawsuits, claims, governmental investigations and audits and legal proceedings that arise due to the nature of its business, including contractual disputes, such as with payors, suppliers and others, employee-related matters and professional and general liability claims.

From time to time, the Company initiates litigation or other legal proceedings as a plaintiff arising out of contracts or other matters. In that regard, the Company had a pending lawsuit in the U.S. Court of Federal Claims against the federal government which was originally filed in May 2011. The lawsuit related to the U.S. Department of Veterans Affairs (VA) underpayment of dialysis services the Company provided from 2005 through 2011 to veterans pursuant to VA regulations. In the first quarter of 2017, the Company received a payment of $538,000 related to the settlement with the VA. The Company's consolidated entities recognized a net gain of $527,000 on this settlement. The Company's nonconsolidated and managed entities recognized a gain of $9,000, of which the Company's equity investment share was $3,000. The net effect was a net increase of $530,000 to the Company's operating income.

* * *

Other than as described above, the Company cannot predict the ultimate outcomes of the various legal proceedings and regulatory matters to which the Company is or may be subject from time to time, including those described in this Note 10, or the timing of their resolution or the ultimate losses or impact of developments in those matters, which could have a material adverse effect on the Company's revenues, earnings and cash flows. Further, any legal proceedings or regulatory matters involving the Company, whether meritorious or not, are time consuming, and often require management's attention and result in significant legal expense, and may result in the diversion of significant operational resources, or otherwise harm the Company's business, financial results or reputation.

***Resolved Matters***

2015 U.S. Attorney Transportation Investigation: In February 2015, the Company announced that it received six administrative subpoenas from the OIG for medical records from six different dialysis centers in southern California operated by the Company. Specifically, each subpoena sought the medical records of a single patient of each respective dialysis center. In February 2016, the Company received four additional subpoenas for four additional dialysis centers in southern California. The subpoenas were similarly limited in scope to the subpoenas received in 2015. On February 8, 2017, the Company was served with a *qui tam* complaint in the U.S. District Court for the Central District of California. The Company was advised by an attorney with the United States Attorney's Office for the Central District of California that the *qui tam* was related to the investigation concerning the medical necessity of patient transportation, which was the basis for the subpoenas. The relator alleged that an ambulance company submitted false claims for patient transportation. Although the Company does not provide transportation nor does it bill for the transport of its dialysis patients, the relator alleged that two of its purported clinical staff caused the submission of a small number of those claims through improper certifications of medical necessity. The DOJ has declined to intervene. In April 2017, the court granted the Company's motion to dismiss and dismissed the complaint without prejudice for failing to state a claim upon which relief can be granted. In May 2017, the relator filed a First Amended Complaint and the Company filed an additional motion to dismiss. In June 2017, the court granted the Company's motion and dismissed the complaint without prejudice. Plaintiff was given until July 24, 2017 to file an amended complaint. Instead, the plaintiff decided not to proceed against the Company and filed a notice of dismissal on July 25, 2017.

2015 U.S. Department of Justice Vascular Access Investigation and Related *Qui Tam* Litigation: In November 2015, the Company announced that RMS Lifeline, Inc., a wholly-owned subsidiary of the Company that operates under the name Lifeline Vascular Access (Lifeline), received a Civil Investigative Demand (CID) from the DOJ. The CID relates to two vascular access centers in Florida that are part of Lifeline's vascular access business. The CID covers the period from January 1, 2008 through the present. The Company acquired these two centers in December 2012. Based on the language of the CID, the DOJ appeared to be looking at whether angiograms performed at the two centers were medically unnecessary and therefore whether related claims filed with federal healthcare programs possibly violated the FCA. Lifeline does not perform dialysis services but instead provides vascular access management services for dialysis patients. The Company cooperated with the government and produced the requested information. The DOJ investigation was initiated pursuant to a complaint brought under the *qui tam* provisions of the FCA (the Complaint). The Complaint was originally filed under seal in August 2014 in the U.S. District Court, Middle District of Florida, United States ex. rel James Spafford v. DaVita HealthCare Partners, Inc., et al., Case Number 6:14-cv-1251-Orl-41DAB, naming several doctors along with the Company as defendants. In December 2015, a First Amended Complaint was filed under seal. In May 2016, the First Amended Complaint was unsealed. The First Amended Complaint alleged violations of the FCA due to the submission of claims to the government for allegedly medically unnecessary angiograms and angiography procedures at the two vascular access centers as well as employment-related claims. The Complaint covers alleged conduct dating from July 2008, prior to the Company's acquisition of the centers, to the present. The DOJ declined to intervene. In January 2017, the Company finalized and executed a settlement agreement with the relator and the government for an immaterial amount, and in April 2017, the court dismissed the case with prejudice.

Vainer Private Civil Suit: As previously disclosed, the Company received a subpoena for documents from the OIG relating to the pharmaceutical products Zemplar, Hectorol, Venofer, Ferrlecit and erythropoietin (EPO), as well as other related matters, covering the period from January 2003 to December 2008. The Company subsequently learned that the allegations underlying this inquiry were made as part of a civil complaint filed by relators, Daniel Barbir and Dr. Alon Vainer, pursuant to the *qui tam* provisions of the federal FCA. The relators also alleged that the Company's drug administration practices for the Company's dialysis operations for Vitamin D and iron agents from 2003 through 2010 fraudulently created unnecessary waste, which was billed to and paid for by the government. In June 2015, the Company finalized the terms of the settlement with plaintiffs, including a settlement amount of $450,000 and attorney fees and other costs of $45,000 which was paid in 2015.

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 OIG. 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 related to payments for infusion drugs covered by Medicaid composite payments for dialysis. The Company cooperated with the government and produced the requested documents. In April 2014, the Company reached an agreement in principle with the government. In March 2016, the Company finalized and executed settlement agreements with the State of New York and the DOJ, including a settlement payment of an immaterial amount.

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

The Company has other potential commitments to provide operating capital to a number of dialysis centers that are wholly-owned by third parties or businesses in which the Company maintains a noncontrolling equity interest as well as to physician-owned vascular access clinics or medical practices that the Company operates under management and administrative services agreements of approximately $5,892.

Certain consolidated joint ventures are originally contractually scheduled to dissolve after terms ranging from 10 to 50 years. While noncontrolling interests in these limited life entities qualify as mandatorily redeemable financial instruments, they are subject to a classification and measurement scope exception from the accounting guidance generally applicable to other mandatorily redeemable financial instruments. Future distributions upon dissolution of these entities would be valued below the related noncontrolling interest carrying balances in the consolidated balance sheet.

**12. Long-term incentive compensation**

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

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 six months ended June 30, 2017, the Company granted 1,426 stock-settled stock appreciation rights with an aggregate grant-date fair value of $20,865 and a weighted-average expected life of approximately 4.2 years, 387 stock units with an aggregate grant-date fair value of $25,517 and a weighted-average expected life of approximately 3.4 years, and 15

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

cash-settled stock appreciation rights with an aggregate grant-date fair value of $204 and a weighted-average expected life of approximately 4.3 years.

For the six months ended June 30, 2017 and 2016, the Company recognized $30,946 and $50,647, respectively, in total LTIP expense, of which $17,504 and $23,717, respectively, represented stock-based compensation expense for stock appreciation rights, restricted stock units, and discounted employee stock plan purchases, which are primarily included in general and administrative expense. The estimated tax benefits recorded for stock-based compensation for the six months ended June 30, 2017 and 2016 was $5,912 and $8,160, respectively. As of June 30, 2017, the Company had $149,543 of total estimated but unrecognized compensation expense for outstanding LTIP awards, including $84,475 related to stock-based compensation arrangements under the Company's equity compensation and employee stock purchase plans. The Company expects to recognize the performance-based cash component of these LTIP costs over a weighted average remaining period of 1.2 years and the stock-based component of these LTIP costs over a weighted average remaining period of 1.5 years.

For the six months ended June 30, 2017 and 2016, the Company received $5,693 and $23,658, respectively, in actual tax benefits upon the exercise of stock awards.

## 13. Share repurchases

During the six months ended June 30, 2017, the Company repurchased a total of 3,575 shares of its common stock for $231,674 or an average price of $64.81 per share.

On July 13, 2016, the Company's Board of Directors approved a share repurchase authorization in the amount of $1,240,748. This share repurchase authorization was in addition to the $259,252 remaining at that time under the Company's Board of Directors' prior share repurchase authorization announced in April 2015. As of June 30, 2017, there was $445,430 available under the current Board authorizations for additional share repurchases. Although these share repurchase authorizations do not have expiration dates, the Company remains subject to share repurchase limitations under the terms of its senior secured credit facilities and the indentures governing its senior notes.

## 14. Comprehensive income

| | For the three months ended June 30, 2017 | | | | For the six months ended June 30, 2017 | | | |
|---|---|---|---|---|---|---|---|---|
| | Interest rate cap agreements | Investment securities | Foreign currency translation adjustments | Accumulated other comprehensive (loss) income | Interest rate cap agreements | Investment securities | Foreign currency translation adjustments | Accumulated other comprehensive (loss) income |
| Beginning balance | $ (13,952) | $ 3,594 | $ (66,528) | $ (76,886) | $ (12,029) | $ 2,175 | $ (79,789) | $ (89,643) |
| Unrealized (losses) gains | (2,969) | 1,446 | 49,142 | 47,619 | (8,186) | 3,428 | 62,403 | 57,645 |
| Related income tax benefit (expense) | 1,154 | (389) | — | 765 | 3,184 | (812) | — | 2,372 |
| | (1,815) | 1,057 | 49,142 | 48,384 | (5,002) | 2,616 | 62,403 | 60,017 |
| Reclassification from accumulated other comprehensive income into net income | 2,070 | (117) | — | 1,953 | 4,139 | (346) | — | 3,793 |
| Related income tax (expense) benefit | (805) | 46 | — | (759) | (1,610) | 135 | — | (1,475) |
| | 1,265 | (71) | — | 1,194 | 2,529 | (211) | — | 2,318 |
| Ending balance | $ (14,502) | $ 4,580 | $ (17,386) | $ (27,308) | $ (14,502) | $ 4,580 | $ (17,386) | $ (27,308) |

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

| | For the three months ended June 30, 2016 | | | | For the six months ended June 30, 2016 | | | |
|---|---|---|---|---|---|---|---|---|
| | Interest rate cap and swap agreements | Investment securities | Foreign currency translation adjustments | Accumulated other comprehensive (loss) income | Interest rate cap and swap agreements | Investment securities | Foreign currency translation adjustments | Accumulated other comprehensive (loss) income |
| Beginning balance | $ (15,929) | $ 1,497 | $ (39,081) | $ (53,513) | $ (10,925) | $ 1,361 | $ (50,262) | $ (59,826) |
| Unrealized (losses) gains | (4,283) | 782 | (4,844) | (8,345) | (13,234) | 1,124 | 6,337 | (5,773) |
| Related income tax benefit (expense) | 1,667 | (293) | — | 1,374 | 5,149 | (406) | — | 4,743 |
| | (2,616) | 489 | (4,844) | (6,971) | (8,085) | 718 | 6,337 | (1,030) |
| Reclassification from accumulated other comprehensive income into net income | 733 | — | — | 733 | 1,494 | (152) | — | 1,342 |
| Related income tax (expense) benefit | (285) | — | — | (285) | (581) | 59 | — | (522) |
| | 448 | — | — | 448 | 913 | (93) | — | 820 |
| Ending balance | $ (18,097) | $ 1,986 | $ (43,925) | $ (60,036) | $ (18,097) | $ 1,986 | $ (43,925) | $ (60,036) |

The reclassification of net cap and swap realized losses into income are recorded as debt expense in the corresponding consolidated statements of income. See Note 9 to these condensed consolidated financial statements for further details.

The reclassification of net investment realized gains into income are recorded in other income in the corresponding consolidated statements of income. See Note 4 to these condensed consolidated financial statements for further details.

## 15. Acquisitions and divestitures

*Acquisition of Renal Ventures*

On May 1, 2017, the Company completed its acquisition of 100% of the equity of Colorado-based Renal Ventures Management, LLC (Renal Ventures) for approximately $361,563 in net cash, subject to certain post-closing adjustments. Renal Ventures operated 36 operating dialysis centers, one uncertified dialysis center and one home program that provided services to approximately 2,600 patients in six states. As a part of this transaction, the Company was required to divest three Renal Ventures outpatient dialysis centers, and three outpatient dialysis centers and one uncertified dialysis center of the Company for approximately $21,219 in net cash. The Company also incurred approximately $4,600 in transaction and integration costs during the six months ended June 30, 2017 associated with the acquisition that are included in general and administrative expenses.

The initial purchase price allocation for the Renal Ventures acquisition is recorded at estimated fair values based upon the best information available to management and will be finalized when certain information arranged to be obtained has been received. In particular, certain working capital items, income tax amounts and the fair value of intangibles and fixed assets are pending final audit, issuance of final tax returns and valuation reports.

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

The following table summarizes the assets acquired and liabilities assumed in the transactions and recognized at the acquisition date at estimated fair values:

| | | |
|---|---|---|
| Current assets | $ | 24,529 |
| Property and equipment | | 36,295 |
| Amortizable intangible and other long-term assets | | 11,547 |
| Goodwill | | 296,582 |
| Current liabilities | | (6,912) |
| Long-term liabilities | | (478) |
| | $ | 361,563 |

The amortizable intangible assets acquired relate to non-compete agreements having a weighted-average useful life of five years. The total estimated amount of goodwill deductible for tax purposes associated with this acquisition was approximately $296,582.

*Other routine acquisitions*

During the six months ended June 30, 2017, the Company acquired dialysis and other businesses consisting of 20 dialysis centers located in the U.S., 55 dialysis centers located outside the U.S., and five other medical businesses for a total of $258,276 in net cash, $3,823 in deferred purchase price obligations, and $8,787 in earn-outs and liabilities assumed. The assets and liabilities for these 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, as are their operating results, from the designated effective dates of the acquisitions.

The initial purchase price allocations for these transactions have been recorded at estimated fair values based on the best information available to management and will be finalized when certain information arranged to be obtained has been received. In particular, certain income tax amounts are pending final evaluation and quantification of pre-acquisition tax contingencies and filing of final tax returns. In addition, valuation of medical claims liabilities, certain working capital items, and the fair value of fixed assets and intangibles are pending final audits and related valuation reports.

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

| | | |
|---|---|---|
| Current assets | $ | 7,439 |
| Property and equipment | | 13,278 |
| Amortizable intangible and other long-term assets | | 14,180 |
| Non-amortizable intangibles | | 4,833 |
| Goodwill | | 276,182 |
| Current liabilities | | (6,467) |
| Long-term liabilities | | (2,484) |
| Noncontrolling interests | | (36,075) |
| | $ | 270,886 |

Amortizable intangible assets acquired during the first six months of 2017 had weighted-average estimated useful lives of approximately five years. The majority of the intangible assets acquired during the first six months of 2017 relate to non-compete agreements having a weighted-average useful life and amortization period of five years. The total estimated amount of goodwill deductible for tax purposes associated with these acquisitions was approximately $207,080.

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

*Pro forma financial information*

The following summary, prepared on a pro forma basis, combines the results of operations as if the acquisitions through June 30, 2017 had been consummated as of the beginning of 2017 and 2016, after including the impact of certain adjustments such as amortization of intangibles and income tax effects.

| | Three months ended June 30, | | Six months ended June 30, | |
|---|---|---|---|---|
| | 2017 | 2016 | 2017 | 2016 |
| | (unaudited) | | | |
| Pro forma net revenues | $ 3,900,750 | $ 3,820,558 | $ 7,678,519 | $ 7,576,206 |
| Pro forma net income attributable to DaVita Inc. | 128,654 | 58,996 | 579,906 | 160,709 |
| Pro forma basic net income per share attributable to DaVita Inc. | 0.67 | 0.29 | 3.02 | 0.79 |
| Pro forma diluted net income per share attributable to DaVita Inc. | 0.66 | 0.28 | 2.98 | 0.77 |

*Contingent earn-out obligations*

The Company has several contingent earn-out obligations associated with acquisitions that could result in the Company paying the former owners of acquired companies a total of up to $16,684 if certain EBITDA, operating income performance targets or quality margins are met primarily over the next one to six years.

Contingent earn-out obligations are remeasured at 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 17 to these condensed consolidated financial statements for further details. As of June 30, 2017, the Company has estimated the fair value of these contingent earn-out obligations to be $11,674, of which a total of $4,666 is included in other liabilities and the remaining $7,008 is included in other long-term liabilities in the Company's consolidated balance sheet.

The following is a reconciliation of changes in the contingent earn-out obligations for the six months ended June 30, 2017:

| | |
|---|---|
| Beginning balance, January 1, 2017 | $ 9,977 |
| Contingent earn-out obligations associated with acquisitions | 3,849 |
| Remeasurement of fair value for contingent earn-out obligations | 415 |
| Payments on contingent earn-out obligations | (2,567) |
| | $ 11,674 |

## 16. Variable interest entities

The Company relies on the operating activities of certain legal 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. generally accepted accounting principles (GAAP), VIEs typically include entities for which (i) the entity's equity is not sufficient to finance its activities without additional subordinated financial support; (ii) 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 entity's expected returns; or (iii) the voting rights of some investors are not proportional to their obligations to absorb the entity's losses.

The Company has determined that substantially all of the legal entities it is associated with that qualify as VIEs must be included in its consolidated financial statements. The Company manages these entities and provides operating and capital funding as necessary for these entities to accomplish their operational and strategic objectives. A number of these entities are subject to nominee ownership 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 entities' operating, strategic and non-clinical governance

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

decisions which transfer substantial powers over and economic responsibility for the entities 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 the nominee owners that effectively indemnify these parties from the economic losses from, or entitle the Company to the economic benefits of, these entities.

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 June 30, 2017, these condensed consolidated financial statements include total assets of VIEs of $765,663 and total liabilities and noncontrolling interests of VIEs to third parties of $402,425.

The Company also sponsors certain deferred compensation plans whose trusts qualify as VIEs and the Company consolidates each of these plans as their primary beneficiary. 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 4 to these condensed consolidated financial statements for disclosures on the assets of these consolidated non-qualified deferred compensation plans.

**17. 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 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 has also classified assets, liabilities and temporary equity that are measured at fair value on a recurring basis into the appropriate fair value hierarchy levels as defined by the Financial Accounting Standards Board (FASB).

The following table summarizes the Company's assets, liabilities and temporary equity that are measured at fair value on a recurring basis as of June 30, 2017:

| | Total | Quoted prices in active markets for identical assets (Level 1) | Significant other observable inputs (Level 2) | Significant unobservable inputs (Level 3) |
|---|---|---|---|---|
| **Assets** | | | | |
| Investments in mutual funds and common stock | $ 53,209 | $ 53,209 | $ — | $ — |
| Cash surrender value of life insurance policies | $ 62,684 | $ — | $ 62,684 | $ — |
| Interest rate cap agreements | $ 1,743 | $ — | $ 1,743 | $ — |
| Funds on deposit with third parties | $ 75,671 | $ 75,671 | $ — | $ — |
| **Liabilities** | | | | |
| Contingent earn-out obligations | $ 11,674 | $ — | $ — | $ 11,674 |
| **Temporary equity** | | | | |
| Noncontrolling interests subject to put provisions | $ 1,009,704 | $ — | $ — | $ 1,009,704 |

Investments in mutual funds and common stock represent available-for-sale investments that are recorded at estimated fair value based upon quoted redemption prices reported by each mutual fund. See Note 4 to these condensed consolidated financial statements for further discussion.

Investments in life insurance policies are carried at their cash surrender value which approximates their fair value. See Note 4 to these condensed consolidated financial statements for further discussion.

Interest rate cap agreements are recorded at fair value estimated from 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 cap agreements would be materially different from the fair value estimates currently reported. See Note 9 to these condensed consolidated financial statements for further discussion.

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 market prices.

Contingent earn-out obligations are measured at estimated fair value based primarily on unobservable inputs including projected EBITDA, estimated probability of achieving gross margins or quality margins 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 and operating income. In addition, a probability adjusted model was used to estimate the fair value amounts of the quality margins. The estimated fair value of these contingent earn-out obligations are 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 11 to these condensed consolidated financial statements for a discussion of the Company's methodology for estimating the fair value of noncontrolling interests subject to put obligations.

Other financial instruments consist primarily of cash, accounts receivable, accounts payable, other accrued liabilities and debt. The balances of the non-debt financial instruments are presented in the condensed consolidated financial statements at June 30, 2017 at their approximate fair values due to the short-term nature of their settlements.

The carrying balance of the Company's senior secured credit facilities totaled $4,148,123 as of June 30, 2017, and the fair value was approximately $4,240,812 based upon quoted market prices, a level 2 input.

The carrying balance of the Company's senior notes was $4,500,000 as of June 30, 2017 and their fair value was approximately $4,565,875, based upon quoted market prices, a level 2 input.

**18. Segment reporting**

The Company operates two major divisions, Kidney Care and DMG. The Kidney Care division is comprised of the Company's U.S. dialysis and related lab services business, its ancillary services and strategic initiatives, including its international operations, and the Company's corporate administrative support. The Company's U.S. dialysis and related lab services business is its largest line of business, and is a leading provider of kidney dialysis services in the U.S. for patients suffering from chronic kidney failure, also known as ESRD. The Company's DMG division is a patient- and physician-focused integrated healthcare delivery and management company with over two decades of experience providing coordinated outcomes-based medical care in a cost-effective manner.

The Company's ancillary services and strategic initiatives consist primarily of pharmacy services, disease management services, vascular access services, clinical research programs, physician services, direct primary care and the Company's international dialysis and integrated health operations.

The Company's operating segments have been defined based on the separate financial information that is regularly produced and reviewed by the Company's chief operating decision maker in making decisions about allocating resources to and assessing the financial performance of the Company's various operating lines of business. The chief operating decision maker for the Company is its Chief Executive Officer.

The Company's separate operating segments include its U.S. dialysis and related lab services business, its DMG operations in each region, each of its ancillary services and strategic initiatives, and its consolidated international kidney care and other healthcare operations in the European and Middle Eastern, Latin America, and Asia Pacific markets, and under the Saudi Ministry of Health charter. The U.S. dialysis and related lab services business and the DMG business each qualify as separately reportable segments, and all of the other ancillary services and strategic initiatives operating segments, including the international operating segments, have been combined and disclosed in the other segments category.

The Company's operating segment financial information included in this report is prepared on the internal management reporting basis that the chief operating decision maker uses to allocate resources and assess the financial performance of the operating segments. For internal management reporting, segment operations include direct segment operating expenses but exclude corporate administrative support costs, which consist primarily of indirect labor, benefits and long-term incentive based compensation of certain departments which provide support to various operating lines of business. These corporate

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

administrative support costs are reduced by internal management fees received from the Company's ancillary lines of businesses.

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

| | Three months ended June 30, | | Six months ended June 30, | |
|---|---|---|---|---|
| | 2017 | 2016 | 2017 | 2016 |
| **Segment net revenues:** | | | | |
| **U.S. dialysis and related lab services** | | | | |
| Patient service revenues: | | | | |
| External sources | $ 2,403,222 | $ 2,352,574 | $ 4,752,123 | $ 4,666,236 |
| Intersegment revenues | 26,436 | 14,470 | 50,196 | 28,779 |
| Total dialysis and related lab services revenues | 2,429,658 | 2,367,044 | 4,802,319 | 4,695,015 |
| Less: Provision for uncollectible accounts | (109,335) | (106,515) | (216,105) | (211,266) |
| Net dialysis and related lab services patient service revenues | 2,320,323 | 2,260,529 | 4,586,214 | 4,483,749 |
| Other revenues[1] | 4,891 | 4,250 | 10,194 | 8,223 |
| Total net dialysis and related lab services revenues | 2,325,214 | 2,264,779 | 4,596,408 | 4,491,972 |
| **DMG** | | | | |
| DMG revenues: | | | | |
| Capitated revenues | 987,420 | 874,119 | 1,877,105 | 1,740,138 |
| Net patient service revenues | 189,529 | 169,167 | 368,501 | 281,601 |
| Other revenues[2] | 19,070 | 16,235 | 37,339 | 26,569 |
| Intersegment capitated and other revenues | 47 | 44 | 105 | 115 |
| Total net DMG revenues | 1,196,066 | 1,059,565 | 2,283,050 | 2,048,423 |
| **Other—Ancillary services and strategic initiatives** | | | | |
| Net patient service revenues | 83,566 | 56,860 | 150,858 | 108,244 |
| Capitated revenues | 34,658 | 25,866 | 63,009 | 47,855 |
| Other external sources | 264,456 | 325,095 | 531,736 | 631,187 |
| Intersegment revenues | 10,913 | 14,720 | 26,216 | 26,546 |
| Total ancillary services and strategic initiatives revenues | 393,593 | 422,541 | 771,819 | 813,832 |
| Total net segment revenues | 3,914,873 | 3,746,885 | 7,651,277 | 7,354,227 |
| Elimination of intersegment revenues | (37,396) | (29,234) | (76,517) | (55,440) |
| Consolidated net revenues | $ 3,877,477 | $ 3,717,651 | $ 7,574,760 | $ 7,298,787 |
| **Segment operating margin (loss):** | | | | |
| U.S. dialysis and related lab services[3] | $ 450,472 | $ 449,190 | $ 1,395,212 | $ 889,245 |
| DMG | (12,880) | (102,059) | (572) | (159,204) |
| Other—Ancillary services and strategic initiatives | (48,245) | (12,644) | (106,466) | (23,745) |
| Total segment operating margin | 389,347 | 334,487 | 1,288,174 | 706,296 |
| **Reconciliation of segment operating margin to consolidated income before income taxes:** | | | | |
| Corporate administrative support | (11,031) | (5,417) | (21,622) | (12,337) |
| Consolidated operating income | 378,316 | 329,070 | 1,266,552 | 693,959 |
| Debt expense | (107,962) | (102,894) | (212,391) | (205,778) |
| Other income, net | 5,253 | 3,215 | 9,496 | 6,191 |
| Consolidated income before income taxes | $ 275,607 | $ 229,391 | $ 1,063,657 | $ 494,372 |

(1) Includes management fees for providing management and administrative services to dialysis centers that are wholly-owned by third parties and legal entities in which the Company owns a noncontrolling equity investment.
(2) Includes medical consulting service fees and management fees for providing management and administrative services to unconsolidated joint ventures and revenue related to the maintenance of existing physician networks.
(3) U.S. dialysis and related lab services operating income includes the net gain on the settlement with the VA.

