UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-K

For the Fiscal Year Ended December 31, 2016

ANNUAL 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, Colorado 80202
Telephone number (303) 405-2100

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

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

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

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

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

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

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

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

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

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

As of June 30, 2016, the number of shares of the Registrant's common stock outstanding was approximately 206.9 million shares and the aggregate market value of the common stock outstanding held by non-affiliates based upon the closing price of these shares on the New York Stock Exchange was approximately $16.0 billion.

As of January 31, 2017, the number of shares of the Registrant's common stock outstanding held by non-affiliates was approximately 194.6 million shares.

Documents incorporated by reference

Portions of the Registrant's proxy statement for its 2017 annual meeting of stockholders are incorporated by reference in Part III of this Form 10-K.

PART I

Item 1. Business

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

Overview of DaVita Inc.

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

For financial information about our reportable segments see Note 25 to the consolidated financial statements included in this report.

Kidney Care Division

U.S. dialysis and related lab services business overview

Our U.S. dialysis and related lab services business is a leading provider of kidney dialysis services for patients suffering from ESRD. As of December 31, 2016, we provided dialysis and administrative services in the U.S. through a network of 2,350 outpatient dialysis centers in 46 states and the District of Columbia, serving a total of approximately 187,700 patients. We also provide acute inpatient dialysis services in approximately 900 hospitals and related laboratory services throughout the U.S. All references in this document to dialysis and related lab services refer only to our U.S. dialysis and related lab services business.

The loss of kidney function is normally irreversible. Kidney failure is typically caused by Type I and Type II diabetes, high blood pressure, polycystic kidney disease, long-term autoimmune attack on the kidney and prolonged urinary tract obstruction. ESRD is the stage of advanced kidney impairment that requires continued dialysis treatments or a kidney transplant to sustain life. Dialysis is the removal of toxins, fluids and salt from the blood of patients by artificial means. Patients suffering from ESRD generally require dialysis at least three times a week for the rest of their lives.

According to the United States Renal Data System, there were approximately 477,000 ESRD dialysis patients in the U.S. in 2014. The underlying ESRD dialysis patient population has grown at an approximate compound rate of 3.8% from 2000 to 2014, the latest period for which such data is available. The growth rate is attributable to the aging of the U.S. population, increased incidence rates for diseases that cause kidney failure such as diabetes and hypertension, lower mortality rates for dialysis patients and growth rates of minority populations with higher than average incidence rates of ESRD.

Since 1972, the federal government has provided healthcare coverage for ESRD patients under the Medicare ESRD program regardless of age or financial circumstances. ESRD is the first and only disease state eligible for Medicare coverage both for dialysis and dialysis-related services and for all benefits available under the Medicare program. For patients with Medicare coverage, all ESRD payments for dialysis treatments are made under a single bundled payment rate. See page 5 for further details.

Although Medicare reimbursement limits the allowable charge per treatment, it provides industry participants with a relatively predictable and recurring revenue stream for dialysis services provided to patients without commercial insurance. For the year ended December 31, 2016, approximately 88% of our total dialysis patients were covered under some form of government-based programs, with approximately 75% of our dialysis patients covered under Medicare and Medicare-assigned plans.

Treatment options for ESRD

Treatment options for ESRD are dialysis and kidney transplantation.

Dialysis options

- *Hemodialysis*

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

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

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

- *Peritoneal dialysis*

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

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

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

Kidney transplantation

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

Dialysis and related lab services we provide

Outpatient hemodialysis services

As of December 31, 2016, we operated or provided administrative services through a network of 2,350 outpatient dialysis centers in the U.S. that are designed specifically for outpatient hemodialysis. In 2016, our overall network of U.S. outpatient dialysis centers increased by 99 primarily as a result of the opening of new dialysis centers, net of center closures and divestitures, and acquisitions, representing a total increase of approximately 4.4% from 2015.

As a condition of our enrollment in Medicare for the provision of dialysis services, we contract with a nephrologist or a group of associated nephrologists to provide medical director services at each of our dialysis centers. In addition, other nephrologists may apply for practice privileges to treat their patients at our centers. Each center has an administrator, typically a registered nurse, who supervises the day-to-day operations of the center and its staff. The staff of each center typically consists of registered nurses, licensed practical or vocational nurses, patient care technicians, a social worker, a registered dietician, biomedical technician support and other administrative and support personnel.

Under Medicare regulations, we cannot promote, develop or maintain any kind of contractual relationship with our patients that would directly or indirectly obligate a patient to use or continue to use our dialysis services, or that would give us any preferential rights other than those related to collecting payments for our dialysis services. Our total patient turnover, which is based upon all causes, averaged approximately 25% in both 2016 and 2015. However, in 2016, the overall number of patients to whom we provided services in the U.S. increased by approximately 4.5% from 2015, primarily from the opening of new dialysis centers and acquisitions, and continued growth within the industry.

Hospital inpatient hemodialysis services

As of December 31, 2016, we provided hospital inpatient hemodialysis services, excluding physician services, to patients in approximately 900 hospitals throughout the U.S. We render these services based on a contracted per-treatment fee that is individually negotiated with each hospital. When a hospital requests our services, we typically administer the dialysis treatment at the patient's bedside or in a dedicated treatment room in the hospital, as needed. In 2016, hospital inpatient hemodialysis services accounted for approximately 4.7% of our U.S. dialysis revenues and 4.0% of our total U.S. dialysis treatments.

Home-based hemodialysis services

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

ESRD laboratory services

We own two separately incorporated, licensed, clinical laboratories which specialize in ESRD patient testing. These specialized laboratories provide routine laboratory tests for dialysis and other physician-prescribed laboratory tests for ESRD patients and are an integral component of overall dialysis services that we provide. Our laboratories provide these tests predominantly for our network of ESRD patients throughout the U.S. These tests are performed to monitor a patient's ESRD condition, including the adequacy of dialysis, as well as other medical conditions of the patient. Our laboratories utilize information systems which provide information to certain members of the dialysis centers' staff and medical directors regarding critical outcome indicators.

Management services

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

Quality care

Centers for Medicare and Medicaid Services' (CMS) Five-Star Quality Rating system, is a rating system that assigns one to five stars to rate the quality of outcomes for dialysis facilities. The rating system provides patients reported information about any given dialysis facility and identifies differences in quality between facilities so that patients can make more informed decisions about where to receive treatment. For the third consecutive year, we are a leader in the industry under the CMS Five-Star Quality Rating system.

In addition, CMS promotes high quality services in outpatient dialysis facilities treating patients with ESRD through its Quality Incentive Program (QIP). QIP associates a portion of payment directly with a facility's performance on quality of care measures. Payment reductions result when a facility's overall score on applicable measures does not meet established standards. For the fourth year in a row, we are an industry leader in QIP standards.

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

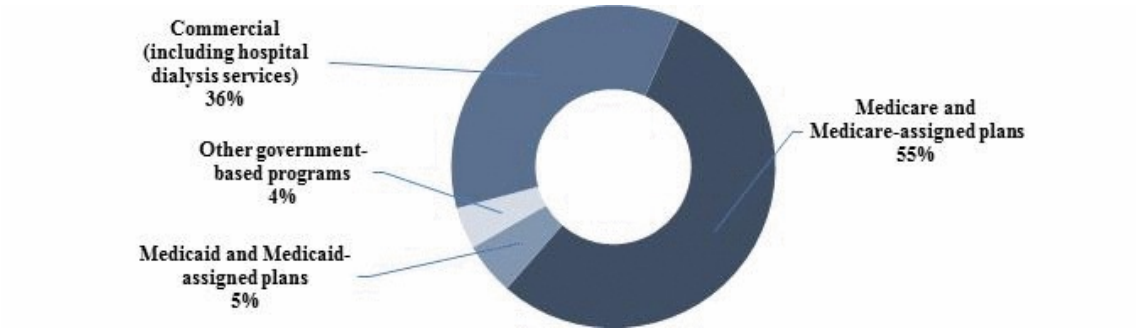
Our physician leadership in the Office of the Chief Medical Officer (OCMO) for our dialysis and related lab services business includes 13 senior nephrologists, led by our Chief Medical Officer, with a variety of academic, clinical practice, and clinical research backgrounds. Our Physician Council is an advisory body to senior management composed of nine physicians with extensive experience in clinical practice. In addition, we currently have nine Group Medical Directors.

Sources of revenue—concentrations and risks

Our U.S. dialysis and related lab services business net revenues represent approximately 62% of our consolidated net revenues for the year ended December 31, 2016. Our U.S. dialysis and related lab services revenues are derived primarily from our core business of providing dialysis services and related laboratory services and, to a lesser extent, the administration of pharmaceuticals and management fees generated from providing management and administrative services to certain outpatient dialysis centers, as discussed above.

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

The following graph summarizes our U.S. dialysis services revenues by source for the year ended December 31, 2016:



The following graph summarizes our U.S. dialysis services revenues by modality for the year ended December 31, 2016:

Medicare revenue

Government dialysis related payment rates in the U.S. are principally determined by federal Medicare and state Medicaid policy. For patients with Medicare coverage, all ESRD payments for dialysis treatments are made under a single bundled payment rate which provides a fixed payment rate to encompass all goods and services provided during the dialysis treatment, including certain pharmaceuticals, such as Epogen® (EPO), vitamin D analogs and iron supplements, irrespective of the level of pharmaceuticals administered to the patient or additional services performed. Most lab services are also included in the bundled payment. Under the ESRD Prospective Payment System (PPS), the bundled payments to a dialysis facility may be reduced by as much as 2% based on the facility's performance in specified quality measures set annually by CMS through QIP, which was established by the Medicare Improvements for Patients and Providers Act of 2008. The bundled payment rate is also adjusted for certain patient characteristics, a geographic usage index and certain other factors.

An important provision in the law is an annual adjustment, or market basket update, to the PPS base rate. Absent action by Congress, the PPS base rate is automatically updated annually by a formulaic inflation adjustment. In December 2013, CMS issued the 2014 final rule for the ESRD PPS, which phases in the payment reductions mandated by the American Taxpayer Relief Act of 2012 (ATRA), as modified by the Protecting Access to Medicare Act of 2014, which reduced our market basket inflation adjustment by

1.25% in 2016 and will reduce our market basket inflation adjustment by 1.25% in 2017 and by 1% in 2018. In November 2016, CMS published the 2017 final rule for the ESRD PPS, which increased dialysis facilities' bundled payment rate for 2017 relative to prior years. In particular, CMS projects that the 2017 final rule for the ESRD PPS will (i) increase the total payments to all ESRD facilities by 0.73% in 2017 compared to 2016; (ii) increase total payments to hospital-based ESRD facilities by 0.9% in 2017 compared to 2016; and (iii) increase total payments for freestanding facilities by 0.7% in 2017 compared to 2016. The 2017 final rule for the ESRD PPS also implements the Trade Preferences Extension Act of 2015 provisions regarding the coverage and payment of renal dialysis services furnished by ESRD facilities to individuals with acute kidney injury.

As a result of the Budget Control Act of 2011 (BCA) and subsequent activity in Congress, a $1.2 trillion sequester (across-the-board spending cuts) in discretionary programs took effect in 2013 reducing Medicare payments by 2%, which was subsequently extended through fiscal year 2025. These across-the-board spending cuts have affected and will continue to adversely affect our revenues, earnings and cash flows.

The CMS Center for Medicare & Medicaid Innovation Center (Innovation Center) is currently working with various healthcare providers to develop, refine and implement Accountable Care Organizations (ACOs) and other innovative models of care for Medicare and Medicaid beneficiaries. We are currently uncertain of the extent to which the long-term operation and evolution of these models of care, including ACOs, Bundled Payments for Care Improvement Initiative, Comprehensive ESRD Care (CEC) Model (which includes the development of ESRD Seamless Care Organizations (ESCOs)), the Comprehensive Primary Care Initiative, the Duals Demonstration, or other models, will impact the healthcare market over time. Our U.S. dialysis business may choose to participate in one or several of these models either as a partner with other providers or independently. We currently participate in the CEC Model with the Innovation Center, including the ESCO organizations in the Arizona, Florida, and adjacent New Jersey and Pennsylvania markets. In areas where our U.S. dialysis business is not directly participating in this or other Innovation Center models, some of our patients may be assigned to an ACO, another ESRD Care Model, or another program, in which case the quality and cost of care that we furnish will be included in an ACO's, another ESRD Care Model's or other program's calculations.

The Department of Health and Human Services (HHS) has also pledged to tie 50% of Medicare payments to quality or alternate payment models by the end of 2018. As new models of care emerge and evolve, we may be at risk for losing our Medicare patient base, which would have a materially adverse effect on our revenues, earnings and cash flow. Other initiatives in the government or private sector may also arise, including the development of models similar to ACOs, independent practice associations (IPAs) and integrated delivery systems or evolutions of those concepts which could adversely impact our business.

We anticipate that we will continue to experience increases in our operating costs in 2017 that will outpace any net Medicare rate increases that we may receive, which could significantly impact our operating results. In addition, we expect to continue experiencing increases in operating costs that are subject to inflation, such as labor and supply costs, regardless of whether there is a compensating inflation-based increase in Medicare payment rates or in payments under the bundled payment rate system.

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

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

The 21st Century Cures Act, enacted in December 2016, included a provision that will allow Medicare beneficiaries with ESRD to choose a Medicare Advantage plan. Until the effective date of this law, this choice is available only to Medicare beneficiaries without ESRD. The ESRD related provisions of the 21st Century Cures Act are scheduled to take effect in 2021.

Medicaid revenue

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

Commercial revenue

Before a patient becomes eligible to have Medicare as their primary payor for dialysis services, a patient's commercial insurance plan, if any, is responsible for payment of such dialysis services for the first 33 months, as discussed above. Although commercial payment rates vary, average commercial payment rates established under commercial contracts are generally significantly higher than Medicare rates. The payments we receive from commercial payors generate nearly all of our profits. Payment methods from commercial payors can include a single lump-sum per treatment, referred to as bundled rates, or in other cases separate payments for dialysis treatments and pharmaceuticals, if used as part of the treatment, referred to as Fee-for-Service (FFS) rates. Commercial payment rates are the result of negotiations between us and insurers or third-party administrators. Our out-of-network payment rates are on average higher than in-network commercial contract payment rates. We continue to enter into some commercial contracts, covering certain patients that will primarily pay us under a single bundled payment rate for all dialysis services provided to these patients. However, some contracts will pay us for certain other services and pharmaceuticals in addition to the bundled payment. These contracts typically contain annual price escalator provisions. We are continuously in the process of negotiating agreements with our commercial payors and if our negotiations result in overall commercial contract payment rate reductions in excess of our commercial contract payment rate increases, our revenues and operating results could be negatively impacted. In addition, if there is an increase in job losses in the U.S., or depending upon changes to the healthcare regulatory system by CMS and/or the impact of healthcare insurance exchanges, we could experience a decrease in the number of patients covered under traditional commercial insurance plans. Patients with commercial insurance who cannot otherwise maintain coverage frequently rely on financial assistance from charitable organizations, such as the American Kidney Fund. If these patients are unable to obtain or continue to receive such financial assistance, our revenues, earnings, and cash flow could be substantially reduced.

Approximately 31% of our dialysis services revenues and approximately 12% of our dialysis treatments and patients are associated with non-acute commercial payors for the year ended December 31, 2016. Non-acute commercial patients as a percentage of our total dialysis patients increased 1% as compared to 2015. Less than 1% of our dialysis and related lab services revenues are due directly from patients. There is no single commercial payor that accounted for more than 10% of total dialysis and related lab services revenues for the year ended December 31, 2016. See Note 23 to the consolidated financial statements included in this report for disclosure on our concentration related to our commercial payors on a total consolidated net revenue basis.

The healthcare reform legislation enacted in 2010 introduced healthcare insurance exchanges which provide a marketplace for eligible individuals and small employers to purchase healthcare insurance. The business and regulatory environment continues to evolve as the exchanges mature, and regulations are challenged, changed and enforced. If commercial payor participation in the exchanges continues to decrease, our revenues, earnings and cash flows could be adversely affected. 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, our revenues, earnings and cash flows could be adversely affected.

In addition, CMS published an interim final rule that establishes new Conditions for Coverage standards for dialysis facilities that require any facility making payments of premiums for individual market health plans to notify patients of potential coverage options and educate them about the benefits of each option. The interim final rule requires facilities to ensure that insurers are informed of and have agreed to accept the payments. On January 25, 2017, the federal court issued a preliminary injunction on CMS's interim final rule. At this time CMS has not appealed the court's ruling and we await the final decision from the court. This and any other guidance or rule issued that limits or prohibits the use of charitable premium assistance and/or the ability of patients with access to alternative coverage from selecting a marketplace plan on or off exchange could have a material adverse effect on our revenue, earnings and cash flows.

Revenue from other pharmaceuticals and EPO

The impact of physician-prescribed pharmaceuticals on our overall revenues that are separately billable has significantly decreased since Medicare's single bundled payment system went into effect beginning in January 2011, as well as some additional

commercial contracts that pay us a single bundled payment rate. Approximately 2% of our total dialysis and related lab services revenues for the years ended December 31, 2016 and 2015, are associated with the administration of separately-billable physician-prescribed pharmaceuticals. Of this, the administration of EPO that was separately billable, accounted for approximately half of our separately billable pharmaceuticals of our dialysis and related lab services revenues for both years. EPO is produced by a single manufacturer, Amgen USA Inc. (Amgen). In January 2017, we entered into a six year Sourcing and Supply Agreement with Amgen that expires on December 31, 2022, replacing our prior agreement that was to expire in 2018. Under the terms of the agreement, we will purchase EPO in amounts necessary to meet no less than 90% of our requirements for ESAs. The actual amount of EPO that we will purchase from Amgen will depend upon the amount of EPO administered during dialysis as prescribed by physicians and the overall number of patients that we serve. Any interruption in the supply of EPO or product cost increases could impact our operations.

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

Physician relationships

An ESRD patient generally seeks treatment at an outpatient dialysis center near his or her home where his or her treating nephrologist has practice privileges. Our relationships with local nephrologists and our ability to meet their needs and the needs of their patients are key factors in the success of our dialysis operations. Approximately 5,100 nephrologists currently refer patients to our outpatient dialysis centers. As is typical in the dialysis industry, one or a few physicians, including the outpatient dialysis center's medical director, usually account for all or a significant portion of an outpatient dialysis center's patient base.

Participation in the Medicare ESRD program requires that dialysis services at an outpatient dialysis center be under the general supervision of a medical director who is a licensed physician. We have engaged physicians or groups of physicians to serve as medical directors for each of our outpatient dialysis centers. At some outpatient dialysis centers, we also separately contract with one or more other physicians to serve as assistant or associate medical directors or to direct specific programs, such as home dialysis training programs. We have approximately 970 individual physicians and physician groups under contract to provide medical director services.

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

Our medical director contracts for our dialysis centers generally include covenants not to compete. Also, except as described below, when we acquire an outpatient dialysis center from one or more physicians or where one or more physicians own minority interests in our outpatient dialysis centers, these physicians have agreed to refrain from owning interests in other competing outpatient dialysis centers within a defined geographic area for various time periods. These non-compete agreements restrict the physicians from owning or providing medical director services to other outpatient dialysis centers, but do not prohibit the physicians from referring patients to any outpatient dialysis center, including competing centers. Many of these non-compete agreements continue for a period of time beyond expiration of the corresponding medical director agreements, although some expire at the same time as the medical director agreement. Occasionally, we experience competition from a new outpatient dialysis center established by a former medical director following the termination of his or her relationship with us. As part of our Corporate Integrity Agreement (CIA), as described below, we also have agreed not to enforce investment non-compete restrictions relating to dialysis clinics or programs that were established pursuant to a partial divestiture joint venture transaction. Therefore, to the extent a joint venture partner or medical director has a contract(s) with us covering dialysis clinics or programs that were established pursuant to a partial divestiture, we will not enforce the investment non-compete provision relating to those clinics and/or programs.

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

Government regulation

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

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

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

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

Licensure and certification

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

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

Federal Anti-Kickback Statute

The federal anti-kickback statute contained in the Social Security Act of 1935, as amended (Anti-Kickback Statute), prohibits, among other things, knowingly and willfully offering, paying, soliciting or receiving remuneration, directly or indirectly, in cash or kind, to induce or reward either the referral of an individual for, or the purchase, or order or recommendation of, any good or service, for which payment may be made under federal and state healthcare programs such as Medicare and Medicaid.

Federal criminal penalties for the violation of the federal Anti-Kickback Statute include imprisonment, fines and exclusion of the provider from future participation in the federal healthcare programs, including Medicare and Medicaid. Violations of the federal Anti-Kickback Statute are punishable by imprisonment for up to five years and fines of up to $25,000 or both. Larger fines can be imposed upon corporations under the provisions of the U.S. Sentencing Guidelines and the Alternate Fines Statute. Individuals and entities convicted of violating the federal Anti-Kickback Statute are subject to mandatory exclusion from participation in Medicare, Medicaid and other federal healthcare programs for a minimum of five years. Civil penalties for violation of this law include up to $50,000 in monetary penalties per violation, repayments of up to three times the total payments between the parties and suspension from future participation in Medicare and Medicaid. Court decisions have held that the statute may be violated even if only one purpose of remuneration is to induce referrals. The Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 (Affordable Care Act (ACA)) amended the federal Anti-Kickback Statute to clarify the intent that is required to prove a violation. Under the statute as amended, the defendant does not need to have actual knowledge of the federal Anti-Kickback Statute or have the specific intent to violate it. In addition, the ACA amended the federal Anti-Kickback Statute to provide that any claims for items or services resulting from a violation of the federal Anti-Kickback Statute are considered false or fraudulent for purposes of the FCA.

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

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

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

Joint Ventures. We own a controlling interest in numerous U.S. dialysis related joint ventures. For the year ended December 31, 2016, these joint ventures represented approximately 24% of our dialysis and related lab services revenues. We may continue to increase the number of our joint ventures. Our relationships with physicians and other referral sources relating to these joint ventures do not fully satisfy the safe harbor for investments in small entities. Although failure to comply with a safe harbor does not render an arrangement illegal under the federal Anti-Kickback Statute, an arrangement that does not operate within a safe harbor may be subject to scrutiny and the Department of Health and Human Services' Office of Inspector General (OIG) has warned in the past that certain joint venture relationships have a potential for abuse. Based upon the foregoing, physician joint ventures that fall outside the safe harbors are not, by definition, prohibited by law. Instead, such joint ventures require case-by-case evaluation under the federal Anti-Kickback Statute.