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

Depreciation and amortization expense by reportable segment is as follows

| | Three months ended June 30, | | Six months ended June 30, | |
|---|---|---|---|---|
| | 2017 | 2016 | 2017 | 2016 |
| U.S. dialysis and related lab services | $ 130,002 | $ 119,350 | $ 255,030 | $ 235,887 |
| DMG | 60,011 | 54,211 | 117,334 | 100,473 |
| Ancillary services and strategic initiatives | 10,025 | 6,820 | 17,880 | 13,376 |
| | $ 200,038 | $ 180,381 | $ 390,244 | $ 349,736 |

Subsequent to the issuance of the Company's fiscal year 2016 consolidated financial statements and their inclusion in its Annual Report on Form 10-K filed with the Securities and Exchange Commission on February 24, 2017 (the "2016 10-K"), the Company determined that it had misstated its disclosure of segment assets at December 31, 2016 in Note 25 to those consolidated financial statements. This misstatement resulted in an overstatement of "U.S. dialysis and related lab services" segment assets of $338,963 and a corresponding understatement of "Other - ancillary services and strategic initiatives" segment assets of the same amount. The Company performed an assessment of the materiality of this misstatement and concluded that this misstatement as originally disclosed was not materially misleading in its 2016 consolidated financial statements taken as a whole. The Company therefore has not amended its financial statements filed on its 2016 10-K to correct this misstatement, but has provided the corrected disclosure here.

Summary of assets by reportable segment is as follows:

| | June 30, 2017 | December 31, 2016 |
|---|---|---|
| **Segment assets** | | |
| U.S. dialysis and related lab services (including equity investments of $83,102 and $66,924, respectively) | $ 11,500,974 | $ 11,099,137 |
| DMG (including equity investments of $13,169 and $10,350, respectively) | 6,282,819 | 6,213,091 |
| Other—Ancillary services and strategic initiatives (including equity investments of $446,197 and $425,115, respectively) | 1,557,991 | 1,429,029 |
| Consolidated assets | $ 19,341,784 | $ 18,741,257 |

Expenditures for property and equipment by reportable segment is as follows:

| | Three months ended June 30, | | Six months ended June 30, | |
|---|---|---|---|---|
| | 2017 | 2016 | 2017 | 2016 |
| U.S. dialysis and related lab services | $ 152,233 | $ 150,932 | $ 325,761 | $ 284,380 |
| DMG | 20,883 | 18,098 | 48,671 | 38,243 |
| Ancillary services and strategic initiatives | 11,289 | 16,410 | 24,508 | 36,004 |
| | $ 184,405 | $ 185,440 | $ 398,940 | $ 358,627 |

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

**19. Changes in DaVita Inc.'s ownership interest in consolidated subsidiaries**

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

| | Three months ended June 30, | | Six months ended June 30, | |
|---|---|---|---|---|
| | 2017 | 2016 | 2017 | 2016 |
| Net income attributable to DaVita Inc. | $ 127,001 | $ 53,382 | $ 574,698 | $ 150,816 |
| Changes in paid-in capital for: | | | | |
| Sales of noncontrolling interests | — | (885) | — | — |
| Purchases of noncontrolling interests | 618 | (1,193) | 195 | (4,530) |
| Net transfers to noncontrolling interests | 618 | (2,078) | 195 | (4,530) |
| Net income attributable to DaVita Inc., net of transfers to noncontrolling interests | $ 127,619 | $ 51,304 | $ 574,893 | $ 146,286 |

**20. New accounting standards**

In May 2014, the FASB issued ASU No. 2014-09, *Revenue from Contracts with Customers*, which requires an entity to recognize the amount of revenue to which it expects to be entitled for the transfer of promised goods or services to customers. In July 2015, the FASB issued ASU 2015-14, *Revenue from Contracts with Customers (Topic* 606): *Deferral of Effective Date*. This guidance approves a one-year deferral of the effective date of ASU 2014-09. The ASU now permits the Company to adopt this standard effective January 1, 2018. Early application is permitted as of January 1, 2017. In March, April, and May 2016, the FASB issued ASU 2016-08, ASU 2016-10, ASU 2016-11, and ASU 2016-12, *Revenue from Contracts with Customers (Topic 606)*, each of which amends the guidance in ASU 2014-09. When they become effective, these ASUs will replace most existing revenue recognition guidance in GAAP. The Company has assembled an internal revenue task force that meets regularly to discuss and evaluate the overall impact this guidance will have on various revenue streams in the condensed consolidated financial statements and related disclosures. Based on the Company's current assessment, which is still ongoing, the Company does not expect this guidance to have a material effect on its net income, and is continuing to evaluate the impact it will have on its disclosures. The Company expects to adopt these ASU's effective January 1, 2018 retrospectively with the cumulative effect of initially applying it recognized at the date of initial application (the cumulative effect method).

In January 2016, the FASB issued ASU No. 2016-01, *Financial Statements - Overall (Subtopic 825-10): Recognition and Measurement of Financial Assets and Financial Liabilities.* The amendments in this ASU revise accounting related to (i) the classification and measurement of investments in equity securities and (ii) the presentation of certain fair value changes for financial liabilities at fair value. The amendments in this ASU are effective for the Company beginning on January 1, 2018 and are to be applied through a cumulative effect adjustment to the statement of financial position. Early adoption is permitted under certain circumstances. The adoption of this ASU is not expected to have a material impact on the Company's condensed consolidated financial statements when adopted on January 1, 2018.

In February 2016, the FASB issued ASU No. 2016-02, *Leases (Topic 842)*. The amendments in this ASU revise the accounting related to lessee accounting. Under the new guidance, lessees will be required to recognize a lease liability and a right-of-use asset for substantially all leases with lease terms in excess of twelve months. The new lease guidance also simplifies the accounting for sale and leaseback transactions primarily because lessees must recognize lease assets and lease liabilities. The amendments in this ASU are effective for the Company beginning on January 1, 2019 and are to be applied through a modified retrospective transition approach for leases existing at, or entered into after, the beginning of the earliest comparative period presented in the financial statements. Early adoption is permitted. The Company has assembled an internal lease task force that meets regularly to discuss and evaluate the overall impact of this guidance on its condensed consolidated financial statements and related disclosures, as well as the expected timing of adoption. The Company believes that the new standard will have a material impact on its condensed consolidated balance sheet but will not have a material impact on its results of operations or liquidity. The Company expects to adopt this ASU on January 1, 2019, and continues to evaluate the effect that the implementation of this ASU will have on its condensed consolidated financial statements and related disclosures.

In March 2016, the FASB issued ASU No. 2016-07, *Investments - Equity Method and Joint Ventures (Topic 323): Simplifying the Transition to the Equity Method of Accounting.* The amendments in this ASU eliminate the requirement that

when an investment qualifies for use of the equity method as a result of an increase in the level of ownership interest or degree of influence, an investor must adjust the investment, results of operations, and retained earnings retroactively on a step-by-step basis as if the equity method had been in effect during all previous periods that the investment had been held. The amendments in this ASU were effective for the Company beginning on January 1, 2017 and was applied prospectively. The adoption of this ASU did not have a material impact on the Company's condensed consolidated financial statements.

In March 2016, the FASB issued ASU No. 2016-09, *Compensation - Stock Compensation (Topic 718): Improvements to Employee Share-Based Payment Accounting*. The changes required by this ASU involve several aspects of the accounting for share-based payment transactions, including income tax consequences, classification of awards as either equity or liabilities, classification on the statement of cash flows, and an election on estimating forfeitures. The amendments in this ASU were effective for the Company beginning January 1, 2017. The method of adoption differs for each of the topics covered by the ASU. The primary effect of this ASU for the Company is the presentation of excess tax benefits or deficiencies as a component of income tax expense within the Company's condensed consolidated statement of income rather than within additional paid-in capital on its condensed consolidated balance sheet. In addition, these excess tax benefits or deficiencies are presented as an operating activity on the condensed consolidated statement of cash flows rather than as a financing activity.

The Company elected to apply the presentation requirements for cash flows related to excess tax benefits prospectively. Additionally, the Company has elected to continue to estimate forfeitures expected to occur in determining the amount of compensation cost to be recognized each period.

The new standard may cause volatility in the Company's effective tax rates and diluted earnings per share due to the tax effects related to share-based payments being recorded within the Company's condensed consolidated statement of income, including a potential increase in the Company's provision for income taxes if a significant number of outstanding stock awards are exercised at recent levels of the Company's stock price.

In August 2016, the FASB issued ASU No. 2016-15, *Statement of Cash Flows (Topic 230): Classification of Certain Cash Receipts and Cash Payments*. The amendments in this ASU clarify how certain cash receipts and cash payments should be classified on the statement of cash flows. The new standard is effective for the Company beginning January 1, 2018 and should be applied retrospectively to all periods presented. The Company has not yet determined the effect that adoption of this ASU will have on its condensed consolidated financial statements.

In October 2016, the FASB issued ASU No. 2016-16, *Income Taxes (Topic 740): Intra-Entity Transfers of Assets Other Than Inventory*. The amendments in this ASU allow entities to recognize the income tax consequences of an intra-entity transfer of an asset other than inventory when the transfer occurs. The current guidance does not allow recognition until the asset has been sold to an outside party. The amendments in this ASU are effective for the Company beginning on January 1, 2018 and are to be applied on a modified retrospective basis. The Company has not yet determined the effect that adoption of this ASU will have on its condensed consolidated financial statements.

In January 2017, the FASB issued ASU No. 2017-04, *Intangibles-Goodwill and Other (Topic 350): Simplifying the Test for Goodwill Impairment*. The amendments in this ASU simplify the test for goodwill impairment by eliminating the second step in testing for goodwill impairment. The amendments in this new ASU are effective for the Company January 1, 2020 and are to be applied on a prospective basis. Early adoption was permitted on or after January 1, 2017 and the Company early adopted this ASU as of January 1, 2017.

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

## 21. 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 condensed 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 a substantial majority of its domestic subsidiaries as measured by revenue, income and assets. The subsidiary guarantors have guaranteed the senior notes on a joint and several basis. However, a subsidiary guarantor will be released from its obligations under its guarantee of the senior notes and the indentures governing the senior notes if, in general, there is a sale or other disposition of all or substantially all of the assets of such subsidiary guarantor, including by merger or consolidation, or a sale or other disposition of all of the equity interests in such subsidiary guarantor held by the Company and its restricted subsidiaries, as defined in the indentures; such subsidiary guarantor is designated by the Company as an unrestricted subsidiary, as defined in the indentures, or otherwise ceases to be a restricted subsidiary of the Company, in each case in accordance with the indentures; or such subsidiary guarantor no longer guarantees any other indebtedness, as defined in the indentures, of the Company or any of its restricted subsidiaries, except for guarantees that are contemporaneously released. The senior notes are not guaranteed by certain of the Company's domestic subsidiaries, any of the Company's foreign subsidiaries, or any entities that do not constitute subsidiaries within the meaning of the indentures, such as corporations in which the Company holds capital stock with less than a majority of the voting power, joint ventures and partnerships in which the Company holds less than a majority of the equity or voting interests, non-owned entities and third parties.

**Condensed Consolidating Statements of Income**

| For The Three Months Ended June 30, 2017 | DaVita Inc. | Guarantor subsidiaries | Non-Guarantor subsidiaries | Consolidating adjustments | Consolidated total |
|---|---|---|---|---|---|
| Patient services revenues | $ — | $ 1,681,249 | $ 1,055,797 | $ (54,579) | $ 2,682,467 |
| Less: Provision for uncollectible accounts | — | (74,413) | (41,072) | — | (115,485) |
| Net patient service revenues | — | 1,606,836 | 1,014,725 | (54,579) | 2,566,982 |
| Capitated revenues | — | 467,852 | 555,947 | (1,721) | 1,022,078 |
| Other revenues | 193,585 | 501,861 | 34,257 | (441,286) | 288,417 |
| Total net revenues | 193,585 | 2,576,549 | 1,604,929 | (497,586) | 3,877,477 |
| Operating expenses and charges | 138,104 | 2,396,723 | 1,461,920 | (497,586) | 3,499,161 |
| Operating income | 55,481 | 179,826 | 143,009 | — | 378,316 |
| Debt expense | (106,159) | (92,346) | (14,943) | 105,486 | (107,962) |
| Other income, net | 102,299 | 2,191 | 6,249 | (105,486) | 5,253 |
| Income tax expense | 22,969 | 70,927 | 20,086 | — | 113,982 |
| Equity earnings in subsidiaries | 98,349 | 79,605 | — | (177,954) | — |
| Net income | 127,001 | 98,349 | 114,229 | (177,954) | 161,625 |
| Less: Net income attributable to noncontrolling interests | — | — | — | (34,624) | (34,624) |
| Net income attributable to DaVita Inc. | $ 127,001 | $ 98,349 | $ 114,229 | $ (212,578) | $ 127,001 |

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

| For The Three Months Ended June 30, 2016 | DaVita Inc. | Guarantor subsidiaries | Non-Guarantor subsidiaries | Consolidating adjustments | Consolidated total |
|---|---|---|---|---|---|
| Patient service revenues | $ — | $ 1,664,361 | $ 959,946 | $ (40,793) | $ 2,583,514 |
| Less: Provision for uncollectible accounts | — | (74,498) | (36,930) | — | (111,428) |
| Net patient service revenues | — | 1,589,863 | 923,016 | (40,793) | 2,472,086 |
| Capitated revenues | — | 463,732 | 436,337 | (84) | 899,985 |
| Other revenues | 196,910 | 521,065 | 31,749 | (404,144) | 345,580 |
| Total net revenues | 196,910 | 2,574,660 | 1,391,102 | (445,021) | 3,717,651 |
| Operating expenses | 134,072 | 2,510,119 | 1,189,411 | (445,021) | 3,388,581 |
| Operating income | 62,838 | 64,541 | 201,691 | — | 329,070 |
| Debt expense | (102,101) | (91,259) | (12,998) | 103,464 | (102,894) |
| Other income | 98,654 | 5,421 | 2,604 | (103,464) | 3,215 |
| Income tax expense | 41,942 | 89,203 | 3,743 | — | 134,888 |
| Equity earnings in subsidiaries | 35,933 | 146,433 | — | (182,366) | — |
| Net income | 53,382 | 35,933 | 187,554 | (182,366) | 94,503 |
| Less: Net income attributable to noncontrolling interests | — | — | — | (41,121) | (41,121) |
| Net income attributable to DaVita Inc. | $ 53,382 | $ 35,933 | $ 187,554 | $ (223,487) | $ 53,382 |

| For The Six Months Ended June 30, 2017 | DaVita Inc. | Guarantor subsidiaries | Non-Guarantor subsidiaries | Consolidating adjustments | Consolidated total |
|---|---|---|---|---|---|
| Patient services revenues | $ — | $ 3,234,605 | $ 2,154,549 | $ (105,309) | $ 5,283,845 |
| Less: Provision for uncollectible accounts | — | (136,694) | (91,774) | — | (228,468) |
| Net patient service revenues | — | 3,097,911 | 2,062,775 | (105,309) | 5,055,377 |
| Capitated revenues | — | 931,479 | 1,010,901 | (2,266) | 1,940,114 |
| Other revenues | 414,971 | 979,536 | 69,894 | (885,132) | 579,269 |
| Total net revenues | 414,971 | 5,008,926 | 3,143,570 | (992,707) | 7,574,760 |
| Operating expenses and charges | 270,014 | 4,276,878 | 2,754,023 | (992,707) | 6,308,208 |
| Operating income | 144,957 | 732,048 | 389,547 | — | 1,266,552 |
| Debt expense | (208,823) | (183,747) | (28,659) | 208,838 | (212,391) |
| Other income, net | 202,636 | 5,728 | 9,970 | (208,838) | 9,496 |
| Income tax expense | 57,062 | 292,348 | 52,337 | — | 401,747 |
| Equity earnings in subsidiaries | 492,990 | 231,309 | — | (724,299) | — |
| Net income | 574,698 | 492,990 | 318,521 | (724,299) | 661,910 |
| Less: Net income attributable to noncontrolling interests | — | — | — | (87,212) | (87,212) |
| Net income attributable to DaVita Inc. | $ 574,698 | $ 492,990 | $ 318,521 | $ (811,511) | $ 574,698 |

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

| For The Six Months Ended June 30, 2016 | DaVita Inc. | Guarantor subsidiaries | Non-Guarantor subsidiaries | Consolidating adjustments | Consolidated total |
|---|---|---|---|---|---|
| Patient services revenues | $ — | $ 3,317,673 | $ 1,827,984 | $ (80,209) | $ 5,065,448 |
| Less: Provision for uncollectible accounts | — | (133,311) | (87,322) | — | (220,633) |
| Net patient service revenues | — | 3,184,362 | 1,740,662 | (80,209) | 4,844,815 |
| Capitated revenues | — | 931,694 | 856,510 | (211) | 1,787,993 |
| Other revenues | 383,885 | 1,005,420 | 59,269 | (782,595) | 665,979 |
| Total net revenues | 383,885 | 5,121,476 | 2,656,441 | (863,015) | 7,298,787 |
| Operating expenses and charges | 256,345 | 4,887,749 | 2,323,749 | (863,015) | 6,604,828 |
| Operating income | 127,540 | 233,727 | 332,692 | — | 693,959 |
| Debt expense | (203,202) | (183,432) | (24,512) | 205,368 | (205,778) |
| Other income, net | 197,214 | 9,757 | 4,588 | (205,368) | 6,191 |
| Income tax expense | 77,088 | 162,457 | 22,165 | — | 261,710 |
| Equity earnings in subsidiaries | 106,352 | 208,757 | — | (315,109) | — |
| Net income | 150,816 | 106,352 | 290,603 | (315,109) | 232,662 |
| Less: Net income attributable to noncontrolling interests | — | — | — | (81,846) | (81,846) |
| Net income attributable to DaVita Inc. | $ 150,816 | $ 106,352 | $ 290,603 | $ (396,955) | $ 150,816 |

**Condensed Consolidating Statements of Comprehensive Income**

| For The Three Months Ended June 30, 2017 | DaVita Inc. | Guarantor subsidiaries | Non-Guarantor subsidiaries | Consolidating adjustments | Consolidated total |
|---|---|---|---|---|---|
| Net income | $ 127,001 | $ 98,349 | $ 114,229 | $ (177,954) | $ 161,625 |
| Other comprehensive income | 436 | — | 49,142 | — | 49,578 |
| Total comprehensive income | 127,437 | 98,349 | 163,371 | (177,954) | 211,203 |
| Less: Comprehensive income attributable to noncontrolling interest | — | — | — | (34,624) | (34,624) |
| Comprehensive income attributable to DaVita Inc. | $ 127,437 | $ 98,349 | $ 163,371 | $ (212,578) | $ 176,579 |

| For The Three Months Ended June 30, 2016 | DaVita Inc. | Guarantor subsidiaries | Non-Guarantor subsidiaries | Consolidating adjustments | Consolidated total |
|---|---|---|---|---|---|
| Net income | $ 53,382 | $ 35,933 | $ 187,554 | $ (182,366) | $ 94,503 |
| Other comprehensive loss | (1,530) | — | (4,844) | — | (6,374) |
| Total comprehensive income | 51,852 | 35,933 | 182,710 | (182,366) | 88,129 |
| Less: Comprehensive income attributable to the noncontrolling interests | — | — | — | (41,270) | (41,270) |
| Comprehensive income attributable to DaVita Inc. | $ 51,852 | $ 35,933 | $ 182,710 | $ (223,636) | $ 46,859 |

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

| For The Six Months Ended June 30, 2017 | DaVita Inc. | Guarantor subsidiaries | Non-Guarantor subsidiaries | Consolidating adjustments | Consolidated total |
|---|---|---|---|---|---|
| Net income | $ 574,698 | $ 492,990 | $ 318,521 | $ (724,299) | $ 661,910 |
| Other comprehensive (loss) income | (70) | — | 62,403 | — | 62,333 |
| Total comprehensive income | 574,628 | 492,990 | 380,924 | (724,299) | 724,243 |
| Less: Comprehensive income attributable to noncontrolling interest | — | — | — | (87,210) | (87,210) |
| Comprehensive income attributable to DaVita Inc. | $ 574,628 | $ 492,990 | $ 380,924 | $ (811,509) | $ 637,033 |

| For The Six Months Ended June 30, 2016 | DaVita Inc. | Guarantor subsidiaries | Non-Guarantor subsidiaries | Consolidating adjustments | Consolidated total |
|---|---|---|---|---|---|
| Net income | $ 150,816 | $ 106,352 | $ 290,603 | $ (315,109) | $ 232,662 |
| Other comprehensive (loss) income | (6,398) | — | 6,337 | — | (61) |
| Total comprehensive income | 144,418 | 106,352 | 296,940 | (315,109) | 232,601 |
| Less: Comprehensive income attributable to the noncontrolling interests | — | — | — | (81,995) | (81,995) |
| Comprehensive income attributable to DaVita Inc. | $ 144,418 | $ 106,352 | $ 296,940 | $ (397,104) | $ 150,606 |

**Condensed Consolidating Balance Sheets**

| As of June 30, 2017 | DaVita Inc. | Guarantor subsidiaries | Non-Guarantor subsidiaries | Consolidating adjustments | Consolidated total |
|---|---|---|---|---|---|
| Cash and cash equivalents | $ 374,973 | $ 40,508 | $ 296,516 | $ — | $ 711,997 |
| Accounts receivable, net | — | 1,278,053 | 775,759 | — | 2,053,812 |
| Other current assets | 254,108 | 891,208 | 112,643 | — | 1,257,959 |
| Total current assets | 629,081 | 2,209,769 | 1,184,918 | — | 4,023,768 |
| Property and equipment, net | 345,667 | 1,669,583 | 1,232,780 | — | 3,248,030 |
| Intangible assets, net | 355 | 1,405,712 | 56,827 | — | 1,462,894 |
| Investments in subsidiaries | 10,368,953 | 2,375,421 | — | (12,744,374) | — |
| Intercompany receivables | 3,266,741 | — | 1,035,735 | (4,302,476) | — |
| Other long-term assets and investments | 45,228 | 92,891 | 579,182 | — | 717,301 |
| Goodwill | — | 7,850,917 | 2,038,874 | — | 9,889,791 |
| Total assets | $ 14,656,025 | $ 15,604,293 | $ 6,128,316 | $ (17,046,850) | $ 19,341,784 |
| Current liabilities | $ 399,436 | $ 1,807,277 | $ 566,612 | $ — | $ 2,773,325 |
| Intercompany payables | — | 2,181,952 | 2,120,524 | (4,302,476) | — |
| Long-term debt and other long-term liabilities | 8,578,628 | 1,246,111 | 462,120 | — | 10,286,859 |
| Noncontrolling interests subject to put provisions | 593,647 | — | — | 416,057 | 1,009,704 |
| Total DaVita Inc. shareholder's equity | 5,084,314 | 10,368,953 | 2,375,421 | (12,744,374) | 5,084,314 |
| Noncontrolling interests not subject to put provisions | — | — | 603,639 | (416,057) | 187,582 |
| Total equity | 5,084,314 | 10,368,953 | 2,979,060 | (13,160,431) | 5,271,896 |
| Total liabilities and equity | $ 14,656,025 | $ 15,604,293 | $ 6,128,316 | $ (17,046,850) | $ 19,341,784 |

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

| As of December 31, 2016 | DaVita Inc. | Guarantor subsidiaries | Non-Guarantor subsidiaries | Consolidating adjustments | Consolidated total |
|---|---|---|---|---|---|
| Cash and cash equivalents | $ 549,921 | $ 59,192 | $ 304,074 | $ — | $ 913,187 |
| Accounts receivable, net | — | 1,215,232 | 702,070 | — | 1,917,302 |
| Other current assets | 277,911 | 736,727 | 135,101 | — | 1,149,739 |
| Total current assets | 827,832 | 2,011,151 | 1,141,245 | — | 3,980,228 |
| Property and equipment, net | 337,200 | 1,689,798 | 1,148,369 | — | 3,175,367 |
| Intangible assets, net | 487 | 1,491,057 | 36,223 | — | 1,527,767 |
| Investments in subsidiaries | 9,717,728 | 2,002,660 | — | (11,720,388) | — |
| Intercompany receivables | 3,250,692 | — | 866,955 | (4,117,647) | — |
| Other long-term assets and investments | 39,994 | 86,710 | 523,874 | — | 650,578 |
| Goodwill | — | 7,838,984 | 1,568,333 | — | 9,407,317 |
| Total assets | $ 14,173,933 | $ 15,120,360 | $ 5,284,999 | $ (15,838,035) | $ 18,741,257 |
| Current liabilities | $ 303,840 | $ 1,865,193 | $ 527,412 | $ — | $ 2,696,445 |
| Intercompany payables | — | 2,322,124 | 1,795,523 | (4,117,647) | — |
| Long-term debt and other long-term liabilities | 8,614,445 | 1,215,315 | 392,053 | — | 10,221,813 |
| Noncontrolling interests subject to put provisions | 607,601 | — | — | 365,657 | 973,258 |
| Total DaVita Inc. shareholder's equity | 4,648,047 | 9,717,728 | 2,002,660 | (11,720,388) | 4,648,047 |
| Noncontrolling interests not subject to put provisions | — | — | 567,351 | (365,657) | 201,694 |
| Total equity | 4,648,047 | 9,717,728 | 2,570,011 | (12,086,045) | 4,849,741 |
| Total liabilities and equity | $ 14,173,933 | $ 15,120,360 | $ 5,284,999 | $ (15,838,035) | $ 18,741,257 |

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

**Condensed Consolidating Statements of Cash Flows**

| For The Six Months Ended June 30, 2017 | DaVita Inc. | Guarantor subsidiaries | Non-Guarantor subsidiaries | Consolidating adjustments | Consolidated total |
|---|---|---|---|---|---|
| **Cash flows from operating activities:** | | | | | |
| Net income | $ 574,698 | $ 492,990 | $ 318,521 | $ (724,299) | $ 661,910 |
| Changes in operating assets and liabilities and non-cash items included in net income | (431,980) | 52,218 | 4,997 | 724,299 | 349,534 |
| Net cash provided by operating activities | 142,718 | 545,208 | 323,518 | — | 1,011,444 |
| **Cash flows from investing activities:** | | | | | |
| Additions of property and equipment, net | (50,966) | (182,494) | (165,480) | — | (398,940) |
| Acquisitions | — | (538,450) | (81,389) | — | (619,839) |
| Proceeds from asset and business sales | — | 70,127 | 109 | — | 70,236 |
| Proceeds (purchases) from investment sales and other items, net | 49,036 | (2,974) | 50,833 | — | 96,895 |
| Net cash used in investing activities | (1,930) | (653,791) | (195,927) | — | (851,648) |
| **Cash flows from financing activities:** | | | | | |
| Long-term debt and related financing costs, net | (54,992) | (6,893) | (2,147) | — | (64,032) |
| Intercompany (payments) borrowing | (37,233) | 98,224 | (60,991) | — | — |
| Other items | (223,511) | (1,432) | (76,203) | — | (301,146) |
| Net cash (used in) provided by financing activities | (315,736) | 89,899 | (139,341) | — | (365,178) |
| Effect of exchange rate changes on cash | — | — | 4,192 | — | 4,192 |
| Net decrease in cash and cash equivalents | (174,948) | (18,684) | (7,558) | — | (201,190) |
| Cash and cash equivalents at beginning of period | 549,921 | 59,192 | 304,074 | — | 913,187 |
| Cash and cash equivalents at end of period | $ 374,973 | $ 40,508 | $ 296,516 | $ — | $ 711,997 |

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

| For The Six Months Ended June 30, 2016 | DaVita Inc. | Guarantor subsidiaries | Non-Guarantor subsidiaries | Consolidating adjustments | Consolidated total |
|---|---|---|---|---|---|
| **Cash flows from operating activities:** | | | | | |
| Net income | $ 150,816 | $ 106,352 | $ 290,603 | $ (315,109) | $ 232,662 |
| Changes in operating assets and liabilities and non-cash items included in net income | (1,505) | 219,697 | 179,676 | 315,109 | 712,977 |
| Net cash provided by operating activities | 149,311 | 326,049 | 470,279 | — | 945,639 |
| **Cash flows from investing activities:** | | | | | |
| Additions of property and equipment, net | (42,266) | (171,164) | (145,197) | — | (358,627) |
| Acquisitions | — | (462,592) | (10,722) | — | (473,314) |
| Proceeds from asset and business sales | — | 17,393 | — | — | 17,393 |
| Proceeds (purchases) from investment sales and other items, net | 21,230 | (10,869) | 45,958 | — | 56,319 |
| Net cash used in investing activities | (21,036) | (627,232) | (109,961) | — | (758,229) |
| **Cash flows from financing activities:** | | | | | |
| Long-term debt and related financing costs, net | (42,493) | (13,917) | (4,823) | — | (61,233) |
| Intercompany borrowing (payments) | 11,208 | 247,765 | (258,973) | — | — |
| Other items | (255,032) | (6,253) | (81,036) | — | (342,321) |
| Net cash (used in) provided by financing activities | (286,317) | 227,595 | (344,832) | — | (403,554) |
| Effect of exchange rate changes on cash | — | — | 444 | — | 444 |
| Net (decrease) increase in cash and cash equivalents | (158,042) | (73,588) | 15,930 | — | (215,700) |
| Cash and cash equivalents at beginning of period | 1,186,636 | 109,357 | 203,123 | — | 1,499,116 |
| Cash and cash equivalents at end of period | $ 1,028,594 | $ 35,769 | $ 219,053 | $ — | $ 1,283,416 |

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

## 22. Supplemental data

The following information is presented as supplemental data as required by the indentures governing the Company's senior notes.

**Condensed Consolidating Statements of Income**

| For The Six Months Ended June 30, 2017 | Consolidated Total | Physician Groups | Unrestricted Subsidiaries | Company and Restricted Subsidiaries[1] |
|---|---|---|---|---|
| Patient service operating revenues | $ 5,283,845 | $ 273,017 | $ — | $ 5,010,828 |
| Less: Provision for uncollectible accounts | (228,468) | (7,351) | — | (221,117) |
| Net patient service operating revenues | 5,055,377 | 265,666 | — | 4,789,711 |
| Capitated revenues | 1,940,114 | 785,139 | — | 1,154,975 |
| Other revenues | 579,269 | 19,596 | — | 559,673 |
| Total net operating revenues | 7,574,760 | 1,070,401 | — | 6,504,359 |
| Operating expenses | 6,308,208 | 1,032,529 | (232) | 5,275,911 |
| Operating income | 1,266,552 | 37,872 | 232 | 1,228,448 |
| Debt expense, including refinancing charges | (212,391) | (3,323) | — | (209,068) |
| Other income | 9,496 | 151 | — | 9,345 |
| Income tax expense | 401,747 | 32,700 | 93 | 368,954 |
| Net income | 661,910 | 2,000 | 139 | 659,771 |
| Less: Net income attributable to noncontrolling interests | (87,212) | — | — | (87,212) |
| Net income attributable to DaVita Inc. | $ 574,698 | $ 2,000 | $ 139 | $ 572,559 |

(1) After elimination of the unrestricted subsidiaries and the physician groups.

**Condensed Consolidating Statements of Comprehensive Income**

| For The Six Months Ended June 30, 2017 | Consolidated Total | Physician Groups | Unrestricted Subsidiaries | Company and Restricted Subsidiaries[1] |
|---|---|---|---|---|
| Net income | $ 661,910 | $ 2,000 | $ 139 | $ 659,771 |
| Other comprehensive income | 62,333 | — | — | 62,333 |
| Total comprehensive income | 724,243 | 2,000 | 139 | 722,104 |
| Less: Comprehensive income attributable to the noncontrolling interests | (87,210) | — | — | (87,210) |
| Comprehensive income attributable to DaVita Inc. | $ 637,033 | $ 2,000 | $ 139 | $ 634,894 |

(1) After elimination of the unrestricted subsidiaries and the physician groups.

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

**Condensed Consolidating Balance Sheets**

| As of June 30, 2017 | Consolidated Total | Physician Groups | Unrestricted Subsidiaries | Company and Restricted Subsidiaries[1] |
|---|---|---|---|---|
| Cash and cash equivalents | $ 711,997 | $ 107,232 | $ — | $ 604,765 |
| Accounts receivable, net | 2,053,812 | 213,804 | — | 1,840,008 |
| Other current assets | 1,257,959 | 13,679 | — | 1,244,280 |
| Total current assets | 4,023,768 | 334,715 | — | 3,689,053 |
| Property and equipment, net | 3,248,030 | 3,368 | — | 3,244,662 |
| Amortizable intangibles, net | 1,462,894 | 4,553 | — | 1,458,341 |
| Other long-term assets | 717,301 | 82,477 | 2,946 | 631,878 |
| Goodwill | 9,889,791 | 29,865 | — | 9,859,926 |
| Total assets | $ 19,341,784 | $ 454,978 | $ 2,946 | $ 18,883,860 |
| Current liabilities | $ 2,773,325 | $ 178,259 | $ — | $ 2,595,066 |
| Payables to parent | — | 114,038 | 2,946 | (116,984) |
| Long-term debt and other long-term liabilities | 10,286,859 | 55,870 | — | 10,230,989 |
| Noncontrolling interests subject to put provisions | 1,009,704 | — | — | 1,009,704 |
| Total DaVita Inc. shareholders' equity | 5,084,314 | 106,811 | — | 4,977,503 |
| Noncontrolling interests not subject to put provisions | 187,582 | — | — | 187,582 |
| Shareholders' equity | 5,271,896 | 106,811 | — | 5,165,085 |
| Total liabilities and shareholder's equity | $ 19,341,784 | $ 454,978 | $ 2,946 | $ 18,883,860 |

(1) After elimination of the unrestricted subsidiaries and the physician groups.

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

**Condensed Consolidating Statements of Cash Flows**

| For The Six Months Ended June 30, 2017 | Consolidated Total | Physician Groups | Unrestricted Subsidiaries | Company and Restricted Subsidiaries[1] |
|---|---|---|---|---|
| **Cash flows from operating activities:** | | | | |
| Net income | $ 661,910 | $ 2,000 | $ 139 | $ 659,771 |
| Changes in operating and intercompany assets and liabilities and non-cash items included in net income | 349,534 | (37,812) | (139) | 387,485 |
| Net cash provided by (used in) operating activities | 1,011,444 | (35,812) | — | 1,047,256 |
| **Cash flows from investing activities:** | | | | |
| Additions of property and equipment | (398,940) | (5,603) | — | (393,337) |
| Acquisitions and divestitures, net | (619,839) | — | — | (619,839) |
| Proceeds from discontinued operations | 70,236 | — | — | 70,236 |
| Investments and other items | 96,895 | (1,386) | — | 98,281 |
| Net cash used in investing activities | (851,648) | (6,989) | — | (844,659) |
| **Cash flows from financing activities:** | | | | |
| Long-term debt | (64,032) | — | — | (64,032) |
| Intercompany | — | 45,342 | — | (45,342) |
| Other items | (301,146) | — | — | (301,146) |
| Net cash (used in) provided by financing activities | (365,178) | 45,342 | — | (410,520) |
| Effect of exchange rate changes on cash | 4,192 | — | — | 4,192 |
| Net (decrease) increase in cash | (201,190) | 2,541 | — | (203,731) |
| Cash and cash equivalents at beginning of period | 913,187 | 104,691 | — | 808,496 |
| Cash and cash equivalents at end of period | $ 711,997 | $ 107,232 | $ — | $ 604,765 |

(1) After elimination of the unrestricted subsidiaries and the physician groups.

**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 contains statements that are forward-looking statements within the meaning of the federal securities laws. All statements that do not concern historical facts are forward-looking statements and include, among other things, statements about our expectations, beliefs, intentions and/or strategies for the future. Without limiting the foregoing, statements including the words "expect," "will," "plan," "anticipate," "believe," "forecast," "guidance," "outlook," "goals," and similar expressions are intended to identify forward-looking statements. These forward-looking statements may include statements regarding our future operations, financial condition and prospects, such as expectations for treatment growth rates, revenue per treatment, expense growth, levels of the provision for uncollectible accounts receivable, operating income, cash flow, operating cash flow, estimated tax rates, estimated charges and accruals, capital expenditures, the development of new dialysis centers and dialysis center acquisitions, government and commercial payment rates, revenue estimating risk and the impact of our level of indebtedness on our financial performance, and including earnings per share. These statements involve substantial known and unknown risks and uncertainties that could cause our actual results to differ materially from those described in the forward-looking statements, including risks resulting from the concentration of profits generated by higher-paying commercial payor plans for which there is continued downward pressure on average realized payment rates, and a reduction in the number of patients under such plans, which may result in the loss of revenues or patients; the extent to which the ongoing implementation of healthcare exchanges or changes in or new legislation, regulations or guidance, or enforcement thereof, including among other things those regarding the exchanges, results in a reduction in reimbursement rates for our services from and/or the number of patients enrolled in higher-paying commercial plans; a reduction in government payment rates under the Medicare End Stage Renal Disease program or other government-based programs; the impact of the Medicare Advantage benchmark structure; risks arising from potential and proposed federal and/or state legislation or regulation, including healthcare-related and labor-related legislation or regulation, that could have a material adverse effect on our operations and profitability; the impact of the 2016 Congressional and Presidential elections and subsequent developments in 2017 on the current health care marketplace and on our business, including with respect to the future of the Affordable Care Act, the exchanges and many other core aspects of the current health care marketplace; 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 the provisions of our current Corporate Integrity Agreement (CIA) and current or potential investigations by various government entities and related government or private-party proceedings, and restrictions on our business and operations required by our corporate integrity agreement and other current or potential settlement terms, and the financial impact thereof and our ability to recover any losses related to such legal matters from third parties; continued increased competition from large- and medium-sized dialysis providers that compete directly with us; our ability to reduce administrative expenses while maintaining targeted levels of service and operating performance; our ability to maintain contracts with physician medical directors, changing affiliation models for physicians, and the emergence of new models of care introduced by the government or private sector, that may erode our patient base and reimbursement rates, such as accountable care organizations (ACOs), independent practice associations (IPAs) and integrated delivery systems; our ability to complete acquisitions, mergers or dispositions that we might be considering or announce, or to integrate and successfully operate any business we may acquire or have acquired, including DaVita Medical Group (DMG), or to successfully expand our operations and services to markets outside the United States, or to businesses outside of dialysis and DMG's business; noncompliance by us or our business associates with any privacy laws or any security breach involving the misappropriation, loss or other unauthorized use or disclosure of confidential information; the variability of our cash flows; the risk that we might invest material amounts of capital and incur significant costs in connection with the growth and development of our international operations, yet we might not be able to operate them profitably anytime soon, if at all; risks arising from the use of accounting estimates, judgments and interpretations in our financial statements; impairment of our goodwill or other intangible assets; the risk that laws regulating the corporate practice of medicine could restrict the manner in which DMG conducts its business; the risk that the cost of providing services under DMG's agreements may exceed our compensation; the risk that reductions in reimbursement rates, including Medicare Advantage rates, and future regulations may negatively impact DMG's business, revenue and profitability; the risk that DMG may not be able to successfully establish a presence in new geographic regions or successfully address competitive threats that could reduce its profitability; the risk that a disruption in DMG's healthcare provider networks could have an adverse effect on DMG's business operations and profitability; the risk that reductions in the quality ratings of health maintenance organization plan customers of DMG could have an adverse effect on DMG's business; the risk that health plans that acquire health maintenance organizations may not be willing to contract with DMG or may be willing to contract only on less favorable terms; and the other risk factors set forth in Part 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 operate two major divisions, DaVita Kidney Care (Kidney Care) and DaVita Medical Group (DMG, formerly known as HealthCare Partners or HCP). Our Kidney Care division is comprised of our U.S. dialysis and related lab services business, our ancillary services and strategic initiatives, including our international dialysis operations, and our corporate administrative support. Our DMG division is comprised of our U.S. integrated healthcare business.

Our largest major line of business is our U.S. dialysis and related lab services, which is a leading provider of kidney dialysis services in the U.S. for patients suffering from ESRD. Our other major line of business, DMG, is a patient- and physician-focused integrated health care delivery and management company. All references to dialysis and related lab services refer only to U.S. dialysis and related lab services business.

The following is a summary of our consolidated operating results for the second quarter of 2017 compared with the prior sequential quarter and the same quarter of 2016, as well as the six months ended June 30, 2017 compared to the same period in 2016.

| | Three months ended | | | | | | Six months ended | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | June 30, 2017 | | March 31, 2017 | | June 30, 2016 | | June 30, 2017 | | June 30, 2016 | |
| | (dollar amounts rounded to nearest million) | | | | | | | | | |
| Net revenues: | | | | | | | | | | |
| Patient service revenues | $ 2,682 | | $ 2,601 | | $ 2,584 | | $ 5,284 | | $ 5,065 | |
| Less: Provision for uncollectible accounts | (115) | | (113) | | (111) | | (228) | | (220) | |
| Net patient service revenues | 2,567 | | 2,488 | | 2,472 | | 5,055 | | 4,845 | |
| Capitated revenues | 1,022 | | 918 | | 900 | | 1,940 | | 1,788 | |
| Other revenues | 288 | | 291 | | 346 | | 579 | | 666 | |
| Total consolidated net revenues | 3,877 | 100 % | 3,697 | 100 % | 3,718 | 100 % | 7,575 | 100 % | 7,299 | 100 % |
| Operating expenses and charges: | | | | | | | | | | |
| Patient care costs | 2,860 | 74 % | 2,723 | 73 % | 2,671 | 72 % | 5,583 | 74 % | 5,253 | 72 % |
| General and administrative | 382 | 10 % | 392 | 11 % | 387 | 10 % | 774 | 10 % | 774 | 11 % |
| Depreciation and amortization | 200 | 5 % | 190 | 5 % | 180 | 5 % | 390 | 5 % | 350 | 5 % |
| Provision for uncollectible accounts | (1) | — % | 2 | — % | 4 | — % | 1 | — % | 6 | — % |
| Equity investment (income) | (4) | — % | (4) | — % | 1 | — % | (8) | — % | (1) | — % |
| Goodwill and asset impairment charges | 61 | 2 % | 39 | 1 % | 176 | 5 % | 100 | 1 % | 253 | 3 % |
| Gain on changes in ownership interests, net | — | — % | (6) | — % | (30) | (1)% | (6) | — % | (30) | — % |
| Gain on settlement, net | — | — % | (527) | (14)% | — | — % | (527) | (7)% | — | — % |
| Total operating expenses and charges | 3,499 | 90 % | 2,809 | 76 % | 3,389 | 91 % | 6,308 | 83 % | 6,605 | 91 % |
| Operating income | $ 378 | 10 % | $ 888 | 24 % | $ 329 | 9 % | $ 1,267 | 17 % | $ 694 | 9 % |

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

The following table summarizes consolidated net revenues for our Kidney Care division and our DMG division:

| | Three months ended | | | Six months ended | |
|---|---|---|---|---|---|
| | June 30, 2017 | March 31, 2017 | June 30, 2016 | June 30, 2017 | June 30, 2016 |
| | (dollar amounts rounded to nearest million) | | | | |
| Net revenues: | | | | | |
| Kidney Care: | | | | | |
| U.S. dialysis and related lab services patient service revenues | $ 2,430 | $ 2,373 | $ 2,367 | $ 4,802 | $ 4,695 |
| Less: Provision for uncollectible accounts | (109) | (107) | (107) | (216) | (211) |
| U.S. dialysis and related lab services net patient service revenues | 2,320 | 2,266 | 2,260 | 4,586 | 4,484 |
| Other revenues | 5 | 5 | 4 | 10 | 8 |
| Total net U.S. dialysis and related lab services revenues | 2,325 | 2,271 | 2,264 | 4,596 | 4,492 |
| Other—Ancillary services and strategic initiatives | 274 | 283 | 340 | 556 | 658 |
| Other—Capitated revenues | 36 | 28 | 26 | 65 | 48 |
| Other—Ancillary services and strategic initiatives net patient service revenues (less provision for uncollectible accounts) | 84 | 67 | 57 | 151 | 108 |
| Total net other-ancillary services and strategic initiatives revenues | 394 | 378 | 423 | 772 | 814 |
| Eliminations within Kidney Care | (19) | (18) | (12) | (38) | (23) |
| Total Kidney Care net revenues | 2,699 | 2,631 | 2,675 | 5,331 | 5,283 |
| DMG: | | | | | |
| DMG capitated revenues | 987 | 890 | 874 | 1,877 | 1,740 |
| DMG net patient service revenues (less provision for uncollectible accounts) | 190 | 179 | 169 | 369 | 282 |
| Other revenues | 19 | 18 | 17 | 37 | 26 |
| Total DMG net revenues | 1,196 | 1,087 | 1,060 | 2,283 | 2,048 |
| Eliminations between Kidney Care and DMG | (18) | (21) | (17) | (39) | (32) |
| Total consolidated net revenues | $ 3,877 | $ 3,697 | $ 3,718 | $ 7,575 | $ 7,299 |

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

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

| | Three months ended | | | Six months ended | |
|---|---|---|---|---|---|
| | June 30, 2017 | March 31, 2017 | June 30, 2016 | June 30, 2017 | June 30, 2016 |
| | (dollar amounts rounded to nearest million) | | | | |
| Operating income (loss): | | | | | |
| Kidney Care: | | | | | |
| U.S. dialysis and related lab services | $ 450 | $ 945 | $ 449 | $ 1,395 | $ 889 |
| Other—Ancillary services and strategic initiatives | | | | | |
| U.S. ancillary services and strategic initiatives | (36) | (53) | — | (89) | (1) |
| International | (13) | (5) | (13) | (18) | (23) |
| | (48) | (58) | (13) | (106) | (24) |
| Corporate administrative support | (11) | (11) | (5) | (22) | (12) |
| Total Kidney Care | 391 | 876 | 431 | 1,267 | 853 |
| DMG | (13) | 12 | (102) | (1) | (159) |
| Total consolidated operating income | 378 | 888 | 329 | 1,267 | 694 |
| Reconciliation of non-GAAP measures: | | | | | |
| Goodwill impairment charges | 61 | 24 | 176 | 85 | 253 |
| Impairment of assets | — | 15 | — | 15 | — |
| Gain on settlement, net | — | (527) | — | (527) | — |
| Equity investment income related to gain on settlement | — | (3) | — | (3) | — |
| Gain on APAC JV ownership changes | — | (6) | — | (6) | — |
| Accruals for legal matters | (4) | — | — | (4) | 16 |
| Gain on sale of Tandigm ownership interests | — | — | (40) | — | (40) |
| Loss on sale of DMG Arizona | — | — | 10 | — | 10 |
| Adjusted consolidated operating income[(1)] | $ 436 | $ 392 | $ 475 | $ 828 | $ 933 |

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

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

*Consolidated net revenues*

Consolidated net revenues for the second quarter of 2017 increased by approximately $180 million, or 4.9%, as compared to the first quarter of 2017. The increase in consolidated net revenues was primarily due to an increase of approximately $54 million in U.S. dialysis and related lab services' net revenues, primarily as a result of higher volume from acquired and non-acquired treatment growth and one additional treatment day during the three months ended June 30, 2017, partially offset by a decrease in our average revenue per treatment of approximately $3, as discussed below. Consolidated net revenues benefited from an increase of $109 million in DMG net revenues. The increase in DMG revenues was primarily driven by the conversion of existing contracts from shared risk to global risk, an increase in senior capitated revenues, and an increase in fee-for-service (FFS) revenues from acquired and non-acquired growth, as described below. In addition, consolidated net revenues was positively impacted by an increase of $16 million in our ancillary and strategic initiatives net revenues, primarily related to growth in our international operations.

Consolidated net revenues for the second quarter of 2017 increased by approximately $159 million, or 4.3%, as compared to the second quarter of 2016. The increase in consolidated net revenues was due to an increase of $61 million in U.S. dialysis and related lab services' net revenues, primarily as a result of higher volume from acquired and non-acquired

treatment growth, partially offset by a decrease in our average dialysis revenue per treatment of approximately $6, as discussed below. The increase in consolidated net revenues also resulted from an increase in DMG net revenues of $136 million, primarily due to the conversion of existing contracts from shared risk to global risk, acquisition-related growth, and an increase in senior capitated revenues, as described below. Consolidated net revenues were negatively impacted by a decrease of approximately $29 million in our ancillary services and strategic initiatives net revenues, primarily due to a decrease in volume in our pharmaceutical business, partially offset by an increase in VillageHealth special needs plans revenues, and growth in our international operations.

Consolidated net revenues for the six months ended June 30, 2017 increased by approximately $276 million, or 3.8%, as compared to the same period in 2016. The increase in consolidated net revenues was due to an increase of $104 million in U.S. dialysis and related lab services' net revenues, primarily as a result of higher volume from acquired and non-acquired treatment growth, partially offset by a decrease in our average dialysis revenue per treatment of approximately $4, as discussed below. The increase in consolidated net revenues also resulted from an increase in DMG net revenues of $235 million, primarily due to the conversion of existing contracts from shared risk to global risk, acquisition-related growth, and an increase in senior capitated revenues, as described below. Consolidated net revenues were negatively impacted by a decrease of approximately $42 million in our ancillary services and strategic initiatives net revenues, primarily due to a decrease in volume in our pharmaceutical business, partially offset by an increase in VillageHealth special needs plans revenues, and growth in our international operations.

*Consolidated operating income*

Consolidated operating income for the second quarter of 2017, which includes goodwill impairment charges of $10 million related to our vascular access reporting unit and $51 million related to our DMG reporting units, as well as a reduction in estimated accruals for legal matters of $4 million, as discussed below, decreased by approximately $510 million as compared to the first quarter of 2017, which included an adjustment to the gain on the APAC JV ownership change of $6 million, a net gain on settlement of $530 million, a goodwill impairment charge of $24 million related to our vascular access reporting unit, and an asset impairment of $15 million related to the restructuring of our pharmacy business, as discussed below. Excluding these items from their respective quarters, adjusted consolidated operating income for the second quarter of 2017 increased by $44 million. Adjusted consolidated operating income increased due to an increase in adjusted operating income in U.S. dialysis and related lab services of $35 million, an increase in adjusted operating income of $22 million related to DMG and an increase in adjusted operating losses in our ancillary and strategic initiatives of $13 million, as described below.

Consolidated operating income for the second quarter of 2017, which includes goodwill impairment charges of $10 million related to our vascular access reporting unit and $51 million related to our DMG reporting units, as well as a reduction in estimated accruals for legal matters of $4 million, as discussed below, increased by $49 million as compared to the second quarter in 2016, which included goodwill impairment charges of $176 million related to certain DMG reporting units, a gain related to the partial sale of our interest in Tandigm of $40 million, and a loss on the DMG Arizona sale of $10 million. Excluding these items from their respective quarters, adjusted consolidated operating income for the second quarter of 2017 decreased by $39 million. Adjusted consolidated operating income decreased due to a decrease in adjusted operating income of $10 million related to DMG and an increase in adjusted operating losses in our ancillary and strategic initiatives of $25 million, partially offset by an increase in operating income in U.S. dialysis and related lab services of $1 million, as described below.

Consolidated operating income for the six months ended June 30, 2017, which includes a gain on the APAC JV ownership change of $6 million, a net gain on settlement of $530 million, goodwill impairment charges of $35 million related to our vascular access reporting unit and $51 million related to our DMG reporting units, a reduction in estimated accruals for legal matters of $4 million, and an asset impairment of $15 million related to the restructuring of our pharmacy business, as discussed below, increased by $573 million as compared to the same period in 2016, which included goodwill impairment charges of $253 million related to certain DMG reporting units, a gain related to the partial sale of our interest in Tandigm of $40 million, a loss on the DMG Arizona sale of $10 million, and estimated accruals for legal matters of $16 million. Excluding these items from their respective periods, adjusted consolidated operating income for the six months ended June 30, 2017 decreased by $105 million. Adjusted consolidated operating income decreased due to a decrease in adjusted operating income in U.S. dialysis and related lab services of $24 million, a decrease in adjusted operating income of $34 million related to DMG and an increase in adjusted operating losses in our ancillary and strategic initiatives of $38 million, as described below.