In this regard, we have structured our joint ventures to satisfy as many elements of the safe harbor for investments in small entities as we believe are commercially reasonable. For example, we believe that these investments are offered and made by us on a fair market value basis and provide returns to the investors in proportion to their actual investment in the venture. We believe that our joint venture arrangements do not violate the federal Anti-Kickback Statute; however, since the arrangements do not satisfy all of the requirements of an applicable safe harbor, these arrangements could be subject to challenge on the ground that they are intended to induce patient referrals. In that regard, we were subject to investigation by the United States Attorney's Office for the District of Colorado, the Civil Division of the United States Department of Justice (DOJ) and the OIG related to our relationships with physicians, including our joint ventures, and whether those relationships and joint ventures comply with the federal Anti-Kickback Statute and the FCA. In October 2014, we entered into a Settlement Agreement with the United States and relator David Barbetta to

resolve the then pending 2010 and 2011 U.S. Attorney physician relationship investigations. In connection with the resolution of this matter, and in exchange for the OIG's agreement not to exclude us from participating in the federal healthcare programs, we have entered into a five-year CIA with the OIG. 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 arrangement. 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.

Lease Arrangements. We lease space for numerous dialysis centers from entities in which physicians, hospitals or medical groups hold ownership interests, and we sublease space to referring physicians at approximately 250 of our dialysis centers as of December 31, 2016. These arrangements comply with the federal Anti-Kickback Statute safe harbor for space rentals in all material respects. Therefore, we believe that these lease arrangements should not be subject to challenge under the federal Anti-Kickback Statute.

Common Stock. Some medical directors and other referring physicians may own our common stock. We believe that these interests materially satisfy the requirements of the Anti-Kickback Statute safe harbor for investments in large publicly traded companies. Therefore, we believe that these investments should not be subject to challenge under the federal Anti-Kickback Statute.

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

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

Stark Law

The Stark Law prohibits a physician who has a financial relationship, or who has an immediate family member who has a financial relationship, with entities providing Designated Health Services (DHS), from referring Medicare and Medicaid patients to such entities for the furnishing DHS, unless an exception applies. DHS includes enumerated items and services, including home health services, outpatient prescription drugs, inpatient and outpatient hospital services and clinical laboratory services. The types of financial arrangements between a physician and a DHS entity that trigger the self-referral prohibitions of the Stark Law are broad and include direct and indirect ownership and investment interests and compensation arrangements. The Stark Law also prohibits the DHS entity receiving a prohibited referral from presenting, or causing to be presented, a claim or billing for the services arising out of the prohibited referral. The prohibition applies regardless of the reasons for the financial relationship and the referral; unlike the federal Anti-Kickback Statute, intent to induce referrals is not required. Sanctions for violation of the Stark Law include denial of payment for claims for services provided in violation of the prohibition, refunds of amounts collected in violation of the prohibition, a civil penalty of up to $15,000 for each service arising out of the prohibited referral, a civil penalty of up to $100,000 against parties that enter into a scheme to circumvent the Stark Law prohibition, civil assessment of up to three times the amount claimed, and potential exclusion from the federal healthcare programs, including Medicare and Medicaid. Amounts collected for prohibited claims must be reported and refunded generally within 60 days after the date on which the overpayment was identified. Furthermore, Stark Law violations and failure to return overpayments timely can form the basis for FCA liability as discussed below.

The definition of DHS under the Stark Law excludes services paid under a composite rate, even if some of the components bundled in the composite rate are DHS, unless the DHS services are themselves payable through a composite rate. Although the ESRD bundled payment system is no longer titled a composite rate, we believe that the former composite rate payment system and the current bundled system are both composite systems excluded from the Stark Law. Since most services furnished to Medicare beneficiaries provided in our dialysis centers are reimbursed through a composite or bundled rate, the services performed in our facilities generally are not DHS, and the Stark Law referral prohibition does not apply to those services. Likewise, the definition of inpatient hospital services, for purposes of the Stark Law, also excludes inpatient dialysis performed in hospitals that are not certified to provide ESRD services. Consequently, our arrangements with such hospitals for the provision of dialysis services to hospital inpatients do not trigger the Stark Law referral prohibition.

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

We have entered into several types of financial relationships with referring physicians, including compensation arrangements. If an arrangement does not meet a Stark Law exception, we could in the future be required to change our practices, face civil penalties, pay substantial fines, return certain payments received from Medicare and beneficiaries or otherwise experience a material adverse effect as a result of a challenge to payments made pursuant to referrals from these physicians under the Stark Law.

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

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

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

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

While we believe that most of our operations do not implicate the Stark Law, particularly under the ESRD bundled payment system, and that to the extent that our dialysis centers furnish DHS, they either meet an exception or do not bill for services that do not meet a Stark Law exception, if CMS determined that we have submitted claims in violation to the Stark Law, we would be subject to the penalties described above. In addition, it might be necessary to restructure existing compensation agreements with our medical directors and to repurchase or to request the sale of ownership interests in subsidiaries and partnerships held by referring physicians or, alternatively, to refuse to accept referrals for DHS from these physicians. Any such penalties and restructuring could have a material adverse effect on our operations.

Fraud and abuse under state law

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

The False Claims Act

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

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

In addition, amendments to the FCA impose severe penalties for the knowing and improper retention of overpayments collected from government payors. Under these provisions, within 60 days of identifying an overpayment, a provider is required to notify CMS or the Medicare Administrative Contractor of the overpayment and the reason for it and return the overpayment. An overpayment impermissibly retained could subject us to liability under the FCA, exclusion, and penalties under the federal Civil Monetary Penalty statute. As a result of these provisions, our procedures for identifying and processing overpayments may be subject to greater scrutiny. We have made significant investments to accelerate the time it takes us to identify and process overpayments and we may be required to make additional investments in the future. Acceleration in our ability to identify and process overpayments could result in us refunding overpayments to government or other payors sooner than we have in the past. A significant acceleration of these refunds could have a material adverse effect on our operating cash flows.

The penalties for a violation of the FCA range from $5,500 to $11,000 (adjusted for inflation) for each false claim, plus up to three times the amount of damages caused by each false claim, which 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 to $10,957 to $21,916 for penalties assessed after February 3, 2017, so long as the underlying conduct occurred after November 2, 2015. The federal government has used the FCA to prosecute a wide variety of alleged false claims and fraud allegedly perpetrated against Medicare and state healthcare programs, including coding errors, billing for services not rendered, the submission of false cost reports, billing for services at a higher payment rate than appropriate, billing under a comprehensive code as well as under one or more component codes included in the comprehensive code and billing for care that is not considered medically necessary. The ACA provides that claims tainted by a violation of the federal Anti-Kickback Statute are false for purposes of the FCA. Some courts have held that filing claims or failing to refund amounts collected in violation of the Stark Law can form the basis for liability under the FCA. In addition to the provisions of the FCA, which provide for civil enforcement, the federal government can use several criminal statutes to prosecute persons who are alleged to have submitted false or fraudulent claims for payment to the federal government.

Privacy and Security

The Health Insurance Portability and Accountability Act of 1996 and its implementing privacy and security regulations, as amended by the federal Health Information Technology for Economic and Clinical Health Act (HITECH Act), (collectively referred to as HIPAA), require us to provide certain protections to patients and their health information. The HIPAA privacy and security regulations extensively regulate the use and disclosure of PHI and require covered entities, which include healthcare providers, to implement and maintain administrative, physical and technical safeguards to protect the security of such information. Additional security requirements apply to electronic PHI. These regulations also provide patients with substantive rights with respect to their health information.

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

Covered entities must report breaches of unsecured PHI to affected individuals without unreasonable delay but not to exceed 60 days of discovery of the breach by a covered entity or its agents. Notification must also be made to the HHS, and, for breaches of unsecured PHI involving more than 500 residents of a state or jurisdiction, to the media. All non-permitted uses or disclosures of

unsecured PHI are presumed to be breaches unless the covered entity or business associate establishes that there is a low probability the information has been compromised. Various state laws and regulations may also require us to notify affected individuals in the event of a data breach involving individually identifiable information without regard to whether there is a low probability of the information being compromised.

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

Healthcare reform

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

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

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

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

Other aspects of the 2010 healthcare reform laws may affect our business, as well, including changes affecting the Medicare and Medicaid programs. We note, however, that the 2016 Presidential and Congressional elections have caused the future state of the exchanges and other ACA reforms to be very unclear. The Republicans, who now control the Administration and Congress, have repeatedly expressed a desire to repeal and replace the ACA. As a result, there is considerable uncertainty regarding the future with respect to the exchanges, and, indeed, many core aspects of the current health care marketplace. While specific changes and their timing are not yet apparent, it does appear likely that there will be significant changes to the healthcare environment in the near and short term. The enacted reforms as well as future legislative changes could have a material adverse effect on our results of operations, including lowering our reimbursement rates and increasing our expenses.

Other regulations

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

up, waste disposal techniques and procedures and work practice controls. Employers are also required to comply with various record-keeping requirements. We believe that we are in material compliance with these laws and regulations.

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

Capacity and location of our U.S. dialysis centers

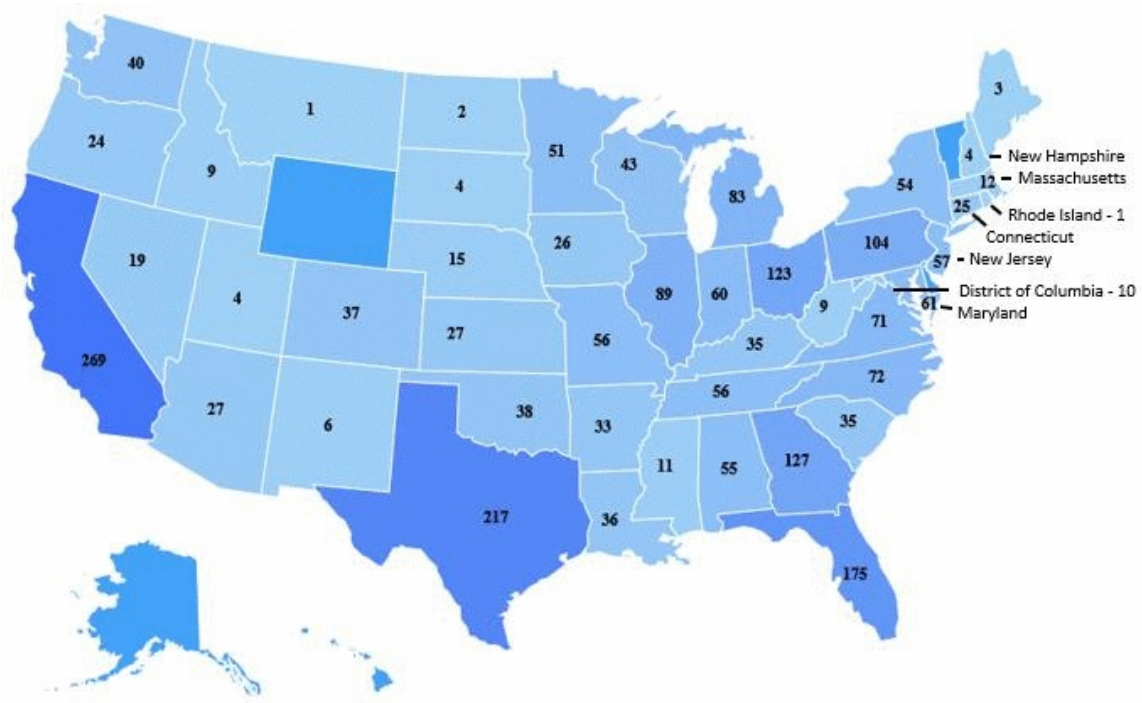
Typically we are able to increase our capacity by extending hours at our existing dialysis centers, expanding our existing dialysis centers, relocating our dialysis centers, developing new dialysis centers and by acquiring dialysis centers. The development of a typical outpatient dialysis center by us generally requires approximately $2.8 million for leasehold improvements, equipment and first-year working capital. Based on our experience, a new outpatient dialysis center typically opens within a year after the property lease is signed, normally achieves operating profitability in the second year after Medicare certification and normally reaches maturity within three to five years. Acquiring an existing outpatient dialysis center requires a substantially greater initial investment, but profitability and cash flows are generally accelerated and more predictable. To a limited extent, we enter into agreements to provide management and administrative services to outpatient dialysis centers in which we either own a noncontrolling equity investment, or are wholly-owned by third parties in return for management fees, which are typically based on a percentage of revenues or cash collections of the managed center's operations.

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

	2016	2015	2014	2013	2012
Number of centers at beginning of year	2,251	2,179	2,074	1,954	1,809
Acquired centers	8	6	18	26	93
Developed centers	100	72	105	98	70
Net change in centers with management and administrative services agreements[1][4]	—	2	—	4	(8)
Sold and closed centers[2]	(4)	(3)	(2)	(5)	(1)
Closed centers[3]	(5)	(5)	(16)	(3)	(9)
Number of centers at end of year	2,350	2,251	2,179	2,074	1,954

(1) Represents dialysis centers in which we either own a noncontrolling equity investment, or are wholly-owned by third parties.
(2) Represents dialysis centers that were sold and/or closed for which patients were not retained.
(3) Represents dialysis centers that were closed for which the majority of patients were retained and transferred to one of our other existing outpatient dialysis centers.
(4) Includes dialysis centers in which we deconsolidated and transferred to management services agreements.

As of December 31, 2016, we operated or provided administrative services to a total of 2,350 U.S. outpatient dialysis centers. A total of 2,316 of such centers are consolidated in our financial statements. Of the remaining 34 unconsolidated U.S. outpatient dialysis centers, we own a noncontrolling interest in 27 centers and provide management and administrative services to seven centers that are wholly-owned by third parties. The locations of the 2,316 U.S. outpatient dialysis centers consolidated in our financial statements at December 31, 2016 were as follows:



Ancillary services and strategic initiatives businesses, including our international operations

As of December 31, 2016, our ancillary services and strategic initiatives consisted primarily of pharmacy services, disease management services, vascular access services, clinical research, physician services, direct primary care and our international dialysis operations and relate primarily to our core business of providing kidney care services.

Ancillary services and strategic initiatives consist primarily of the following as of December 31, 2016:

- *Pharmacy services*. DaVita Rx is a pharmacy that specializes in providing oral medications and medication management services to patients with ESRD and other chronic diseases. The main objective of the pharmacy is to improve clinical outcomes and reduce total healthcare costs by facilitating increased patient compliance and to provide our patients a convenient way to fill their prescription needs. Revenues are recognized as prescriptions are filled and shipped to patients or when services are completed.

- *Disease management services.* VillageHealth provides advanced integrated care management services to health plans and government programs for members/beneficiaries diagnosed with ESRD and/or chronic kidney failure. Through a combination of clinical coordination, innovative interventions, medical claims analysis and information technology, we endeavor to assist our customers and patients in obtaining superior renal healthcare and improved clinical outcomes, as well as helping to reduce overall medical costs. Integrated care management revenues are typically based upon an established contract fee and are recognized as earned over the contract period and can include additional fees for cost savings recognized by certain customers. VillageHealth also operates Medicare Advantage ESRD Special Needs Plans in partnership with payors that work with CMS to provide ESRD patients full service healthcare. We are at risk for all medical costs of the program in excess of the capitation payments. Furthermore, in October 2015, VillageHealth entered into a management service agreement to support three ESCO joint ventures in which we are an investor through certain wholly- or majority-owned dialysis clinics. The ESCOs were formed under the Innovation Center's CEC Model to demonstrate the coordination of care for ESRD patients in a dialysis-center oriented ACO setting. Each ESCO joint venture has a shared risk arrangement with CMS for this program.

- *Vascular access services.* Lifeline provides management and administrative services to physician-owned vascular access clinics that provide vascular services for dialysis and other patients. Lifeline is also the majority-owner of nine vascular access clinics and wholly-owns one vascular access clinic. Management fees generated from providing management and administrative services are recognized as earned typically based on a percentage of revenues or cash collections generated by the clinics. Revenues associated with the vascular access clinics that are majority-owned are recognized in the period when the services are provided.

- *Clinical research programs.* DaVita Clinical Research (DCR) is a provider-based specialty clinical research organization with a full spectrum of services for clinical drug research and device development. DCR uses its extensive, applied database and real-world healthcare experience to assist in the design, recruitment and completion of retrospective, prospective pragmatic and clinical trials. Revenues are based upon an established fee per study, as determined by contract with drug companies and other sponsors and are recognized as earned according to the contract terms.

- *Physician services.* Nephrology Practice Solutions (NPS) is an independent business that partners with physicians committed to providing outstanding clinical and integrated care to patients. NPS provides nephrologist employment opportunities in select markets and offers physician practice management services to nephrologists under administrative services agreements. These services include physician practice management, billing and collections, credentialing, coding, and other support services that enable physician practices to increase efficiency and manage their administrative needs. Fees generated from these services are recognized as earned typically based upon flat fees or cash collections generated by the physician practice. NPS also provides leading nephrology recruitment and staffing services which are billed on a per search basis.

- *Direct primary care.* Paladina Health is a healthcare services organization that operates membership-based primary care clinics mainly through employer-based on-site and near-site clinics. The clinics offer patients more personalized and improved access to primary care physicians, including unlimited visits and same-day or next-day appointments. Physicians focus on clinical outcomes and patient satisfaction. Revenues are recognized over the membership period.

International dialysis operations

As of December 31, 2016, we operated or provided administrative services to a total of 154 outpatient dialysis centers, which includes consolidated and nonconsolidated centers, located in 11 countries outside of the U.S., serving approximately 15,100 patients. Our international dialysis operations continue to grow steadily and expand as a result of developing and acquiring outpatient dialysis centers in various strategic markets. Our international operations are included as a component of our ancillary services and strategic initiatives. The table below summarizes the number and locations of our international outpatient dialysis centers.

	2016	2015	2014	2013	2012
Number of centers at beginning of year	118	91	73	36	11
Acquired centers	21	21	9	38	13
Developed and hospital operated centers	15	7	11	2	9
Managed centers, net	—	(1)	—	—	3
Closed centers	—	—	(2)	(3)	—
Number of centers at end of year	154	118	91	73	36

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

Malaysia(1)	38
Germany	34
India(1)	19
Colombia	18
Saudi Arabia	15
Poland	8
Brazil	8
Portugal	5
Taiwan(1)	5
China(1)	3
Singapore(1)	1
	154

(1) Includes centers that are operated or managed by our Asia Pacific Joint Venture (APAC JV).

Corporate Administrative Support

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

DaVita Medical Group (DMG) Division

DMG business overview

DMG is a patient- and physician-focused integrated healthcare delivery and management company with over two decades of experience providing coordinated, outcomes-based medical care in a cost-effective manner. As of December 31, 2016, DMG served approximately 749,300 members under its care in southern California, central and south Florida, southern Nevada and central New Mexico through capitation contracts with some of the nation's leading health plans. Of these members, approximately 305,200 individuals were patients enrolled in Medicare and Medicare Advantage, and the remaining approximately 444,100 individuals were managed care members whose health coverage is provided through their employer or who have individually acquired health coverage directly from a health plan or as a result of their eligibility for Medicaid benefits. In addition to its managed care business, during the year ended December 31, 2016, DMG provided care across all markets to over 896,200 patients whose health coverage is structured on a FFS basis, including patients enrolled through traditional Medicare and Medicaid programs, preferred provider organizations and other third party payors.

DMG patients as well as the patients of DMG's associated physicians, physician groups and IPAs benefit from an integrated approach to medical care that places the physician at the center of patient care. As of December 31, 2016, DMG delivered services to its members via a network of approximately 700 primary care physicians, over 2,500 associated group and other network primary care physicians, approximately 200 network hospitals, and several thousand associated group and network specialists. Together with hundreds of case managers, registered nurses and other care coordinators, these medical professionals utilize a comprehensive

information technology system, sophisticated risk management techniques and clinical protocols to provide high-quality, cost-effective care to DMG's members.

U.S. healthcare spending has increased steadily over the past twenty years. These increases have been driven, in part, by the aging of the baby boomer generation, lack of healthy lifestyle both in terms of exercise and diet, rapidly increasing costs in medical technology and pharmaceutical research, and provider reimbursement structures that may promote volume over quality in a FFS environment. These factors, as well as the steady growth of the U.S. population, have made the healthcare industry a growing market. In 2015, CMS reported that healthcare accounted for 17.8% of the U.S. gross domestic product and that healthcare spending increased 5.8% to reach $3.2 trillion. Medicare spending grew 4.5% to $646 billion in 2015 or 20% of National Health Expenditures, according to CMS. Medicare's share of the federal budget was 14.8% in 2015 according to the Congressional Budget Office (CBO). Medicare is frequently the focus of discussions on how to moderate the growth of both federal spending and healthcare spending in the U.S.

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

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

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

Managed care health plans were developed, primarily during the 1980s, in an attempt to mitigate the rising cost of providing healthcare benefits to populations covered by traditional health insurance. These managed care health plans often enroll members through their employers. As a result of the prevalence of these health plans, many seniors now becoming eligible for Medicare have been interacting with managed care companies through their employers for the last 30 years. Individuals turning 65 now are likely to be far more familiar with the managed care setting than previous Medicare populations. According to Kaiser Family Foundation, in 2016, Medicare Advantage represented 31% of total Medicare members, creating a significant opportunity for additional Medicare Advantage penetration of newly eligible seniors.

In an effort to reduce the number of uninsured and to begin to control healthcare expenditures, President Obama signed the ACA into law in March 2010, which was affirmed, in substantial part, by the U.S. Supreme Court in June 2012. As of the end of 2015, the number of uninsured nonelderly Americans was 28.5 million, a decrease of nearly 13 million since 2013. These previously uninsured Americans and potentially newly eligible Medicaid beneficiaries represent a significant new market opportunity for health plans. We believe that health plans looking to cover these newly eligible individuals under fixed premium arrangements will seek provider arrangements that can effectively manage the cost and quality of the care being provided to these newly eligible individuals, although the 2016 Presidential and Congressional elections have caused the future state of the ACA to be unclear.

One of the primary ways in which the ACA funded increased health insurance coverage is through cuts in Medicare Advantage reimbursement. County benchmarks are transitioning to a system in which each county's benchmark in 2017 will be a certain percentage (ranging from 95% to 115%) of FFS. In a March 2016 report to Congress, the Medicare Payment Advisory Commission (MedPAC) estimated that 2016 Medicare Advantage benchmarks (including the average 4% for quality bonuses), bids, and payments would average 107%, 94%, and 102% of FFS spending, respectively.

Despite the fact that the plan bids average less than FFS spending, payments for enrollees in these plans usually exceed FFS spending because the benchmarks are high relative to FFS spending. For example, health maintenance organizations (HMOs) as a group bid an average of 90% of FFS spending, yet 2016 payments for HMO enrollees are estimated to average 101% of FFS spending because the benchmarks, including the quality bonuses, average 106% of FFS spending.

Nonetheless, changes in benchmarks and/or bids that lower payments to Medicare Advantage plans could adversely affect DMG's operating results.

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

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

Brand name

In 2016, we started the transition of the medical group brand name from HealthCare Partners (HCP) and several other names to DaVita Medical Group (DMG). The marketing plan as it relates to the transition will be a phased approach and will occur over the course of one to two years with the exception of the Washington market which is still in the planning stages. Coming together under one name is part of DMG's vision to strive to be the leading independent medical group in the U.S.

Healthcare reform

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

The ACA reflects sweeping legislation that, once fully implemented, may have a significant impact on the U.S. healthcare system generally and the operations of DMG's business. There are numerous steps required to implement the ACA, and implementation remains ongoing. Congress also has enacted, and may continue to seek, legislative changes that alter, delay, or eliminate some of their provisions. For example, under the 2016 Omnibus budget agreement, Congress voted to delay certain new taxes that the ACA had enacted, including the excise tax on certain high-cost health plans, the medical device tax, and the tax on health insurers. In addition, the 2016 Presidential and Congressional elections have caused the future state of the ACA to be unclear. While specific changes and their timing are not yet apparent, the enacted reforms as well as future legislative changes could have a material adverse effect on our results of operations, including lowering our reimbursement rates and increasing our expenses.

One provision of the ACA required CMS to establish a Medicare Shared Savings Program (MSSP) that promotes accountability and coordination of care through the creation of ACOs. The program allows certain providers and suppliers (including hospitals, physicians and other designated professionals) to voluntarily form ACOs and work together along with other ACO participants to invest in infrastructure and redesign delivery processes to achieve high quality and efficient delivery of services. In 2014, DMG entered into an agreement with CMS to participate in the MSSP in California, Florida and Nevada. Under this program, which ran through 2016, DMG strove to attain improved clinical outcomes to its Medicare FFS patients in a more cost-effective manner, and had the opportunity to share with CMS in any financial savings created. To date, DMG has not received a shared savings payment associated with this program, with one final measurement period still remaining. As part of our commitment to the Medicare ACO space, DMG applied for and was selected to participate in the CMS Innovation Center's Next Generation ACO in our California market, which begins in 2017.

Payor environment

Government programs

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

Medicare. The Medicare program was established in 1965 and became effective in 1967 as a federally funded U.S. health insurance program for persons aged 65 and older, and it was later expanded to include individuals with ESRD and certain disabled persons, regardless of income or age. Since its formation, Medicare has grown to an approximately $646 billion program in 2015, covering approximately 57 million Americans and, based on the growing number of eligible beneficiaries and increases in the cost of healthcare, CBO projects that net Medicare spending will increase from $592 billion in 2016 to $1.1 trillion in 2026.

Initially, Medicare was offered only on a FFS basis. Under the Medicare FFS payment system, an individual can choose any licensed physician enrolled in Medicare and use the services of any hospital, healthcare provider or facility certified by Medicare. CMS reimburses providers for covered services if CMS considers them medically necessary.

FFS Medicare pays for physician services according to a physician fee schedule (PFS) set each year by CMS in accordance with formulas mandated by Congress. Historically, CMS annually adjusted the Medicare Physician Fee Schedule (Medicare PFS) payment rates based on an updated formula that included application of the Sustainable Growth Rate (SGR). On April 16, 2015, President Obama signed and enacted into law H.R. 2, the Medicare Access and CHIP Reauthorization Act of 2015, which, among other things, repealed the SGR and instituted a 0% update to the single conversion factor under the Medicare PFS from January 1 through June 30, 2015, a 0.5% update for July 2015 through the end of 2019, and a 0% update for 2020 through 2025. For 2026 and subsequent years, the update will be either 0.75% or 0.25%, depending on which Alternate Payment Model (APM) the physician participates. On October 14, 2016, CMS released a final rule implementing, among other changes, the Advanced APM incentive applicable to the physician fee schedule, under which physicians may receive bonus payments for participating in an Advanced APM. Among other things, the final rule identifies the criteria an APM must satisfy to be considered an Advanced APM, which could include some MSSP ACOs or providers participating in the CEC Model. Whether DMG's subsidiary ACO or dialysis providers participating in CEC are considered to be Advanced APMs could potentially affect physicians' willingness to participate in such entities, which may indirectly impact the operations of DMG's subsidiary ACO or its providers participating in the CEC Model. In addition, under the final rule, DMG's subsidiary ACO may also be required to submit certain quality data to CMS on behalf of its Merit-Based Incentive Payment System MIPS-eligible clinicians, which could result in an increase in operational costs. Given that the payment updates for APMs have yet to take effect, we cannot determine the impact of such payment models on our business at this time.

In addition, in recent years, Congress has enacted various laws seeking to reduce the federal debt level and contain healthcare expenditures. For example, the BCA called for the establishment of a Joint Select Committee (the Committee) on Deficit Reduction, tasked with reducing the federal debt level. However, because the Committee did not draft a proposal by the BCA's deadline, President Obama issued an initial sequestration order that imposed automatic spending cuts on various federal programs. In particular, a 2% reduction to Medicare payments took effect on April 1, 2013, which was subsequently extended through 2025.

The instability of the federal budget may lead to legislation that could result in further cuts in Medicare and Medicaid payments to providers. In recent years, the government has enacted a patchwork of appropriations legislation to temporarily suspend the debt ceiling and continue government operations. The Medicare program is frequently mentioned as a target for spending cuts. Spending cuts to the Medicare program could adversely affect our operating results.

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

In 2004, CMS adopted a risk adjustment payment system for Medicare Advantage health plans in which the participating health plans' premiums are adjusted based on the actual illness burden of the members that enroll. The model bases a portion of the total CMS reimbursement payments on various clinical and demographic factors, including hospital inpatient diagnoses, additional

diagnosis data from ambulatory treatment settings, hospital outpatient department and physician visits, gender, age and Medicaid eligibility. CMS requires that all managed care companies capture, collect and submit the necessary diagnosis code information to CMS twice a year for reconciliation with CMS's internal database. Medical providers, such as DMG, provide this diagnosis code information to health plan customers for submission to CMS. Under this system, the risk-adjusted portion of the total CMS payment to the Medicare Advantage plans will equal the local rate set forth in the traditional demographic rate book, adjusted to reflect the plan members' gender, age and morbidity.

Most Medicare beneficiaries have the option to enroll in private health insurance plans that contract with Medicare under the Medicare Advantage program. According to the Kaiser Family Foundation, the share of Medicare beneficiaries in such plans has risen rapidly in recent years; it reached approximately 31% in 2016 from approximately 13% in 2004. Plan costs for the standard benefit package can be significantly lower or higher than the corresponding cost for beneficiaries in the traditional Medicare FFS payment program, but prior to the ACA, private plans were generally paid a higher average amount, and they used the additional payments to reduce enrollee cost-sharing requirements, provide extra benefits, and/or reduce Medicare premiums. These enhancements were valuable to enrollees, but also resulted in higher Medicare costs overall and higher premiums for all Medicare Part B beneficiaries and not just those enrolled in Medicare Advantage plans. The ACA requires that future payments to plans be based on benchmarks in a range of 95% to 115% of local FFS Medicare costs, with bonus amounts payable to plans meeting high quality-of-care standards. In addition, health plans offering Medicare Advantage are required to spend at least 85% of their premium dollars on medical care, the so-called medical loss ratio (MLR). Since DMG is not a health plan, except for DaVita Health Plan of California, Inc. (DHPC), it is not subject to the 85% MLR requirement. See "DaVita Medical Group Division (DMG)—Knox-Keene" below. However, payments that health plans make to DMG will apply in full towards the health plans' 85% MLR requirement. If a health plan does not meet the 85% MLR requirement, it must provide a rebate to its customers. Any such shortfalls would not impact amounts paid by health plans to DMG.

Medicaid. Medicaid is a federal entitlement program administered by the states that provides healthcare and long-term care services and support to low-income Americans. Medicaid is funded jointly by the states and the federal government. The federal government guarantees matching funds to states for qualifying Medicaid expenditures based on each state's federal medical assistance percentage, which is calculated annually and varies inversely with average personal income in the state. Subject to federal rules, each state establishes its own eligibility standards, benefit packages, payment rates and program administration within broad federal statutory and regulatory guidelines. Every state Medicaid program must balance a number of potentially competing demands, including the need for quality care, adequate provider access, and cost-effectiveness. In an effort to improve quality and provide more uniform and cost-effective care, many states have implemented Medicaid managed care programs to improve access to coordinated healthcare services, including preventative care, and to control healthcare costs. Under Medicaid managed care programs, a health plan receives capitation payments from the state. The health plan, in turn, arranges for the provision of healthcare services by contracting with a network of medical providers, such as DMG. DMG has entered into capitation agreements with health plans to manage approximately 105,800 Medicaid managed care members in its southern California market.

Commercial payors

According to the 2016 Annual Survey conducted by the Kaiser Family Foundation, approximately 150 million non-elderly people in the U.S. received their health insurance through their employers, which contracted with health plans to administer these healthcare benefits. Patients enrolled in health plans offered through an employment setting are generally referred to as commercial members. According to the survey, the percentage of workers covered was 55% in 2016, similar to the 56% covered in 2015. Under the ACA, many uninsured individuals and many individuals who receive their health insurance benefits through small employers may purchase their healthcare benefits through insurance exchanges in which health plans compete directly for individual or small group members' enrollment. DMG derives a significant amount of its enrollment from commercial members; however, these members represent a disproportionately small share of DMG's operating profits.

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

Capitation and FFS revenue

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

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

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

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

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

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

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

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

Risk-sharing model. In California, DMG currently utilizes a capitation model in several different forms. While there are variations specific to each arrangement, HealthCare Partners Affiliates Medical Group and DaVita Medical Group Associates California, Inc. (collectively AMG), which are medical groups that have entered into management services agreements with DMG, have historically contracted with health plans to receive a PMPM or percentage of premium (POP) capitation payment for professional (physician) services and assumed the financial responsibility for professional services. In some cases, the health plans separately enter into capitation contracts with third parties (typically hospitals) who directly receive a capitation payment and assume contractual financial responsibility for institutional (hospital) services. In other cases, the health plan does not pay a capitation payment to the hospital, but rather administers and pays fee-for-service claims for hospital expenses. In both cases, AMG has been responsible under its health plan agreements for managing the care dollars associated with both the professional and institutional services provided for in the AMG capitation payment. In the case of institutional services and as a result of its managed care-related administrative services agreements with hospitals, AMG has recognized a percentage of the surplus of institutional revenues less institutional expense as AMG net revenues and has also been responsible for some percentage of any short-fall in the event that institutional expenses exceed institutional revenues. In connection with DMG's obtaining a restricted Knox-Keene license in California, substantially all of the California health plan contracts, along with the revenues received under such contracts, have been assigned from AMG to DHPC. In

addition, DMG now has the legal authority to transition these health plan contracts to global capitation arrangements in which DMG is responsible for arranging professional and institutional services in exchange for a single capitation payment. DMG has evaluated its various risk sharing arrangements, and is working with the Department of Managed Health Care and several health plans to accept global capitation. DMG has converted three separate contracts covering approximately 3% of total DHPC membership to global risk and is in the approval and implementation process to convert additional contracts to global risk in 2017. Completion of evaluation of possible additional conversions is expected to continue over time.

Government regulation

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

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

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

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

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

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

not occur in that state. Therefore, if a DMG-associated physician is licensed in multiple states, sanctions or loss of licensure in one state may result in sanction or the loss of licensure in other states. Professional licensing sanctions may also result in exclusion from participation in governmental healthcare programs, such as Medicare and Medicaid, as well as other third-party programs.

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

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

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

In Colorado, any physician found to have abetted or assisted or conspired to engage in unprofessional conduct with respect to the practice of medicine is subject to disciplinary action, including the loss of licensure. Corporate entities or lay persons who are found to have engaged in the unauthorized practice of medicine may be subject to injunctive action and other criminal penalties. In Washington, the Secretary of Health is responsible for investigating complaints concerning the unlicensed practice of medicine and violations may be subject to a cease and desist order, civil fines, injunctive action, and other criminal penalties. In our markets where the corporate practice of medicine is prohibited, DMG has historically operated by maintaining long-term management contracts with multiple associated professional organizations which, in turn, employ or contract with physicians to provide those professional medical services required by the enrollees of the payors with which the professional organizations contract. Under these management agreements, DMG performs only non-medical administrative services, does not represent that it offers medical services, and does not exercise influence or control over the practice of medicine by the physicians or the associated physician groups with which it contracts. For example, in California, DMG has full-service management contracts with AMG. The AMG entities are owned by California-licensed physicians and professional medical corporations and contract with physicians to provide professional medical services. In Nevada and Washington, DMG's Nevada and Washington subsidiaries have similar management agreements with Nevada and Washington professional corporations, as applicable, that employ and contract with physicians to provide professional medical services. In Colorado, the physician groups contract through a provider network to include a pharmacy and ambulatory surgery center.

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

If we were required to restructure DMG's operating structures in our markets due to determination that a corporate practice of medicine violation existed, such a restructuring might include revisions of the California, Colorado, Nevada or Washington management services agreements, which might include a modification of the management fee, and/or establishing an alternative structure. For example, our subsidiaries in those states might have to obtain the equivalent of a California Knox-Keene license in such state in order to comply with the corporate practice of medicine rules while contracting directly with payors and, in turn, physicians, to provide physician services to the payors' enrollees. In California, DMG's restricted Knox-Keene license has created potential flexibility for DMG in the event regulatory authorities seek to enforce corporate practice of medicine or fee splitting laws based upon current management services relationships with AMG. DMG's restricted Knox-Keene license allows DHPC to contract with or employ physicians as a result of an exemption from California's corporate practice of medicine laws applicable to Knox-Keene licensees.

Knox-Keene. The California Department of Managed Health Care (DMHC) licenses and regulates Health Care Service Plans (HCSPs) pursuant to the Knox-Keene Health Care Service Plan Act of 1975, as amended. In addition to regulating Knox-Keene's various patient's rights protections for HCSP-enrolled individuals, the DMHC is responsible for ensuring the financial sustainability over time of HCSPs and other regulated entities. As such, the DMHC is charged with continually monitoring the financial health of

regulated entities. The DMHC's Division of Financial Oversight conducts examinations of the fiscal and administrative affairs of licensed HCSPs to protect consumers and providers from potential insolvencies. Financial examination reviews include examinations of cash flow, premium receivables, intercompany transactions and medical liabilities. The examination also ensures that there is adequate tangible net equity (TNE), as determined according to calculations included in Knox-Keene. The TNE regulations for organizations holding a Knox-Keene license, like DMG, vary depending on circumstances, but generally require any licensee to have on hand in cash or cash equivalents a minimum of the greater of (i) $1 million, (ii) the sum of 2% of the first $150 million of annualized premium revenues plus 1% of annualized premium revenues in excess of $150 million, or (iii) the sum of 8% of the first $150 million of annualized healthcare expenditures (except those paid on a capitated basis or managed hospital payment basis) plus 4% of the annualized healthcare expenditures, except those paid on a capitated basis or managed hospital payment basis, which are in excess of $150 million; plus 4% of annualized hospital expenditures paid on a managed hospital payment basis. In its sole discretion, the DMHC may require, as a condition to obtaining or maintaining an HCSP license, that a licensee accept certain contractual undertakings such that the licensee is obligated to maintain TNE in amounts greater than the minimum amount described above. Such contractual undertakings may require 130% or more of TNE to be maintained by a licensee. During the 2016 financial examination, DaVita Health Plan of California, Inc. (DHPC, formerly known as DaVita HealthCare Partners Plan, Inc.) was required to provide evidence of exclusive fidelity bond coverage in the amount of at least $2 million, with a deductible amount not in excess of $100,000 with a requirement to notify the Director of DMHC 30 days prior to cancellation.

The DMHC interprets Knox-Keene to apply to both HCSPs and downstream contracting entities, including provider groups that enter into global risk contracts with licensed HCSPs. A global risk contract is a healthcare services contract in which a downstream contracting entity agrees to provide both professional (physician) services and institutional (hospital) services subject to an at-risk or capitated reimbursement methodology. According to the DMHC, entities that accept global risk must obtain a restricted Knox-Keene license. Under a restricted Knox-Keene license, entities may enter into global risk contracts with other licensed HCSPs. Holders of restricted Knox-Keene licenses must comply with the same financial requirements as HCSPs with full licenses, including demonstrating specific levels of TNE, but are granted waivers from meeting marketing and other terms of full Knox-Keene licensure requirements. The consequences of operating without a license include civil penalties, criminal penalties and the issuance of cease and desist orders.

DHPC holds a restricted Knox-Keene license, which was approved by the DMHC on December 31, 2013. This allows DMG, under its DHPC plan to contract directly with HCSPs to simplify its historic contractual and financial structure and to facilitate expansion into new markets in California. However, this also subjects DMG and DHPC to additional regulatory obligations, including (i) regulatory oversight of operations, (ii) the need to seek approval for all material business changes, (iii) significant requirements to maintain certain TNE levels, and (iv) other operating limitations imposed by Knox-Keene and its regulations. Under its restricted Knox-Keene license, DHPC is prohibited from declaring or paying any dividends or making any distribution of cash or property to its parent, affiliates, or shareholders, if such a distribution would cause it to fail to maintain the minimum applicable TNE, have insufficient working capital or cash flow as required by DMHC regulation or otherwise be unable to provide or arrange healthcare services. In addition, DHPC is subject to DMHC oversight and must seek approval before incurring any debt or guaranteeing any debt relating to its parent, affiliates, or shareholders. DHPC must also submit proposed global capitation contracts to the DMHC for approval.

DMG services

Approximately 83% of DMG's operating revenues for the year ended December 31, 2016 were derived from multi-year capitation contracts with health plans. Under these contracts, DMG's health plan customers delegate full responsibility for member care to physicians and healthcare facilities that are part of DMG's provider network. In return, DMG receives a PMPM fee for each DMG member. As a result, DMG has financial and clinical accountability for a population of members. In California, DMG does not assume direct financial risk for institutional (hospital) services in most cases, but is responsible for managing the care dollars associated with both the professional (physician) and institutional services being provided for the PMPM fee attributable to both professional and institutional services. In those cases and as a result of its managed care-related administrative services agreements with hospitals, DMG recognizes the surplus of institutional revenues less institutional expense as DMG net revenues and is also responsible for any short-fall in the event that institutional expenses exceed institutional revenues. In addition to revenues recognized for financial reporting purposes, DMG measures its total care dollars under management. This includes the PMPM fee payable to third parties for institutional (hospital) services where DMG manages the care provided to its members by hospitals and other institutional services. These fees are not included in generally accepted accounting principles (GAAP) revenues.

DMG provides comprehensive and quality medical care through a network of participating physicians and other healthcare professionals. Through its group model, DMG employs, directly (where permitted by state law) and through its associated physician groups, approximately 700 primary care physicians. Through its IPA model, DMG contracts with a network of over 2,500 associated groups and other network primary care physicians who provide care for DMG's members in an independent office setting. These physicians are complemented by several thousand network specialists and approximately 200 network hospitals that provide specialty or institutional care to the patients of DMG's associated physicians, physician groups and IPAs.

In order to comply with local regulations prohibiting the corporate practice of medicine, many of DMG's group physicians are employed by associated medical groups with which DMG has entered into long-term management agreements. The largest of these DMG managed medical groups is AMG, which employs, directly or indirectly, over 700 primary care physicians, specialists and hospitalists. See "Government Regulation—Corporate practice of medicine and fee splitting" above.

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

DMG group physicians typically see 15 to 20 patients per day, which we believe is an appropriate benchmark to ensure there is sufficient time to understand all of the patients' clinical needs. DMG care teams, including nurses, engage in outreach to patients in order help monitor fragile and high risk patients, and help improve adherence to physicians' care plans. During these visits, DMG's physicians, nurses and educators use the time to educate patients and manage their healthcare needs. The goal of this preventative care delivery model is to keep patients healthy. Education improves self-management and compliance which allows the patient to recognize early signs of their disease and seek appropriate care. We believe this translates into earlier intervention, which in turn leads to fewer emergency room visits, fewer hospital admissions and fewer hospital bed days (the most expensive location for healthcare). This clinical model seeks to provide early diagnosis of disease or deterioration in a chronic and complex condition and provide preventive care to maintain optimal health and avert unnecessary hospitalization. Clinic-based case managers and hospitalists coordinate with the primary care physicians to ensure that patients are receiving proper care whether they are in the clinic, in the hospital or are not regularly accessing healthcare. Physicians and case managers encourage patients to regularly visit the clinics in order to enhance their day-to-day health and diagnose any illness or deterioration in condition as early as possible.

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

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

In addition, DMG uses its data to carefully track high utilizing patients through robust data warehousing and data mining technologies. DMG filters the data warehouse to identify and reach out to patients with high-utilization patterns who are inefficiently using resources, such as visiting an emergency room when either a same-day appointment or urgent care center would be more appropriate and satisfactory for the member. High utilizing patients are identified and tracked as part of DMG's electronic health record by their physician and DMG's care management staff. Specific care plans are attached to each of these patients and tracked carefully for full compliance. The objective is to proactively manage their care at times when these patients are either not compliant with the care plan or when changing circumstances require care managers to develop new and more suitable care plans. By using these resources, DMG has achieved improvements in quality of care, satisfaction and cost.

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

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

- DMG's clinical leadership and associated group and network physicians devote significant efforts to ensure that DMG's members receive the most appropriate care in the most appropriate manner.
- DMG is committed to maximizing its patients' satisfaction levels.
- DMG has the scale which, combined with its strong reputation and high quality patient care, makes it an attractive partner for health plans, compared to smaller provider groups that may have a higher risk of default and may not have the same resources to devote and develop the same level of patient care.
- DMG has over two decades of experience in managing complex disease cases for its population of patients. As a result, DMG has developed a rich dataset of patient care experiences and outcomes which permits DMG to proactively monitor and intervene in improving the care of its members.
- DMG's senior management team possesses substantial experience with the healthcare industry with average experience over 20 years, as of December 31, 2016.

Locations of DMG clinics

As of December 31, 2016, DMG managed a total of 247 medical clinics, of which 59 clinics were located in California, 13 clinics were located in Colorado, 85 clinics were located in Florida, 52 clinics were located in Nevada, 15 clinics were located in New Mexico, two clinics were located in Georgia and 21 clinics were located in Washington.

Competition

U.S. and International dialysis competition

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

The two largest dialysis companies, Fresenius Medical Care (FMC) and our Company, account for approximately 72% of outpatient dialysis patients in the U.S. with our Company serving approximately 36% of the total outpatient dialysis patients. Approximately 44% of the centers not owned by us or FMC are owned or controlled by hospitals or non-profit organizations. Hospital-based and non-profit dialysis units typically are more difficult to acquire than physician-owned dialysis centers.