***U.S. dialysis and related lab services business***

***Results of operations***

| | Three months ended | | | Six months ended | |
|---|---|---|---|---|---|
| | June 30, 2017 | March 31, 2017 | June 30, 2016 | June 30, 2017 | June 30, 2016 |
| | (dollar amounts rounded to nearest million, except per treatment data) | | | | |
| Net revenues: | | | | | |
| Dialysis and related lab services patient service revenues | $ 2,430 | $ 2,373 | $ 2,367 | $ 4,802 | $ 4,695 |
| Less: Provision for uncollectible accounts | (109) | (107) | (107) | (216) | (211) |
| Dialysis and related lab services net patient service revenues | 2,320 | 2,266 | 2,260 | 4,586 | 4,484 |
| Other revenues | 5 | 5 | 4 | 10 | 8 |
| Total net dialysis and related lab services revenues | 2,325 | 2,271 | 2,264 | 4,596 | 4,492 |
| Operating expenses and charges: | | | | | |
| Patient care costs | 1,561 | 1,548 | 1,515 | 3,109 | 3,012 |
| General and administrative | 189 | 188 | 185 | 377 | 364 |
| Depreciation and amortization | 130 | 125 | 119 | 255 | 236 |
| Equity investment income | (5) | (8) | (4) | (13) | (9) |
| Gain on settlement, net | — | (527) | — | (527) | — |
| Total operating expenses and charges | 1,875 | 1,326 | 1,815 | 3,201 | 3,603 |
| Operating income | 450 | 945 | 449 | 1,395 | 889 |
| Reconciliation of non-GAAP measures: | | | | | |
| Gain on settlement, net | — | (527) | — | (527) | — |
| Equity investment income related to gain on settlement | — | (3) | — | (3) | — |
| Adjusted operating income[(1)] | $ 450 | $ 415 | $ 449 | $ 865 | $ 889 |
| Dialysis treatments | 7,035,894 | 6,804,384 | 6,745,610 | 13,840,278 | 13,385,484 |
| Average dialysis treatments per treatment day | 90,204 | 88,369 | 86,482 | 89,292 | 85,859 |
| Average dialysis and related lab services revenue per treatment | $ 345 | $ 349 | $ 351 | $ 347 | $ 351 |

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

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

*Net revenues*

Dialysis and related lab services' net revenues for the second quarter of 2017 increased by approximately $54 million, or 2.4%, as compared to the first quarter of 2017. The increase in dialysis and related lab services' net revenues was due to an increase in the number of treatments, partially offset by a decrease in our average revenue per treatment of approximately $3. The increase in the number of treatments was primarily due to acquired and non-acquired treatment growth, including the acquisition of Renal Ventures Management, LLC (Renal Ventures) which was completed on May 1, 2017, as well as one additional treatment day during the three months ended June 30, 2017 as compared to the prior quarter. The decrease in our average dialysis revenue per treatment was primarily due to a revenue adjustment taken in the first quarter of 2017 that did not reoccur in the second quarter of 2017 and lower acute treatment volume.

Dialysis and related lab services' net revenues for the second quarter of 2017 increased by approximately $61 million, or 2.7%, as compared to the second quarter of 2016. The increase in net revenues was principally due to volume growth from

additional treatments, partially offset by a decrease in our average dialysis revenue per treatment of approximately $6. The increase in the number of treatments was primarily attributable to acquired and non-acquired treatment growth including the acquisition of Renal Ventures. The decrease in our average dialysis revenue per treatment was primarily due to a decline in commercial mix, including exchange patients.

Dialysis and related lab services' net revenues for the six months ended June 30, 2017 increased by approximately $104 million, or 2.3%, as compared to the same period in 2016. The increase in net revenues was principally due to volume growth from additional treatments, partially offset by a decrease in our average dialysis revenue per treatment of approximately $4. The increase in the number of treatments was primarily attributable to acquired and non-acquired treatment growth including the acquisition of Renal Ventures, partially offset by one less treatment day during the six months ended June 30, 2017, as compared to the same period in 2016. The decrease in our average dialysis revenue per treatment was primarily due to a decline in commercial mix, including exchange patients.

*Provision for uncollectible accounts.* The provision for uncollectible accounts receivable for dialysis and related lab services was 4.5% for the first and second quarters of 2017 and the second quarter of 2016. Based upon our historical cash collection experience and trends, we assess the provision for uncollectible accounts and adjust the provision as necessary as a result of changes in our cash collections.

*Operating expenses and charges*

*Patient care costs.* Dialysis and related lab services' patient care costs of approximately $222 per treatment for the second quarter of 2017 decreased by approximately $6 per treatment as compared to the first quarter of 2017. The decrease was primarily attributable to a decrease in pharmaceutical costs due to a price reduction, as well as a decrease in pharmaceutical intensity, a decrease in labor and benefits costs due to an increase in productivity, a decrease in professional fees, and a decrease in other direct operating expenses associated with our dialysis centers. These decreases were partially offset by an increase in travel expenses related to annual management meetings.

Dialysis and related lab services' patient care costs per treatment for the second quarter of 2017 decreased by approximately $3 per treatment as compared to the second quarter of 2016. The decrease was primarily attributable to a decrease in pharmaceutical costs, as discussed above, and a decrease in profit sharing expense, partially offset by an increase in labor and benefits costs and an increase in other direct operating expenses associated with our dialysis centers.

Dialysis and related lab services' patient care costs per treatment for the six months ended June 30, 2017 was relatively flat as compared to the same period in 2016. Pharmaceutical costs decreased, as well as profit sharing expense, offset by an increase in labor and benefits costs and an increase in other direct operating expenses associated with our dialysis centers.

*General and administrative expenses.* Dialysis and related lab services' general and administrative expenses of approximately $189 million in the second quarter of 2017 increased by approximately $1 million as compared to the first quarter of 2017. The increase in general and administrative expenses was primarily due to increases in consulting and legal costs, an increase in travel due to management meetings, and an increase in asset impairments related to expected center closures. These increases were partially offset by a decrease in labor and benefits costs and a decrease in long-term incentive compensation expense.

Dialysis and related lab services' general and administrative expenses for the second quarter of 2017 increased by approximately $4 million as compared to the second quarter of 2016. This was primarily due to increases in labor and benefits costs, occupancy costs, professional fees, travel due to management meetings and an increase in asset impairments related to expected center closures, partially offset by a decrease in long-term incentive compensation expense and profit sharing expense.

Dialysis and related lab services' general and administrative expenses for the six months ended June 30, 2017 increased by approximately $13 million as compared to the same period in 2016. This increase was primarily due to increases in labor and benefits costs, occupancy costs, legal and consulting costs, and asset impairments related to expected center closures, partially offset by a decrease in long-term incentive compensation and profit sharing expense.

*Depreciation and amortization.* Depreciation and amortization for dialysis and related lab services was approximately $130 million for the second quarter of 2017, $125 million for the first quarter of 2017, and $119 million for the second quarter of 2016. The increase in depreciation and amortization in the second quarter of 2017, as compared to the first quarter of 2017 and the second quarter of 2016, was primarily due to growth in newly developed centers and from acquired centers, as well as technology investments in our clinical network.

*Equity investment income.* Equity investment income for dialysis and related lab services was approximately $5 million for the second quarter of 2017, $8 million for the first quarter of 2017, and $4 million for the second quarter of 2016. Equity investment income in the second quarter of 2017 decreased by approximately $3 million as compared to the first quarter of 2017 primarily due to the equity investment income recognized related to the gain on settlement with the U.S. Department of Veterans Affairs (VA) of approximately $3 million in the first quarter of 2017. Equity investment income in the second quarter of 2017 increased by approximately $1 million as compared to the same period in 2016 primarily due to an increase in profitability of certain joint ventures.

*Gain on settlement, net.* During the first quarter of 2017, we reached an agreement with the government for amounts owed to us for dialysis services provided from 2005 through 2011 to patients covered by the VA. As a result of this settlement we recognized a one-time net gain of $527 million.

*Accounts receivable*

Our dialysis and related lab services' accounts receivable balances, net of the provision for uncollectible accounts, were $1.420 billion and $1.335 billion at June 30, 2017 and March 31, 2017, respectively, which represented approximately 56 days and 54 days, respectively. Our day sales outstanding (DSO) increased over two days as a result of some changes we made in our collection policies and procedures to improve overall collections. Overall, we expect DSO to stay at the current level for the foreseeable future. Our DSO calculation is based on the current quarter's average revenues per day. There were no significant changes during the second quarter of 2017 from the first quarter of 2017 in the amount of unreserved accounts receivable over one year old or the amounts pending approval from third-party payors.

*Segment operating income*

Dialysis and related lab services' operating income for the second quarter of 2017 decreased by approximately $495 million as compared to the first quarter of 2017, which included a net gain on settlement of $530 million. Excluding the net gain on the settlement with the VA, adjusted operating income increased by $35 million. The increase in adjusted operating income was primarily due to an increase in treatments, partially offset by a decrease in our average dialysis revenue per treatment of approximately $3 compared to the prior quarter, as discussed above. Adjusted operating income was also positively impacted by decreases in pharmaceutical costs and intensity, lower labor and benefits costs, a decrease in other direct operating expenses associated with our dialysis centers, and a reduction in long-term incentive compensation expense. Adjusted operating income was negatively impacted by increases in consulting and legal costs, asset impairments related to expected center closures, and an increase in travel due to management meetings, as discussed above.

Dialysis and related lab services' operating income for the second quarter of 2017, increased by approximately $1 million as compared to the second quarter of 2016. This increase in operating income was principally due to volume growth from additional treatments, partially offset by a decrease in our average dialysis revenue per treatment of approximately $6, during the three months ended June 30, 2017, as compared to the three months ended June 30, 2016, as discussed above. Operating income also benefited from a decrease in pharmaceutical costs and intensity, as well as a decrease in profit sharing expense and in long-term incentive compensation expense. Operating income was negatively impacted by an increase in other direct operating expenses associated with our dialysis centers, higher labor and benefits costs, an increase in asset impairments related to expected center closures, and increases in occupancy and legal costs.

Dialysis and related lab services' operating income for the six months ended June 30, 2017, which includes a net gain on settlement with the VA of $530 million, increased by approximately $506 million as compared to the same period in 2016. Excluding the net gain on the settlement, adjusted operating income decreased by $24 million. This decrease in adjusted operating income was due to a decrease in our average dialysis revenue per treatment of approximately $4 and one less treatment day during the six months ended June 30, 2017, as compared to the six months ended June 30, 2016, as discussed above. Adjusted operating income was also negatively impacted by an increase in other direct operating expenses associated with our dialysis centers, higher labor and benefits costs, an increase in asset impairments related to expected center closures, and increases in occupancy and legal costs. Adjusted operating income benefited from an increase in volume growth from additional treatments, a decrease in pharmaceutical costs, as well as a decrease in profit sharing expense and a decrease in long-term incentive compensation expense.

***DMG business***

***Results of operations***

| | Three months ended | | | Six months ended | |
|---|---|---|---|---|---|
| | June 30, 2017 | March 31, 2017 | June 30, 2016 | June 30, 2017 | June 30, 2016 |
| | (dollar amounts rounded to nearest millions) | | | | |
| Net revenues: | | | | | |
| DMG capitated revenue | $ 987 | $ 890 | $ 874 | $ 1,877 | $ 1,740 |
| Patient service revenue | 195 | 185 | 174 | 380 | 290 |
| Less: Provision for uncollectible accounts | (6) | (6) | (4) | (12) | (9) |
| Net patient service revenue | 190 | 179 | 169 | 369 | 282 |
| Other revenues | 19 | 18 | 17 | 37 | 26 |
| Total net revenues | 1,196 | 1,087 | 1,060 | 2,283 | 2,048 |
| Operating expenses: | | | | | |
| Patient care costs | 983 | 892 | 840 | 1,875 | 1,633 |
| General and administrative expense | 120 | 129 | 118 | 248 | 244 |
| Depreciation and amortization | 60 | 57 | 54 | 117 | 100 |
| Goodwill impairment charges | 51 | — | 176 | 51 | 253 |
| Gain on sales of business interests, net | — | — | (30) | — | (30) |
| Equity investment (income) loss | (4) | (3) | 4 | (8) | 7 |
| Total expenses | 1,209 | 1,075 | 1,162 | 2,284 | 2,207 |
| Operating income (loss) | (13) | 12 | (102) | (1) | (159) |
| Reconciliation of non-GAAP: | | | | | |
| Goodwill impairment charges | 51 | — | 176 | 51 | 253 |
| Accruals for legal matters | (4) | — | — | (4) | 16 |
| Gain on sale of Tandigm ownership interests | — | — | (40) | — | (40) |
| Loss on sale of DMG Arizona | — | — | 10 | — | 10 |
| Adjusted operating income[(1)] | $ 34 | $ 12 | $ 44 | $ 46 | $ 80 |

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

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

*Capitated membership information*

The following table provides (i) the total number of capitated members to whom DMG provided healthcare services and (ii) the aggregate member months. Member months represent the aggregate number of months of healthcare services DMG has provided to capitated members during a period of time:

| | Members at | | | Member months for | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | Three months ended | | | Six months ended | |
| | June 30, 2017 | March 31, 2017 | June 30, 2016 | June 30, 2017 | March 31, 2017 | June 30, 2016 | June 30, 2017 | June 30, 2016 |
| Payor classification: | | | | | | | | |
| Senior | 305,600 | 306,600 | 305,400 | 918,200 | 920,200 | 957,400 | 1,838,500 | 1,932,700 |
| Commercial | 323,700 | 329,000 | 345,600 | 983,000 | 995,900 | 1,037,500 | 1,978,900 | 2,086,100 |
| Medicaid | 96,700 | 99,800 | 110,400 | 291,200 | 305,200 | 333,000 | 596,300 | 675,500 |
| | 726,000 | 735,400 | 761,400 | 2,192,400 | 2,221,300 | 2,327,900 | 4,413,700 | 4,694,300 |

Members and member months for the second quarter of 2017 decreased from the first quarter of 2017 primarily due to a decrease in commercial members as employers shift to less expensive options for medical services for their employees, a decline in Medicaid members due to increased competition, and a decline in senior members due to the termination of certain affiliated physician relationships.

Members and member months for the second quarter of 2017 decreased from the second quarter of 2016 primarily due to the decrease in commercial members, as described above, as well as a decrease in senior member months due to the sale of our Arizona business. Members and member months were also impacted by a decline in Medicaid membership due to increased competition, non renewal of certain Medicaid contracts, the termination of affiliates, and the sale of our Georgia operations. These decreases were partially offset by increased senior members resulting from acquired and non-acquired growth.

Members and member months for the six months ended June 30, 2017 decreased from the same period of 2016 due to the changes described above.

In addition to the members above, DMG provided healthcare services to members in two of its nonconsolidated operating joint ventures that are accounted for as equity investments. These joint ventures provided healthcare services for approximately 157,600, 157,000, and 142,600 members as of June 30, 2017, March 31, 2017 and June 30, 2016, respectively, and for approximately 471,600, 465,500, and 427,200 member months for the quarters ended June 30, 2017, March 31, 2017 and June 30, 2016, respectively. The increase in members and member months was due to an increase in enrollment of members related to our Tandigm Health (Tandigm) joint venture.

*Revenues*

The following table summarizes DMG's revenue by source:

| | Three months ended | | | Six months ended | |
|---|---|---|---|---|---|
| | June 30, 2017 | March 31, 2017 | June 30, 2016 | June 30, 2017 | June 30, 2016 |
| | (dollars rounded to nearest millions) | | | | |
| DMG revenues: | | | | | |
| Senior revenues | $ 753 | $ 660 | $ 638 | $ 1,413 | $ 1,286 |
| Commercial revenues | 194 | 188 | 189 | 381 | 361 |
| Medicaid revenues | 41 | 42 | 47 | 83 | 93 |
| Total capitated revenues | 987 | 890 | 874 | 1,877 | 1,740 |
| Patient service revenue, net of provision for uncollectible accounts | 190 | 179 | 169 | 369 | 282 |
| Other revenues | 19 | 18 | 17 | 37 | 26 |
| Total net revenues | $ 1,196 | $ 1,087 | $ 1,060 | $ 2,283 | $ 2,048 |

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

*Net revenues*

DMG's net revenue for the second quarter of 2017 increased by approximately $109 million, or 10.0%, as compared to the first quarter of 2017. The increase in revenues was primarily driven by the conversion in the second quarter of 2017 of additional contracts from shared risk to global risk in California, with an associated change in presentation of both senior and commercial revenues and patient care costs from a net basis to a gross basis. In addition, senior revenues increased due to the timing of shared savings revenue, and patient FFS revenues increased from acquired and non-acquired growth. These increases were partially offset by a decrease in commercial, senior, and Medicaid members to whom DMG provides health care services.

DMG's net revenue for the second quarter of 2017 increased by approximately $136 million, or 12.8%, as compared to the second quarter of 2016, primarily due the conversion of existing contracts from shared risk to global risk, as described above. In addition, FFS revenues and senior revenues increased, also described above. These increases were partially offset by a decrease in commercial risk sharing revenue due to commercial revenue adjustments recognized in the second quarter of 2016, a decrease in senior capitated revenues from the sale of our DMG Arizona business, a decrease in commercial and Medicaid members to whom DMG provides health care services, and a decrease in Medicare Advantage rates.

DMG's net revenue for the six months ended June 30, 2017 increased by approximately $235 million, or 11.5%, as compared to the same period in 2016, primarily due to the conversion of existing contracts from shared risk to global risk in both the first and second quarters of 2017, as described above, an increase in FFS and other revenues due to a full six months of revenue from the acquisition of The Everett Clinic Medical Group (TEC) compared to only four months in the six months ended June 30, 2016, an increase in FFS revenues from other acquired and non-acquired growth, a shift in membership from affiliated to owned, and an increase in senior revenues, as described above. These increases were partially offset by a decrease in senior capitated revenues from the sale of our DMG Arizona business, a decrease in commercial risk sharing revenue, as described above, a decrease in commercial and Medicaid members to whom DMG provides health care services, and a decrease in Medicare Advantage rates.

On April 3, 2017, CMS issued final guidance for 2018 Medicare Advantage benchmark payment rates (the Rate Announcement). Based upon our analysis of the final rule, we estimate that the change in 2018 rates, including adjustments for benchmark county rates, qualifying bonuses, and the Health Insurer Fee, will result in Medicare Advantage rates to DMG that are nearly flat compared to 2017. This compares, according to CMS, to an industry average rate increase of approximately 0.45%. The difference in Medicare Advantage rates for DMG compared to the industry average are largely driven by DMG's higher mix of Medicare Advantage patients in counties that will receive a lower-than-average benchmark rate increase.

*Operating expenses*

*Patient care costs.* DMG's patient care costs of approximately $983 million for the second quarter of 2017 increased by approximately $91 million as compared to the first quarter of 2017, primarily due to the conversion of additional existing contracts in the second quarter of 2017 from shared risk to global risk, which is associated with a change in presentation of both revenues and expenses from a net basis to a gross basis, the true-up of risk share arrangements, and other acquired and non-acquired growth. The increase in costs was partially offset by a decrease in utilization and a decrease in commercial, senior, and Medicaid members to whom DMG provides healthcare services.

DMG's patient care costs for the second quarter of 2017 increased by approximately $143 million as compared to the second quarter of 2016, primarily due to the contract conversion to global risk, as described above, an increase in utilization, an increase in labor costs, and an increase in costs due to acquired and non-acquired growth. This increase in costs was partially offset by a decrease due to a full quarter without our DMG Arizona business and a decrease in commercial and Medicaid members to whom DMG provides healthcare services.

DMG's patient care costs for the six months ended June 30, 2017 increased by approximately $242 million as compared to the same period in 2016, primarily due to the contract conversion to global risk, as described above, a full six months of operations from TEC compared to only four months in the six months ended June 30, 2016, an increase in utilization, an increase in labor costs, and an increase in costs due to acquired and non-acquired growth. This increase in costs was partially offset by the true-up of risk share arrangements, a decrease due to a full six months without our DMG Arizona business, and a decrease in commercial and Medicaid members to whom DMG provides healthcare services.

*General and administrative expenses.* DMG's general and administrative expenses of approximately $120 million for the second quarter of 2017, which includes a reduction in estimated accruals for legal matters of $4 million, decreased by approximately $9 million as compared to the first quarter of 2017. Excluding this item from the second quarter of 2017, adjusted general and administrative expenses decreased by $5 million. The decrease was primarily attributable to decreased

professional and legal fees and decreased labor costs due to payroll taxes and headcount, offset by an increase due to acquired growth.

DMG's general and administrative expenses for the second quarter of 2017, which includes a reduction in estimated accruals for legal matters of $4 million, increased by $2 million as compared to the second quarter of 2016. Excluding this item from the second quarter of 2016, adjusted general and administrative expenses increased by $6 million. The increase was primarily attributable to acquisition-related growth and an increase in corporate administrative support expenses due to increased labor costs and costs associated with growth initiatives, offset by a decrease in legal fees.

DMG's general and administrative expenses for the six months ended June 30, 2017, which includes a reduction in estimated accruals for legal matters of $4 million in the second quarter of 2017 increased by $4 million as compared to the same period in 2016, which included an estimated accrual for legal matters of $16 million in the first quarter of 2016. Excluding these items from their respective periods, adjusted general and administrative expenses increased by $24 million. This is primarily attributable to an increase in corporate administrative support expenses due to increased labor costs and costs associated with growth initiatives, a full six months of operations from the TEC acquisition, compared to only four months in the six months ended June 30, 2016, and other acquisition-related growth, offset by a decrease in legal fees.

*Depreciation and amortization.* DMG's depreciation and amortization was approximately $60 million for the second quarter of 2017, $57 million for the first quarter of 2017 and $54 million for the second quarter of 2016. As of September 1, 2016, we committed to a plan to change HCP-related trade names to DMG. As a result of this decision we began to accelerate the amortization of the remaining carrying value of HCP-related trade names, which will continue through the first quarter of 2019, the remaining expected life of this asset.

Depreciation and amortization increased by approximately $3 million as compared to the first quarter of 2017 due to an increase in technology and property investments as part of our growth initiatives. Depreciation and amortization increased approximately $6 million as compared to the second quarter of 2016, due to an increase in amortization related to the acceleration of the HCP-related trade names of approximately $7 million and an increase in technology and property investments as part of our growth initiatives, offset by amortization adjustments in the second quarter of 2016.

*Equity investment (income) losses.* DMG's equity investment income was approximately $4 million for the second quarter of 2017, $3 million for the first quarter of 2017, and a $4 million loss for the second quarter of 2016. The increase from the first quarter of 2017 was primarily attributable to an increase in profitability of certain joint ventures. The increase from the second quarter of 2016 was due to an increase in profitability of certain joint ventures, as well as the sale of our Fullwell minority ownership interest during the fourth quarter of 2016, which resulted in a reduced share of equity investment losses from this investment.

*Goodwill impairment charges.* During the second quarter of 2017, we recognized goodwill impairment charges of $50 million at our DMG Florida reporting unit and $1 million at our DMG New Mexico reporting unit. These charges resulted primarily from changes in expectations concerning government reimbursement, including the effect of Medicare Advantage final benchmark payment rates for 2018 announced on April 3, 2017 and our expected ability to mitigate them, as well as medical cost and utilization trends.

We did not recognize any goodwill impairments at our DMG reporting units during the first quarter of 2017.

During the three and six months ended June 30, 2016, we recognized goodwill impairment charges for certain DMG reporting units of $176 million and $253 million, respectively. These charges resulted primarily from then-continuing developments in our DMG business, including the Medicare Advantage final benchmark rates for 2017 announced on April 4, 2016, further changes in our expectations concerning future government reimbursement rates and our expected ability to mitigate them, as well as medical cost and utilization trends, underperformance of at-risk reporting units and other market conditions.

*Gain on sales of business interests.* Effective June 30, 2016, we sold a portion of DMG's ownership interest in Tandigm, reducing our ownership from 50% to 19% and resulting in a pre-tax gain of $40 million. In addition, on June 1, 2016, we sold our DMG Arizona business for a pre-tax loss of $10 million.

*Segment operating income*

DMG's operating results for the second quarter of 2017, which includes goodwill impairment charges of $51 million and a reduction in estimated accruals for legal matters of $4 million, decreased by approximately $25 million as compared to the first quarter of 2017. Excluding these items, DMG adjusted operating income increased by $22 million compared to the first

quarter of 2017. The increase in DMG adjusted operating income was primarily due to a decrease in utilization throughout the second quarter of 2017 and an increase in senior revenues due to the timing of shared savings revenue. These increases were partially offset by the true-up of risk share arrangements, and a decrease in commercial, senior, and Medicaid members to whom DMG provides health care services.

DMG's operating results for the second quarter of 2017, which includes a goodwill impairment charge of $51 million and a reduction in estimated accruals for legal matters of $4 million increased by approximately $89 million as compared to the second quarter of 2016, which included a goodwill impairment charge of $176 million related to certain DMG reporting units, a gain related to the partial sale of our interest in Tandigm of $40 million, and a loss on the HCP Arizona sale of $10 million. Excluding these items from their respective periods, DMG adjusted operating income for the second quarter of 2017 decreased by $10 million compared to the second quarter of 2016. The decrease in adjusted operating income was primarily due to an increase in utilization, an increase in corporate support expenses associated with growth initiatives, an increase in depreciation and amortization related to the HCP trade names acceleration, a decrease in commercial and Medicaid members to whom DMG provides health care services, and a decrease in Medicare Advantage rates. These decreases were offset by an increase in senior revenues due to the timing of shared savings revenue.

DMG's operating results for the six months ended June 30, 2017, which includes a goodwill impairment charge of $51 million and a reduction in estimated accruals for legal matters of $4 million increased by approximately $158 million as compared to the same period in 2016, which included a goodwill impairment charge of $253 million related to certain DMG reporting units, a gain related to the partial sale of our interest in Tandigm of $40 million, and a loss on the HCP Arizona sale of $10 million and estimated accruals for legal matters of $16 million. Excluding these items from their respective periods, DMG adjusted operating income for the six months ended June 30, 2017 decreased by $34 million compared to the same period in 2016. The decrease in adjusted operating income was primarily due to an increase in utilization, an increase in corporate support expenses associated with growth initiatives, an increase in depreciation and amortization related to the HCP trade names acceleration, a decrease in commercial and Medicaid members to whom DMG provides health care services, and a decrease in Medicare Advantage rates. These decreases were offset by the true-up of risk share arrangements and an increase in senior revenues, as discussed above.

***Other—Ancillary services and strategic initiatives business***

Our other operations include ancillary services and strategic initiatives which are primarily aligned with our U.S. dialysis and lab business. As of June 30, 2017, these consisted primarily of pharmacy services, disease management services, vascular access services, clinical research programs, physician services, direct primary care and our international dialysis operations. The ancillary services and strategic initiatives generated approximately $394 million of net revenues in the second quarter of 2017, representing approximately 9.9% 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. and internationally. However, any significant change in market conditions, business performance or the regulatory environment may impact the economic viability of any of these strategic initiatives. Any unfavorable changes in these strategic initiatives could result in a write-off or an impairment of some or all of our investments, including goodwill, and could also result in significant termination costs if we were to exit a certain line of business or one or more of our international markets.