FMC also manufactures a full line of dialysis supplies and equipment in addition to owning and operating outpatient dialysis centers worldwide. This may give FMC cost advantages over us because of its ability to manufacture its own products. Additionally, FMC has been one of our largest suppliers of dialysis products and equipment over the last several years. In January 2010, we entered into and subsequently extended an agreement with FMC to purchase a certain amount of dialysis equipment, parts and supplies from FMC through December 31, 2017. In addition, we entered in to a product supply agreement with Baxter Healthcare Corporation (Baxter) that commits us to purchase a certain amount of dialysis supplies through 2018. Our purchases of products in these categories generally offered by both FMC and Baxter represent approximately 4% of our total U.S. dialysis and related lab services operating expenses for the year ended December 31, 2016. In 2016, we purchased hemodialysis products and supplies from both FMC and Baxter that each represented approximately 2% of our total U.S. dialysis operating expenses. The amount of purchases in future years

from FMC will depend upon a number of factors, including the operating requirements of our centers, the number of centers we acquire, and growth of our existing centers.

DMG's competition

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

Corporate compliance program

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

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

We have a code of conduct that each of our teammates and affiliated professionals must follow and we have a confidential toll-free hotline for teammates and patients to report potential instances of noncompliance. Our Chief Compliance Officer administers the compliance program. The Chief Compliance Officer reports directly to our Chief Executive Officer, our Chief Executive Officer of Kidney Care and Chair of the Compliance Committee of our Board of Directors (Board Compliance Committee). On October 22, 2014, DaVita signed a CIA with HHS and the OIG. The CIA:

- requires that we maintain certain elements of our compliance programs;
- imposes certain expanded compliance-related requirements during the term of the CIA, including increased training for teammates, physician partners and board members, implementing a series of procedures prior to entering into arrangements with referrals sources, execution of annual certifications by senior executives that evidence compliance with federal healthcare laws and regulations, internal compliance policies and the CIA, imposition of an executive recoupment program and quarterly and annual reports to the OIG;
- requires the formal allocation of certain oversight responsibility to the Board Compliance Committee and a resolution from that committee that it has made reasonable inquiry into the operations of the compliance program and the retention of an independent compliance advisor in year three of the CIA;
- contains certain business restrictions related to a subset of our joint venture arrangements, including our agreeing to not enter into certain types of partial divestiture joint venture transactions with nephrologists during the term of the CIA, among other restrictions; and
- requires that we engage an Independent Monitor who will provide additional oversight and reporting to the OIG for the term of the CIA.

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

Insurance

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

Teammates

As of December 31, 2016, we employed approximately 70,300 teammates, including our international teammates:

• Licensed professional staff (physicians, nurses and other healthcare professionals)	29,500
• Other patient care and center support staff and laboratory personnel	27,400
• Corporate, billing and regional administrative staff	13,400

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

Item 1A. Risk Factors.

This Annual Report on Form 10-K contains statements that are forward-looking statements within the meaning of the federal securities laws. These statements involve known and unknown risks and uncertainties including the risks discussed below. The risks discussed below are not the only ones facing our business. Please read the cautionary notice regarding forward-looking statements in Item 7 of this Part 1 under the heading "Management's Discussion and Analysis of Financial Condition and Results of Operations."

Risk factors related to our overall business:

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

Our operations are subject to extensive federal, state and local government regulations, including Medicare and Medicaid payment rules and regulations, federal and state anti-kickback laws, the Stark Law and analogous state self-referral prohibition statutes, Federal Acquisition Regulations, the 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 related to claims submission, enrollment and licensing requirements, cost reporting, and payment processes 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 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.

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

In addition, failure to report and return overpayments within 60 days of when the overpayment was identified 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 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. 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. As of December 31, 2016, we recorded an estimated accrual of $38 million for potential damages and liabilities associated with write-offs and discounts of patient co-payment obligations, and credits to payors for returns of prescriptions drugs related to our pharmacy business that were identified during the course of an internally-initiated compliance review. We have disclosed the results of this ongoing review to the government. We may accrue additional reserves for refunds and related damages and potential liabilities arising out of this review.

Additionally, 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, including coding errors, billing for services not rendered, submitting false cost reports, billing for services at a higher payment rate than appropriate, billing under a comprehensive code as well as under one or more component codes included in the comprehensive code, and billing for care that is not considered medically necessary. Moreover, amendments to the federal Anti-Kickback Statute in the health reform law make claims tainted by anti-kickback violations potentially subject to liability under the FCA, including *qui tam* or whistleblower suits. 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 $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.

The civil investigative demand received by our wholly-owned pharmacy services subsidiary, DaVita Rx, LLC, specifically references that it is in connection with an FCA investigation concerning allegations that this subsidiary presented or caused to be presented false claims for payment to the government for prescription medications, as well as into our relationship with pharmaceutical manufacturers. See "Item 3. Legal Proceedings" and Note 17 to the consolidated financial statements included in this report for further details.

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

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

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

We are, and may in the future be, 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, 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 us.

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 2015 U.S. Attorney Transportation Investigation, the investigations underlying the two subpoenas regarding patient diagnosis coding received by DMG and its JSA subsidiary, the 2015 DOJ Vascular Access Investigation, 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 3. Legal Proceedings" and Note 17 to the consolidated financial statements included in this report, we cannot predict the ultimate outcomes of the various legal proceedings and regulatory matters to which we are or may be subject from time to time, including those described in the aforementioned sections of this report, or the timing of their resolution or the ultimate losses or impact of developments in those matters, which could have a material adverse effect on our revenues, earnings, and cash flows. See "Item 3. Legal Proceedings" and Note 17 to the 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 revenues, earnings and cash flows and otherwise adversely affect our financial condition.

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

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

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

The federal healthcare reform legislation, enacted in 2010, introduced healthcare insurance exchanges which provide a marketplace for eligible individuals and small employers to purchase healthcare insurance. The business and regulatory environment continues to evolve as the exchanges mature, and regulations are challenged, changed and enforced. If commercial payor participation in the exchanges continues to decrease, our revenues, earnings and cash flows could be adversely affected. 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, our revenues, earnings and cash flows could be adversely affected.

The healthcare reform legislation also added several new tax provisions that, among other things, impose various fees and excise taxes, and limit compensation deductions for health insurance providers and their affiliates. These rules could negatively impact our cash flow and tax liabilities. In addition, the healthcare reform legislation broadened the potential for penalties under the FCA for the knowing and improper retention of overpayments collected from government payors and reduced the timeline to file Medicare claims. As a result, we made significant investments in new resources to accelerate the time it takes us to identify and process overpayments and we deployed significant resources to reduce our timeline and improve our claims processing methods to ensure that our Medicare claims are filed in a timely fashion. 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 may have a negative impact on our revenues, earnings and cash flows. Failure to file a claim within the one year window could result in payment denials, adversely affecting our revenues, earnings and cash flows.

With the healthcare reform legislation, 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 New Jersey and Pennsylvania markets. 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 this or other Innovation Center models, some of our patients may be assigned to an ACO, another ESRD Care Model, or another program, in which case the quality and cost of care that we furnish will be included in an ACO's, another ESRD Care Model's, or other program's calculations. Additionally, CMS instituted new screening procedures which we expect will delay the Medicare contractor approval process, potentially causing a delay in reimbursement. We anticipate the new screening and enrollment requirements will require additional personnel and financial resources and will potentially delay the enrollment and revalidation of our centers which in turn will delay payment. These delays may negatively impact our revenues, earnings and cash flows.

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

There is also a considerable amount of uncertainty as to the prospective implementation of the federal healthcare reform legislation and what similar measures might be enacted at the state level. There have been multiple attempts through legislative action and legal challenges to repeal or amend the ACA. In addition, the 2016 Presidential and Congressional elections have caused the future state of the exchanges and other ACA reforms to be unclear. As a result, there is considerable uncertainty regarding the future with respect to the exchanges, and, indeed, many core aspects of the current health care marketplace. While specific changes and their timing are not yet apparent, it does appear likely that there will be significant changes to the healthcare environment in the near and short term. The enacted reforms as well as future legislative changes could have a material adverse effect on our results of operations, including lowering our reimbursement rates and increasing our expenses.

In addition, CMS published an interim final rule that establishes new Conditions for Coverage standards for dialysis facilities that require any facility making payments of premiums for individual market health plans to notify patients of potential coverage options and educate them about the benefits of each option. The interim final rule requires facilities to ensure that insurers are informed of and have agreed to accept the payments. On January 25, 2017, the federal court issued a preliminary injunction on CMS' interim final rule. At this time CMS has not appealed the court's ruling and we await the final decision from the court. This and any other law, rule or guidance or rule issued by CMS limiting or prohibiting the use of charitable premium assistance and/or the ability of patients with access to alternative coverage from selecting a marketplace plan on or off exchange could have a material adverse effect on our revenues, earnings and cash flows.

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

We must comply with numerous federal and state laws and regulations governing the collection, dissemination, access, use, security and privacy of PHI, including HIPAA and its implementing privacy and security regulations, as amended by the federal 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, our business, reputation, results of operations, financial position and cash flows could be materially and adversely affected.

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

We are continuously implementing multiple layers of security measures through technology, processes, and our people. We utilize current security technologies and our defenses are monitored and routinely tested internally and by external parties. Despite these efforts, our facilities and systems and those of our third-party service providers may be vulnerable to privacy and security incidents; security attacks and breaches; acts of vandalism or theft; computer viruses 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, reputation, financial condition, cash flows, or results of operations. 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 result in interruptions, delays, the loss or corruption of data, cessations in the availability of systems or liability under privacy and security laws, all of which could have a material adverse effect on our financial position and results of operations and harm our business reputation 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, operations, and financial results may be materially adversely affected. Failure to adequately protect and maintain the integrity of our information systems (including our networks) and data, or to defend against cybersecurity attacks, could subject us to monetary fines, civil suits, civil penalties or criminal sanctions and requirements to disclose the breach publicly, and may further result in a material adverse effect on our results of operations, financial position, and cash flows. 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 materially and adversely affect our business.

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 adversely impact our results of operations. Further, we cannot be certain that key talented individuals at the business being acquired will continue to work for us after the acquisition or that they will be able to continue to successfully manage or have adequate resources to successfully operate any acquired business.

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

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.

Acquisitions, patient retention and medical director and physician retention are an important part of our growth strategy. We face intense competition from other companies for acquisition targets. In our U.S. dialysis business, we continue to face increased competition from large and medium-sized providers, which compete directly with us for acquisition targets as well as for individual patients and medical directors. In addition, as we continue our international dialysis expansion into various international markets, we will face competition from large and medium-sized providers for these acquisition targets as well. Because of the ease of entry into the

dialysis business and the ability of physicians to be medical directors for their own centers, competition for growth in existing and expanding markets is not limited to large competitors with substantial financial resources. Occasionally, we have experienced competition from former medical directors or referring physicians who have opened their own dialysis centers. In addition, FMC, our largest competitor, manufactures a full line of dialysis supplies and equipment in addition to owning and operating dialysis centers. This may give it cost advantages over us because of its ability to manufacture its own products. If we are not able to continue to make acquisitions, continue to maintain acceptable levels of non-acquired growth, or if we face significant patient attrition to our competitors or a reduction in the number of our medical directors or associated physicians, it could adversely affect our business.

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 substantially reduce our revenues, earnings and cash flows.

We have significant suppliers that are either the sole or primary source of products critical to the services we provide, including Amgen, Baxter, FMC, NxStage Medical, Inc. and others or to which we have committed obligations to make purchases. If any of these suppliers 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 revenues, earnings and cash flows could be substantially reduced. In addition, the technology related to the products critical to the services we provide is subject to new developments and may result in superior products. If we are not able to access superior products on a cost-effective basis or if suppliers are not able to fulfill our requirements for such products, we could face patient attrition which could substantially reduce our revenues, earnings and cash flows.

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 and adverse impact on our revenues and operating results. 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, the results of operations and financial condition may be materially and adversely affected, and in that regard, we have taken goodwill impairment charges of $189 million, $77 million and $176 million in December 2015, March 2016 and June 2016, respectively, and may continue incurring additional impairment charges.

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 earnings and cash flow and our ability to service our indebtedness;
- place us at a competitive disadvantage compared to our competitors that have less debt; and
- limit our ability to borrow additional funds.

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

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

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

The borrowings under our senior secured credit facilities are guaranteed by a substantial portion of our direct and indirect wholly-owned domestic subsidiaries and are secured by a substantial portion of DaVita Inc.'s and its 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 reduce our earnings and cash flows.

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

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

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

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

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

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

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 adversely affect our business, results of operations and cash flows.

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 financial condition, results of operations and cash flows.

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 revenues, earnings and cash flows.

Approximately 36% of our dialysis services revenues for the year ended December 31, 2016 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 financial results. Consolidations have significantly increased the negotiating leverage of commercial payors. Our negotiations with payors are also influenced by competitive pressures, and we may experience decreased contracted rates with commercial payors or experience decreases in patient volume as our negotiations with commercial payors continue. In addition to downward pressure on contracted commercial payor rates, payors have been attempting to 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 have 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 revenues, earnings and cash flows. For additional details regarding specific risks we face regarding regulatory changes that could result in fewer patients covered under commercial plans or an increase of patients covered under more restrictive commercial plans with lower reimbursement rates, see the discussion in the risk factor under the heading “Healthcare reform could substantially reduce our revenues, earnings and cash flows.”

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

Our revenue levels are sensitive to the percentage of our patients with higher-paying commercial insurance coverage. A patient's insurance coverage may change for a number of reasons, including changes in the patient's or a family member's employment status. Currently, for a patient covered by an employer group health plan, Medicare generally becomes the primary payor after 33 months, or earlier, if the patient's employer group health plan coverage terminates. Patients with commercial insurance frequently 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. Although CMS' interim final rule is currently subject to a preliminary injunction issued by a federal court judge, CMS or a regulatory agency may issue a new rule to challenge charitable premium assistance. If any of these challenges to kidney patients' use of premium assistance are successful or regulators impose restrictions on the use of financial assistance from such charitable organizations such that these patients are unable to obtain, or continue to receive or receive for a limited duration, such financial assistance, our revenues, earnings, and cash flow could be substantially reduced.

When Medicare becomes the primary payor, the payment rate we receive for that patient decreases from the employer group health plan rate to the lower Medicare payment rate. 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 revenues, earnings and cash flows.

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

Approximately 42% of our dialysis services revenues for the year ended December 31, 2016 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 the ESRD Prospective Payment System (PPS), which phases in the reductions to the ESRD 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 revenues, earnings and cash flows.

- Risk that, if our clinical systems fail to accurately capture the data we report to CMS in connection with claims for which at least part of the government's payments to us is based on clinical performance or patient outcomes or co-morbidities, we might be over-reimbursed by the government which could subject us to certain liability. For example, CMS published a final rule that implemented a statute under the ACA. This statute requires 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 regulations that apply to our business, we could suffer severe consequences that could have a material adverse effect on our revenues, earnings, cash flows and stock price."

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

Approximately 22% of our dialysis services revenues for the year ended December 31, 2016 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 2% of our dialysis services revenues for the year ended December 31, 2016 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 adversely affect our revenues, earnings and cash flows.

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

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

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

Additionally, evaluations on the utilization and reimbursement for ESAs, which have occurred in the past and may occur in the future, and related actions by the U.S. Congress and federal agencies, could result in further restrictions on the utilization and

reimbursement for ESAs. Commercial payors have increasingly examined their administration policies for EPO and, in some cases, have modified those policies. Changes in labeling of EPO and other pharmaceuticals in a manner that alters physician practice patterns or accepted clinical practices, and/or changes in private and governmental payment criteria, including the introduction of EPO administration policies could have a material adverse effect on our revenues, earnings and cash flows. Further increased utilization of EPO for patients for whom the cost of EPO is included in a bundled reimbursement rate, or further decreases in reimbursement for EPO and other pharmaceuticals that are not included in a bundled reimbursement rate, could also have a material adverse effect on our revenues, earnings and cash flows.

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

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

In October 2014, we entered into a Settlement Agreement with the United States and relator David Barbetta to resolve the then pending 2010 and 2011 U.S. Attorney physician relationship investigations and paid $406 million in settlement amounts, civil forfeiture, and interest to the United States and certain states. In connection with the resolution of these matters, and in exchange for the OIG's agreement not to exclude us from participating in the federal healthcare programs, we have entered into a five-year CIA with the OIG. The CIA (i) requires that we maintain certain elements of our compliance programs; (ii) imposes certain expanded compliance-related requirements during the term of the CIA; (iii) requires ongoing monitoring and reporting by an independent monitor, imposes certain reporting, certification, records retention and training obligations, allocates certain oversight responsibility to the Board's Compliance Committee, 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 revenues, earnings and cash flows. For our domestic dialysis business, we are required under the CIA to report to the OIG (i) probable violations of criminal, civil or administrative laws applicable to any federal health care program for which penalties or exclusions may be authorized under applicable laws and regulations; (ii) substantial overpayments of amounts of money we have received in excess of the amounts due and payable under the federal healthcare program requirements; and (iii) employment of or contracting with individuals ineligible from participating in the federal healthcare programs (we refer to these collectively as Reportable Events). We have provided the OIG notice of Reportable Events, and we may identify and report additional events in the future. If any of our operations are found to violate government laws and regulations, we could suffer severe consequences that would have a material adverse effect on our revenues, earnings, cash flows and stock price, including those consequences described under the risk factor "If we fail to adhere to all of the complex government regulations that apply to our business, we could suffer severe consequences that would substantially reduce our revenues, earnings, cash flows and stock price."

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

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

close centers or our centers' operating performance deteriorates, and it could have an adverse effect on our revenues, earnings and cash flows.

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

As of December 31, 2016, 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 year ended December 31, 2016. 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 effect on our revenues, earnings and cash flows".

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

There are significant estimating risks associated with the amount of dialysis and related lab services revenues and related refund liabilities that we recognize in a reporting period. The billing and collection process is complex due to ongoing insurance coverage changes, geographic coverage differences, differing interpretations of contract coverage and other payor issues. Determining applicable primary and secondary coverage for approximately 187,700 U.S. patients at any point in time, together with the changes in patient coverage that occur each month, requires complex, resource-intensive processes. Errors in determining the correct coordination of benefits may result in refunds to payors. Revenues associated with Medicare and Medicaid programs are also subject to estimating risk related to the amounts not paid by the primary government payor that will ultimately be collectible from other government programs paying secondary coverage, the patient's commercial health plan secondary coverage or the patient. Collections, refunds and payor retractions typically continue to occur for up to three years and longer after services are provided. We generally expect our range of 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 significant impact on our operating results.

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 revenues, earnings and cash flows may be negatively impacted and we may have to write off our investment and incur other exit costs.

Our ancillary services and strategic initiatives 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, our revenues, earnings and cash flows may be negatively impacted, we may incur a material write-off or an impairment of our investment, including goodwill, in one or more of these activities, or we could incur significant termination costs if we were to exit a certain line of business.

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

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

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

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

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

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

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

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

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

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

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 have a material adverse effect on our revenues, cash flows and operating results.

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 materially and adversely affect DMG's revenues, earnings or cash flows.

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

Over 83% of DMG's revenue for the year ended December 31, 2016 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, may have a material adverse effect on DMG's financial condition, results of operations or cash flows.

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 reduce DMG's revenues and profitability.

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

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 may have a material adverse effect on our DMG division and the Company's future revenues and profitability.

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

Some states have laws that prohibit business entities, such as DMG, 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, financial condition or results of operations.

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 operations and financial results. 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.

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 impact 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 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.

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.

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.

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.

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

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 revenues, earnings and cash flows.

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

We have taken impairment charges against the goodwill of three of our DMG reporting units in the fourth quarter of 2015 and the first and second quarters of 2016 based on continuing developments at our DMG reporting units, 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 units in recent quarters 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 changes 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 impact on DMG's ongoing financial performance.

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

- Medicare Advantage benchmarks for 2011 were frozen at 2010 levels. From 2012 through 2016, Medicare Advantage benchmark rates were phased down from prior levels. The new benchmarks 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 significant negative impact on DMG's earnings and cash flows.

- Rebates received by Medicare Advantage plans that were reduced, with larger reductions for plans failing to receive certain quality ratings.

- The Secretary of HHS has been granted the explicit authority to deny Medicare Advantage plan bids that propose significant increases in cost sharing or decreases in benefits. If the bids submitted by plans contracted with DMG are denied, this would have a significant negative impact on DMG's revenues, earnings and cash flows.

- Medicare Advantage plans with medical loss ratios below 85% are required to pay a rebate to the Secretary of HHS. The rebate amount is the total revenue under the contract year multiplied by the difference between 85% and the plan's actual medical loss ratio. The Secretary of HHS will halt enrollment in any plan failing to meet this ratio for three consecutive years, and terminate any plan failing to meet the ratio for five consecutive years. If a DMG-contracting Medicare Advantage plan experiences a limitation on enrollment or is otherwise terminated from the Medicare Advantage program, DMG may suffer materially adverse consequences to its business or financial condition.

- 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 revenues, earnings and cash flows.

- CMS increased coding intensity adjustments for Medicare Advantage plans beginning in 2014 and continuing through 2018, which reduces CMS payments to Medicare Advantage plans, which in turn will likely reduce the amounts payable to DMG and its associated physicians, physician groups, and IPAs under its capitation agreements.

However, the 2016 Presidential and Congressional elections have caused the future state of the Health Reform Acts 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 our results of operations.

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 now predicts that enrollment in Medicare Advantage (and other contracts covering Medicare Parts A and B) could reach 30 million by 2026. 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 2015, CMS announced an average increase of 0.4%; for 2016, 1.25%; and for 2017, 0.85%. Uncertainty over Medicare Advantage enrollment and payment rates present a continuing risk to DMG's business.

Medicare Advantage enrollment continues to be highly concentrated among a few payors, both nationally and in local markets. In 2017, in 439 counties in 26 states, only one company will offer Medicare Advantage plans– an indicator that those markets may lack competition. 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 negative impact of DMG's revenues, earnings, and/or cash flows.

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

For the year ended December 31, 2016, 63% 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 financial condition, results of operations and/or cash flows.

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

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

To expand the operations of its network outside of the Existing Geographic Regions, DMG must devote resources to identify and explore perceived opportunities. Thereafter, DMG must, among other things, recruit and retain qualified personnel, develop new offices, establish potential new relationships with one or more health plans, and establish new relationships with physicians and other healthcare providers. The ability to establish such new relationships may be significantly inhibited by competition for such relationships and personnel in the healthcare marketplace in the targeted new geographic regions. Additionally, DMG may face the risk that a substantial portion of the patients served in a new geographic area may be enrolled in a Medicare FFS program and will not desire to transition to a Medicare Advantage program, such as those offered through the health plans that DMG serves, or they may enroll with other health plans with 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 an adverse effect on its results of operations, financial condition and/or cash flow.

As a result of the Health Reform Acts, 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 an adverse effect on its results of operations, financial condition, and/or cash flows.

Given each health plan's control of its plans and the many other providers that serve such plans, DMG believes that it will have limited ability to influence the overall quality rating of any such plan. 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 an adverse effect on DMG's results of operations, financial condition and/or cash flows.

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

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

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 3. Legal Proceedings" and Note 17 to the 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 to $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 3. Legal Proceedings" and Note 17 to the 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 profitability.

Patient care costs include estimates of future medical claims that have been incurred by the patient but for which the provider has not yet billed 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.

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 Health Reform Acts, many Medicare beneficiaries may decide that an original Medicare FFS program is more attractive than a Medicare Advantage plan. As a result, enrollment in the health plans 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 Health Reform Acts 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 financial condition and results of operations.

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 an 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 Health Reform Acts established Medicare Shared Savings Programs (MSSP) for ACOs, which took effect in January 2012. Under the MSSP, eligible organizations are accountable for the quality, cost and overall care of Medicare beneficiaries assigned to an ACO and may be eligible to share in any savings below a specified benchmark amount. The Secretary of HHS is also authorized, but not required, to use capitation payment models with ACOs. 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. We also are participating as a dialysis provider in Arizona, Florida, New Jersey, and Pennsylvania for the Innovation Center's CEC Model.

The ACO programs are relatively new and therefore operational and regulatory guidance is limited. It is possible that the operations of 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 FFS 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 financial condition, and results of operations.

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 adversely affect DMG operations.

Any negative changes in governmental capitation or FFS rates or methods of reimbursement for the services DMG provides could have a significant adverse impact on DMG's revenue and financial results. 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 and financial operations may be materially 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 Health Reform Acts have increased the participation of individuals in the Medicaid program in states that elected to participate in the expanded Medicaid coverage. A shift in payor mix from managed care and other private payors to government payors as well as an increase in the number of uninsured patients may result in a reduction in the rates of reimbursement to 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 Health Reform Acts and state decisions on whether to participate in the expansion of such programs also could increase the number of patients who participate in such programs and the number of uninsured patients. Even for those patients who remain in private insurance plans, changes to those plans could increase patient financial responsibility, resulting in a greater risk of uncollectible receivables. These factors and events could have a material adverse effect on DMG's business, financial condition and results of operations.

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

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

- requiring DMG to change its products and services;

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

Risk factors related to ownership of our common stock:

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

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

Most of our outstanding employee stock-based compensation awards include a provision accelerating the vesting of the awards in the event of a change of control. We also maintain a change of control protection program for our employees who do not have a significant number of stock awards, which has been in place since 2001, and which provides for cash bonuses to the employees in the event of a change of control. Based on the market price of our common stock and shares outstanding on December 31, 2016, these cash bonuses would total approximately $493 million if a change of control transaction occurred at that price and our Board of Directors did not modify this program. These change of control provisions may affect the price an acquirer would be willing to pay for our Company.

We are also subject to Section 203 of the Delaware General Corporation Law that, subject to exceptions, would prohibit us from engaging in any business combinations with any interested stockholder, as defined in that section, for a period of three years following the date on which that stockholder became an interested stockholder.
These provisions may discourage, delay or prevent an acquisition of our Company at a price that our stockholders may find attractive. These provisions could also make it more difficult for our stockholders to elect directors and take other corporate actions and could limit the price that investors might be willing to pay for shares of our common stock.

Item 1B. Unresolved Staff Comments.

None.

Item 2. Properties.

Our corporate headquarters are located in Denver, Colorado, consisting of one owned 240,000 square foot building and one leased 116,000 square foot building. Our headquarters are occupied by teammates engaged in management, finance, marketing, strategy, legal, compliance and other administrative functions. We lease six business offices located in California, Pennsylvania, Tennessee and Washington for our U.S. dialysis and related lab services business. For our DMG business we lease nine business offices located in California, Colorado, Nevada, New Mexico, Florida and Washington. Our laboratories are based in Florida where we operate our lab services out of five buildings, one owned and four leased. DaVita Rx leases four buildings located in Arizona, California, Florida and Texas. We also own four administrative offices and lease administrative offices worldwide. Our leases on the properties listed above expire at various dates through the year 2031.

For our U.S. dialysis and related lab services business we own the land and buildings for 16 of our outpatient dialysis centers. We also own eight separate land and buildings and nine land parcels for development. We lease a total of three owned properties to third-party tenants. Our remaining outpatient dialysis centers are located on premises that we lease.

For DMG, we own the land and buildings for 18 of our clinics. We also own the building for one other clinic and we own one separate land parcel. Our remaining clinics are located on premises that we lease.

Our leases for our U.S. dialysis and related lab services and for DMG generally cover periods from five to 20 years and typically contain renewal options of five to ten years at the fair rental value at the time of renewal. Our leases are generally subject to periodic

consumer price index increases, or contain fixed escalation clauses. Our outpatient dialysis centers range in size from approximately 600 to 33,000 square feet, with an average size of approximately 7,500 square feet. DMG's clinics range in size from approximately 800 to 86,000 square feet, with an average size of approximately 10,500 square feet. Our international leases generally range from one to ten years.

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

Item 3. Legal Proceedings.

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. While these accruals reflect our best estimate of the probable loss for those matters as the dates of those accruals, the recorded amounts may differ materially from the actual amount of the losses for those matters. 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.

Swoben Private Civil Suit: In April 2013, HealthCare Partners (HCP), now known as our DaVita Medical Group (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 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.

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 have been advised by an attorney with the United States Attorney's Office for the Central District of California that the *qui tam* is related to the investigation concerning the medical necessity of patient transportation, which was the basis for the subpoenas. The relator alleges 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 alleges that two of our purported clinical staff caused the submission of a small number of those claims through improper certifications of medical necessity. We are investigating these allegations and intend to defend accordingly. The DOJ has declined to intervene.

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 OIG. We have been advised by an attorney with the Civil Division of the DOJ in Washington, D.C. that the subpoena relates to an ongoing civil investigation concerning Medicare Advantage service providers' risk adjustment practices and data, including identification and verification of patient diagnoses and factors used in making the diagnoses. The subpoena requests documents and information for the period from January 1, 2008 through December 31, 2013, for certain Medicare Advantage plans for which JSA provided services. It also requests information regarding JSA's communications about patient diagnoses as they relate to certain Medicare Advantage plans generally, and more specifically as related to two Florida physicians with whom JSA previously contracted. 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 Medicare Advantage plans and related patient diagnosis coding and risk adjustment submissions and payments. We believe that the request is part of a broader industry investigation into Medicare Advantage patient diagnosis coding and risk adjustment practices and potential overpayments by the government. 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.

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 with us 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 alleges 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 the third quarter of 2016 we recorded an accrual of a non-material amount for potential damages and liabilities. In January 2017, we finalized and executed a settlement agreement with the relator and the government for an immaterial amount.

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. It appears the government is conducting an FCA investigation concerning allegations that DaVita Rx presented or caused to be presented false claims for payment to the government for prescription medications, 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. We notified the government in September 2015 that we were conducting this review of DaVita Rx and began providing regular updates of our review. Through the fourth quarter of 2016, we recorded estimated accruals totaling $38 million for potential damages and liabilities associated with write-offs and discounts of patient co-payment obligations, and credits to payors for returns of prescriptions drugs, related to DaVita Rx that were identified during the course of this internal compliance review. Upon completion of our review, we filed a self-disclosure with the OIG in early February 2016 and we have been working to address and update the practices we identified in the self-disclosure, some of which overlap with information requested by the U.S. Attorney's Office. We may accrue additional reserves for refunds and related damages and potential liabilities arising out of this review. We do not know if the U.S. Attorney's Office, which is part of the DOJ, knew when it served the CID on us that we were already in the process of developing a self-disclosure to the OIG. The OIG

informed us in 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 and are producing the requested information.

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 intend to cooperate with the government in this investigation.

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 of Georgia Securities Laws 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 our 2016 proxy statement 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, 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.

From time to time, we initiate litigation or other legal proceedings as a plaintiff arising out of contracts or other matters. In that regard, we 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 that we provided from 2005 through 2011 to veterans pursuant to VA regulations. In January 2017, we reached a resolution of our claims with the government for $538 million, which we expect to recognize in our first quarter 2017 financial statements.

* * *

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 3. Legal Proceedings," 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 or reputation.

Item 4. Mine Safety Disclosures.

Not applicable.

PART II

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

Our common stock is traded on the New York Stock Exchange under the symbol DVA. The following table sets forth, for the periods indicated, the high and low sales prices for our common stock as reported by the New York Stock Exchange.

	High	Low
Year ended December 31, 2016:		
1st quarter	$ 74.18	$ 61.36
2nd quarter	78.00	72.31
3rd quarter	78.77	62.76
4th quarter	67.44	54.50
Year ended December 31, 2015:		
1st quarter	$ 83.04	$ 71.89
2nd quarter	85.17	79.31
3rd quarter	81.89	70.12
4th quarter	78.94	67.34

The closing price of our common stock on January 31, 2017 was $63.75 per share. According to Computershare, our registrar and transfer agent, as of January 31, 2017, there were 9,853 holders of record of our common stock. We have not declared or paid cash dividends to holders of our common stock since 1994. We have no current plans to pay cash dividends and we are restricted from paying dividends under the terms of our senior secured credit facilities and the indentures governing our senior notes. See "Liquidity and capital resources" under "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations" and the notes to our consolidated financial statements.

Stock Repurchases

The following table summarizes our repurchases of our common stock during the fourth quarter of 2016:

Period	Total Number of Shares Purchased	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs(1)	Approximate Dollar Value of Shares that May Yet Be Purchased Under the Plans or Programs (in millions)
October 1 - October 31, 2016	3,367,024	$ 63.07	3,367,024	$ 881.0
November 1 - November 30, 2016	3,351,634	$ 60.85	3,351,634	$ 677.1
December 1 - December 31, 2016	—	—	—	$ 677.1
Total	6,718,658	$ 61.96	6,718,658	$ 677.1

(1) 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 twelve months ended December 31, 2016, we purchased a total of 16,649,090 shares of our common stock for $1.072 billion, or an average price of $64.41. As of December 31, 2016, there was approximately $677 million available under our current Board authorizations for additional share repurchases. We have not repurchased any shares from January 1, 2017 through February 24, 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.

Item 6. Selected Financial Data.

The following financial and operating data should be read in conjunction with "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations" and our consolidated financial statements filed as part of this report. The following table presents selected consolidated financial and operating data for the periods indicated. These selected consolidated financial results have been recast for all prior periods presented to reflect the retrospective application of these new presentation and disclosure requirements for patient service revenues.

	Year ended December 31,				
	2016	2015	2014	2013	2012 (5)
	(in thousands, except share data)				
Income statement data:					
Net revenues	$ 14,745,105	$ 13,781,837	$ 12,795,106	$ 11,764,050	$ 8,186,280
Operating expenses and charges(2)	12,850,562	12,611,142	10,979,965	10,213,916	6,889,196
Operating income	1,894,543	1,170,695	1,815,141	1,550,134	1,297,084
Debt expense	(414,382)	(408,380)	(410,294)	(429,943)	(288,554)
Debt refinancing and redemption charges	—	(48,072)	(97,548)	—	(10,963)
Other income, net	8,734	8,893	2,374	4,787	3,737
Income from continuing operations before income taxes	1,488,895	723,136	1,309,673	1,124,978	1,001,304
Income tax expense	455,813	295,726	446,343	381,013	359,845
Income from continuing operations	1,033,082	427,410	863,330	743,965	641,459
Income from operations of discontinued operations, net of tax(3)	—	—	—	(139)	(222)
Gain (Loss) on disposal of discontinued operations, net of tax(3)	—	—	—	13,375	—
Net income	$ 1,033,082	$ 427,410	$ 863,330	$ 757,201	$ 641,237
Less: Net income attributable to noncontrolling interests	(153,208)	(157,678)	(140,216)	(123,755)	(105,220)
Net income attributable to DaVita Inc.	$ 879,874	$ 269,732	$ 723,114	$ 633,446	$ 536,017
Basic income from continuing operations per share attributable to DaVita Inc.(3)(4)	$ 4.36	$ 1.27	$ 3.41	$ 2.95	$ 2.79
Diluted income from continuing operations per share attributable to DaVita Inc.(3)(4)	$ 4.29	$ 1.25	$ 3.33	$ 2.89	$ 2.74
Weighted average shares outstanding:(4)					
Basic	201,641,000	211,868,000	212,302,000	209,939,000	192,036,000
Diluted	204,905,000	216,252,000	216,928,000	214,764,000	195,942,000
Ratio of earnings to fixed charges(6)	3.17:1	1.95:1	3.05:1	2.73:1	3.17:1
Balance sheet data:					
Working capital(1)	$ 1,283,783	$ 2,104,142	$ 1,547,519	$ 600,788	$ 546,478
Total assets(1)	18,741,257	18,514,875	17,617,432	16,612,401	15,594,345
Long-term debt(1)	8,947,327	9,001,308	8,298,624	8,064,196	8,230,393
Total DaVita Inc. shareholders equity(4)	4,648,047	4,870,780	5,170,513	4,432,479	3,763,137

(1) In 2015, we retrospectively adopted ASU 2015-03 related to simplification of debt issuance costs as well as ASU 2015-17 related to classification of deferred taxes. See "New Accounting Standards" below. All prior periods have been recast to conform to the current year presentation.

(2) Operating expenses and charges in 2016 include estimated goodwill impairment charges of $253,000 related to our DMG reporting units and $28,415 related to our vascular access reporting unit, an impairment of a minority equity investment of $14,993, a gain on the APAC JV ownership changes of $374,374, a gain related to the sale of our Tandigm ownership interest of $40,280, a loss on the sale of our DMG Arizona business of $10,489, an adjustment to reduce receivables associated with the DMG acquisition escrow provision relating to income tax items of $30,934, and an estimated accrual for damages and liabilities associated with our DMG Nevada hospice business of $16,000 and $15,770 associated with our pharmacy business. 2015 included a settlement charge of $495,000 related to a private civil suit, estimated goodwill and intangible asset impairment charges of $210,234, primarily related to certain DMG reporting units, and an estimated accrual for damages and liabilities of $22,530 associated with our pharmacy business. Operating expenses and charges in 2014 and 2013 include an additional $17,000 and $397,000, loss contingency accrual related to the settlement of the 2010 and 2011 U.S. Attorney physician relationship investigations, respectively. Operating expenses and charges in 2013 also include a contingent earn-out obligation gain adjustment of $56,977 related to a decrease in DMG's 2013 contingent earn-out obligation and an adjustment to reduce a tax asset associated with the DMG acquisition escrow provisions of $7,721. In addition, 2012 included $85,837 for a legal settlement and related expenses, and $30,753 of transaction expenses associated with the acquisition of DMG.

(3) Income from operations of discontinued operations, net of tax includes the operations for all prior periods presented of HomeChoice Partners Inc. (HomeChoice) which was divested on February 1, 2013.

(4) In the third quarter of 2013, the Board of Directors approved a two-for-one stock split of our common stock in the form of a stock dividend payable on September 6, 2013 to stockholders of record on August 23, 2013. Our common stock began trading on a post-split basis on September 9, 2013. All share and per share data for all prior periods presented have been adjusted to reflect the effects of the stock split. Share repurchases consisted of 16,649,090 shares of common stock for $1,072,377 in 2016, and 7,779,958 shares of common stock for $575,380 in 2015. Shares issued in connection with stock awards were $1,011,328 in 2016, 1,479,217 in 2015, 2,179,766 in 2014, 1,928,137 in 2013 and 4,751,142 in 2012.

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

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

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

Forward-looking statements

This Annual Report on Form 10-K, including this Management's Discussion and Analysis of Financial Condition and Results of Operations, contains statements that are forward-looking statements within the meaning of the federal securities laws. All statements that do not concern historical facts are forward-looking statements and include, among other things, statements about our expectations, beliefs, intentions and/or strategies for the future. These forward-looking statements include statements regarding our future operations, financial condition and prospects, including the expected impact of the policy change for Medicaid patients seeking Affordable Care Act (ACA) plans, including on our future operating income and other impacts of this policy change, 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, and the extent to which the ongoing implementation of healthcare exchanges or changes in regulations or enforcement of regulations 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 ESRD program or other government-based programs, the impact of the CMS Medicare Advantage benchmark structure, risks arising from potential federal and/or state legislation that could have an adverse effect on our operations and profitability, the impact of the 2016 Congressional and Presidential elections on the current health care marketplace and on our business, including with respect to the future of the ACA, 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, the restrictions on our business and operations required by the CIA and other settlement terms, and the financial impact thereof, continued increased competition from large- and medium-sized dialysis providers that compete directly with us, our ability to maintain contracts with physician medical directors, changing affiliation models for physicians, and the emergence of new models of care introduced by the government or private sector that may erode our patient base and reimbursement rates such as Accountable Care Organizations (ACOs), independent practice associations (IPAs) and integrated delivery networks, 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 expand our operations and services to markets outside the U.S., or to businesses outside of dialysis and DMG's business, 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, 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, or 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 Annual Report on Form 10-K. We base our forward-looking statements on information currently available to us at the time of this Annual Report on Form 10-K, and except as required by law we undertake no obligation to update or revise any forward-looking statements, whether as a result of changes in underlying factors, new information, future events or otherwise.

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

Company overview

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

Our overall financial performance for 2016 in U.S. dialysis and related lab services benefited from increased treatment volume, primarily from non-acquired growth at existing and new dialysis centers, cost control initiatives, and payor mix improvements in our dialysis business. This was partially offset by an increase in labor costs and other center related costs. DMG experienced a decrease in adjusted operating income primarily due to a reduction in Medicare Advantage reimbursement rates and an increase in medical costs.

Some of our major accomplishments and financial operating performance indicators in 2016 and year over year were as follows:

- improved clinical outcomes in our U.S. dialysis operations, including third consecutive year as a leader in CMS' Five –Star Quality Rating system;
- consolidated net revenue growth of 7.0%;
- 5.7% total net revenue growth in our U.S. dialysis segment, including an increase of $4 per treatment;
- improved performance in our normalized non-acquired U.S. dialysis treatment growth of 4.2%, which contributed to an increase of approximately 4.5% in the overall number of U.S. dialysis treatments;
- net increase of 99 U.S. dialysis centers and 36 international dialysis centers;
- an increase in DMG's net revenue of 7.2% related to an increase in its fee-for-service (FFS) business from the acquisition of The Everett Clinic Medical Group (TEC);
- formation of a strategic joint venture in our Asia-Pacific market;
- an increase in other ancillary services and strategic initiatives net revenue of 17.3%; and
- strong operating cash flows of $1.963 billion.

We believe that 2017 will be challenging due to the uncertainty around the ACA and the ability of our patients to utilize charitable premium assistance, average commercial rate pressure, increases in clinical costs due to inflation, employee turnover and other factors affecting U.S. dialysis and related lab services. In addition, the 2016 Presidential and Congressional elections have caused the future state of the exchanges and other ACA reforms and the healthcare landscape in general to be very unclear. DMG continues to face challenges due to announced decreases in Medicare Advantage and Medicaid reimbursement rates as the government continues to modify the rate structure. We also remain committed to our international expansion plans that will continue to require investment.

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

	Year ended December 31,					
	2016		2015		2014	
	(dollar amounts rounded to nearest million)					
Net revenues:						
Patient service revenues	10,354		9,481		8,869	
Less: Provision for uncollectible accounts	(451)		(428)		(367)	
Net patient service revenues	9,903		9,053		8,502	
Capitated revenues	3,519		3,509		3,261	
Other revenues	1,323		1,220		1,032	
Total net consolidated revenues	$ 14,745	100%	$ 13,782	100%	$ 12,795	100%
Operating expenses and charges:						
Patient care costs	$ 10,647	72%	$ 9,825	71%	$ 9,119	71%
General and administrative	1,592	11%	1,452	11%	1,262	10%
Depreciation and amortization	720	5%	638	5%	591	5%
Provision for uncollectible accounts	12	—	9	—	14	—
Equity investment income	(13)	—	(18)	—	(23)	—
Gain on changes in ownership interests, net	(404)	(3%)	—	—	—	
Goodwill and other asset impairment charges	296	2%	210	2%	—	—
Settlement charge	—	—	495	4%	—	—
Loss contingency accruals	—	—	—	—	17	—
Total operating expenses and charges	12,850	87%	12,611	92%	10,980	86%
Operating income	$ 1,895	13%	$ 1,171	8%	$ 1,815	14%

The following table summarizes our consolidated net revenues:

	Year ended December 31,		
	2016	2015	2014
	(dollar amounts rounded to nearest million)		
Net revenues:			
Dialysis and related lab services patient service revenues	$ 9,551	$ 9,034	$ 8,551
Less: Provision for uncollectible accounts	(430)	(406)	(353)
Dialysis and related lab services net patient service revenues	9,121	8,628	8,198
Other revenues	17	14	13
Total net dialysis and related lab services revenues	9,138	8,642	8,211
DMG capitated revenues	3,431	3,437	3,191
DMG net patient service revenues (less provision for uncollectible accounts of $20, $15 and $13, respectively)	622	318	219
Other revenue	61	82	92
Total net DMG revenues	4,114	3,837	3,502
Other-ancillary services and strategic initiatives revenues	1,305	1,150	947
Other-capitated revenues	88	72	70
Other-ancillary services and strategic initiatives net patient service revenues (less provision for uncollectible accounts)	228	160	122
Total net other-ancillary services and strategic initiatives revenues	1,621	1,382	1,139
Total net segment revenues	14,873	13,861	12,852
Elimination of intersegment revenues	(128)	(79)	(57)
Consolidated net revenues	$ 14,745	$ 13,782	$ 12,795

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

	Year ended December 31,		
	2016	2015	2014
	(dollar amounts rounded to nearest million)		
Dialysis and related lab services	$ 1,777	$ 1,260	$ 1,638
DMG services	(104)	34	215
Other — ancillary services and strategic initiatives loss	267	(104)	(25)
Total segment operating income	1,940	1,190	1,828
Reconciling corporate items:			
Corporate administrative support	(14)	(19)	(13)
Reduction in a receivable associated with the DMG acquisition escrow provision	(31)	—	—
Consolidated operating income	1,895	1,171	1,815
Reconciliation of non-GAAP measure:			
Add:			
Goodwill and other asset impairment charges	281	210	—
Impairment of minority equity investment	15	—	—
Loss on sale of DMG Arizona	10	—	—
Hospice accrual	16	—	—
Pharmacy accrual	16	22	—
Settlement charge	—	495	—
Loss contingency accruals	—	—	17
Reduction in a receivable associated with the DMG acquisition escrow provision	31	—	—
Less:			
Gain on APAC JV ownership changes	(374)	—	—
Gain on sale of Tandigm ownership interest	(40)	—	—
Adjusted consolidated operating income[1]	$ 1,849	$ 1,898	$ 1,832

(1) For the year ended December 31, 2016, we have excluded goodwill impairment charges of $253 million related to our DMG reporting units and $28 million related to our vascular access reporting unit, an impairment of $15 million related to a minority equity investment, the loss on sale of our DMG Arizona business of $10 million, estimated accruals for damages and liabilities associated with our DMG Nevada hospice business of $16 million and our pharmacy business of $16 million, an adjustment to reduce receivables associated with the DMG acquisition escrow provision relating to income tax items of $31 million, the gain on changes in ownership interest upon the formation of the Asia Pacific joint venture (APAC JV) of $374 million and the gain related to the sale of a portion of our Tandigm ownership interest of $40 million. For the year ended December 31, 2015, we have excluded estimated goodwill and other intangible asset impairment charges of $210 million primarily related to certain DMG reporting units, an estimated accrual of $22 million for damages and liabilities associated with our pharmacy business, which is included in general and administrative expenses, and $495 million related to a settlement charge in connection with a private civil suit. In addition, for the year ended December 31, 2014, we have excluded $17 million, related to a loss contingency accrual for the settlement of the 2010 and 2011 U.S. Attorney physician relationship investigations. These are non-GAAP measures and are not intended as substitutes for the equivalent GAAP measures. We have presented these adjusted amounts because management believes that these presentations enhance a user's understanding of our normal consolidated operating income by excluding certain 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 2016 increased by approximately $963 million, or 7.0%, from 2015. This increase in consolidated net revenues was due to an increase in dialysis and related lab services net revenues of approximately $496 million, principally due to solid volume growth from additional treatments from non-acquired growth, one additional treatment day in 2016, and an increase of $4 in the average dialysis revenue per treatment, as discussed below. Consolidated net revenues also increased due to an increase in DMG's net revenues of $277 million, primarily due to an increase in FFS revenues from acquisitions and an increase in senior capitated revenues, as described below. In addition, revenue increased by approximately $239 million in our ancillary services and strategic initiatives driven primarily from growth in our pharmacy services and an increase in net revenues from our expansion in our international business and other strategic initiatives.