As of June 30, 2017, we provided dialysis and administrative services to a total of 217 outpatient dialysis centers located in 11 countries outside of the U.S. The total net revenues generated from our international operations are provided below.

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

| | Three months ended | | | Six months ended | |
|---|---|---|---|---|---|
| | June 30, 2017 | March 31, 2017 | June 30, 2016 | June 30, 2017 | June 30, 2016 |
| | (dollar amounts rounded to nearest millions) | | | | |
| **U.S. revenues** | | | | | |
| Net patient service revenues | $ 6 | $ 6 | $ 7 | $ 11 | $ 14 |
| Other revenues | 272 | 281 | 339 | 553 | 655 |
| Capitated revenues | 36 | 28 | 26 | 65 | 48 |
| Total | 314 | 315 | 372 | 630 | 717 |
| **International revenues** | | | | | |
| Net patient service revenues | 78 | 61 | 50 | 140 | 94 |
| Other revenues | 1 | 2 | 1 | 3 | 3 |
| Total | 79 | 63 | 51 | 142 | 97 |
| Total net revenues | $ 394 | $ 378 | $ 423 | $ 772 | $ 814 |
| | | | | | |
| **U.S. operating (loss) income** | $ (36) | $ (53) | $ — | $ (89) | $ (1) |
| Reconciliation of non-GAAP: | | | | | |
| Add: Goodwill impairment charges | 10 | 24 | — | 35 | — |
| Impairment of assets | — | 15 | — | 15 | — |
| Adjusted operating loss[1] | $ (26) | $ (14) | $ — | $ (39) | $ (1) |
| | | | | | |
| **International operating (loss) income** | $ (13) | $ (5) | $ (13) | $ (18) | $ (23) |
| Reconciliation of non-GAAP: | | | | | |
| Less: Gain on APAC JV ownership changes | — | (6) | — | (6) | — |
| Adjusted operating (loss) income[1] | $ (13) | $ (11) | $ (13) | $ (24) | $ (23) |
| | | | | | |
| **Total ancillary services and strategic initiatives operating loss** | $ (48) | $ (58) | $ (13) | $ (106) | $ (24) |
| **Total adjusted ancillary services and strategic initiatives operating loss[1]** | $ (38) | $ (25) | $ (13) | $ (62) | $ (24) |

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

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

*Net revenues*

Net revenues from our ancillary services and strategic initiatives for the second quarter of 2017 increased by approximately $16 million, or 4.2%, as compared to the first quarter of 2017. This increase is primarily due to an increase in net revenues from our international expansion due to acquired and non-acquired growth.

Net revenues from our ancillary services and strategic initiatives for the second quarter of 2017 decreased by approximately $29 million, or 6.9%, as compared to the second quarter of 2016. This decrease is primarily due to a decrease in our pharmacy services volume and a decrease in other pharmacy services revenues. Net revenues were positively impacted by an increase in VillageHealth special needs plans revenues and an increase in net revenues from our international expansion.

Ancillary services and strategic initiatives net revenues for the six months ended June 30, 2017 decreased by approximately $42 million, or 5.2%, as compared to the same period in 2016. The decrease is primarily due to a decrease in our pharmacy services volume and a decrease in other pharmacy services revenues, partially offset by an increase in VillageHealth special needs plans revenues and our international expansion.

*Operating and general expenses*

Ancillary services and strategic initiatives operating expenses for the second quarter of 2017 increased by approximately $30 million from the first quarter of 2017, primarily related to an increase in labor and benefits costs, an increase in medical costs at VillageHealth, an increase in pharmaceutical costs in our pharmacy business and an increase in costs related to our international operations.

Ancillary services and strategic initiatives operating expenses for the second quarter of 2017 decreased by approximately $3 million, as compared to the second quarter of 2016, primarily due to higher labor and benefits costs, an increase in medical costs at VillageHealth and an increase in expenses associated with our international operations, partially offset by a decrease in pharmaceutical costs due to decreased volume in our pharmacy business.

Ancillary services and strategic initiatives operating expenses for the six months ended June 30, 2017 decreased by approximately $3 million, as compared to the same period in 2016, primarily due to a decrease in pharmaceutical costs resulting from decreased volume in our pharmacy business, partially offset by higher labor and benefits costs, an increase in medical costs at VillageHealth, and additional expenses associated with our international operations.

*Goodwill and other asset impairment charges.* During the second quarter of 2017, we recognized an incremental goodwill impairment charge of $10 million at our vascular access reporting unit, for total goodwill impairment charges of $35 million for this business during the six months ended June 30, 2017. This additional charge resulted primarily from changes in our outlook since the first quarter of 2017. Our partners and operators have been continuing to evaluate and make decisions concerning changes in operations, including termination of their management services agreements and center closures, as a result of recent changes in Medicare reimbursement for this business announced in November 2016.

During the three months ended March 31, 2017 and six months ended June 30, 2017, we recognized other asset impairment charges of $15 million related to a planned restructuring of our pharmacy business.

*Gain on changes in ownership interests in Asia Pacific joint venture (APAC JV)*

As a result of our agreement with Khazanah Nasional Berhad (Khazanah) and Mitsui and Co., Ltd (Mitsui), we recorded an additional $6 million non-cash gain during the quarter ended March 31, 2017 and six months ended June 30, 2017 related to a change in estimate of pending post-closing adjustments for the formation of the APAC JV.

*Segment operating losses*

Ancillary services and strategic initiatives operating loss for the second quarter of 2017, which includes a goodwill impairment charge of $10 million related to our vascular access reporting unit decreased by approximately $10 million from the first quarter of 2017, which included an adjustment to the gain on the APAC JV ownership changes of $6 million, a goodwill impairment charge of $24 million related to our vascular access reporting unit, and an asset impairment of $15 million related to the restructuring of our pharmacy business. Excluding these items from their respective periods, adjusted operating losses increased by $13 million. Adjusted operating losses increased primarily due to an increase in labor and benefits costs, an increase in medical costs at VillageHealth, an increase in pharmaceutical costs in our pharmacy business and an increase in costs related to our international expansion, partially offset by an increase in net revenues from our international expansion.

Ancillary services and strategic initiatives operating loss for the second quarter of 2017, which includes a goodwill impairment charge of $10 million related to our vascular access reporting unit increased by approximately $35 million from the second quarter of 2016. Excluding this item, adjusted operating losses increased by $25 million, primarily related to a decrease in our pharmacy services volume, a decrease in other pharmacy services revenues, higher labor and benefits costs, an increase in medical costs expense at VillageHealth and additional expenses associated with our international expansion. These increases to adjusted operating losses were partially offset by a decrease in pharmaceutical costs in our pharmacy business, an increase in VillageHealth special needs plans revenues, and an increase in net revenues from our international expansion.

Ancillary services and strategic initiatives operating loss for the six months ended June 30, 2017, which includes an adjustment to the gain on the APAC JV ownership changes of $6 million, goodwill impairment charges of $35 million related to our vascular access reporting unit, and an asset impairment of $15 million related to the restructuring of our pharmacy business,

increased by approximately $82 million from the same period in 2016. Excluding these items from the six months ended June 30, 2017, adjusted operating losses increased by $38 million, primarily due to a decrease in our pharmacy services volume, a decrease in other pharmacy services revenues, higher labor and benefits costs, an increase in medical costs at VillageHealth, and additional expenses associated with our international expansion. These increases to adjusted operating losses were partially offset by a decrease in pharmaceutical costs in our pharmacy business, an increase in VillageHealth special needs plans revenues and an increase in net revenues from our international expansion.

**Corporate-level charges**

*Debt expense.* Debt expense was $108 million in the second quarter of 2017, $104 million in the first quarter of 2017 and $103 million in the second quarter of 2016. Debt expense increased by $4 million as compared to the first quarter of 2017 and by $5 million as compared to the second quarter of 2016 primarily due to an increase in our average interest rate, partially offset by a decrease in our average outstanding balance.

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

Corporate administrative support was approximately $11 million in the second and first quarters of 2017, and $5 million in the second quarter of 2016. The increase in corporate administrative support in the second and first quarters of 2017 as compared to the second quarter of 2016 was primarily due to a decrease in long-term incentive compensation expense and a decrease in internal management fees paid by our ancillary lines of business.

*Other income.* Other income was $5 million for the second quarter of 2017, $4 million for the first quarter of 2017, and $3 million in the second quarter of 2016. The increase in other income for the second quarter of 2017 as compared to the first quarter of 2017 and the second quarter of 2016 was primarily related to an increase in interest income.

*Noncontrolling interests*

Net income attributable to noncontrolling interests was $35 million for the second quarter of 2017 compared to $53 million for the first quarter of 2017 and $41 million for the second quarter of 2016. The decrease in net income attributable to noncontrolling interests in the second quarter of 2017 compared to the first quarter of 2017 was primarily due to additional noncontrolling interests recognized related to the net gain on the settlement with the VA of $24 million in the first quarter of 2017, offset by a net $4 million decrease in noncontrolling interests from the goodwill impairment charge related to our vascular access reporting unit in the first quarter of 2017. The decrease in net income attributable to noncontrolling interests in the second quarter of 2017 compared to the second quarter of 2016 was primarily due to a decrease in noncontrolling interests of $3 million from the goodwill impairment charge related to our vascular access reporting unit in the second quarter of 2017 and a decrease in the profitability of certain joint ventures.

*Accounts receivable*

Our consolidated total accounts receivable balances at June 30, 2017 and March 31, 2017 were $2.054 billion and $1.901 billion, respectively, which is net of the provision for uncollectible accounts. The increase in accounts receivable was as a result of some changes we made in our collection policies and procedures to improve overall collections.

*Liquidity and capital resources*

Cash flow from operations during the second quarter of 2017 was $146 million, compared to $517 million during the second quarter of 2016. The decrease in cash flow from operations in the second quarter of 2017 was primarily due to a decrease in cash collections, an increase in tax payments related to the VA settlement, and the timing of other working capital items. Non-operating cash outflows for the second quarter of 2017 included capital asset expenditures of $184 million, including $129 million for new center developments and relocations and $55 million for maintenance and information technology. In addition, we spent $543 million for acquisitions and also paid distributions to noncontrolling interests of $73 million and we repurchased a total of 3,574,573 shares of our common stock for $232 million during the quarter ended June 30, 2017. Non-operating cash outflows for the second quarter of 2016 included capital asset expenditures of $185 million, including $104 million for new center developments and relocations and $81 million for maintenance and information technology. In addition, we spent $68 million for acquisitions. We paid distributions to noncontrolling interests of $44 million during the second quarter of 2016.

Cash flow from operations during the six months ended 2017 was $1.011 billion, compared to $946 million during the same period in 2016. The increase in cash flow from operations in the first quarter of 2017 was primarily due to the payment received from the settlement with the VA, offset by associated tax payments, a decrease in cash collections and the timing of other working capital items. Non-operating cash outflows for the six months ended June 30, 2017 included capital asset expenditures of $399 million, including $255 million for new center developments and relocations and $144 million for maintenance and information technology. In addition, we spent $620 million for acquisitions and also paid distributions to noncontrolling interests of $116 million and we repurchased a total of 3,574,573 shares of our common stock for $232 million during the six months ended June 30, 2017. Non-operating cash outflows for the six months ended June 30, 2016 included capital asset expenditures of $359 million, including $204 million for new center developments and relocations and $155 million for maintenance and information technology. In addition, we spent $473 million for acquisitions, including the acquisition of TEC. We paid distributions to noncontrolling interests of $94 million and we repurchased a total of 3,689,738 shares of our common stock for $249 million during the six months ended June 30, 2016. We also settled $25 million related to fourth quarter 2015 repurchases in early 2016.

During the second quarter of 2017, our U.S. dialysis and related lab services business opened 27 dialysis centers, acquired 44 dialysis centers, including dialysis centers associated with the acquisition of Renal Ventures, closed and merged two dialysis centers, and divested six dialysis centers. In addition, our international dialysis operations acquired 52 dialysis centers, opened four dialysis centers, and closed two dialysis centers. During the second quarter of 2016, our U.S. dialysis and related lab services business opened 15 dialysis centers, acquired four dialysis centers, closed and merged three dialysis centers. In addition, our international dialysis operations acquired two dialysis centers and opened one dialysis center.

During the six months ended June 30, 2017, our U.S. dialysis and related lab services business opened 51 dialysis centers, acquired 56 dialysis centers, including dialysis centers associated with the acquisition of Renal Ventures, closed and merged two dialysis centers, closed three dialysis centers, and divested six dialysis centers. In addition, our international dialysis operations acquired 55 dialysis centers, opened nine dialysis centers, and closed two dialysis centers. During the six months ended June 30, 2016, our U.S. dialysis and related lab services business opened 45 dialysis centers, acquired four dialysis centers, and closed and merged seven centers. In addition, our international dialysis operations acquired three dialysis centers and opened six dialysis centers.

During the second quarter of 2017, our DMG business acquired two private medical practices and one primary care physician practice. During the second quarter of 2016, DMG acquired two primary care physician practices.

During the six months ended June 30, 2017, our DMG business acquired three private medical practices and two primary care physician practices. During the six months ended June 30, 2016, DMG acquired one private medical practice and three primary care physician practices, including the purchase of TEC.

On May 1, 2017, we completed our acquisition of 100% of the equity in Colorado-based Renal Ventures for approximately $361.5 million in net cash, subject to certain post-closing adjustments.

During the first six months of 2017, we made mandatory principal payments under our senior secured credit facilities totaling $37.5 million on Term Loan A and $17.5 million on Term Loan B.

*Cap agreements*

As of June 30, 2017, we maintained several interest rate cap agreements that were entered into in November 2014 with notional amounts totaling $3.5 billion. These cap agreements became effective September 30, 2016 and have the economic effect of capping the LIBOR variable component of our interest rate at a maximum of 3.50% on an equivalent amount of our debt. The cap agreements expire on June 30, 2018. As of June 30, 2017, the total fair value of these cap agreements was an asset of approximately $0.6 thousand. During the six months ended June 30, 2017, we recognized debt expense of $4.1 million from these caps. During the six months ended June 30, 2017, we recorded a loss of $0.1 million in other comprehensive income due to a decrease in the unrealized fair value of these cap agreements.

As of June 30, 2017, we also maintained several forward interest rate cap agreements that were entered into in October 2015 with notional amounts totaling $3.5 billion. These forward cap agreements will become effective June 29, 2018 and will have the economic effect of capping the LIBOR variable component of our interest rate at a maximum of 3.50% on an equivalent amount of our debt. These cap agreements expire on June 30, 2020. As of June 30, 2017, the total fair value of these cap agreements was an asset of approximately $1.7 million. During the six months ended June 30, 2017, we recorded a loss of $8.1 million in other comprehensive income due to a decrease in the unrealized fair value of these forward cap agreements.

*Other items*

As of June 30, 2017, the interest rate on our Term Loan B debt bears interest at LIBOR plus an interest rate margin of 2.75%. Term Loan B is subject to interest rate caps if LIBOR should rise above 3.50%. Term Loan A bears interest at LIBOR plus an interest rate margin of 2.00%. The capped portion of Term Loan A is $105.0 million if LIBOR should rise above 3.50%. In addition, the uncapped portion of Term Loan A, which is subject to the variability of LIBOR, is $720.0 million. Interest rates on our senior notes are fixed by their terms.

Our weighted average effective interest rate on the senior secured credit facilities at end of the quarter was 4.20%, based on the current margins in effect of 2.00% for Term Loan A and 2.75% for Term Loan B, as of June 30, 2017.

Our overall weighted average effective interest rate during the quarter ended June 30, 2017 was 4.69% and as of June 30, 2017 was 4.76%.

As of June 30, 2017, our interest rates are fixed on approximately 53.3% of our total debt.

As of June 30, 2017, we had undrawn revolving credit facilities totaling $1.0 billion, of which approximately $94.6 million was committed for outstanding letters of credit. The remaining amount is unencumbered. In addition, we have approximately $1.3 million of committed letters of credit outstanding related to DMG, which is backed by a certificate of deposit.

We believe that we will generate significant operating cash flows and will have sufficient liquidity 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.

*Goodwill*

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

Based on continuing developments at our DMG and vascular access reporting units during the second quarter of 2017, we performed impairment assessments for certain at-risk reporting units.

As a result of these assessments, during the second quarter of 2017 we recognized goodwill impairment charges of $49.9 million at our DMG Florida reporting unit and $0.7 million at our DMG New Mexico reporting unit. These charges resulted primarily from changes in expectations concerning government reimbursement, including the effect of Medicare Advantage final benchmark payment rates for 2018 announced on April 3, 2017 and our expected ability to mitigate them, as well as medical cost and utilization trends.

We also recognized an incremental goodwill impairment charge of $10.5 million at our vascular access reporting unit. This additional charge resulted primarily from changes in our outlook since the first quarter of 2017. Our partners and operators have been continuing to evaluate and make decisions concerning potential changes in operations, including termination of their management services agreements and center closures, as a result of changes in Medicare reimbursement for this business announced in November 2016. As of June 30, 2017 there was no goodwill remaining at our vascular access reporting unit.

For the three and six months ended June 30, 2017, we have recognized total goodwill impairment charges of $61.1 million and $85.3 million, respectively.

The goodwill impairment charge of $24.2 million recognized at our vascular access reporting unit during the first quarter of 2017 resulted primarily from changes in our outlook since the fourth quarter of 2016. During the first quarter, our partners and operators had been continuing to evaluate and make decisions concerning potential changes in operations, including termination of their management services agreements and center closures, as a result of the recently announced changes in Medicare reimbursement for this business.

During the second quarter of 2016, we recognized goodwill impairment charges of $97.0 million at our DMG Florida reporting unit and $79.0 million at our DMG Nevada reporting unit. These charges resulted primarily from continuing developments in our DMG business, including the Medicare Advantage final benchmark rates for 2017 announced on April 4, 2016, further changes in our expectations concerning future government reimbursement rates and our expected ability to

mitigate them, as well as medical cost and utilization trends, underperformance of certain at-risk reporting units and other market conditions.

For the three and six months ended June 30, 2016, we recognized total goodwill impairment charges of $176.0 million and $253.0 million, respectively.

Further reductions in reimbursement rates, increases in medical cost or utilization trends, or other significant adverse changes in expected future cash flows or valuation assumptions could result in goodwill impairment charges in the future for the following reporting units, which remain at risk of goodwill impairment as of June 30, 2017:

| Reporting unit | Goodwill balance as of June 30, 2017 (in thousands) | Carrying amount coverage[1] | Sensitivities | |
|---|---|---|---|---|
| | | | Operating income[2] | Discount rate[3] |
| DMG Nevada | $ 275,914 | 17.0% | (2.4)% | (3.8)% |
| DMG Florida | $ 397,127 | —% | (1.6)% | (2.8)% |
| DMG New Mexico | $ 70,253 | —% | (1.6)% | (2.4)% |
| DMG Washington | $ 247,552 | 9.3% | (1.7)% | (3.6)% |

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

Except as described above, none of our various other reporting units was considered at risk of goodwill impairment as of June 30, 2017. Since the dates of their last annual goodwill impairment tests, there have been certain developments, events, changes in operating performance and other changes in key circumstances that have affected these other businesses. However, except as further described above, these changes did not cause management to believe it is more likely than not that the fair value of any of its reporting units would be less than their respective carrying amounts.

*Long-term incentive compensation*

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

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

During the six months ended June 30, 2017, we granted 1,426,055 stock-settled stock appreciation rights with an aggregate grant-date fair value of $20.9 million and a weighted-average expected life of approximately 4.2 years. We also granted 387,395 stock units with an aggregate grant-date fair value of $25.5 million and a weighted-average expected life of approximately 3.4 years as well as 15,000 cash-settled stock appreciation rights with an aggregate grant-date fair value of $0.2 million and a weighted-average expected life of approximately 4.3 years.

Long-term incentive compensation expense of $13.8 million in the second quarter of 2017 decreased by approximately $3.4 million as compared to the first quarter of 2017. This decrease in long-term incentive compensation expense was primarily due to the final vesting of prior year broad grants at the end of the first quarter of 2017, with only a partial quarter of expense for a new broad grant that was granted during the second quarter of 2017.

Long-term incentive compensation expense decreased by approximately $12.1 million as compared to the second quarter of 2016 primarily due to cumulative revaluation of liability-based awards that increased expense in the second quarter of 2016

but did not repeat in the second quarter of 2017, as well as lower estimated ultimate payouts on outstanding broad grants as of June 30, 2017.

Long-term incentive compensation expense for the six months ending June 30, 2017 decreased by approximately $19.7 million as compared to the six months ending June 30, 2016. This decrease in long-term incentive compensation was primarily due to cumulative revaluation of liability based awards that increased expense in the second quarter of 2016 but did not repeat in the second quarter of 2017, as well as the final vesting of a prior broad grant that is no longer contributing expense.

As of June 30, 2017, there was $149.5 million in total estimated but unrecognized compensation expense for LTIP awards outstanding, including $84.5 million relating to stock-based arrangements under our equity compensation and employee stock purchase plans. We expect to recognize the performance-based cash component of these LTIP costs over a weighted average remaining period of 1.2 years and the stock-based component of these LTIP costs over a weighted average remaining period of 1.5 years.

*Stock repurchases*

During the quarter ended and six months ended June 30, 2017, we repurchased a total of 3,574,573 shares of our common stock for $232 million, or an average price of $64.81 per share. We have not repurchased any shares from July 1, 2017 through August 1, 2017.

On July 13, 2016, our Board of Directors approved a share repurchase authorization in the amount of approximately $1.2 billion. This share repurchase authorization was in addition to the approximately $259 million authorization remaining at that time under our Board of Directors' prior share repurchase authorization announced in April 2015. As a result of the above authorizations, there was approximately $445 million available under our current Board authorizations for additional share repurchases as of August 1, 2017. Although these share repurchase authorizations have no expiration dates, we are subject to share repurchase limitations under the terms of the senior secured credit facilities and the indentures governing our senior notes.

*Off-balance sheet arrangements and aggregate contractual obligations*

In addition to the debt obligations reflected on our balance sheet, we have commitments associated with operating leases and letters of credit, as well as potential obligations associated with our equity investments in nonconsolidated businesses and to dialysis centers that are wholly-owned by third parties. Substantially all of our U.S. dialysis facilities are leased. We have potential obligations to purchase the noncontrolling interests held by third parties in several of our majority-owned entities and other nonconsolidated legal entities. These obligations are in the form of put provisions and are exercisable at the third-party owners' discretion within specified periods as outlined in each specific put provision. If these put provisions were exercised, we would be required to purchase the third-party owners' noncontrolling interests at either the appraised fair market value or a predetermined multiple of earnings or cash flow attributable to the noncontrolling interests put to us, which is intended to approximate fair value. The methodology we use to estimate the fair values of noncontrolling interests subject to put provisions assumes the higher of either a liquidation value of net assets or an average multiple of earnings, based on historical earnings, patient mix and other performance indicators that can affect future results, as well as other factors. The estimated fair values of the noncontrolling interests subject to put provisions is a critical accounting estimate that involves significant judgments and assumptions and may not be indicative of the actual values at which the noncontrolling interests may ultimately be settled, which could vary significantly from our current estimates. The estimated fair values of noncontrolling interests subject to put provisions can fluctuate and the implicit multiple of earnings at which these noncontrolling interest obligations may be settled could vary significantly depending upon market conditions including potential purchasers' access to the capital markets, which can impact the level of competition for dialysis and non-dialysis related businesses, the economic performance of these businesses and the restricted marketability of the third-party owners' noncontrolling interests. The amount of noncontrolling interests subject to put provisions that employ a contractually predetermined multiple of earnings rather than fair value are immaterial. For additional information see Note 11 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 businesses in which we maintain a noncontrolling equity interest as well as to physician-owned vascular access clinics or medical practices that we operate under management and administrative services agreements of approximately $5.9 million.

The following is a summary of these contractual obligations and commitments as of June 30, 2017 (in millions):

| | Remainder of 2017 | 1-3 years | 4-5 years | After 5 years | Total |
|---|---|---|---|---|---|
| Scheduled payments under contractual obligations: | | | | | |
| Long-term debt | $ 86 | $ 924 | $ 4,540 | $ 3,309 | $ 8,859 |
| Interest payments on the senior notes | 118 | 710 | 473 | 367 | 1,668 |
| Interest payments on Term Loan B[1] | 69 | 403 | 65 | — | 537 |
| Interest payments on Term Loan A[2] | 13 | 35 | — | — | 48 |
| Capital lease obligations | 11 | 66 | 43 | 186 | 306 |
| Operating leases | 259 | 1,385 | 691 | 1,300 | 3,635 |
| | $ 556 | $ 3,523 | $ 5,812 | $ 5,162 | $ 15,053 |
| Potential cash requirements under other commitments: | | | | | |
| Letters of credit | $ 96 | $ — | $ — | $ — | $ 96 |
| Noncontrolling interests subject to put provisions | 568 | 235 | 100 | 107 | 1,010 |
| Non-owned and minority owned put provisions | 31 | — | 30 | — | 61 |
| Operating capital advances | 1 | 2 | 1 | 2 | 6 |
| | $ 696 | $ 237 | $ 131 | $ 109 | $ 1,173 |

(1) Assuming no changes to LIBOR-based interest rates as Term Loan B currently bears interest at LIBOR plus an interest rate margin of 2.75%.
(2) Based upon current LIBOR-based interest rates in effect at June 30, 2017 plus an interest rate margin of 2.00% for Term Loan A.

In addition to the above commitments, we have committed to purchase a certain amount of our hemodialysis products and supplies at fixed prices through 2018 from Baxter Healthcare Corporation (Baxter) in connection with a purchase agreement. We also have an agreement with Fresenius Medical Care (Fresenius), currently extended through December 31, 2017, which commits us to purchase a certain amount of dialysis equipment, parts and supplies.

Our total expenditures for the six months ended June 30, 2017 on such products for Fresenius was approximately 3% and for Baxter was 2% of our total U.S. dialysis and related lab services operating costs. The actual amount of such purchases in future years will depend upon a number of factors, including the operating requirements of our centers, the number of centers we acquire and growth of our existing centers.

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

Settlements of approximately $32 million of existing income tax liabilities for unrecognized tax benefits, including interest, penalties and other long-term tax liabilities, are excluded from the table above as reasonably reliable estimates of their timing cannot be made.

**Supplemental Information Concerning Certain Physician Groups and Unrestricted Subsidiaries**

The following information is presented as supplemental data as required by the indentures governing our senior notes.

We provide services to certain physician groups that, while consolidated in our financial statements for financial reporting purposes, are not subsidiaries of or owned by us, do not constitute Subsidiaries as defined in the indentures governing our outstanding senior notes, and which do not guarantee those senior notes. In addition, we have entered into management agreements with these physician groups pursuant to which we receive management fees from them.

As of June 30, 2017, if these physician groups were not consolidated in our financial statements, our consolidated indebtedness would have been approximately $9.165 billion excluding the debt discount associated with our Term Loan B, our

consolidated other liabilities (excluding indebtedness) would have been approximately $3.661 billion, and our consolidated assets would have been approximately $18.887 billion. If these physician groups were not consolidated in our financial statements for the six months ended June 30, 2017, our consolidated total net revenues (including approximately $399 million of management fees payable to us), consolidated operating income, and consolidated net income would be reduced by approximately $671 million, $38 million, and $2 million, respectively.

In addition, we own a 67% equity interest in California Medical Group Insurance (CMGI). CMGI is an Unrestricted Subsidiary as defined in the indentures governing our outstanding senior notes, and does not guarantee those senior notes. Our equity interest in CMGI is accounted for under the equity method of accounting, meaning that although CMGI is not consolidated in our financial statements for financial reporting purposes, our consolidated income statements reflect our pro rata share of CMGI's net earnings as equity investment income.

For the six months ended June 30, 2017, our equity investment income attributable to CMGI was approximately $232 thousand, and for the six months ended June 30, 2017. Excluding our equity investment income attributable to CMGI, our consolidated operating income and consolidated net income decreased by approximately $232 thousand and $139 thousand, respectively. See Note 22, Supplemental data, to the condensed consolidated financial statements for further details.

**New Accounting Standards**

See discussion of new accounting standards in Note 20 to the condensed consolidated financial statements included in Part I, Item 1 of this report.

**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 June 30, 2017. The variable rates presented reflect the weighted average LIBOR rates in effect for all debt tranches plus interest rate margins in effect as of June 30, 2017. Term Loan A currently bears interest at LIBOR plus an interest rate margin of 2.00%. Term Loan A and the revolving line of credit are subject to adjustment depending upon changes in certain of our financial ratios, including a leverage ratio. Term Loan B currently bears interest at LIBOR plus an interest rate margin of 2.75%.

| | Expected maturity date | | | | | | | | Average interest rate | Fair Value |
|---|---|---|---|---|---|---|---|---|---|---|
| | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | Thereafter | Total | | |
| | (dollars in millions) | | | | | | | | | |
| Long term debt: | | | | | | | | | | |
| Fixed rate | $ 27 | $ 30 | $ 26 | $ 26 | $ 22 | $ 1,272 | $ 3,490 | $ 4,893 | 5.25% | $ 4,959 |
| Variable rate | $ 70 | $ 142 | $ 721 | $ 45 | $ 3,281 | $ 8 | $ 5 | $ 4,272 | 4.20% | $ 4,293 |

| | Notional amount | Contract maturity date | | | | | Receive variable | Fair Value |
|---|---|---|---|---|---|---|---|---|
| | | 2017 | 2018 | 2019 | 2020 | 2021 | | |
| | (dollars in millions) | | | | | | | |
| Cap agreements | $ 7,000 | $ — | $ 3,500 | $ — | $ 3,500 | $ — | LIBOR above 3.5% | $ 2 |

Our senior secured credit facilities, which include Term Loan A and Term Loan B, consist of various individual tranches of debt that can range in maturity from one month to twelve months (currently, all tranches are one month in duration). For Term Loan A and Term Loan B, each tranche bears interest at a LIBOR rate that is determined by the duration of such tranche plus an interest rate margin. The LIBOR variable component of the interest rate for each tranche is reset as such tranche matures and a new tranche is established. LIBOR can fluctuate significantly depending upon conditions in the credit and capital markets.

As of June 30, 2017, our Term Loan A bears interest at LIBOR plus an interest rate margin of 2.00% and our Term Loan B debt bears interest at LIBOR plus an interest rate margin of 2.75%. LIBOR was higher than the 0.75% embedded LIBOR floor on Term Loan B, resulting in Term Loan B being subject to LIBOR-based interest rate volatility on the LIBOR variable component of our interest rate as of June 30, 2017. The LIBOR based interest component is limited to a maximum LIBOR rate of 3.50% on the outstanding principal debt on Term Loan B and $105.0 million on Term Loan A as a result of the interest rate cap agreements, as described below.

As of June 30, 2017, we maintained several interest rate cap agreements that were entered into in November 2014 with notional amounts totaling $3.5 billion. These cap agreements became effective September 30, 2016 and have the economic effect of capping the LIBOR variable component of our interest rate at a maximum of 3.50% on an equivalent amount of our debt. The cap agreements expire on June 30, 2018. As of June 30, 2017, the total fair value of these cap agreements was an asset of approximately $0.6 thousand. During the six months ended June 30, 2017, we recognized debt expense of $4.1 million from these caps. During the six months ended June 30, 2017, we recorded a loss of $0.1 million in other comprehensive income due to a decrease in the unrealized fair value of these cap agreements.

As of June 30, 2017, we also maintained several forward interest rate cap agreements that were entered into in October 2015 with notional amounts totaling $3.5 billion. These forward cap agreements will become effective June 29, 2018 and will have the economic effect of capping the LIBOR variable component of our interest rate at a maximum of 3.50% on an equivalent amount of our debt. These cap agreements expire on June 30, 2020. As of June 30, 2017, the total fair value of these cap agreements was an asset of approximately $1.7 million. During the six months ended June 30, 2017, we recorded a loss of $8.1 million in other comprehensive income due to a decrease in the unrealized fair value of these forward cap agreements.

Our weighted average effective interest rate on the senior secured credit facilities at end of the quarter was 4.20%, based on the current margins in effect of 2.00% for Term Loan A and 2.75% for Term Loan B, as of June 30, 2017.

As of June 30, 2017, our Term Loan B debt bears interest at LIBOR plus an interest rate margin of 2.75%. Term Loan B is also subject to interest rate caps if LIBOR should rise above 3.50%. Term Loan A bears interest at LIBOR plus an interest rate margin of 2.00%. The capped portion of Term Loan A is $105.0 million. In addition, the uncapped portion of Term Loan A, which is subject to the variability of LIBOR, is $720.0 million. Interest rates on our senior notes are fixed by their terms.

Our overall weighted average effective interest rate during the three months ended June 30, 2017 was 4.69% and as of June 30, 2017 was 4.76%.

As of June 30, 2017, we had undrawn revolving credit facilities totaling $1.0 billion of which approximately $94.6 million was committed for outstanding letters of credit. The remaining amount is unencumbered. In addition, we have approximately $1.3 million of committed letters of credit outstanding related to DMG, which is backed by a certificate of deposit.

*Exchange rate sensitivity*

While our business is predominantly conducted in the U.S. we have developing operations in 11 other countries as well. For financial reporting purposes, the U.S. dollar is our reporting currency. However, the functional currencies of our operating businesses in other countries are typically those of the countries in which they operate. Therefore, changes in the rate of exchange between the U.S. dollar and the local currencies in which our international operations are conducted affect our results of operations and financial position as reported in our consolidated financial statements.

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

**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. 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 that was identified during the evaluation that occurred during the fiscal quarter covered by this report 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*

We operate in a highly regulated industry and are a party to various lawsuits, claims, governmental investigations and audits (including investigations resulting from our obligation to self-report suspected violations of law) and other legal proceedings. We record accruals for certain legal proceedings and regulatory matters to the extent that we determine an unfavorable outcome is probable and the amount of the loss can be reasonably estimated. As of June 30, 2017 and December 31, 2016 our total recorded accruals with respect to legal proceedings and regulatory matters, net of anticipated third party recoveries, were approximately $62 million and $69 million, respectively. While these accruals reflect our best estimate of the probable loss for those matters as of the dates of those accruals, the recorded amounts may differ materially from the actual amount of the losses for those matters, and any anticipated third party recoveries for any such losses may not ultimately be recoverable.

Additionally, in some cases, no estimate of the possible loss or range of loss in excess of amounts accrued, if any, can be made because of the inherently unpredictable nature of legal proceedings and regulatory matters, which may be exacerbated by various factors, including that they may involve indeterminate claims for monetary damages or may involve fines, penalties or non-monetary remedies; present novel legal theories or legal uncertainties; involve disputed facts; represent a shift in regulatory policy; are in the early stages of the proceedings; or result in a change of business practices. Further, there may be various levels of judicial review available to us in connection with any such proceeding.

The following is a description of certain lawsuits, claims, governmental investigations and audits and other legal proceedings to which we are subject.

***Inquiries by the Federal Government and Certain Related Civil Proceedings***

Swoben Private Civil Suit: In April 2013, HealthCare Partners (HCP), now known as our DMG subsidiary, was one of several defendants served with a civil complaint filed by a former employee of SCAN Health Plan (SCAN), an HMO. On July 13, 2009, pursuant to the *qui tam* provisions of the federal FCA and the California False Claims Act, James M. Swoben, as relator, filed his initial *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 2009 and 2010, the relator twice amended his complaint and added additional defendants, and in November 2011, he filed his Third Amended Complaint under seal alleging violations of the federal FCA and the California False Claims Act, and added additional defendants, including HCP and certain health insurance companies (the defendant HMOs). The allegations in the complaint against HCP relate to patient diagnosis coding to determine reimbursement in the Medicare Advantage (MA) program, referred to as HCC and RAF scores. The complaint sought monetary damages and civil penalties as well as costs and expenses. The U.S. Department of Justice (DOJ) reviewed these allegations and in January 2013 declined to intervene in the case. HCP and the other defendants filed motions to dismiss the Third Amended Complaint, and the court dismissed with prejudice the claims and judgment was entered in September 2013. Upon the plaintiff's appeal, a panel of the Ninth Circuit overturned the trial court's ruling and vacated the dismissal of the case. Together with certain defendants, we petitioned the Ninth Circuit for a rehearing, but in December 2016, the Ninth Circuit rejected the petition and determined the relator should be given an opportunity to amend the complaint, and remanded the case back to district court. In March 2017, the relator filed his Fourth Amended Complaint alleging that HCP and certain health insurance companies employed one-way retrospective reviews that were designed only to identify additional diagnoses that would be submitted to CMS for risk adjustment purposes, and thereby drive higher risk scores that would increase the capitated payments made by the federal government under the MA program. In March 2017, the DOJ partially intervened as to certain defendant HMOs, but elected not intervene with respect to HCP. We dispute the allegations and intend to defend accordingly.

2015 U.S. Office of Inspector General (OIG) Medicare Advantage Civil Investigation: In March 2015, JSA HealthCare Corporation (JSA), a subsidiary of DMG, received a subpoena from the Office of Inspector General (OIG) for the U.S. Department of Health and Human Services (HHS). We have been advised by an attorney with the Civil Division of the DOJ in Washington, D.C. that the subpoena relates to an ongoing civil investigation concerning MA service providers' risk adjustment practices and data, including identification and verification of patient diagnoses and factors used in making the diagnoses. The subpoena requests documents and information for the period from January 1, 2008 through December 31, 2013, for certain MA plans for which JSA provided services. It also requests information regarding JSA's communications about patient diagnoses as

they relate to certain MA plans generally, and more specifically as related to two Florida physicians with whom JSA previously contracted. We are producing the requested information and are cooperating with the government's investigation.

In addition to the subpoena described above, in June 2015, we received a subpoena from the OIG. This civil subpoena covers the period from January 1, 2008 through the present and seeks production of a wide range of documents relating to our and our subsidiaries' (including DMG's and its subsidiary JSA's) provision of services to MA plans and related patient diagnosis coding and risk adjustment submissions and payments. We believe that the request is part of a broader industry investigation into MA patient diagnosis coding and risk adjustment practices and potential overpayments by the government. The information requested includes information relating to patient diagnosis coding practices for a number of conditions, including potentially improper historical DMG coding for a particular condition. With respect to that condition, the guidance related to that coding issue was discontinued following our November 1, 2012 acquisition of DMG, and we notified CMS in April 2015 of the coding practice and potential overpayments. In that regard, we have identified certain additional coding practices which may have been problematic and are in discussions with the DOJ about the scope and nature of a review of claims relating to those practices. We are cooperating with the government and are producing the requested information. In addition, we are continuing to review other DMG coding practices to determine whether there were any improper coding issues. In connection with the DMG merger, we have certain indemnification rights against the sellers and an escrow was established as security for the indemnification. We have submitted an indemnification claim against the sellers secured by the escrow for any and all liabilities incurred relating to these matters and intend to pursue recovery from the escrow. However, we can make no assurances that the indemnification and escrow will cover the full amount of our potential losses related to these matters.

2016 U.S. Attorney Prescription Drug Investigation: In early February 2016, we announced that our pharmacy services' wholly-owned subsidiary, DaVita Rx, received a CID from the U.S. Attorney's Office for the Northern District of Texas. The government is conducting an FCA investigation concerning allegations that DaVita Rx presented or caused to be presented false claims for payment to the government for prescription medications, as well as into our relationship with pharmaceutical manufacturers. The CID covers the period from January 1, 2006 through the present. In the spring of 2015, we initiated an internal compliance review of DaVita Rx during which we identified potential billing and operational issues, including potential write-offs and discounts of patient co-payment obligations, and credits to payors for returns of prescription drugs related to DaVita Rx. We notified the government in September 2015 that we were conducting this review of DaVita Rx and began providing regular updates of our review. Upon completion of our review, we filed a self-disclosure with the OIG in February 2016 and we have been working to address and update the practices we identified in the self-disclosure, some of which overlap with information requested by the U.S. Attorney's Office. The OIG informed us in February 2016 that our submission was not accepted. They indicated that the OIG is not expressing an opinion regarding the conduct disclosed or our legal positions. We are cooperating with the government.

2017 U.S. Attorney American Kidney Fund Investigation. On January 4, 2017, we were served with an administrative subpoena for records by the United States Attorney's Office, District of Massachusetts, relating to an investigation into possible federal health care offenses. The subpoena covers the period from January 1, 2007 through the present, and seeks documents relevant to charitable patient assistance organizations, particularly the American Kidney Fund, including documents related to efforts to provide patients with information concerning the availability of charitable assistance. We are cooperating with the government and are producing the requested information.

Although we cannot predict whether or when proceedings might be initiated or when these matters may be resolved (other than as described above), it is not unusual for inquiries such as these to continue for a considerable period of time through the various phases of document and witness requests and on-going discussions with regulators. In addition to the inquiries and proceedings specifically identified above, we are frequently subject to other inquiries by state or federal government agencies and/or private civil *qui tam* complaints filed by relators. Negative findings or terms and conditions that we might agree to accept as part of a negotiated resolution of pending or future government inquiries or relator proceedings could result in, among other things, substantial financial penalties or awards against us, substantial payments made by us, harm to our reputation, required changes to our business practices, exclusion from future participation in the Medicare, Medicaid and other federal health care programs and, if criminal proceedings were initiated against us, possible criminal penalties, any of which could have a material adverse effect on us.

***Shareholder Claims***

Peace Officers' Annuity and Benefit Fund of Georgia Securities Class Action Civil Suit: On February 1, 2017, the Peace Officers' Annuity and Benefit Fund of Georgia filed a putative federal securities class action complaint in the U.S. District Court for the District of Colorado against us and certain executives. The complaint covers the time period of August 2015 to October 2016 and alleges, generally, that we and our executives violated federal securities laws concerning our financial results and revenue derived from patients who received charitable premium assistance from an industry-funded non-profit

organization. The complaint further alleges that the process by which patients obtained commercial insurance and received charitable premium assistance was improper and "created a false impression of DaVita's business and operational status and future growth prospects." We dispute these allegations and intend to defend this action accordingly.

Blackburn Shareholder Derivative Civil Suit: On February 10, 2017, Charles Blackburn filed a derivative shareholder lawsuit in the U.S. District Court for the District of Delaware against us, as nominal defendant, the Board of Directors and certain executives. The complaint covers the time period from 2015 to present and alleges, generally, breach of fiduciary duty, unjust enrichment and misrepresentations and/or failures to disclose certain information in violation of the federal securities laws in connection with an alleged practice to direct patients with government-subsidized health insurance into private health insurance plans to maximize our profits. We dispute these allegations and intend to defend this action accordingly.

Gabilondo Shareholder Derivative Civil Suit: On May 30, 2017, Antonio Gabilondo filed a derivative shareholder lawsuit in the U.S. District Court for the District of Delaware against us, as nominal defendant, the Board of Directors and certain executives. The complaint covers the time period from 2015 to present and alleges, generally, breach of fiduciary duty, unjust enrichment, abuse of control, gross mismanagement, corporate waste, and misrepresentations and/or failures to disclose certain information in violation of the federal securities laws in connection with an alleged practice to direct patients with government-subsidized health insurance into private health insurance plans to maximize our profits. We dispute these allegations and intend to defend this action accordingly.

City of Warren Police and Fire Retirement System Shareholder Derivative Civil Suit: On June 9, 2017, the City of Warren Police and Fire Retirement System filed a derivative shareholder lawsuit in the U.S. District Court for the District of Delaware against us, as nominal defendant, the Board of Directors, and certain executives. The complaint covers the time period of 2015 to the present and alleges, generally, a breach of fiduciary duty, corporate waste, unjust enrichment, and misrepresentations and/or failures to disclose certain information in violation of the federal securities laws in connection with an alleged practice to direct patients with government-subsidized health insurance into private health insurance plans to maximize our profits. We dispute these allegations and intend to defend this action accordingly.

***Other Proceedings***

In addition to the foregoing, from time to time we are subject to other lawsuits, demands, claims, governmental investigations and audits and legal proceedings that arise due to the nature of our business, including contractual disputes, such as with payors, suppliers and others, employee-related matters and professional and general liability claims.

***Resolved Matters***

2015 U.S. Attorney Transportation Investigation: In February 2015, we announced that we received six administrative subpoenas from the OIG for medical records from six different dialysis centers in southern California operated by us. Specifically, each subpoena sought the medical records of a single patient of each respective dialysis center. In February 2016, we received four additional subpoenas for four additional dialysis centers in southern California. The subpoenas were similarly limited in scope to the subpoenas received in 2015. On February 8, 2017, we were served with a *qui tam* complaint in the U.S. District Court for the Central District of California. We were advised by an attorney with the United States Attorney's Office for the Central District of California that the *qui tam* was related to the investigation concerning the medical necessity of patient transportation, which was the basis for the subpoenas. The relator alleged that an ambulance company submitted false claims for patient transportation. Although we do not provide transportation ourselves nor do we bill for the transport of our dialysis patients, the relator alleged that two of our purported clinical staff caused the submission of a small number of those claims through improper certifications of medical necessity. The DOJ has declined to intervene. In April 2017, the court granted our motion to dismiss and dismissed the complaint without prejudice for failing to state a claim upon which relief can be granted. In May 2017, the relator filed a First Amended Complaint and we filed an additional motion to dismiss. In June 2017, the court granted our motion and dismissed the complaint without prejudice. Plaintiff was given until July 24, 2017 to file an amended complaint. Instead, the plaintiff decided not to proceed against the Company and filed a notice of dismissal on July 25, 2017.

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

The DOJ investigation was initiated pursuant to a complaint brought under the *qui tam* provisions of the FCA (the Complaint). The Complaint was originally filed under seal in August 2014 in the U.S. District Court, Middle District of Florida, United States ex. rel James Spafford v. DaVita HealthCare Partners, Inc., et al., Case Number 6:14-cv-1251-Orl-41DAB, naming several doctors along with the Company as defendants. In December 2015, a First Amended Complaint was filed under seal. In May 2016, the First Amended Complaint was unsealed. The First Amended Complaint alleged violations of the FCA due to the submission of claims to the government for allegedly medically unnecessary angiograms and angiography procedures at the two vascular access centers as well as employment-related claims. The Complaint covers alleged conduct dating from July 2008, prior to our acquisition of the centers, to the present. The DOJ declined to intervene. In January 2017, we finalized and executed a settlement agreement with the relator and the government for an immaterial amount, and in April 2017, the court dismissed the case with prejudice.

* * *

Other than as described above, we cannot predict the ultimate outcomes of the various legal proceedings and regulatory matters to which we are or may be subject from time to time, including those described in this "Item 1. Legal Proceedings," in Part II of this report or the timing of their resolution or the ultimate losses or impact of developments in those matters, which could have a material adverse effect on our revenues, earnings and cash flows. Further, any legal proceedings or regulatory matters we are involved in, whether meritorious or not, are time consuming, and often require management's attention and result in significant legal expense, and may result in the diversion of significant operational resources, or otherwise harm our business, financial results or reputation.

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

*An updated 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 previously disclosed in Part I, Item 1A of our Annual Report on Form 10-K for the year ended December 31, 2016. The risks discussed below are not the only ones facing our business. Please read the cautionary notice regarding forward-looking statements in Item 2 of Part 1 of this Quarterly Report on Form 10-Q under the heading "Management's Discussion and Analysis of Financial Condition and Results of Operations".*

**Risk factors related to our overall business:**

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

Our operations are subject to extensive federal, state and local government laws and regulations, including Medicare and Medicaid payment rules and regulations, federal and state anti-kickback laws, the Stark Law and analogous state self-referral prohibition statutes, Federal Acquisition Regulations, the False Claims Act (FCA), the Civil Monetary Penalty statute, the Foreign Corrupt Practices Act (FCPA) and federal and state laws regarding the collection, use and disclosure of patient health information (e.g., Health Insurance Portability and Accountability Act of 1996 (HIPAA)) and the storage, handling and administration of pharmaceuticals. The Medicare and Medicaid reimbursement rules impose complex and extensive requirements upon dialysis providers as well. Moreover, additional laws and regulations potentially affecting providers continue to be promulgated. For example, on December 13, 2016, the 21st Century Cures Act was signed into law and, among other provisions, authorizes the Department of Health and Human Services (HHS) Office of Inspector General (OIG) to impose penalties on providers that engage in information blocking where there is knowledge that such practice is unreasonable and likely to interfere with, prevent, or materially discourage access, exchange, or use of electronic health information. A violation or departure from any of these legal requirements may result in government audits, lower reimbursements, significant fines and penalties, the potential loss of certification, recoupment efforts or voluntary repayments, among other things.

We endeavor to comply with all legal requirements; however, there is no guarantee that we will be able to adhere to all of the complex government regulations that apply to our business. We further endeavor to structure all of our relationships with physicians to comply with state and federal anti-kickback and physician self-referral laws. We utilize considerable resources to monitor laws and regulations and implement necessary changes. However, the laws and regulations in these areas are complex and often subject to varying interpretations. For example, if an enforcement agency were to challenge the level of compensation that we pay our medical directors or the number of medical directors whom we engage, we could be required to change our practices, face criminal or civil penalties, pay substantial fines or otherwise experience a material adverse effect on our business, results of operations and financial condition as a result of a challenge to these arrangements.

In addition, failure to report and return overpayments within 60 days of when the overpayment was identified and quantified can lead to a violation of the FCA and associated penalties, as described in further detail below, and exclusion and penalties under the federal Civil Monetary Penalty statute, including civil monetary penalties of up to $10,000 (adjusted for inflation) for each item or service for which a person received an identified overpayment and failed to report and return such overpayment. These obligations to report and return overpayments could subject our procedures for identifying and processing overpayments to greater scrutiny. We have made significant investments in resources to decrease the time it takes to identify, quantify and process overpayments, and we may be required to make additional investments in the future. From time to time we may conduct internal compliance reviews, the results of which may involve the identification of overpayments or other liabilities. In that regard, in the spring of 2015, we initiated an internal compliance review of our pharmacy business during which we identified potential billing and operational issues, including potential write-offs and discounts of patient co-payment obligations, and credits to payors for returns of prescriptions drugs, related to our pharmacy business. We have disclosed the results of this ongoing review to the government. An acceleration in our ability to identify and process overpayments could result in us refunding overpayments to government and other payors more rapidly than we have in the past which could have a material adverse effect on our operating cash flows. Overpayments subject us to refunds and related damages and potential liabilities.

Additionally, the federal government has used the FCA to prosecute a wide variety of alleged false claims and fraud allegedly perpetrated against Medicare and state health care programs. Moreover, amendments to the federal Anti-Kickback Statute in the 2010 Affordable Care Act (ACA) make claims tainted by anti-kickback violations potentially subject to liability under the FCA, including *qui tam* or whistleblower suits. The penalties for a violation of the FCA range from $5,500 to $11,000 (adjusted for inflation) for each false claim plus three times the amount of damages caused by each such claim which generally means the amount received directly or indirectly from the government. On February 3, 2017, the Department of Justice (DOJ)

issued a final rule announcing adjustments to FCA penalties, under which the per claim penalty range increases to a range from $10,957 to $21,916 for penalties assessed after February 3, 2017, so long as the underlying conduct occurred after November 2, 2015. Given the high volume of claims processed by our various operating units, the potential is high for substantial penalties in connection with any alleged FCA violations.

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

Certain civil investigative demands received by us or our subsidiaries specifically reference that they are in connection with FCA investigations alleging, among other things, that we or our subsidiaries presented or caused to be presented false claims for payment to the government. See “Item 1. Legal Proceedings” in Part II of this report and Note 10 to the condensed consolidated financial statements included in this report for further details.

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

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

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

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

We are the subject of a number of investigations and audits by the federal government. We have received subpoenas or other requests for documents from the federal government in connection with the Swoben private civil suit, the investigations underlying the two subpoenas regarding patient diagnosis coding received by DMG and its JSA subsidiary, the 2016 U.S.

Attorney Prescription Drug Investigation and the 2017 U.S. Attorney American Kidney Fund Investigation. In addition to the foregoing inquiries and proceedings, we are frequently subject to other investigations and audits by state or federal government agencies and/or private civil *qui tam* complaints filed by relators and other lawsuits, claims and legal proceedings.