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

Consolidated operating income

Consolidated operating income of $1.895 billion for 2016, which includes impairment charges of $296 million, estimated accruals for damages and liabilities associated with our pharmacy and DMG Nevada hospice businesses of $32 million, an adjustment to reduce receivables associated with the DMG acquisition escrow provision of $31 million, and the net gain on the APAC JV, Tandigm and DMG Arizona ownership changes of $404 million, increased by approximately $724 million from 2015, which included estimated impairment charges of approximately $210 million, an estimated pharmacy accrual of $22 million and a private litigation settlement charge of $495 million. Excluding these items from their respective periods, adjusted consolidated operating income for 2016 would have decreased by $49 million. Adjusted consolidated operating income decreased primarily as a result of a decrease in adjusted operating income related to DMG of $105 million, partially offset by an increase in adjusted operating income for the dialysis and related lab services of $22 million and a decrease in adjusted operating losses in our ancillary services and strategic initiatives of $30 million, each discussed in detail below.

Consolidated operating income of $1.171 billion for 2015, which included estimated impairment charges of approximately $210 million, an estimated pharmacy accrual of $22 million and a private litigation settlement charge of $495 million, decreased by approximately $644 million from 2014, which included a $17 million loss contingency accrual. Excluding these items from their respective periods, adjusted consolidated operating income for 2015 would have increased by $66 million, or 3.6%. Adjusted consolidated operating income increased primarily as a result of an increase in adjusted operating income in dialysis and related lab services of $100 million and an increase in adjusted operating income at DMG of $25 million, partially offset by an increase in the amount of adjusted operating losses in our ancillary services and strategic initiatives of $53 million, each discussed in detail below.

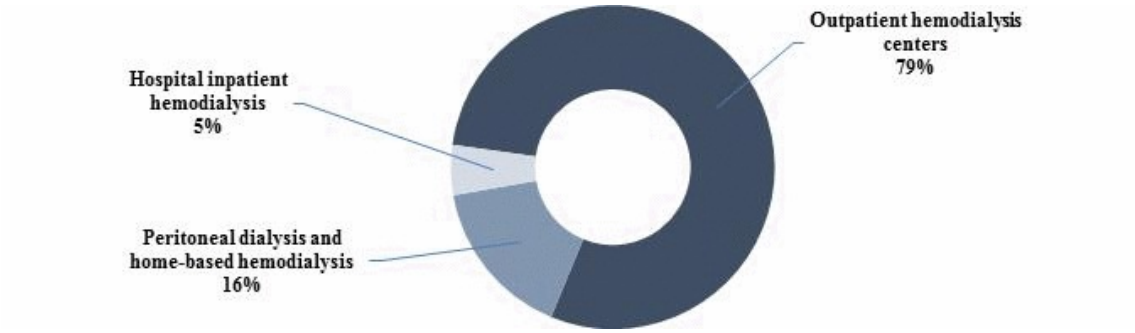
U.S. dialysis and related lab services business

Our U.S. dialysis and related lab services business is a leading provider of kidney dialysis services through a network of 2,350 outpatient dialysis centers which we own and manage through management services agreements, in 46 states and the District of Columbia, serving a total of approximately 187,700 patients. We also provide acute inpatient dialysis services in approximately 900 hospitals. We estimate that we have approximately a 36% market share in the U.S. based upon the number of patients that we serve. In 2016, our overall network of U.S. outpatient dialysis centers increased by 99 dialysis centers primarily as a result of opening new dialysis centers and from acquisitions of existing dialysis centers. In addition, the overall number of patients that we serve in the U.S. increased by approximately 4.5% in 2016 as compared to 2015.

Our dialysis and related lab services stated mission is to be the provider, partner and employer of choice. We believe our attention to these three stakeholders—our patients, our business partners, and our teammates—represents the major driver of our long-term performance, although we are subject to the impact of several external factors such as government policy, physician practice patterns, commercial payor payment rates and the mix of commercial and government patients. Two principal non-financial metrics we track are quality clinical outcomes and teammate turnover. We have developed our own composite index for measuring improvements in our clinical outcomes, which we refer to as the DaVita Quality Index (DQI). Our clinical outcomes as measured by DQI have improved over each of the past several years which we believe directly decreases patient mortalities. Our patient mortality percentages have decreased from 19.0% in 2001 to 13.8% in 2015. For the third consecutive year, we continue to be a leader in the industry under both the CMS QIP and Five-Star quality Rating systems. Over the last two years our clinical teammate turnover has increased slightly, causing productivity to slightly decrease; however, despite this, we have continued to improve our clinical performance. We will continue to focus on these three stakeholders and our clinical outcomes as we believe these are fundamental long-term value drivers.

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

The following graph summarizes our dialysis services revenues by modality for the year ended December 31, 2016:



Approximately 62% of our 2016 consolidated net revenues were derived directly from our dialysis and related lab services business. Approximately 79% of our 2016 dialysis and related lab services revenues were derived from outpatient hemodialysis services in the 2,316 U.S. dialysis centers that we consolidate. Other dialysis services, which are operationally integrated with our dialysis operations, are peritoneal dialysis, home-based hemodialysis, hospital inpatient hemodialysis services and management and administrative services provided to dialysis centers in which we own a noncontrolling interest or which are wholly owned by third parties. These services collectively accounted for the balance of our 2016 dialysis and related lab services revenues.

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

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

The total patient base is a relatively stable factor, which we believe is influenced by a demographically growing need for dialysis services as indicated by the United States Renal Data System which reported an approximate compound growth rate of 3.8% from 2000 to 2014 for the dialysis patient population, our relationships with referring physicians, together with the quality of our clinical care which can lead to reduced patient mortality rates as indicated above, and our ability to open and acquire new dialysis centers.

Our average dialysis and related lab services revenue per treatment is driven by changes in our mix of commercial and government (principally Medicare and Medicaid) patients, commercial and government payment rates, and our billing and collecting operations performance.

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

Government dialysis-related payment rates in the U.S. are principally determined by federal Medicare and state Medicaid policy. For patients with Medicare coverage, all ESRD payments for dialysis treatments are made under a single bundled payment rate which provides a fixed payment rate encompassing all goods and services provided during the dialysis treatment, including certain pharmaceuticals, such as Epogen® (EPO), vitamin D analogs and iron supplements, irrespective of the level of pharmaceuticals administered to the patient or additional services performed. Most lab services are also included in the bundled payment. The bundled payment rate is also adjusted for certain patient characteristics, a geographic usage index and certain other factors.

The bundled payment system presents operating, clinical and financial risks. For example, with regard to the expanded list of case-mix adjustors, there is a risk that our dialysis centers or billing and other systems may not accurately document and track the

appropriate patient-specific characteristics, resulting in a reduction or overpayment in the amounts of the payments that we would otherwise be entitled to receive.

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

In December 2013, CMS issued the 2014 final rule for the ESRD PPS, which phases in the payment reductions mandated by ATRA, as modified by the Protecting Access to Medicare Act of 2014 which reduced our market basket inflation adjustment by 1.25% in 2016 and will reduce our market basket inflation adjustment by 1.25% in 2017 and 1% in 2018. CMS recently published the 2017 final rule for the ESRD PPS and projects it will (i) increase the total payments to all ESRD facilities by 0.73% in 2017 compared to 2016; (ii) increase total payments to hospital-based ESRD facilities by 0.9% in 2017 compared to 2016; and (iii) increase total payments for freestanding facilities by 0.7% in 2017 compared to 2016. The 2017 final rule for the ESRD PPS also implements the Trade Preferences Extension Act of 2015 provisions regarding the coverage and payment for renal dialysis services furnished by ESRD facilities to individuals with acute kidney injury.

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

The CMS Innovation Center is currently working with various healthcare providers to develop, refine and implement ACOs and other innovative models of care for Medicare and Medicaid beneficiaries. We are currently uncertain of the extent to which the long-term operation and evolution of these models of care, including ACOs, Bundled Payments for Care Improvement Initiative, the CEC Model (which includes the development of ESCOs), the Comprehensive Primary Care Initiative, the Duals Demonstration, or other models, will impact the healthcare market over time. Our U.S. dialysis business may choose to participate in one or several of these models either as a partner with other providers or independently. We currently participate in the CEC Model with the Innovation Center, including with the ESCO organizations in the Arizona, Florida, and adjacent New Jersey and Pennsylvania markets. In areas where DaVita is not directly participating in this or other Innovation Center models, some of our patients may be assigned to an ACO, another ESRD Care Model, or another program, in which case the quality and cost of care that we furnish will be included in an ACO's, another ESRD Care Model's or other programs' calculations. As new models of care emerge and evolve, we may be at risk of losing our Medicare patient base, which would have a materially adverse effect on our revenues, earnings and cash flow. Other initiatives in the government or private sector may also arise, including the development of models similar to ACOs, IPAs and integrated delivery networks or evolutions of those concepts which could adversely impact our business.

We anticipate that we will continue to experience increases in our operating costs in 2017 that will outpace any net Medicare rate increases that we may receive, which could significantly impact our operating results. In addition, we expect to continue experiencing increases in operating costs that are subject to inflation, such as labor and supply costs, regardless of whether there is a compensating inflation-based increase in Medicare payment rates or in payments under the bundled payment rate system.

Dialysis payment rates from commercial payors can vary and a major portion of our commercial rates are set at contracted amounts with payors and are subject to intense negotiation pressure. Our commercial payment rates also include payments for out-of-network patients that on average are higher than our in-network commercial contract rates. We continue to enter into some commercial contracts covering certain patients that will primarily pay us a single bundled payment rate for all dialysis services provided to these patients. However, some contracts will pay us for certain other services and pharmaceuticals in addition to the bundled payment. We are continuously in the process of negotiating agreements with our commercial payors, and if our negotiations result in overall commercial contract payment rate reductions in excess of our commercial contract payment rate increases, our revenues and operating results could be negatively impacted. In addition, if there is an increase in job losses in the U.S., or depending upon changes to the healthcare regulatory system by CMS and/or the impact of healthcare insurance exchanges, we could experience a decrease in the number of patients covered under traditional commercial insurance plans. Patients with commercial insurance who cannot otherwise maintain coverage frequently rely on financial assistance from charitable organizations, such as the American Kidney Fund. If these patients are unable to obtain or continue to receive such financial assistance, our revenues, earnings, and cash flows could be substantially reduced. For further details, see the risk factor in Item 1A Risk Factors under the heading "If patients in commercial plans are subject to restriction in plan designs or the average rates that commercial payors pay us decline significantly, it would have a material adverse effect on our revenues, earnings and cash flows."

Our operating performance with respect to dialysis services billing and collection can also be a significant factor in the average dialysis and related lab services revenue per treatment we recognize and are able to collect. Over the past several years we have invested heavily in upgrades to our systems and internal processes that we believe have helped improve our operating performance and reduced our regulatory compliance risks, and we expect to continue to improve these systems and processes. We continue to

upgrade our billing and other systems and modify our processes to improve our ability to capture the necessary patient characteristics, co-morbidities and certain other factors under Medicare's bundled payment system. We believe this will potentially enable us to capture additional reimbursement amounts from Medicare and enhance our overall billing and collection performance. However, as we continue to make upgrades to our systems and processes, or as payors change their systems and requirements, such as changes to Medicare's billing codes, we could experience a negative impact to our cash collection performance, which would affect our average dialysis and related lab services revenue per treatment.

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

Our annual average dialysis and related lab services revenue per treatment was approximately $352, $348 and $342 for 2016, 2015 and 2014, respectively. In 2016, the average dialysis and related lab services revenue per treatment increased by approximately $4 per treatment due to an increase in our average commercial payment rates and improvements in our commercial payor mix. In 2015, the average dialysis and related lab services revenue per treatment increased by approximately $6 per treatment due to an increase in our average commercial payment rates and improvements in our commercial payor mix, partially offset by an increase in our provision for uncollectible accounts.

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

The principal drivers of our dialysis and related lab services patient care costs are clinical hours per treatment, labor rates, vendor pricing of pharmaceuticals, utilization levels of pharmaceuticals, business infrastructure costs, which include the operating costs of our dialysis centers, and certain professional fees. However, other cost categories can also represent significant cost variability, such as employee benefit costs, payroll taxes, insurance costs and medical supply costs. Our average clinical hours per treatment, or productivity levels, declined slightly in 2016 compared to 2015. We are always striving for improved productivity levels, however, changes in federal and state policies or regulatory billing requirements can lead to increased labor costs in order to implement these new requirements, which can adversely impact our ability to achieve optimal productivity levels. In addition, improvements in the U.S. economy have stimulated additional competition for skilled clinical personnel resulting in slightly higher teammate turnover in 2016, which we believe negatively affected productivity levels. In 2016 and 2015, we experienced an increase in our clinical labor rates of approximately 2.8% and 0.9%, respectively, as clinical labor rates have increased, consistent with general industry trends, mainly due to the high demand for skilled clinical personnel, along with general inflation increases. We also continue to experience increases in our infrastructure and operating costs of our dialysis centers, primarily due to the number of new dialysis centers opened, and general increases in rent, utilities and repairs and maintenance. In 2016, we continued to implement certain cost control initiatives to manage our overall operating costs, including labor productivity.

Our dialysis and related lab services general and administrative expenses represented 8.2% of our dialysis and related lab services net revenues in both 2016 and 2015. Although relatively flat as a percentage of net revenue, general and administrative expenses increased by $42 million, primarily due to an increase in labor and benefit costs and legal costs, partially offset by lower long-term incentive compensation. Increases in general and administrative expenses over the last several years primarily related to strengthening our dialysis business, improving our regulatory compliance and other operational processes, responding to certain legal and compliance matters, and professional fees associated with enhancing our information technology systems. We expect that these levels of expenditures on our dialysis and related lab services general and administrative expenses will continue in 2017 and could possibly increase as we seek out new business opportunities within the dialysis industry and continue to invest in improving our information technology infrastructure and the level of support required for our regulatory compliance and legal matters.

Results of Operations

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

	Year ended December 31,					
	2016		2015		2014	
	(dollar amounts rounded to nearest million)					
Dialysis and related lab services patient service revenues	$ 9,551		$ 9,034		$ 8,551	
Less: Provision for uncollectible accounts	(430)		(406)		(353)	
Dialysis and related lab services net patient service revenues	9,121		8,628		8,198	
Other revenues	17		14		13	
Total net dialysis and related lab services revenues	9,138	100%	8,642	100%	8,211	100%
Operating expenses and charges:						
Patient care costs	6,145	67%	5,755	67%	5,485	67%
General and administrative	751	8%	709	8%	682	8%
Depreciation and amortization	483	5%	438	5%	403	5%
Settlement charge and loss contingency accruals	—	—	495	6%	17	—
Equity investment income	(18)	—	(15)	—	(14)	—
Total operating expenses and charges	7,361	81%	7,382	85%	6,573	80%
Operating income	1,777	19%	1,260	15%	1,638	20%
Reconciliation of non-GAAP measures:						
Settlement charge	—		495		—	
Loss contingency accruals	—		—		17	
Adjusted operating income[1]	$ 1,777		$ 1,755		$ 1,655	
Dialysis treatments	27,162,545		25,986,719		24,981,553	
Average dialysis treatments per treatment day	86,532		83,104		79,864	
Average dialysis and related lab services revenue per treatment	$ 352		$ 348		$ 342	

(1) For the year ended December 31, 2015, we have excluded $495 million related to a settlement charge in connection with a private civil suit. In addition, for the year ended December 31, 2014, we have excluded $17 million, related to loss contingency accrual for the settlement of the 2010 and 2011 U.S. Attorney physician relationship investigations. These are non-GAAP measures and are not intended as substitutes for the equivalent GAAP measures. We have presented these adjusted amounts because management believes that these presentations enhance a user's understanding of our normal consolidated operating income by excluding certain 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 2016 increased by approximately $496 million, or 5.7%, from 2015. The increase in net revenues was primarily driven by solid volume growth from additional treatments of approximately 4.5% due to an increase in acquired and non-acquired treatment growth at existing and new dialysis centers, as well as one additional treatment day in 2016 as compared to 2015. Dialysis and related lab services' net revenues also benefited from an increase in the average dialysis revenue per treatment of approximately $4, primarily due to an increase in our average commercial payment rates and improvements in our commercial payor mix, offset by an increase in the provision for uncollectible accounts of $24 million.

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

The following table summarizes our U.S. dialysis services revenues by source:

	2016	2015	2014
Medicare and Medicare-assigned plans	55%	56%	58%
Medicaid and Medicaid-assigned plans	5%	6%	6%
Other government-based programs	4%	4%	3%
Total government-based programs	64%	66%	67%
Commercial (including hospital dialysis services)	36%	34%	33%
Total dialysis and related lab services revenues	100%	100%	100%

Approximately 64% of our total dialysis and related lab services revenues for the year ended December 31, 2016 were from government-based programs, principally Medicare, Medicaid, Medicare-assigned and Medicaid-assigned plans, representing approximately 88% of our total patients. Over the last two years, the growth of our commercial patients slightly outpaced the growth of our government-based patients as more of our patients are covered by commercial contracted plans. Less than 1% of our dialysis and related lab services revenues are due directly from patients. There is no single commercial payor that accounted for more than 10% of total dialysis and related lab services revenues for the year ended December 31, 2016.

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

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

Operating expenses and charges

Patient care costs. Dialysis and related lab services patient care costs are those costs directly associated with operating and supporting our dialysis centers and consist principally of labor, benefits, pharmaceuticals, medical supplies and other operating costs of the dialysis centers. Dialysis and related lab services patient care costs on a per treatment basis were $226 and $221 for 2016 and 2015, respectively. The $5 increase in per treatment costs in 2016 as compared to 2015 was primarily attributable to an increase in labor and benefit costs due to a decrease in productivity, increased turnover and clinical labor rates, an increase in other direct operating expenses associated with our dialysis centers and an increase in pharmaceutical unit costs. These increases were partially offset by a decrease in professional fees.

Dialysis and related lab services patient care costs on a per treatment basis were $221 and $219 for 2015 and 2014, respectively. The $2 increase in per treatment costs in 2015 as compared to 2014 was primarily attributable to higher overall pharmaceutical costs due to higher pharmaceutical unit costs, an increase in other direct operating expenses associated with our dialysis centers, and a slight increase in labor costs, partially offset by improvements in productivity, and lower general and professional insurance costs.

General and administrative expenses. Dialysis and related lab services general and administrative expenses in 2016 increased by approximately $42 million as compared to 2015. The increase was primarily due to an increase in our labor and benefit costs, occupancy, and legal costs, partially offset by a decrease in long-term compensation costs.

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

Depreciation and amortization. Dialysis and related lab services depreciation and amortization expenses for 2016 increased by approximately $45 million as compared to 2015 and increased by $35 million in 2015 as compared to 2014. The increases were primarily due to both growth through new dialysis center developments and additional informational technology initiatives.

Provision for uncollectible accounts receivable. The provision for uncollectible accounts receivable for our dialysis and related lab services business was 4.5% for 2016 and 2015, and 4.1% for 2014. The provision for uncollectible accounts receivable was flat as a percent of revenue in 2016 and 2015. We currently expect the level of the provision for uncollectible accounts in 2017 to be consistent with 2016 although it may increase if we encounter collection issues.

Equity investment income. Equity investment income was approximately $18 million, $15 million and $14 million in 2016, 2015 and 2014, respectively. The increases in equity investment income over the last three years were primarily due to the increase in the number of nonconsolidated dialysis joint ventures and an increase in profitability at some of these joint ventures.

Accounts receivable. Our U.S. dialysis and related lab services accounts receivable balances at December 31, 2016 and December 31, 2015 were $1.358 billion and $1.255 billion, respectively, representing approximately 55 days and 53 days of revenue, respectively, net of the allowance for uncollectible accounts. The increase in day sales outstanding (DSO) for our dialysis and related lab services business was primarily the result of improved cash collection performance in 2015 which we did not experience in 2016. Our DSO calculation is based on the current quarter's average revenues per day.

As of December 31, 2016 and 2015, our dialysis and related lab services unreserved accounts receivable balances that were more than six months old were approximately $216 million and $233 million, respectively, representing approximately 16% and 18% of our dialysis accounts receivable balances, respectively. There were no significant unreserved balances over one year old. Less than 1% of our revenues are classified as patient pay. Substantially all revenue realized is from government and commercial payors, as discussed above.

Amounts pending approval from third-party payors associated with Medicare bad debt claims as of December 31, 2016 and 2015, other than the standard monthly billing, consisted of approximately $105 million in 2016 and $106 million in 2015 and is classified as other receivables. Currently, a significant portion of our Medicare bad debt claims are typically paid to us before the Medicare fiscal intermediary audits the claims. However, the payment received from Medicare is subject to adjustment based upon the actual results of the audits. Such audits typically occur one to four years after the claims are filed.

Segment operating income

Dialysis and related lab services operating income for 2016 increased by approximately $517 million as compared to 2015, which included a settlement charge of $495 million. Excluding this item from 2015, dialysis and related lab services adjusted operating income would have increased by $22 million. This increase in adjusted operating income was primarily due to treatment growth as a result of additional dialysis treatments, one additional treatment day, and an increase in the average dialysis revenue per treatment of approximately $4, as described above. Adjusted operating income also increased due to a decrease in long-term compensation costs, partially offset by higher patient care costs and an increase general administrative expenses.

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

DMG business

DMG is a patient- and physician-focused, integrated healthcare delivery and management company with over two decades of experience providing coordinated, outcomes-based medical care in a cost-effective manner. As of December 31, 2016, DMG served approximately 749,300 members under its care in southern California, central and south Florida, southern Nevada and central New Mexico through capitation contracts with some of the nation's leading health plans. Of these 749,300 members, approximately 305,200 individuals were patients enrolled in Medicare and Medicare Advantage, and the remaining approximately 444,100 individuals were managed care members whose health coverage is provided through their employer or who have individually acquired health coverage directly from a health plan or as a result of their eligibility for Medicaid benefits. In addition to its managed care business, during the year ended December 31, 2016, DMG provided care across all markets to over 896,200 patients whose health coverage is structured on a FFS basis, including patients enrolled through traditional Medicare and Medicaid programs, preferred provider organizations and other third party payors.

DMG's patients as well as the patients of DMG's associated physicians, physician groups and IPAs benefit from an integrated approach to medical care that places the physician at the center of patient care. As of December 31, 2016, DMG delivered services to

its members via a network of approximately 700 primary care physicians, over 2,500 associated groups and other network primary care physicians, approximately 200 network hospitals, and several thousand associated group and network specialists. Together with hundreds of case managers, registered nurses and other care coordinators, these medical professionals utilize a comprehensive information technology system, sophisticated risk management techniques and clinical protocols to provide high-quality, cost-effective care to DMG's members. DMG's total revenue for the year ended December 31, 2016, was approximately $4.114 billion, or approximately 28% of our consolidated net revenues.

Key Financial Measures and Indicators

Operating revenues

DMG's consolidated revenues consist primarily of capitated revenues, including revenues attributable to capitated contracts with health plans, patient fee-for-service revenues and other operating revenues, each as described in more detail below.

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

- *Global capitation model*. DMG records the aggregate global capitation PMPM fee as revenue and the amounts paid with respect to claims as medical expenses or hospital expenses, as applicable. See "Patient care costs-Medical expenses" and "Patient care costs-Hospital expenses" below. Revenue with respect to both professional and institutional capitation is recorded in the month in which enrollees are entitled to receive healthcare. In DMG's central Florida market, DMG also receives capitation revenue and is liable for corresponding expenses for prescription drug activity rendered on behalf of DMG's senior members through the Part D component under the Medicare Advantage program.

- *Risk-sharing model*. As compensation under its various managed care-related administrative services agreements with hospitals, DMG is entitled to receive a percentage of the amount by which the institutional capitation revenue received from health plans exceeds institutional expenses, and any such risk-share amount to which DMG is entitled is recorded as medical revenues. In addition, pursuant to such managed care-related administrative services agreements, DMG agrees to be responsible should the third party incur institutional expenses in excess of institutional capitation revenue. As with global capitation, revenue with respect to professional capitation is reported in the month in which enrollees are entitled to receive healthcare. However, risk-share revenues (that is, the portion of the excess or deficit of institutional capitation revenue to which DMG is entitled less institutional expenses), in contrast, are based on the number of enrollees and estimates of institutional utilization and associated costs incurred by assigned health plan enrollees, and the amounts earned are accrued when they can be reasonably estimated. Differences between actual contract settlements and estimated receivables and payables are recorded in the year of final settlement. In December 2013, DMG obtained a restricted Knox-Keene license in California, which permits DMG to enter into global capitation agreements with health plans that allow DMG to assume financial responsibility for both professional and institutional services. DMG has evaluated its various risk sharing arrangements, and is working with the Department of Managed Health Care and several health plans to accept global capitation. DMG has converted three separate contracts covering approximately 3% of total DHPC's membership to global risk and is in the approval and implementation process to convert additional contracts to global risk in 2017. Completion of evaluation of possible additional conversions is expected to continue to occur over time.

- *Retroactive revenue adjustments.* The Medicare Advantage revenue received by DMG's health plan customers is adjusted periodically to give effect to the relative clinical and demographic profile of the members for whom DMG is financially responsible. The model employed by CMS bases a portion of the total reimbursement payments on various clinical and demographic factors, including hospital inpatient diagnoses, additional diagnosis data from ambulatory treatment settings, hospital outpatient department and physician visits, gender, age and Medicaid eligibility. CMS requires that all managed care companies capture, collect and submit the necessary diagnosis code information to CMS twice a year for reconciliation with CMS's internal database. Capitation payments under this methodology are paid at interim rates during the year and retroactive adjustments occur in subsequent periods (generally in the third quarter of the same year, with a final adjustment in the third quarter of the following year) after the data is compiled by CMS. DMG estimates the amount of the current year adjustments in revenues during the first and second quarters of any given year and adjusts its estimates during the third quarter, upon receipt of payments from CMS. Differences between actual contract settlements and estimated revenues are recorded in the year of final settlement. To date, all such adjustments have resulted in increases in revenue.

- *Patient service revenues.* Patient service revenues are recorded when the services are provided to patients on a FFS basis. Such revenues are based on a negotiated fixed-fee schedule with the applicable payor.

- *Other operating revenues.* In addition to the revenues discussed above, other operating revenues primarily consists of (i) hospital subsidy payments, (ii) management fees DMG receives as the manager of its unconsolidated joint ventures, (iii) revenues from the maintenance of existing physicians' networks, (iv) medical consulting revenues, and (v) revenues recognized under meaningful use programs established by federal and state governments which provide financial incentives for providers to implement and utilize electronic health record technology to improve patient care.

Patient care costs

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

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

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

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

Other operating expenses

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

Results of Operations

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

	Year ended December 31,					
	2016		2015		2014	
	(dollar amounts rounded to nearest millions)					
Net revenues:						
DMG capitated revenue	$ 3,431		$ 3,437		$ 3,191	
Patient service revenue	642		333		232	
Less: Provision for uncollectible accounts	(20)		(15)		(13)	
Net patient service revenue	622		318		219	
Other revenues	61		82		92	
Total net revenues	$ 4,114	100%	$ 3,837	100%	$ 3,502	100%
Operating expenses:						
Patient care costs	$ 3,291	80%	$ 3,006	78%	$ 2,796	80%
General and administrative expense	489	12%	421	11%	331	9%
Depreciation and amortization	211	5%	174	5%	170	5%
Goodwill and other asset impairment charges	253	6%	206	5%	—	—
Gains on changes in ownership interests, net	(30)	(1%)	—	—	—	—
Equity investment loss (income)	4	—	(4)	—	(10)	—
Total expenses	4,218	103%	3,803	99%	3,287	94%
Operating income	$ (104)	(3%)	$ 34	1%	$ 215	6%
Reconciliation of non-GAAP measures:						
Add:						
Goodwill and other intangible asset impairment charges	253		206		—	
Loss on sale of DMG Arizona	10		—		—	
Hospice accrual	16		—		—	
Less: Gain on sale of Tandigm ownership interest	(40)		—		—	
Adjusted operating income(1)	$ 135	3%	$ 240	6%	$ 215	6%

(1) For the year ended December 31, 2016, we have excluded the goodwill impairment charges of $253 million, the loss on sale of our DMG Arizona business of $10 million, an estimated accrual for damages and liabilities associated with our DMG Nevada hospice business of $16 million, which is included in general and administrative expenses, and the gain related to the sale of a portion of our Tandigm ownership interest of $40 million. For the year ended December 31, 2015, we have excluded estimated goodwill and other intangible asset impairment charges of $206 million related to certain DMG reporting units. These are non-GAAP measures and are not intended as substitutes for the equivalent GAAP measures. We have presented these adjusted amounts because management believes that these presentations enhance a user's understanding of our normal consolidated operating income by excluding certain 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 table set forth below provides (i) the total number of capitated members to whom DMG provided healthcare services as of December 31, 2016, 2015 and 2014, and (ii) the aggregate member months for the years ended December 31, 2016, 2015 and 2014. Member months represent the aggregate number of months of healthcare services DMG has provided to capitated members during a period of time.

Members at December 31,

	Senior	Commercial	Medicaid
2014	310,500	387,400	139,400
2015	317,400	367,400	122,600
2016	305,200	338,300	105,800

Members months for the year ended December 31,

	Senior	Commercial	Medicaid
2014	3,587,900	4,713,100	1,465,200
2015	3,774,300	4,497,900	1,556,400
2016	3,760,000	4,130,800	1,320,800

In addition to the members above, DMG provided healthcare services to members in two of its operating unconsolidated joint ventures that are accounted for as equity investments. These joint ventures provided healthcare services for approximately 148,700, 130,700 and 45,700 members as of December 31, 2016, 2015 and 2014, respectively, and for approximately 1,760,000, 1,564,200 and 538,000 member months for the years ended December 31, 2016, 2015 and 2014, respectively. The increase in members and member months was primarily due to an increase in members related to Tandigm.

During the year ended December 31, 2016, DMG members decreased by approximately 58,100 and member months decreased by approximately 617,000. The decrease in members and member months was due to planned non-renewals of certain commercial and Medicaid contracts, a decrease in commercial members as employers shift to less expensive options for medical services for their employees, and the sale of our DMG Arizona business which caused a decrease in senior members, partially offset by an increase in senior members from new acquisitions and non-acquired growth.

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

Revenues

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

	Year ended December 31,		
	2016	2015	2014
	(dollars in millions)		
DMG revenues:			
Commercial revenues	$ 701	$ 727	$ 726
Senior revenues	2,537	2,473	2,319
Medicaid revenues	193	237	146
Total capitated revenues	3,431	3,437	3,191
Patient service revenue, net of provision for uncollectible accounts	622	318	219
Other revenues	61	82	92
Total net revenues	$ 4,114	$ 3,837	$ 3,502

Net revenues

DMG's net revenues for 2016 increased $277 million, or 7.2%, primarily due to an increase in FFS revenues due to the acquisition of The Everett Clinic Medical Group (TEC) in March 2016 and an increase in senior capitated revenues due to an increase in the number of senior capitated members during the year attributable to non-acquired growth and acquisitions. These increases were partially offset by a decrease in Medicare Advantage and Medicaid rates, as described below, a decrease in senior capitated revenues from the sale of our DMG Arizona business, a decrease in Medicaid revenues due to the timing of the recognition of additional Medicaid risk sharing revenue in 2015, a decrease in other revenues due to the recognition of additional revenues related to the maintenance of existing physician networks in 2015, a decrease in other consulting revenues and a decrease in commercial and Medicaid members to whom DMG provides health care services.

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

On April 4, 2016, CMS issued final guidance for 2017 Medicare Advantage benchmark payment rates (Rate Announcement). In 2017, CMS will fully implement the 2017 Risk Adjustment model proposed in the Rate Announcement, but with updated coefficients. Based upon our preliminary analysis of the final rule, we estimate that the reduction in 2017 rates, including adjustments for the new ACA blended benchmark county rates and qualifying bonuses, will lead to a reduction in Medicare Advantage rates to DMG of approximately 1.0%, or a net decrease of approximately $25 million to our 2017 operating income. This compares, according to CMS, to an industry average rate increase of approximately 0.85% without accounting for the expected growth in coding acuity that has typically added another 2.2%. The final impact of 2017 Medicare Advantage rates may vary from this estimate and will be 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 have underestimated the impact of the 2017 Medicare Advantage rates on our business, which may have a material adverse effect on our financial position, results of operation or cash flows. The more significant decreases in Medicare Advantage rates for the Company compared to the industry average are largely driven by two factors: DMG's higher mix of Medicare Advantage patients in counties that will receive a lower-than-average benchmark rate increase, and a higher-than-average impact from a revision to the risk model to differentiate payment levels between dual-eligible and non-dual-eligible patients.

The 2016 Medicare Advantage rates incorporated a modification to the risk adjustment model calculation that CMS utilizes to determine the risk acuity scores of Medicare Advantage patients. These changes to the rate structure and risk model calculation decreased DMG's 2016 Medicare Advantage rates by approximately 2.0% of the Medicare Advantage revenues DMG manages on behalf of its senior capitated population as compared to 2015. This compares, according to CMS, to the industry average rate increase of approximately 1.25%.

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

Patient care costs

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

	Year ended December 31,		
	2016	2015	2014
	(dollars in millions)		
Medical expenses	$ 1,991	$ 1,865	$ 1,734
Hospital expenses	617	602	586
Clinic support and other operating costs	683	539	476
Total	$ 3,291	$ 3,006	$ 2,796

Operating expenses

Patient care costs. DMG's patient care costs for 2016 increased by approximately $285 million from 2015. The increase was primarily attributable to the acquisition of TEC, an increase in medical claim expenses, hospital expenses, and clinic support costs due

to increased senior capitated members from acquisitions and non-acquired growth, and increased headcount. The increase in costs was partially offset by a decrease due to the sale of our Arizona business, decreased consulting expenses, a decrease in benefits, and a decrease in commercial and Medicaid members to whom DMG provides healthcare services.

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

General and administrative expenses. DMG's general and administrative costs for 2016, which includes an estimated accrual for damages and liabilities associated with our DMG Nevada hospice business of $16 million, increased $68 million from 2015. Excluding this item, adjusted general and administrative expenses would have increased by $52 million. This increase was primarily attributable to the acquisition of TEC, an increase in corporate administrative support expenses due to increased labor costs and costs associated with growth initiatives, partially offset by a decrease due to the sale of our DMG Arizona business and a decrease in benefits.

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

Depreciation and amortization. DMG's depreciation and amortization for 2016 increased $37 million from 2015. The increase was primarily attributable to the acquisition of TEC, an increase in amortization related to the acceleration of the HCP-related trade names, and an increase in technology and property investments as part of our growth initiatives. As of September 1, 2016, we committed to a plan to change HCP trade names to DMG. As a result of this decision we began to accelerate the amortization of the remaining carrying value of HCP trade names, which resulted in additional amortization of $9 million for 2016. This additional amortization will continue at a rate of approximately $7 million per quarter through the first quarter of 2019 which represents the remaining life of these assets.

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

Goodwill and other intangible asset impairment charges. During the year ended December 31, 2015, we recognized impairment charges of $189 million on goodwill and $17 million on other intangible assets of certain DMG reporting units based on assessments performed after circumstances indicated it had become more likely than not that the goodwill of certain DMG reporting units had become impaired. These circumstances included underperformance of the business in recent quarters, as well as changes in other market conditions, including government reimbursement cuts and our expected ability to mitigate them.

Based on continuing developments at our DMG reporting units during 2016, 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 units in recent quarters and other market conditions, we performed additional goodwill impairment assessments for certain at-risk DMG reporting units during each of the first three quarters of 2016 and as of their November 1 annual assessment date.

As a result of the assessments described above, we have recognized the DMG goodwill impairment charges shown below:

	Year ended December 31,		
Reporting unit	**2016**	**2015**	**2014**
	(dollar amounts rounded to nearest million)		
DMG Nevada	$ 162	$ 181	$ —
DMG Florida	91	6	—
DMG Arizona	—	2	—
Total	$ 253	$ 189	$ —

Gain on sales of business interests. Effective June 30, 2016, we sold a portion of our 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.

Equity investment loss (income). DMG's share of equity investment income from our nonconsolidated joint ventures for 2016 decreased $8 million from 2015. This increase in equity losses was primarily attributable to a decrease in profitability of certain joint ventures, partially offset by the sale of a portion of our Tandigm ownership interest during second quarter which resulted in a reduced share of equity investment losses during the third and fourth quarters of 2016.

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

Segment operating income

DMG's operating income for 2016, which includes the goodwill impairment charges of $253 million, the gain related to the sale of a portion of our Tandigm ownership interest of $40 million, the loss on the sale of our DMG Arizona business of $10 million and an estimated accrual for damages and liabilities associated with our DMG Nevada hospice business of $16 million, decreased $138 million from 2015, which included estimated goodwill and other intangible asset impairment charges of $206 million related to certain reporting units. Excluding these items from their respective periods, adjusted operating income for the year ended December 31, 2016 would have decreased by approximately $105 million. This decrease in adjusted operating income was primarily attributable to a decrease in Medicare Advantage and Medicaid rates, a decrease in revenue due to the timing of Medicaid risk sharing revenue and additional revenues related to the maintenance of existing physicians networks recognized in 2015, the acquisition of TEC, an increase in depreciation and amortization related to the trade names acceleration, and an increase in technology and property investments and corporate administrative support costs, partially offset by a decrease in benefits and an increase in senior capitated members due to acquisitions and non-acquired growth.

DMG's operating income for 2015, which included estimated goodwill and other intangible asset impairment charges of $206 million related to certain reporting units decreased $181 million from 2014. Excluding this item from 2015, adjusted operating income for the year ended December 31, 2015 would have increased by approximately $25 million, or 11.6%. This increase in adjusted operating income was primarily attributable to an increase in FFS revenue from acquisitions and non-acquired growth, an increase in Medicaid members due to Medicaid expansion, the timing of recognition of additional Medicare risk share revenue and a reduction of claims expense due to the planned non-renewal of some plans due to unfavorable economics in certain markets. This increase was partially offset by a decrease in commercial members, and higher general and administrative costs.

Other—Ancillary services and strategic initiatives business

Our other operations include ancillary services and strategic initiatives which are primarily aligned with our core business of providing dialysis services to our network of patients. As of December 31, 2016, these consisted primarily of pharmacy services, disease management services, vascular access services, clinical research programs, physician services, direct primary care and our international dialysis operations. The ancillary services and strategic initiatives generated approximately $1.621 billion of net revenues in 2016, representing approximately 10% of our consolidated net revenues. We currently expect to continue to invest in our ancillary services and strategic initiatives, including our continued expansion into certain international markets, as we work to develop successful new business operations. However, any significant change in market conditions, business performance or in the regulatory environment may impact the economic viability of any of these strategic initiatives. Any unfavorable changes in these strategic initiatives could result in a write-off or an impairment of some or all of our investments, including goodwill, and could also result in significant termination costs if we were to exit a certain line of business or one or more of our international markets.

As of December 31, 2016, we provided dialysis and administrative services to a total of 154 outpatient dialysis centers located in 11 countries outside of the U.S. Our international dialysis operations are still in an early phase of development as we primarily commenced operations during the fourth quarter of 2011. The total net revenues generated from our international operations, as reflected below, were approximately 1% of our 2016 consolidated net revenues.

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

	Year ended December 31,		
	2016	2015	2014
	(dollar amounts rounded to nearest million)		
U.S. revenues			
Net patient service revenues	$ 26	$ 26	$ 20
Other revenues	1,299	1,144	941
Capitated revenues	88	72	70
Total	1,413	1,242	1,031
International revenues			
Net patient service revenues	202	134	102
Other revenues	6	6	6
Total	208	140	108
Total net revenues	$ 1,621	$ 1,382	$ 1,139
U.S. operating income	$ (65)	$ (45)	$ 17
Reconciliation of non-GAAP:			
Add:			
Goodwill impairment	28	—	—
Pharmacy accrual	16	22	—
Adjusted operating loss(1)	$ (21)	$ (23)	$ 17
International operating income	$ 332	$ (59)	$ (42)
Reconciliation of non-GAAP:			
Add: Impairment of minority equity investment	15	4	—
Less: Gain from APAC JV	(374)	—	—
Adjusted operating loss(1)	(27)	(55)	(42)
Total Adjusted operating loss(1)	$ (48)	$ (78)	$ (25)

(1) For the year ended December 31, 2016, we have excluded a goodwill impairment charge of $28 million related to our vascular access reporting unit, an estimated accrual of $16 million for damages and liabilities associated with our pharmacy business, an impairment of $15 million related to a minority equity investment, and a gain on the APAC JV ownership changes of $374 million. For the year ended December 31, 2015, we have excluded estimated goodwill impairment charges of $4 million and an estimated accrual of $22 million for damages and liabilities associated with our pharmacy business. These are non-GAAP measures and are not intended as substitutes for the equivalent GAAP measures. We have presented these adjusted amounts because management believes that these presentations enhance a user's understanding of our normal consolidated operating income by excluding certain 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

Ancillary services and strategic initiatives net revenues for 2016 increased by approximately $239 million, or 17.3%, as compared to 2015. The increase was primarily related to an increase in pharmaceutical rates, a decrease in reserves due to refunds of pharmacy reimbursements taken in 2015 that did not reoccur in 2016, an increase in VillageHealth special needs plan revenues and an increase in net revenues from our expansion in our international business and other strategic initiatives. These increases were partially offset by a decrease in our pharmacy services volume.

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

Operating and general expenses

Ancillary services and strategic initiatives operating expenses for 2016, which includes an estimated accrual for damages and liabilities associated with our pharmacy business of $16 million, increased by approximately $203 million from 2015, which included an estimated accrual for damages and liabilities associated with our pharmacy business of $22 million. Excluding these items from their respective periods, ancillary services and strategic initiatives adjusted operating expenses would have increased by $209 million. This increase in adjusted operating expenses was primarily due to an increase in pharmaceutical unit costs, labor and benefit costs, professional fees, other general and administration expenses, and additional expenses associated with our international dialysis expansion, partially offset by a decrease in prescription dispensing volume and long-term incentive compensation expense.

Ancillary services and strategic initiatives operating expenses for 2015, which included an estimated accrual for damages and liabilities associated with our pharmacy business of $22 million, increased by approximately $318 million from 2014. Excluding this item from 2015, the ancillary services and strategic initiatives adjusted operating expenses would have increased by $296 million. This increase in adjusted operating expenses was primarily due to an increase in prescription dispensing volume, higher pharmaceutical costs, higher labor costs and related payroll taxes and benefit costs, additional expenses associated with our international dialysis expansion, and an increase in costs associated with the right to use intellectual property and general and administrative and corporate administrative support expenses.

Goodwill and other asset impairment charges. During the quarter ended December 31, 2016, we determined that circumstances indicated it had become more likely than not that the goodwill of our vascular access reporting unit had become impaired. These circumstances included changes in governmental reimbursement and our expected ability to mitigate them. Specifically, on November 2, 2016, CMS released the 2017 Physician Fee Schedule Final Rule and the Ambulatory Surgical Center Payment Final Rule which reflected significant changes in reimbursement structure for this business unit. We have performed the required valuations to estimate the fair value of the net assets and implied goodwill of this reporting unit with the assistance of a third-party valuation firm. Based on this assessment, we recorded a goodwill impairment charge of $28 million.

In 2016, we also recorded an impairment of $15 million related to a minority equity investment in one of our international reporting units.

In 2015, we recorded a goodwill impairment charge of $4 million in one of our international reporting units.

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

On August 1, 2016, we consummated an agreement with Khazanah Nasional Berhad (Khazanah) and Mitsui and Co., Ltd (Mitsui) whereby Khazanah and Mitsui subscribed to invest a total of $300 million over three years in exchange for a 40% total equity interest in our APAC JV. Khazanah and Mitsui each made related initial investments of $50 million in this business on August 1, 2016.