Responding to subpoenas, investigations and other lawsuits, claims and legal proceedings as well as defending ourselves in such matters will continue to require management's attention and cause us to incur significant legal expense. Negative findings or terms and conditions that we might agree to accept as part of a negotiated resolution of pending or future government inquiries or relator proceedings could result in, among other things, substantial financial penalties or awards against us, substantial payments made by us, harm to our reputation, required changes to our business practices, exclusion from future participation in the Medicare, Medicaid and other federal healthcare programs and, in certain cases, criminal penalties, any of which could have a material adverse effect on us. It is possible that criminal proceedings may be initiated against us in connection with investigations by the federal government. To our knowledge, no such proceedings have been initiated by the federal government against us at this time. Other than as described in "Item 1. Legal Proceedings" in Part II of this report and Note 10 to the condensed consolidated financial statements included in this report, we cannot predict the ultimate outcomes of the various legal proceedings and regulatory matters to which we are or may be subject from time to time, including those described in the aforementioned sections of this report, or the timing of their resolution or the ultimate losses or impact of developments in those matters, which could have a material adverse effect on our business results of operations and financial condition. See "Item 1. Legal Proceedings" in Part II of this report and Note 10 to the condensed consolidated financial statements included in this report for further details regarding these and other matters.

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

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

**Healthcare reform could have a material adverse effect on our business, financial condition and results of operations.**

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

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

The ACA also added several new tax provisions that, among other things, impose various fees and excise taxes, and limit compensation deductions for health insurance providers and their affiliates. These rules could negatively impact our cash flow and tax liabilities. In addition, the ACA broadened the potential for penalties under the FCA for the knowing and improper retention of overpayments collected from government payors and reduced the timeline to file Medicare claims. As a result, we made significant investments in new resources to accelerate the time it takes us to identify, quantify and process overpayments and we deployed significant resources to reduce our timeline and improve our claims processing methods to ensure that our Medicare claims are filed in a timely fashion. However, we may be required to make additional investments in the future. Failure to timely identify and return overpayments may result in significant penalties, which could have a material adverse

effect on our business, results of operations and financial condition. Failure to file a claim within the one year window could result in payment denials, adversely affecting our business, results of operations and financial condition.

With the ACA, new models of care emerge and evolve and other initiatives in the government or private sector may arise, which could adversely impact our business. For example, the CMS Innovation Center (Innovation Center) is currently working with various healthcare providers to develop, refine and implement Accountable Care Organizations (ACOs) and other innovative models of care for Medicare and Medicaid beneficiaries, including Bundled Payments for Care Improvement Initiative, CEC Model (which includes the development of ESRD Seamless Care Organizations), the Comprehensive Primary Care Initiative, the Duals Demonstration, and other models. We are currently participating in the CEC Model with the Innovation Center, including with organizations in Arizona, Florida, and adjacent markets in New Jersey and Pennsylvania. Our U.S. dialysis business may choose to participate in additional models either as a partner with other providers or independently. Even in areas where we are not directly participating in these or other Innovation Center models, some of our patients may be assigned to an ACO, another ESRD Care Model, or another program, in which case the quality and cost of care that we furnish will be included in an ACO's, another ESRD Care Model's, or other program's calculations. Additionally, CMS instituted new screening procedures, as required by the ACA, which we expect will delay the Medicare contractor approval process, potentially causing a delay in reimbursement. We anticipate the new screening and enrollment requirements will require additional personnel and financial resources and will potentially delay the enrollment and revalidation of our centers which in turn will delay payment. These delays could adversely affect our business, results of operations and financial condition.

Other ACA reform measures allow CMS to place a moratorium on new enrollment of providers and to suspend payment to providers upon a credible allegation of fraud from any source. These types of reform measures, as well as other measures, could adversely affect our business, results of operations, and financial condition, depending on the scope and breadth of the implementing regulations.

There is also a considerable amount of uncertainty as to the prospective implementation of the ACA and what similar measures or other changes might be enacted at the federal and/or state level. There have been multiple attempts through legislative action and legal challenges to repeal or amend the ACA. In addition, the 2016 Presidential and Congressional elections and subsequent developments in 2017 have caused the future state of the exchanges and other ACA reforms to be unclear. While it does appear likely that there will be significant changes to the healthcare environment in the future, the specific changes and their timing are not yet apparent. As a result, there is considerable uncertainty regarding the future with respect to ACA reforms including the exchanges, and, indeed, many core aspects of the current health care marketplace. Previously enacted reforms as well as future changes could have a material adverse effect on our business, financial condition and results of operations, including, for example, by limiting the scope of coverage or the number of patients who are able to obtain coverage through the exchanges and other health insurance programs, lowering or eliminating the cost-sharing reduction subsidies under the ACA, lowering our reimbursement rates, and/or increasing our expenses.

In addition, CMS published an interim final rule that questioned the use of charitable premium assistance for ESRD patients and would have established new Conditions for Coverage standards for dialysis facilities that would have required facilities that provide education to patients seeking individual market health plans to notify such patients of potential coverage options and educate them about the benefits of each option. The interim final rule would have required facilities to ensure that insurers are informed of and have agreed to accept charitable assistance from a third party. In January 2017, a federal district court in Texas issued a preliminary injunction on CMS' interim final rule and in June 2017, at the request of CMS, the court stayed the proceedings while CMS conducts new rulemaking proceedings. This and any other law, rule, or guidance issued by CMS or other regulatory or legislative authorities limiting or prohibiting the ability of patients with access to alternative coverage from selecting a marketplace plan on or off exchange, and/or otherwise limiting or prohibiting the use of charitable premium assistance, could have a material adverse effect on our business, results of operations, and financial condition.

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

We must comply with numerous federal and state laws and regulations governing the collection, dissemination, access, use, security and privacy of PHI, including HIPAA and its implementing privacy, security, and related regulations, as amended by the federal Health Information Technology for Economic and Clinical Health Act (HITECH) and collectively referred to as HIPAA. If we fail to comply with applicable privacy and security laws, regulations and standards, including with respect to third-party service providers that utilize sensitive personal information, including PHI, on our behalf, properly maintain the

integrity of our data, protect our proprietary rights to our systems, or defend against cybersecurity attacks, it could harm our reputation or have a material adverse effect on our business, results of operations and financial condition. As set forth in applicable laws and regulations, we are required to report known privacy breaches to the Office of Civil Rights (OCR) and/or the appropriate state regulatory bodies. From time to time, we are subject to both federal and state inquiries related to HIPAA, HITECH and related state laws associated with complaints, desk audits, and self-reported breaches.

Information security risks have significantly increased in recent years in part because of the proliferation of new technologies, the use of the Internet and telecommunications technologies to conduct our operations, and the increased sophistication and activities of organized crime, hackers, terrorists and other external parties, including foreign state agents. Our operations rely on the secure processing, transmission and storage of confidential, proprietary and other information in our computer systems and networks.

We are continuously implementing multiple layers of security measures through technology, processes, and our people. We utilize current security technologies and our defenses are monitored and routinely tested internally and by external parties. Despite these efforts, our facilities and systems and those of our third-party service providers may be vulnerable to privacy and security incidents; security attacks and breaches; acts of vandalism or theft; computer viruses and other malicious code; coordinated attacks by activist entities; emerging cybersecurity risks; misplaced or lost data; programming and/or human errors; or other similar events that could impact the security, reliability, and availability of our systems. Emerging and advanced security threats, including coordinated attacks, require additional layers of security which may disrupt or impact efficiency of operations. Cybersecurity requires ongoing investment and diligence against evolving threats.

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

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

Our business strategy includes growth through acquisitions of dialysis centers and other businesses, as well as entry into joint ventures. We may engage in acquisitions, mergers, joint ventures, dispositions or new business models, which may affect our results of operations, debt-to-capital ratio, capital expenditures or other aspects of our business. There can be no assurance that we will be able to identify suitable acquisition targets or merger partners or that, if identified, we will be able to acquire these targets on acceptable terms or agree to terms with merger partners. There can also be no assurance that we will be successful in completing any acquisitions, mergers or dispositions that we announce, executing new business models or integrating any acquired business into our overall operations. There is no guarantee that we will be able to operate acquired businesses successfully as stand-alone businesses, or that any such acquired business will operate profitably or will not otherwise have a material adverse effect on our business, results of operations and financial condition. Further, we cannot be certain that key talented individuals at the business being acquired will continue to work for us after the acquisition or that they will be able to continue to successfully manage or have adequate resources to successfully operate any acquired business.

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

Additionally, joint ventures, including our Asia Pacific Joint Venture (APAC JV), and minority investments inherently involve a lesser degree of control over business operations, thereby potentially increasing the financial, legal, operational and/or compliance risks associated with the joint venture or minority investment. In addition, we may be dependent on joint venture partners, controlling shareholders or management who may have business interests, strategies or goals that are inconsistent with ours. Business decisions or other actions or omissions of the joint venture partner, controlling shareholders or management may adversely affect the value of our investment, result in litigation or regulatory action against us, result in reputational harm to us or adversely affect the value of our investment or partnership.

**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, results of operations and financial condition.**

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. Individual nephrologists have opened their own dialysis units or facilities. In addition, Fresenius USA, our largest competitor, manufactures a full line of dialysis supplies and equipment in addition to owning and operating dialysis centers. This may give it cost advantages over us because of its ability to manufacture its own products. 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 if a physician chooses not to refer to DaVita, it could adversely affect our business, results of operations and financial condition.

**Our ability to effectively provide the services we offer could be negatively impacted if certain of our suppliers do not meet our needs, if there are material price increases, or if we are unable to effectively access new technology, which could have a material adverse effect on our business, results of operations and financial condition.**

We have significant suppliers that are either the sole or primary source of products critical to the services we provide, including Amgen, Baxter, Fresenius USA, NxStage Medical, Inc. and others or to which we have committed obligations to make purchases. If any of these suppliers do not meet our needs for the products they supply, including in the event of a product recall, shortage or dispute, and we are not able to find adequate alternative sources, if we experience material price increases from these suppliers that we are unable to mitigate, or if some of the drugs that we purchase are not reimbursed or not adequately reimbursed by commercial payors or through the bundled payment rate by Medicare, our business, results of operations and financial condition could be materially reduced. In addition, the technology related to the products critical to the services we provide is subject to new developments which may result in superior products. If we are not able to access superior products on a cost-effective basis or if suppliers are not able to fulfill our requirements for such products, we could face patient attrition which could have a material adverse effect on our business, results of operations and financial condition.

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

DMG operates in a different line of business from our historical 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 DMG requires implementation of appropriate operations, management, and financial reporting systems and controls. We experience difficulties in effectively implementing these and other systems. The management of

DMG requires and will continue to require the focused attention of our management team, including a significant commitment of its time and resources. The need for management to focus on these matters could have a material adverse effect on our business, results of operations and financial condition. If the DMG 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, our results of operations and financial condition may be materially and adversely affected, and in that regard, we have taken goodwill impairment charges of $492 million in total and may continue incurring additional impairment charges.

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

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

In California, Colorado, Nevada and Washington, DMG 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, DMG provides management services and, receives a management fee for providing non-medical management services; however, DMG 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, DMG has certain contractual rights relating to the orderly transfer of equity interests in certain of its associated California, Colorado, Nevada and Washington physician groups through succession agreements and other arrangements with their physician equity holders. However, such equity interests cannot be transferred to or held by DMG or by any non-professional organization. Accordingly, neither DMG nor DMG's subsidiaries directly own any equity interests in any physician groups in California, Colorado, Nevada and Washington. In the event that any of these associated physician groups fail to comply with the management arrangement or any management arrangement is terminated and/or DMG 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 DMG's business, results of operations and financial condition.

It is possible that a state regulatory agency or a court could determine that DMG's agreements with physician equity holders of certain managed California, Colorado, Nevada and Washington associated physician groups as described above, either independently or coupled with the management services agreements with such associated physician groups, are in violation of the corporate practice of medicine doctrine. As a result, these arrangements could be deemed invalid, potentially resulting in a loss of revenues and an adverse effect on results of operations derived from such associated physician groups. Such a determination could force a restructuring of DMG's management arrangements with associated physician groups in California, Colorado, Nevada and/or Washington, which might include revisions of the management services agreements, including a modification of the management fee and/or establishing an alternative structure that would permit DMG to contract with a physician network without violating the corporate practice of medicine prohibition. There can be no assurance that such a restructuring would be feasible, or that it could be accomplished within a reasonable time frame without a material adverse effect on DMG's business, results of operations and financial condition. In December 2013, DHPC obtained a restricted Knox-Keene license in California, which permits DHPC to contract with health plans in California to accept global risk without violating the corporate practice of medicine prohibition. However, DMG and DMG's Colorado, Nevada and Washington associated physician groups, as well as those physician equity holders of associated physician groups who are subject to succession agreements with DMG, could be subject to criminal or civil penalties or an injunction for practicing medicine without a license or aiding and abetting the unlicensed practice of medicine.

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

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

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

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

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

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

The borrowings under our senior secured credit facilities are guaranteed by a substantial portion of our direct and indirect wholly-owned domestic subsidiaries and are secured by a substantial portion of our and our subsidiaries' assets.

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

Our operations and how we manage our Company may subject us, as well as our officers and directors to whom we owe certain defense and indemnity obligations, to litigation and liability for damages. Our business, profitability and growth prospects could suffer if we face negative publicity or we pay damages or defense costs in connection with a claim that is outside the scope or limits of coverage of any applicable insurance coverage, including claims related to adverse patient events, contractual disputes, professional and general liability and directors' and officers' duties. In addition, we have received several notices of claims from commercial payors and other third parties, as well as subpoenas and CIDs from the federal government, related to our business practices, including our historical billing practices and the historical billing practices of acquired businesses. Although the ultimate outcome of these claims cannot be predicted, an adverse result with respect to one or more of these claims could have a material adverse effect on our business, results of operations and financial condition. 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 business, results of operations and financial condition. Additionally, as a result of the broad scope of our DMG division's medical practice, we are exposed to medical malpractice claims, as well as claims for damages and other expenses, that may not be covered by insurance or for which adequate limits of insurance coverage may not be available.

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

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

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

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

**Deterioration in economic conditions and further disruptions in the financial markets could have a material adverse effect on our business, results of operations and financial condition.**

Deterioration in economic conditions could have a material adverse effect on our business, results of operations and financial condition. Among other things, the potential decline in federal and state revenues that may result from such conditions may create additional pressures to contain or reduce reimbursements for our services from Medicare, Medicaid and other government sponsored programs. Increases in job losses in the U.S. as a result of adverse economic conditions has and may continue to result in a smaller percentage of our patients being covered by an employer group health plan and a larger percentage being covered by lower paying Medicare and Medicaid programs. Employers may also select more restrictive commercial plans with lower reimbursement rates. To the extent that payors are negatively impacted by a decline in the economy, we may experience further pressure on commercial rates, a further slowdown in collections and a reduction in the amounts we expect to collect. In addition, uncertainty in the financial markets could adversely affect the variable interest rates payable under our credit facilities or could make it more difficult to obtain or renew such facilities or to obtain other forms of financing in the future, if at all. Any or all of these factors, as well as other consequences of a deterioration in economic conditions which cannot currently be anticipated, could have a material adverse effect on our business, results of operations and financial condition.

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

We are continuing to expand 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 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. laws, such as the FCPA, or local laws that prohibit us, our partners, or our partners' or our intermediaries from making improper payments to foreign officials for the purpose of obtaining or retaining business.

Issues relating to the failure to comply with any of the above may impact our domestic business and/or raise scrutiny on our domestic practices.

Additionally, some factors that will be critical to the success of our international business and operations will be different than those affecting our domestic business and operations. For example, conducting international operations requires us to devote significant management resources to implement our controls and systems in new markets, to comply with local laws and regulations 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 business, results of operations and financial condition.

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

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

Approximately 33% of our dialysis services revenues for the six months ended June 30, 2017 were generated from patients who have commercial payors (including hospital dialysis services) as their primary payor. The majority of these patients have insurance policies that pay us on terms and at rates that are generally significantly higher than Medicare rates. The payments we receive from commercial payors generate nearly all of our profit and all of our nonacute dialysis profits come from commercial payors. We continue to experience downward pressure on some of our commercial payment rates as a result of general conditions in the market, including as employers shift to less expensive options for medical services, recent and future consolidations among commercial payors, increased focus on dialysis services and other factors. In addition, many commercial payors that sell individual plans both on and off exchange have publicly announced losses in the marketplace. These payors may seek discounts on rates for marketplace plans on and off exchange. There is no guarantee that commercial payment rates will not be materially lower in the future.

We are continuously in the process of negotiating existing and potential new agreements with commercial payors who aggressively negotiate terms with us. Sometimes many significant agreements are being renegotiated at the same time. In the event that our continual negotiations result in overall commercial rate reductions in excess of overall commercial rate increases, the cumulative effect could have a material adverse effect on our business, results of operations and financial condition. Consolidations have significantly increased the negotiating leverage of commercial payors. Our negotiations with payors are also influenced by competitive pressures, and we may experience decreased contracted rates with commercial payors or experience decreases in patient volume as our negotiations with commercial payors continue. In addition to downward pressure on contracted commercial payor rates, payors have been attempting to design and implement plans to restrict access to coverage, and the duration and/or the breadth of benefits, which may result in decreased payments. In addition, payors have been attempting to impose restrictions and limitations on patient access to commercial exchange plans and non-contracted or out-of-network providers, and in some circumstances designate our centers as out-of-network providers. Rates for commercial exchange products and out-of-network providers are on average higher than rates for government products and in-network providers, respectively. In 2017, a number of commercial payors incorporated policies into their provider manuals refusing to accept charitable premium assistance from bona fide non-profit organizations, such as the American Kidney Fund, which may

impact the number of patients who are able to afford commercial exchange plans. We also 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 the number of patients with commercial exchange plans, decreases in out-of-network rates and restrictions on out-of-network access, our turning away new patients in instances where we are unable to come to agreement 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 business, results of operations and financial condition. For additional details regarding specific risks we face regarding regulatory changes that could result in fewer patients covered under commercial plans or an increase of patients covered under more restrictive commercial plans with lower reimbursement rates, see the discussion in the risk factor under the heading "Healthcare reform could have a material adverse effect on our business, financial condition and results of operations."

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

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. Many patients with commercial and government insurance rely on financial assistance from charitable organizations, such as the American Kidney Fund. However, certain payors are challenging our patients' and other providers' patients' ability to utilize assistance from charitable organizations for the payment of premiums, including through litigation and other legal proceedings. Regulators have also questioned the use of charitable premium assistance for ESRD patients, including CMS, which had issued an interim final rule on charitable premium assistance in December 2016. In January 2017, a federal district court in Texas issued a preliminary injunction on CMS' interim final rule and in June 2017, at the request of CMS, the court stayed the proceedings while CMS conducts new rulemaking proceedings. CMS or another regulatory agency or legislative authority may issue a new rule or guidance that challenges charitable premium assistance. If any of these challenges to kidney patients' use of premium assistance are successful or restrictions are imposed on the use of financial assistance from such charitable organizations such that kidney patients are unable to obtain, or continue to receive or receive for a limited duration, such financial assistance, it could have a material adverse effect on our business, results of operations and financial condition.

When Medicare becomes the primary payor, the payment rate we receive for that patient decreases from the employer group health plan rate to the lower Medicare payment rate. The number of our patients who have government-based programs as their primary payors could increase and the percentage of our patients covered under commercial insurance plans could be negatively impacted as a result of improved mortality or declining macroeconomic conditions. To the extent there are sustained or increased job losses in the U.S., independent of whether general economic conditions improve, we could experience a decrease in the number of patients covered under commercial plans. We could also experience a further decrease in the payments we receive for services if changes to the healthcare regulatory system result in fewer patients covered under commercial plans or an increase of patients covered under more restrictive commercial plans with lower reimbursement rates. In addition, our continual negotiations with commercial payors under existing and potential new agreements could result in a decrease in the number of our patients covered by commercial plans to the extent that we cannot reach agreement with commercial payors on rates and other terms, resulting in termination or non-renewals of existing agreements and our inability to enter into new agreements. Commercial payors have taken and may continue to take steps to control the cost of and/or the eligibility for access to healthcare services, including relative to products on and off the healthcare exchanges. These efforts could impact the number of our patients who are eligible to enroll in commercial insurance plans, and remain on the plans, including plans offered through healthcare exchanges. 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 business, results of operations and financial condition.

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

Approximately 42% of our dialysis services revenues for the six months ended June 30, 2017 were generated from patients who have Medicare as their primary payor. For patients with Medicare coverage, all ESRD payments for dialysis treatments are made under a single bundled payment rate which provides a fixed payment rate to encompass all goods and services provided during the dialysis treatment, including pharmaceuticals that were historically separately reimbursed to the dialysis providers, such as EPO, vitamin D analogs and iron supplements, irrespective of the level of pharmaceuticals administered or additional services performed. Most lab services are also included in the bundled payment. Under the ESRD Prospective Payment System (PPS), the bundled payments to a dialysis facility may be reduced by as much as 2% based on the facility's performance in specified quality measures set annually by CMS through the ESRD Quality Incentive Program, which

was established by the Medicare Improvements for Patients and Providers Act of 2008. The bundled payment rate is also adjusted for certain patient characteristics, a geographic usage index and certain other factors.

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

- Risk that our rates are reduced by CMS. Uncertainty about future payment rates remains a material risk to our business. Each year, CMS publishes a final rule for PPS, which phases in the reductions to the PPS base rate mandated by the American Taxpayer Relief Act of 2012 as modified by the Protecting Access to Medicare Act of 2014.
- Risk that increases in our operating costs will outpace the Medicare rate increases we receive. We expect operating costs to continue to increase due to inflationary factors, such as increases in labor and supply costs, regardless of whether there is a compensating inflation-based increase in Medicare payment rates or in payments under the bundled payment rate system.
- Risk of federal budget sequestration cuts. As a result of the Budget Control Act of 2011 and the Bipartisan Budget Act of 2015, an annual 2% reduction to Medicare payments took effect on April 1, 2013 and has been extended through 2025. These across-the-board spending cuts have affected and will continue to adversely affect our business, results of operations and financial condition.
- Risk that, if our clinical systems fail to accurately capture the data we report to CMS in connection with claims for which at least part of the government's payments to us is based on clinical performance or patient outcomes or co-morbidities, we might be over-reimbursed by the government, which could subject us to certain liability. For example, CMS published a final rule that implemented a provision of the ACA, requiring providers to report and return Medicare and Medicaid overpayments within the later of (a) 60 days after the overpayment is identified, or (b) the date any corresponding cost report is due, if applicable. An overpayment impermissibly retained under this statute could subject us to liability under the FCA, exclusion, and penalties under the federal Civil Monetary Penalty statute.

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 laws and regulations that apply to our business, we could suffer severe consequences that could have a material adverse effect on our business, results of operations, financial condition and stock price."

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

Approximately 25% of our dialysis services revenues for the six months ended June 30, 2017 were generated from patients who have state Medicaid or other non-Medicare government-based programs, such as coverage through the Department of Veterans Affairs (VA), as their primary coverage. As state governments and other governmental organizations face increasing budgetary pressure, we may in turn face reductions in payment rates, delays in the receipt of payments, limitations on enrollee eligibility or other changes to the applicable programs. For example, certain state Medicaid programs and the VA have recently considered, proposed or implemented payment rate reductions.

The VA adopted Medicare's bundled PPS pricing methodology for any veterans receiving treatment from non-VA providers under a national contracting initiative. Since we are a non-VA provider, these reimbursements are tied to a percentage of Medicare reimbursement, and we have exposure to any dialysis reimbursement changes made by CMS. Approximately 3% of our dialysis services revenues for the six months ended June 30, 2017 were generated by the VA.

In 2013, we entered into a five-year Nationwide Dialysis Services contract with the VA which is subject to one-year renewal periods, consistent with all provider agreements with the VA under this contract. During the length of the contract, the VA has elected not to make adjustments to reimbursement percentages that are tied to a percentage of Medicare reimbursement rates. These agreements provide the VA with the right to terminate the agreements without cause on short notice. Should the VA not renew or cancel these agreements for any reason, we may cease accepting patients under this program and may be forced to close centers, which could have a material adverse effect on our business, results of operations and financial condition.

State Medicaid programs are increasingly adopting Medicare-like bundled payment systems, but sometimes these payment systems are poorly defined and are implemented without any claims processing infrastructure, or patient or facility adjusters. If these payment systems are implemented without any adjusters and claims processing changes, Medicaid payments will be substantially reduced and the costs to submit such claims may increase, which will have a negative impact on our business, results of operations and financial condition. In addition, some state Medicaid program eligibility requirements

mandate that citizen enrollees in such programs provide documented proof of citizenship. If our patients cannot meet these proof of citizenship documentation requirements, they may be denied coverage under these programs, resulting in decreased patient volumes and revenue. These Medicaid payment and enrollment changes, along with similar changes to other non-Medicare government programs could reduce the rates paid by these programs for dialysis and related services, delay the receipt of payment for services provided and further limit eligibility for coverage which could materially adversely effect our business, results of operations and financial condition.

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

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

Additionally, evaluations on the utilization and reimbursement for ESAs, which have occurred in the past and may occur in the future, and related actions by the U.S. Congress and federal agencies, could result in further restrictions on the utilization and reimbursement for ESAs. Commercial payors have increasingly examined their administration policies for EPO and, in some cases, have modified those policies. Changes in labeling of EPO and other pharmaceuticals in a manner that alters physician practice patterns, whom are the ultimate determiners of EPO dosing or accepted clinical practices, and/or changes in private and governmental payment criteria, including the introduction of EPO administration policies could have a material adverse effect on our business, results of operations and financial condition. Further increased utilization of EPO for patients for whom the cost of EPO is included in a bundled reimbursement rate, or further decreases in reimbursement for EPO and other pharmaceuticals that are not included in a bundled reimbursement rate, could also have a material adverse effect on our business, results of operations and financial condition.

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

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

In October 2014, we entered into a Settlement Agreement with the United States and relator David Barbetta to resolve the then pending 2010 and 2011 U.S. Attorney physician relationship investigations and paid $406 million in settlement amounts, civil forfeiture, and interest to the United States and certain states. In connection with the resolution of these matters, and in exchange for the OIG's agreement not to exclude us from participating in the federal healthcare programs, we have entered into a five-year CIA with the OIG. The CIA (i) requires that we maintain certain elements of our compliance programs; (ii) imposes certain expanded compliance-related requirements during the term of the CIA; (iii) requires ongoing monitoring and reporting by an independent monitor, imposes certain reporting, certification, records retention and training obligations, allocates certain oversight responsibility to the Board's Compliance Committee, and necessitates the creation of a Management Compliance Committee and the retention of an independent compliance advisor to the Board; and (iv) contains certain business restrictions related to a subset of our joint venture arrangements, including our agreeing to (1) unwind 11 joint venture transactions that were created through partial divestitures to, or partial acquisitions from, nephrologists, and that cover 26 of our 2,119 clinics that existed at the time we entered into the Settlement Agreement, all of which have been completed, (2) not enter into certain types of partial divestiture joint venture transactions with nephrologists during the term of the CIA, (3) non-enforcement of certain patient-related non-solicitation restrictions, and (4) certain other restrictions. The costs associated with compliance with the CIA could be substantial and may be greater than we currently anticipate. In addition, in the event of a breach of the CIA, we could become liable for payment of certain stipulated penalties, and could be excluded from participation in federal healthcare programs. The OIG notified us that it considered us to be previously in breach of the CIA because of three implementation deficiencies. While we have remediated the deficiencies and have paid certain stipulated penalties, we cannot provide any assurances that we may not be found in breach of the CIA in the future. In general, the costs associated with compliance with the CIA, or any liability or consequences associated with a breach, could have a material adverse effect on our

business, results of operations and financial condition. For our domestic dialysis business, we are required under the CIA to report to the OIG (i) probable violations of criminal, civil or administrative laws applicable to any federal health care program for which penalties or exclusions may be authorized under applicable laws and regulations; (ii) substantial overpayments of amounts of money we have received in excess of the amounts due and payable under the federal healthcare program requirements; and (iii) employment of or contracting with individuals ineligible from participating in the federal healthcare programs (we refer to these collectively as Reportable Events). We have provided the OIG notice of Reportable Events, and we may identify and report additional events in the future. If any of our operations are found to violate government laws and regulations, we could suffer severe consequences that could have a material adverse effect on our business, results of operations, financial condition and stock price, including those consequences described under the risk factor "If we fail to adhere to all of the complex government laws and regulations that apply to our business, we could suffer severe consequences that could have a material adverse effect on our business, results of operations, financial condition and stock price."

**Delays in state Medicare and Medicaid certification or other licensing of our dialysis centers could adversely affect our business, results of operations and financial condition.**

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

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

As of June 30, 2017, we owned a controlling interest in numerous dialysis-related joint ventures, which represented approximately 24% of our dialysis and related lab services revenues for the six months ended June 30, 2017. In addition, we also owned noncontrolling equity investments in several other dialysis related joint ventures. We may continue to increase the number of our joint ventures. Many of our joint ventures with physicians or physician groups also have certain physician owners providing medical director services to centers we own and operate. Because our relationships with physicians are governed by the federal and state anti-kickback statutes, we have sought to structure our joint venture arrangements to satisfy as many federal safe harbor requirements as we believe are commercially reasonable. However, although our joint venture arrangements do not satisfy all of the elements of any safe harbor under the federal Anti-Kickback Statute, they are not automatically prohibited under the federal Anti-Kickback Statute but are susceptible to government scrutiny. For example, in October 2014, we entered into a Settlement Agreement with the United States and relator David Barbetta to resolve the then pending 2010 and 2011 U.S. Attorney physician relationship investigations regarding certain of our joint ventures and paid $406 million in settlement amounts, civil forfeiture, and interest to the United States and certain states. For further details, see "If we fail to comply with our Corporate Integrity Agreement, we could be subject to substantial penalties and exclusion from participation in federal healthcare programs that could have a material adverse effect on our business, results of operations and financial condition".

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

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 194,600 U.S. patients at any point in time, together with the changes in patient coverage that occur each month, requires complex, resource-intensive processes. Errors in determining the correct coordination of benefits may result in refunds to payors. Revenues associated with Medicare and Medicaid programs are also subject to estimating risk related to the amounts not paid by the primary government payor that will ultimately be collectible from other government programs paying secondary coverage, the patient's commercial health plan

secondary coverage or the patient. Collections, refunds and payor retractions typically continue to occur for up to three years and longer after services are provided. We generally expect our range of dialysis and related lab services revenues estimating risk to be within 1% of net revenues for the segment. 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 material adverse impact on our business, results of operations and financial condition.

**Our ancillary services and strategic initiatives, including our pharmacy services and 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, our business, results of operations and financial condition may be negatively impacted and we may have to write off our investment and incur other exit costs.**

Our ancillary services and strategic initiatives currently include pharmacy services, disease management services, vascular access services, ESRD clinical research programs, physician services, physician practice management services, direct primary care and our international dialysis operations. We expect to add additional service offerings and pursue additional strategic initiatives in the future as circumstances warrant, which could include healthcare services not related to dialysis. Many of these initiatives require or would require investments of both management and financial resources and can generate significant losses for a substantial period of time and may not become profitable. There can be no assurance that any such strategic initiative will ultimately be successful. Any significant change in market conditions, or business performance, or in the political, legislative or regulatory environment, may impact the economic viability of any of these strategic initiatives.

If any of our ancillary services or strategic initiatives, including our pharmacy services and our international dialysis operations, do not perform as planned, it could have a negative impact on our business, results of operations and financial condition, 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 business, results of operations and financial condition.**

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

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

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

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

**If there are shortages of skilled clinical personnel, or if changes to state staffing ratios are implemented with which we are required to comply, we may experience disruptions in our business operations and increases in operating expenses, among other things, which could have a material adverse effect on our business, results of operations and financial condition.**

We are experiencing increased labor costs and difficulties in hiring nurses due to a nationwide shortage of skilled clinical personnel. We compete for nurses with hospitals and other healthcare providers. This nursing shortage may limit our ability to

expand our operations. In addition, if we experience a higher than normal turnover rate for our skilled clinical personnel, our operations and treatment growth may be negatively impacted, which could adversely affect our business, results of operations and financial condition.

In addition, currently proposed and/or future legislation or policy changes could impose additional requirements on our operations, including increases in the required staffing levels or staffing ratios for clinical personnel. For example, SB 349 is a bill that was introduced in the California legislature that, if passed and signed into law in its current form, would among other things mandate staffing ratios for nurses, technicians, dietitians, and social workers as well as minimum transition times between treatments. These changes would likely increase our operating expense and impact our ability to staff our clinics to the new, elevated staffing levels, in particular given the ongoing nationwide shortage of healthcare workers, especially nurses. Any of these events or circumstances could materially increase our operating costs, require us to close dialysis centers or reduce shifts, and could have a material adverse effect on our employee relations, treatment growth, productivity, business, results of operations and financial condition.

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

Our business is labor intensive, and our financial and operating 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. Political efforts at the national or local level could result in actions or proposals that increase the likelihood or success of union organizing activities at our facilities and union organizing activities could increase for other reasons. Labor and employment claims, including the filing of class action suits, or work stoppages, wages and benefits or adverse outcomes of these types of claims could trend upwards. Any of these events or circumstances could have a material adverse effect on our employee relations, treatment growth, productivity, business, results of operations and financial condition.

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

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

**Risk factors related to DMG:**

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

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

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

Approximately 83% of DMG's revenue for the six months ended June 30, 2017 is derived from fixed per member per month (PMPM) fees paid by health plans under capitation agreements with DMG or its associated physician groups. While there are variations specific to each arrangement, DMG, through DaVita Health Plan of California, Inc. (DHPC), a subsidiary of HealthCare Partners Holdings, LLC and a restricted Knox-Keene licensed entity, and, in certain instances, DMG's associated physician groups generally contract with health plans to receive a PMPM fee for professional services and assume the financial responsibility for professional services only. In some cases, the health plans separately enter into capitation contracts with third parties (typically hospitals) who receive directly a PMPM fee and assume contractual financial responsibility for hospital services. In other cases, the health plan does not pay any portion of the PMPM fee to the hospital, but rather administers claims for hospital expenses itself. In both scenarios, DMG enters into managed care-related administrative services agreements or similar arrangements with those third parties (typically hospitals) under which DMG agrees to be responsible for utilization review, quality assurance, and other managed care-related administrative functions and claim payments. As compensation for such administrative services, DMG is entitled to receive a percentage of the amount by which the institutional capitation revenue received from health plans exceeds institutional expenses; any such risk-share amount to which DMG is entitled is recorded as medical revenues, and DMG is also responsible for a percentage of any short-fall in the event that institutional

expenses exceed institutional revenues. To the extent that members require more care than is anticipated, 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, DMG will not be able to increase the PMPM fee received under these risk agreements during their then-current terms and could, directly or indirectly through its contracts with its associated physician groups, suffer losses with respect to such agreements.

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

Historically, DMG'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 DMG's affiliated primary care physicians and specialists;
- changes in the demographics of the participating members and medical trends;
- contractual or claims disputes with providers, hospitals or other service providers within a health plan's network;
- the occurrence of catastrophes, major epidemics or acts of terrorism; and
- the reduction of health plan premiums.

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

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

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

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

contract. Since DMG does not negotiate with CMS or any health plan regarding the benefits to be provided under their Medicare Advantage plans, DMG often has just a few months to familiarize itself with each new annual package of benefits it is expected to offer. Depending on the health plan at issue and the amount of revenue associated with the health plan's risk agreement, the renegotiated terms or termination could have a material adverse effect on DMG's business, results of operations and financial condition.

**If DMG'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 have a material adverse effect on DMG's consolidation of total revenues derived from such associated physician groups.**

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

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

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

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

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

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

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

- Maintain, at all times, a minimum cash-to-claims ratio (where cash-to-claims ratio means the organization's cash, marketable securities and certain qualified receivables, divided by the organization's total unpaid claims liability). The regulation currently requires a cash-to-claims ratio of 0.75.
- Submit periodic reports to the California DMHC containing various data and attestations regarding performance and financial solvency, including incurred but not reported calculations and documentation, and attestations as to whether or not the organization was in compliance with Knox-Keene requirements related to claims payment timeliness, had maintained positive TNE (i.e., at least $1.00) and had maintained positive working capital (i.e., at least $1.00).

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

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

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

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

We have taken impairment charges against the goodwill of several of our DMG reporting units in four of the seven quarters since the fourth quarter of 2015 based on continuing developments in our DMG business, including recent annual updates to Medicare Advantage benchmark reimbursement rates, changes in our expectations concerning future government reimbursement rates and our expected ability to mitigate them, medical cost and utilization trends, underperformance of certain at-risk reporting units and other market conditions. We may also need to take additional goodwill impairment charges against earnings in a future period, depending on the impact of continuing developments on the value of our DMG reporting units. A goodwill impairment occurs when the carrying amount of a reporting unit's goodwill is in excess of its implied fair value, and the amount of such non-cash charge, if any, could be significant. In estimating the fair value of our DMG reporting units, we update our forecasts for our at-risk DMG reporting units to reflect the expected future cash flows that we believe market participants would use in determining fair values of our DMG reporting units if they were to acquire these businesses. We and our independent advisors also use certain estimates and key assumptions in determining the estimate of these fair values, including applicable market multiples, discount and long-term growth rates, market data and future reimbursement rates. Our estimates of the fair value of our DMG reporting units could differ from the actual values that a market participant would pay for these reporting units.

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

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

- Medicare Advantage benchmarks for 2011 were frozen at 2010 levels. From 2012 through 2016, Medicare Advantage benchmark rates were phased down from prior levels. The new benchmarks will be fully phased-in in 2017 and will range between 95% and 115% of the Medicare FFS costs, depending on a plan's geographic area. If our costs escalate faster than can be absorbed by the level of revenues implied by these benchmark rates, then it could have a material adverse effect on DMG's business and results of operations.
- Rebates received by Medicare Advantage plans that were reduced, with larger reductions for plans failing to receive certain quality ratings.
- The Secretary of the Department of Health and Human Services (HHS) has been granted the explicit authority to deny Medicare Advantage plan bids that propose significant increases in cost sharing or decreases in benefits. If the bids submitted by plans contracted with DMG are denied, this could have a material adverse effect on DMG's business and results of operations.

- Medicare Advantage plans with medical loss ratios below 85% are required to pay a rebate to the Secretary of HHS. The rebate amount is the total revenue under the contract year multiplied by the difference between 85% and the plan's actual medical loss ratio. The Secretary of HHS will halt enrollment in any plan failing to meet this ratio for three consecutive years, and terminate any plan failing to meet the ratio for five consecutive years. If a DMG-contracting Medicare Advantage plan experiences a limitation on enrollment or is otherwise terminated from the Medicare Advantage program, it could have a material adverse effect on DMG's business and results of operations.
- Prescription drug plans are required to provide coverage of certain drug categories on a list developed by the Secretary of HHS, which could increase the cost of providing care to Medicare Advantage enrollees, and thereby reduce DMG's revenues and earnings. The Medicare Part D premium amount subsidized for high-income beneficiaries has been reduced, which could lower the number of Medicare Advantage enrollees, which would have a negative impact on DMG's business and results of operations.
- CMS increased coding intensity adjustments for Medicare Advantage plans beginning in 2014 and continuing through 2018, which reduces CMS payments to Medicare Advantage plans, which in turn will likely reduce the amounts payable to DMG and its associated physicians, physician groups, and IPAs under its capitation agreements.

The 2016 Presidential and Congressional elections, and recent legislative efforts to enact further healthcare reform legislation, have caused the future state of the exchanges and other ACA reforms to be unclear. While specific changes and their timing are not yet apparent, enacted reforms and future legislative changes could have a material adverse effect on DMG's business, results of operations and financial condition.

There is also uncertainty regarding both Medicare Advantage payment rates and beneficiary enrollment, which, if reduced, would reduce DMG's overall revenues and net income. For example, although the Congressional Budget Office (CBO) predicted in 2010 that Medicare Advantage participation would drop substantially by 2020, the CBO has more recently predicted, without taking into account potential future reforms, that enrollment in Medicare Advantage (and other contracts covering Medicare Parts A and B) could reach 31 million by 2027. Although Medicare Advantage enrollment increased by approximately 5.6 million, or by 50%, between the enactment of the ACA in 2010 and 2015, there can be no assurance that this trend will continue. Further, fluctuation in Medicare Advantage payment rates are evidenced by CMS's annual announcement of the expected average change in revenue from the prior year: for 2017, CMS announced an average increase of 0.85%; and for 2018, 0.45%. Uncertainty over Medicare Advantage enrollment and payment rates present a continuing risk to DMG's business.

According to the Kaiser Family Foundation (KFF), Medicare Advantage enrollment continues to be highly concentrated among a few payors, both nationally and in local markets. In 2017, the KFF reported that three payors together account for more than half of Medicare Advantage enrollment; eight firms account for approximately 75% of the market; and in 439 counties in 26 states, only one company offers Medicare Advantage plans, an indicator that those markets may lack competition. In 2016 and 2017, mergers between major Medicare Advantage carriers have been subject to regulatory review. Consolidation among Medicare Advantage plans, or the Medicare program's failure to attract additional plans to participate in the Medicare Advantage program, could have a material adverse effect on DMG's business, results of operations and financial condition.

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

For the six months ended June 30, 2017, 66% of DMG's consolidated capitated medical revenues were earned through contracts with three health plans.

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

Notwithstanding each health plan's and DMG's current shared interest in providing service to DMG's members who are enrolled in the subject health plans, the health plans may have different and, at times, opposing economic interests from those of DMG. The health plans provide a wide range of health insurance services across a wide range of geographic regions, utilizing a vast network of providers. As a result, they and DMG may have different views regarding the proper pricing of services and/or the proper pricing of the various service providers in their provider networks, the cost of which DMG bears to

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

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

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

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

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

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

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

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

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

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

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

In June 2015, we received a subpoena from the OIG requesting information relating to our and our subsidiaries' (including DMG's and its subsidiary JSA's) provision of services to Medicare Advantage plans and related patient diagnosis coding and risk adjustment submissions and payments. See "Item 1. Legal Proceedings" in Part II of this report and Note 10 to the condensed consolidated financial statements included in this report for further details.

Additionally, CMS audits Medicare Advantage plans for documentation to support RAF-related payments for members chosen at random. The Medicare Advantage plans ask providers to submit the underlying documentation for members that they serve. It is possible that claims associated with members with higher RAF scores could be subject to more scrutiny in a CMS or plan audit. There is a possibility that a Medicare Advantage plan may seek repayment from DMG should CMS make any payment adjustments to the Medicare Advantage plan as a result of its audits. The plans also may hold DMG liable for any penalties owed to CMS for inaccurate or unsupportable RAF scores provided by DMG. In addition, DMG could be liable for penalties to the government under the FCA that range from $5,500 to $11,000 (adjusted for inflation) for each false claim, plus up to three times the amount of damages caused by each false claim, which can be as much as the amounts received directly or indirectly from the government for each such false claim. On February 3, 2017, the DOJ issued a final rule announcing adjustments to FCA penalties, under which the per claim penalty range increases from $10,957 to $21,916 for penalties assessed after February 3, 2017, so long as the underlying conduct occurred after November 2, 2015.

CMS has indicated that payment adjustments will not be limited to RAF scores for the specific Medicare Advantage enrollees for which errors are found but may also be extrapolated to the entire Medicare Advantage plan subject to a particular CMS contract. CMS has described its audit process as plan-year specific and stated that it will not extrapolate audit results for plan years prior to 2011. Because CMS has not stated otherwise, there is a risk that payment adjustments made as a result of one plan year's audit would be extrapolated to prior plan years after 2011.

There can be no assurance that a health plan will not be randomly selected or targeted for review by CMS or that the outcome of such a review will not result in a material adjustment in DMG's revenue and profitability, even if the information DMG submitted to the plan is accurate and supportable.

Separately, as described in further detail in "Item 1. Legal Proceedings" in Part II of this report and Note 10 to the condensed consolidated financial statements included in this report, on March 13, 2015, JSA, a subsidiary of DMG, received a subpoena from the OIG that relates, in part, to risk adjustment practices and data.

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

Patient care costs include estimates of future medical claims that have been incurred by the patient but for which the provider has not yet billed DMG. These claim estimates are made utilizing actuarial methods and are continually evaluated and adjusted by management, based upon DMG's historical claims experience and other factors, including an independent assessment by a nationally recognized actuarial firm. Adjustments, if necessary, are made to medical claims expense and capitated revenues when the assumptions used to determine DMG's claims liability 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 DMG's financial statements for a particular period under different conditions or using different, but still reasonable, assumptions. It is possible that DMG's estimates of this type of claim may be inadequate in the future. In such event, DMG's results of operations could be adversely impacted. Further, the inability to estimate these claims accurately may also affect DMG's ability to take timely corrective actions, further exacerbating the extent of any adverse effect on DMG's results of operations.

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

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

- As a result of the direct and indirect impacts of the ACA, many Medicare beneficiaries may decide that an original Medicare FFS program is more attractive than a Medicare Advantage plan. As a result, enrollment in the health plans DMG serves may decrease.
- Managed care companies offer alternative products such as regional preferred provider organizations (PPOs) and private FFS plans. Medicare PPOs and private FFS plans allow their patients more flexibility in selecting physicians than Medicare Advantage health plans, which typically require patients to coordinate care with a primary care physician. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 has encouraged the creation of regional PPOs through various incentives, including certain risk corridors, or cost reimbursement provisions, a stabilization fund for incentive payments, and special payments to hospitals not otherwise contracted with a Medicare Advantage plan that treat regional plan enrollees. The formation of regional Medicare PPOs and private FFS plans may affect DMG's relative attractiveness to existing and potential Medicare patients in their service areas.
- The payments for the local and regional Medicare Advantage plans are based on a competitive bidding process that may indirectly cause a decrease in the amount of the PMPM fee or result in an increase in benefits offered.
- The annual enrollment process and subsequent lock-in provisions of the ACA may adversely affect DMG's level of revenue growth as it will limit the ability of a health plan to market to and enroll new Medicare beneficiaries in its established service areas outside of the annual enrollment period.
- CMS allows Medicare beneficiaries who are enrolled in a Medicare Advantage plan with a quality rating of 4.5 stars or less to enroll in a 5-star rated Medicare Advantage plan at any time during the benefit year. Therefore, DMG may face a competitive disadvantage in recruiting and retaining Medicare beneficiaries.

In addition to the competitive threats intrinsic to the Medicare programs, competition among health plans and among healthcare providers may also have a negative impact on DMG's profitability. For example, due to the large population of Medicare beneficiaries, DMG's Existing Geographic Regions have become increasingly attractive to health plans that may compete with DMG. DMG may not be able to continue to compete profitably in the healthcare industry if additional competitors enter the same market. If DMG cannot compete profitably, the ability of DMG to compete with other service providers that contract with competing health plans may be substantially impaired. Furthermore, if DMG is unable to obtain new members or experiences a loss of existing members to competitors during the open enrollment period for Medicare it could have a material adverse effect on DMG's business, results of operations and financial condition.

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

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

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

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

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

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

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

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

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

In California, AMG maintains significant hospital arrangements designed to facilitate the provision of coordinated hospital care with those services provided to members by AMG and its associated physicians, physician groups and IPAs. Through contractual arrangements with certain key hospitals, AMG provides utilization review, quality assurance and other management services related to the provision of patient care services to members by the contracted hospitals and downstream hospital contractors. In the event that any one of these key hospital agreements is amended in a financially unfavorable manner

or is otherwise terminated, such events could have a material adverse effect on DMG's business, results of operations and financial condition.

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

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

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

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

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

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

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

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

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

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

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

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

**Risk factors related to ownership of our common stock:**

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

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

Most of our outstanding employee stock-based compensation awards include a provision accelerating the vesting of the awards in the event of a change of control. We also maintain a change of control protection program for our employees who do not have a significant number of stock awards, which has been in place since 2001, and which provides for cash bonuses to the employees in the event of a change of control. Based on the market price of our common stock and shares outstanding on June 30, 2017, these cash bonuses would total approximately $488 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) Share repurchases**

The following table summarizes the Company's repurchases of its common stock during the second quarter of 2017:

| 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) |
|---|---|---|---|---|
| April 1-30, 2017 | — | — | — | 677.1 |
| May 1-31, 2017 | 2,922,760 | $ 64.75 | 2,922,760 | 487.9 |
| June 1-30, 2017 | 651,813 | 65.08 | 651,813 | 445.4 |
| Total | 3,574,573 | $ 64.81 | 3,574,573 | |

On July 13, 2016, our Board of Directors approved share repurchases in the amount of approximately $1.2 billion. These share repurchases were in addition to the approximately $259 million remaining at that time under our Board of Directors' prior share repurchase authorization announced in April 2015. 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. During the quarter ended June 30, 2017, we repurchased a total of 3,574,573 shares of our common stock for $232 million, or an average price of $64.81 per share. As of June 30, 2017, we have a total of approximately $445 million in outstanding Board repurchase authorizations. We have not repurchased any shares from July 1, 2017 through August 1, 2017. Although these share repurchase authorizations have no expiration dates, 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 | |
|---|---|
| 10.1 | Employment Agreement, effective April 27, 2016, by and between DaVita Inc. and Kathleen A. Waters. ✓ |
| 12.1 | Ratio of earnings to fixed charges. ✓ |
| 31.1 | Certification of the Chief Executive Officer, dated August 1, 2017, 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 August 1, 2017, 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 August 1, 2017, 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 August 1, 2017, 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.

* Portions of this exhibit are subject to a request for confidential treatment and have been redacted and filed separately with the SEC.

**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 INC.

BY: /s/ JAMES K. HILGER

**James K. Hilger**

**Chief Accounting Officer***

Date: August 1, 2017

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

**INDEX TO EXHIBITS**

| Exhibit Number | |
|---|---|
| 10.1 | Employment Agreement, effective April 27, 2016, by and between DaVita Inc. and Kathleen A. Waters. ✓ |
| 12.1 | Ratio of earnings to fixed charges. ✓ |
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| 101.LAB | XBRL Taxonomy Extension Label Linkbase Document. ✓ |
| 101.PRE | XBRL Taxonomy Extension Presentation, Linkbase Document. ✓ |

✓ Filed herewith.

* Portions of this exhibit are subject to a request for confidential treatment and have been redacted and filed separately with the SEC.

**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 noncontrolling interests. Fixed charges include debt expense (interest expense and the amortization of deferred financing costs), the estimated interest component of rent expense on operating leases, and capitalized interest.

| | Six months ended June 30, 2017 | Year ended December 31, | | | | |
|---|---|---|---|---|---|---|
| | | 2016 | 2015 | 2014 | 2013 | 2012 |
| | (dollars in thousands) | | | | | |
| **Earnings adjusted for fixed charges:** | | | | | | |
| Income from continuing operations before income taxes | $ 1,063,657 | $ 1,488,895 | $ 723,136 | $ 1,309,673 | $ 1,124,978 | $ 1,001,304 |
| Add: | | | | | | |
| Debt expense | 212,391 | 414,382 | 408,380 | 410,294 | 429,943 | 288,554 |
| Interest portion of rent expense | 98,342 | 181,888 | 166,821 | 149,432 | 137,558 | 112,424 |
| Less: Noncontrolling interests | (87,559) | (153,640) | (158,304) | (140,949) | (124,276) | (105,891) |
| | 223,174 | 442,630 | 416,897 | 418,777 | 443,225 | 295,087 |
| | $ 1,286,831 | $ 1,931,525 | $ 1,140,033 | $ 1,728,450 | $ 1,568,203 | $ 1,296,391 |
| Fixed charges: | | | | | | |
| Debt expense | 212,391 | 414,382 | 408,380 | 410,294 | 429,943 | 288,554 |
| Interest portion of rent expense | 98,342 | 181,888 | 166,821 | 149,432 | 137,558 | 112,424 |
| Capitalized interest | 8,408 | 12,990 | 9,723 | 7,888 | 6,408 | 8,127 |
| | $ 319,141 | $ 609,260 | $ 584,924 | $ 567,614 | $ 573,909 | $ 409,105 |
| Ratio of earnings to fixed charges | 4.03 | 3.17 | 1.95 | 3.05 | 2.73 | 3.17 |

**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 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: August 1, 2017

**EXHIBIT 31.2**

**SECTION 302 CERTIFICATION**

I, Joel Ackerman, certify that:

1. I have reviewed this quarterly report on Form 10-Q of DaVita 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/ Joel Ackerman

**Joel Ackerman**

**Chief Financial Officer**

Date: August 1, 2017

**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 Inc. (the "Company") on Form 10-Q for the quarter ended June 30, 2017 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**
August 1, 2017

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 Inc. (the "Company") on Form 10-Q for the quarter ended June 30, 2017 as filed with the Securities and Exchange Commission on the date hereof (the "Periodic Report"), I, Joel Ackerman, Chief Financial 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/ Joel Ackerman

**Joel Ackerman**
**Chief Financial Officer**
August 1, 2017

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.