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

Segment operating income (loss)

Ancillary services and strategic initiatives operating income for 2016, which includes a gain on the APAC JV ownership changes of $374 million, a goodwill impairment charge of $28 million related to our vascular access reporting unit, an estimated accrual for damages and liabilities associated with our pharmacy business of $16 million and an impairment of $15 million related to a minority equity investment, increased by approximately $371 million from 2015, which includes an estimated accrual for damages and liabilities of $22 million, as well as a goodwill impairment charge of $4 million related to our international operations. Excluding these items from their respective periods, adjusted operating losses would have decreased by $30 million. This decrease in adjusted operating losses was primarily due to an increase in pharmaceutical rates, a decrease in reserves due to refunds of pharmacy reimbursements taken in 2015 that did not reoccur in 2016, an increase in VillageHealth special needs plan revenues and an increase in net revenues from our expansion in our international business and other strategic initiatives. The decrease in adjusted operating losses was partially offset by an increase in pharmaceutical unit costs, higher labor and benefits costs and additional expenses associated with our international dialysis expansion.

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

costs associated with the right to use intellectual property and an increase in general and administrative costs. The increase in adjusted operating losses was partially offset by an increase in net revenue in our pharmacy business, primarily from additional volume and increases in pharmaceutical rates.

Corporate level charges

Debt expense. Debt expense for 2016, 2015, and 2014 consisted of interest expense of approximately $394 million, $390 million, and $386 million, respectively, and amortization and accretion of debt discounts and premiums, amortization of deferred financing costs and amortization of interest rate cap agreements of approximately $20 million in 2016, $18 million in 2015 and $25 million in 2014. The increase in debt expense in 2016 as compared to 2015 was primarily related to an increase in our weighted average outstanding principal balances as a result of a full year of interest on our 5.0% Senior Notes, which were issued in April 2015, and an increase in our interest rate on the amortization of our cap agreements in the fourth quarter of 2016. Our overall weighted average effective interest rate in 2016 was 4.43% as compared to 4.42% in 2015.

The increase in debt expense in 2015 as compared to 2014 was primarily related to an increase in weighted average outstanding principal balances offset by lower weighted average interest rates as a result of the issuance of our 5.0% Senior Notes in April 2015, as well as the entry into a new credit agreement and the issuance of senior notes in June 2014. Our overall weighted average effective interest rate in 2015 was 4.42% as compared to 4.68% in 2014.

Corporate administrative support. Corporate administrative support consists primarily of labor, benefits and long-term incentive compensation costs, as well as professional fees for departments which provide support to all of our various operating lines of business. In 2016, it also included an adjustment to reduce receivables associated with the DMG acquisition escrow provision relating to income tax items of $31 million, as discussed below. These expenses are included in our consolidated general and administrative expenses.

In connection with the acquisition of DMG, we recorded receivables against the acquisition escrow balance to offset specific potential tax liabilities. Certain of these potential tax liabilities expired, resulting in the reduction of these assets during 2016. This negatively impacted our corporate administrative support cost by $31 million. This cost was directly offset by a corresponding reduction in income tax expense due to the expiration of the corresponding tax liabilities.

Corporate administrative support costs were approximately $45 million in 2016, which included the adjustment to reduce receivables associated with the DMG acquisition escrow provision relating to an income tax item of $31 million, as compared to $19 million in 2015. This increase of approximately $26 million in corporate administrative support costs is primarily attributable to the tax receivables related to the DMG acquisition escrow provision, as well as increases in labor and benefits, professional fees, and other general and administrative expenses. These increases were offset by a decrease in long-term incentive compensation, primarily due to reductions in ultimate expected pay-outs as well as the departure of a senior executive.

Corporate administrative support costs were approximately $19 million in 2015, as compared to $13 million in 2014. The change of approximately $6 million in corporate administrative support costs was primarily attributable to an increase in labor and benefits and professional fees, offset by an increase in management fee allocations.

Other income. Other income was approximately $9 million in both 2016 and 2015, and $2 million in 2014, and consisted principally of interest income. Other income in 2016 as compared to 2015 was flat, as short-term investment interest income increased but was offset by an increase in foreign currency transaction losses. Other income increased in 2015 as compared to 2014 due to an increase in short-term investment interest income and a decrease in foreign currency transaction losses.

Provision for income taxes. The provision for income taxes for 2016, 2015 and 2014 represented an effective annualized tax rate of 30.6%, 40.9% and 34.1% of income from continuing operations, respectively. The effective tax rate in 2016 was lower primarily due to the gain on the APAC JV ownership changes, offset by goodwill impairment charges.

Noncontrolling interests

Net income attributable to noncontrolling interests for 2016, 2015 and 2014 was approximately $153 million, $158 million and $140 million, respectively. The decrease in noncontrolling interests in 2016 was primarily due to the impairment of our vascular access reporting unit, which resulted in a decrease in noncontrolling interest of $8 million. The increase in noncontrolling interests expense in 2015 was primarily due to increases in the profitability of our dialysis-related joint ventures. The percentage of U.S. dialysis and related lab services net revenues generated from dialysis-related joint ventures was approximately 24%, 23% and 22% in 2016, 2015 and 2014, respectively.

Accounts receivable

Our accounts receivable balances at December 31, 2016 and December 31, 2015 were $1.917 billion and $1.724 billion, respectively, representing approximately 49 days and 46 days of revenue, respectively, net of the allowance for uncollectible accounts. The increase in DSO was primarily related to our U.S. dialysis and related lab services business, mainly as a result of improved cash collection performance in 2015 which we did not experience in 2016. Our DSO calculation is based on the current quarter's average revenues per day.

As of December 31, 2016 and 2015, our unreserved patient services accounts receivable balances more than six months old were approximately $252 million and $246 million, respectively, representing approximately 16% and 18% of our net patient and other services accounts receivable balances, respectively. There were no significant unreserved balances over one year old. Less than 1% of our revenues are classified as patient pay. Substantially all revenue realized is from government and commercial payors, as discussed above.

For receivables associated with our 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. The majority of our capitated health plans accounts receivable is three to six months old with collections occurring on a periodic basis throughout the duration of the corresponding plan year.

Liquidity and capital resources

Available liquidity. As of December 31, 2016, our cash balance was $913 million and we also had approximately $310 million in short-term investments. We also had an undrawn revolving line of credit under our senior secured credit facilities totaling $1.0 billion, of which approximately $95.2 million was committed for outstanding letters of credit. The remaining amount is unencumbered. In addition, DMG has an outstanding letter of credit of approximately $1.3 million that is secured by a certificate of deposit. We believe that we will have sufficient liquidity, operating cash flows and access to borrowings to fund our scheduled debt service payments and other obligations for the foreseeable future. Our primary sources of liquidity are cash from operations and cash from borrowings.

Cash flow from operations during 2016 amounted to $2.0 billion compared with $1.6 billion for 2015. The increase in our operating cash flows in 2016 as compared to 2015 was primarily due to payments of $494 million, or $304 million after-tax, made in connection with the settlement of a private civil suit in 2015 and due to the timing of other working capital items, offset by an increase in our income tax payments and a slight increase in our cash interest payments. Cash flow from operations in 2016 included cash interest payments of approximately $407 million and cash tax payments of $339 million. Cash flow from operations in 2015 included cash interest payments of approximately $405 million and cash tax payments of $156 million.

Non-operating cash outflows in 2016 included $829 million for capital asset expenditures, including $470 million for new center developments and relocations, and $359 million for maintenance and information technology. We also spent an additional $564 million for acquisitions. During 2016, we also received $1.3 billion from the maturity and sale of investments. However, these proceeds were principally used to repurchase other investments or to fund distributions from our deferred compensation plans. In addition, during 2016 we received $37 million associated with stock award exercises and other share issuances and related excess tax benefits. We also made distributions to noncontrolling interests of $192 million, and received contributions from noncontrolling interests of $48 million associated with new joint ventures and from additional equity contributions. We also repurchased a total of 16,649,090 shares of our common stock for $1.072 billion, or an average price of $64.41 per share. In addition, we settled $25 million in share repurchases related to 2015.

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

On August 9, 2016, we entered into an amendment to our agreement to acquire Colorado-based Renal Ventures Limited, LLC (Renal Ventures). As a result of the amended agreement, we will acquire a 100% interest in all 38 outpatient dialysis centers owned by Renal Ventures, including one new center under construction, and a 51% interest in one vascular access clinic. The purchase price will be approximately $360 million in cash subject to, among other things, adjustments for certain items such as working capital. The transaction is subject to approval by the Federal Trade Commission (FTC) including Hart-Scott-Rodino antitrust clearance. We

anticipate that we will be required by the FTC to divest some outpatient dialysis centers as a condition of the transaction. We currently expect the transaction to close in mid 2017.

During 2016, we opened 100 new U.S. dialysis centers, acquired a total of eight U.S. dialysis centers, merged five centers, added two centers which we operate under a management and administrative services agreement, terminated two management and administration services agreements, deconsolidated three centers which we now operate under management and administrative services agreements and closed four centers. Outside the U.S., we acquired 21 dialysis centers and opened 15 new dialysis and hospital operated centers.

During 2016, our DMG business acquired three primary care physician practices including the acquisition of TEC, and four private medical practices.

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

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

During the year ended December 31, 2016, we made mandatory principal payments under our senior secured credit facilities totaling $63 million on Term Loan A and $35 million on Term Loan B. During the year ended December 31, 2015, we made mandatory principal payments under our senior secured credit facilities totaling $50 million on Term Loan A and $35 million on Term Loan B.

Interest rate swap and cap agreements

As of December 31, 2016, we maintain several interest rate cap agreements that were entered into in November 2014 with notional amounts totaling $3.5 billion. These previously forward 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. These cap agreements expire on June 30, 2018. As of December 31, 2016, the total fair value of these cap agreements was an asset of approximately $0.1 million. During the year ended December 31, 2016, we recorded a loss of $1.2 million in other comprehensive income due to a decrease in the unrealized fair value of these cap agreements.

As of December 31, 2016, we maintain several forward interest rate cap agreements that were entered into in October 2015 with notional amounts totaling $3.5 billion. These forward cap agreements will 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 December 31, 2016, the total fair value of these cap agreements was an asset of approximately $9.8 million. During the year ended December 31, 2016, we recorded a loss of $4.0 million in other comprehensive income due to a decrease in the unrealized fair value of these forward cap agreements.

Previously, we maintained several interest rate cap agreements with notional amounts totaling $2.7 billion on our Term Loan B debt. These agreements had the economic effect of capping the LIBOR variable component of our interest rate at a maximum of 2.50% on an equivalent amount of our Term Loan B. These interest rate cap agreements expired September 30, 2016. During the year ended December 31, 2016, we recognized debt expense of $1.8 million from these caps.

We also previously maintained several interest rate swap agreements. These agreements had the economic effect of modifying the LIBOR variable component of our interest rate on an equivalent amount of our Term Loan A to fixed rates ranging from 0.49% to 0.52%. These interest rate swap agreements required monthly interest payments and expired September 30, 2016. During the year ended December 31, 2016, we recognized debt expense of $0.3 million from these swaps and recorded a loss of $0.8 million in other comprehensive income due to a decrease in the unrealized fair value of these swap agreements.

Other items

As of December 31, 2016, 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 1.75%. The capped portion of Term Loan A is $87.5 million. In addition, the uncapped portion of Term Loan A, which is subject to the variability of LIBOR, is $775 million. Interest rates on our senior notes are fixed by their terms.

Our overall weighted average effective interest rate on the senior secured credit facilities was 3.68%, based on the current margins in effect of 1.75% for Term Loan A and 2.75% for Term Loan B, as of December 31, 2016.

As of December 31, 2016, our interest rates are fixed on approximately 53% of our total debt.

Our overall weighted average effective interest rate during the year ended December 31, 2016 was 4.43% and as of December 31, 2016 was 4.52%.

As of December 31, 2016, we had undrawn revolving credit facilities totaling $1.0 billion of which approximately $95.2 million was committed for outstanding letters of credit. In addition, we have approximately $1.3 million of committed letters of credit outstanding related to DMG which are 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 and indefinite-lived intangible assets

During the year ended December 31, 2015, we recognized impairment charges of $189 million on goodwill and $17 million on other intangible assets of certain DMG reporting units based on assessments performed after circumstances indicated it had become more likely than not that the goodwill of certain DMG reporting units had become impaired. These circumstances included underperformance of the businesses in recent quarters, as well as changes in other market conditions, including government reimbursement cuts and our expected ability to mitigate them.

Based on continuing developments at our DMG reporting units during 2016, 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 units in recent quarters and other market conditions, we performed additional goodwill impairment assessments for certain at-risk DMG reporting units during each of the first three quarters of 2016 and as of their November 1 annual assessment date.

In addition, during the quarter ended December 31, 2016, we determined that circumstances indicated it had become more likely than not that the goodwill of our vascular access reporting unit had become impaired. These circumstances included changes in future governmental reimbursement and our expected ability to mitigate them. Specifically, on November 2, 2016, CMS released the 2017 Physician Fee Schedule Final Rule and the Ambulatory Surgical Center Payment Final Rule which reflected significant changes in reimbursement structure for this business unit. Accordingly, we performed the required valuations to estimate the fair value of the net assets and implied goodwill of this reporting unit with the assistance of a third-party valuation firm.

As a result of the assessments described above, we have recognized the goodwill impairment charges below:

	Year ended December 31,		
Reporting unit	**2016**	**2015**	**2014**
	(dollar amounts rounded to nearest million)		
DMG Nevada	$ 162	$ 181	$ —
DMG Florida	91	6	—
DMG Arizona	—	2	—
Vascular access	28	—	—
International operations	—	4	1
Total	$ 281	$ 193	$ 1

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 December 31, 2016	Carrying amount coverage(1)	Sensitivities	
			Operating income(2)	Discount rate(3)
	(in millions)			
DMG Nevada	$ 261	11.4%	-2.2%	-3.9%
DMG Florida	$ 443	7.1%	-1.7%	-3.2%
DMG New Mexico	$ 71	2.6%	-1.5%	-2.2%
DMG Washington	$ 245	3.7%	-1.8%	-3.4%
Vascular access	$ 35	4.3%	-2.7%	-5.3%

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

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

Except as described above, none of our various other reporting units was considered at risk of goodwill impairment as of December 31, 2016. Since the dates of our last annual goodwill impairment tests, there have been certain developments, events, changes in operating performance and other changes in key circumstances that have affected our businesses. However, except as further described above, these did not cause management to believe it is more likely than not that the fair value of any of our other reporting units would be less than their respective carrying amount.

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 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 2016, we granted approximately 1,280,034 stock-settled stock appreciation rights (SSARs) with an aggregate grant-date fair value of $17.6 million and a weighted-average expected life of approximately 4.2 years and approximately 328,457 stock units with an aggregate grant-date fair value of $23.6 million and a weighted-average expected life of approximately 3.3 years. We also granted 9,600 cash-settled stock-based awards with an aggregate grant-date fair value of $0.2 million.

Long-term incentive compensation costs of $73.3 million for the year ended December 31, 2016 decreased by approximately $57.3 million as compared to 2015. This decrease in long-term incentive compensation was primarily due to a cumulative revaluation of liability-based awards for reductions in estimated ultimate payouts, as well as the final vesting of a prior broad grant that is no longer contributing expense.

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

As of December 31, 2016, there was $93.0 million in total estimated but unrecognized long-term incentive compensation costs for LTIP awards outstanding, including $59.0 million relating to stock-based awards under our equity compensation plans. We expect to recognize the performance-based cash component of these LTIP costs over a weighted average remaining period of 1.0 year and the stock-based component of these LTIP costs over a weighted average remaining period of 1.4 years.

For the years ended December 31, 2016, 2015 and 2014, we received $28.4 million, $45.7 million and $59.1 million, respectively, in actual tax benefits upon the exercise of stock awards. Since the Company issues stock-settled stock appreciation rights rather than stock options, it did not receive cash proceeds from stock option exercises during the years ended December 31, 2016, 2015 and 2014.

Stock repurchases

In 2016, we repurchased a total of 16,649,090 shares of our common stock for $1.072 billion, or an average price of $64.41 per share. In 2015, we repurchased 7,779,958 shares of our common stock for $575 million, or an average price of $73.96 per share. In 2014, we did not repurchase any of our common stock. We have not repurchased any additional shares of our common stock from January 1, 2017 through February 24, 2017.

On July 13, 2016, our Board of Directors approved a share repurchase authorization in the amount of approximately $1.241 billion. This share repurchase authorization is in addition to the $259 million remaining at that time under our Board of Directors' prior share repurchase authorization announced in April 2015. As a result of the above transactions, there was approximately $677 million available under our current Board authorizations for additional share repurchases as of February 24, 2017. Although our share repurchase authorizations have no expiration dates, we are subject to share repurchase limitations under the terms of our senior secured credit facility and the indentures governing our senior notes.

Off-balance sheet arrangements and aggregate contractual obligations

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

We also have certain other potential commitments to provide operating capital to several dialysis centers that are wholly-owned by third parties or centers in which we own a noncontrolling equity interest as well as to physician-owned vascular access clinics or medical practices that we operate under management and administrative services agreements. We have certain other potential commitments related to service agreements of approximately $1.5 million.

The following is a summary of these contractual obligations and commitments as of December 31, 2016 (in millions):

	Less than 1 year	1-3 years	3-5 years	After 5 years	Total
Scheduled payments under contractual obligations:					
Long-term debt	$ 143	$ 874	$ 3,327	$ 4,549	$ 8,893
Interest payments on the senior notes	237	473	473	603	1,786
Interest payments on Term Loan B(1)	121	239	176	—	536
Interest payments on Term Loan A(2)	23	30	—	—	53
Capital lease obligations	22	42	43	193	300
Operating leases	474	844	665	1,244	3,227
	$ 1,020	$ 2,502	$ 4,684	$ 6,589	$ 14,795
Potential cash requirements under existing commitments:					
Letters of credit	$ 97	$ —	$ —	$ —	$ 97
Noncontrolling interests subject to put provisions	552	222	100	99	973
Non-owned and minority owned put provisions	28	—	30	—	58
Operating capital advances	—	—	—	1	1
	$ 677	$ 222	$ 130	$ 100	$ 1,129

(1) Based upon current LIBOR-based interest rates in effect at December 31, 2016 plus an interest rate margin of 2.75% for Term Loan B.
(2) Based upon current LIBOR-based interest rates in effect at December 31, 2016 plus an interest rate margin of 1.75% for Term Loan A.

We are committed to purchase a certain amount of our hemodialysis non-equipment product supplies, such as dialyzers, from Baxter at fixed prices through 2018. Our total expenditures for the year ended December 31, 2016 on such products were approximately 2% of our total U.S. dialysis and related lab services operating expenses.

In 2010, we entered into and subsequently extended an agreement with FMC to purchase a certain amount of dialysis equipment, parts and supplies from FMC through December 31, 2017. Our total expenditures for the year ended December 31, 2016 on such products were approximately 2% of our total U.S. dialysis and related lab services operating expenses. The actual amount of purchases in future years from FMC will depend upon a number of factors, including the operating requirements of our centers, the number of centers we acquire, and growth of our existing centers.

In 2014, we entered in to an agreement with Baxter Healthcare Corporation (Baxter) that commits us to purchase a certain amount of hemodialysis non-equipment product supplies, such as dialyzers, at fixed prices through 2018. Our total expenditures for the year ended December 31, 2016 on such products were approximately 2% of our total U.S. dialysis and related lab service operating expenses.

In January 2017, we entered into a six year Sourcing and Supply Agreement with Amgen that expires on December 31, 2022, replacing our prior agreement that was to expire in 2018. Under the terms of the agreement we will purchase EPO in amounts necessary to meet no less than 90% of our requirements for ESAs 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 $28 million of existing income tax liabilities for unrecognized tax benefits, including interest, penalties and other long-term tax liabilities, are excluded from the above table as reasonably reliable estimates of their timing cannot be made.

Supplemental information concerning certain Physician Groups and unrestricted subsidiaries

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

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

As of December 31, 2016, if these physician groups were not consolidated in our financial statements, our consolidated indebtedness would have been approximately $9.192 billion, our consolidated other liabilities (excluding indebtedness) would have been approximately $3.459 billion and our consolidated assets would have been approximately $18.313 billion. If these physician groups were not consolidated in our financial statements for the year ended December 31, 2016, our consolidated total net revenues (including approximately $737 million of management fees payable to us), consolidated operating income and consolidated net income would be reduced by approximately $1.350 billion, $53 million, and $32 million, respectively.

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

For the year ended December 31, 2016, excluding our equity investment income attributable to CMGI, our consolidated operating income and consolidated net income would be increased by approximately $0.1 million and $0.1 million, respectively. See Note 28 to the consolidated financial statements for further details.

Contingencies

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

Critical accounting policies, estimates and judgments

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

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

Revenues associated with Medicare and Medicaid programs are recognized based on (a) the payment rates that are established by statute or regulation for the portion of the payment rates paid by the government payor (e.g., 80% for Medicare patients) and (b) for the portion not paid by the primary government payor, the estimated amounts that will ultimately be collectible from other government programs paying secondary coverage (e.g., Medicaid secondary coverage), the patient's commercial health plan secondary coverage, or the patient. Our dialysis related reimbursements from Medicare are subject to certain variations under Medicare's new single bundled payment rate system whereby our reimbursements can be adjusted for certain patient characteristics and certain other factors. Our revenue recognition depends upon our ability to effectively capture, document and bill for Medicare's base payment rate and these other factors. In addition, as a result of the potential range of variations that can occur in our dialysis-related reimbursements from Medicare under the new single bundled payment rate system, our revenue recognition is now subject to a greater degree of estimating risk.

Commercial healthcare plans, including contracted managed-care payors, are billed at our usual and customary rates; however, revenue is recognized based on estimated net realizable revenue for the services provided. Net realizable revenue is estimated based on contractual terms for the patients covered under commercial healthcare plans with which we have formal agreements, non-contracted commercial healthcare plan coverage terms if known, estimated secondary collections, historical collection experience,

historical trends of refunds and payor payment adjustments (retractions), inefficiencies in our billing and collection processes that can result in denied claims for payments, a slowdown in collections, a reduction in the amounts that we expect to collect and regulatory compliance issues. Determining applicable primary and secondary coverage for our approximately 187,700 U.S. patients at any point in time, together with the changes in patient coverage's that occur each month, requires complex, resource-intensive processes. Collections, refunds and payor retractions typically continue to occur for up to three years or longer after services are provided.

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

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

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

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

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

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

Accounting for income taxes. Our income tax expense, deferred tax assets and liabilities, and liabilities for unrecognized tax benefits reflect management's best assessment of estimated current and future taxes to be paid. We are subject to income taxes in the United States and numerous state and foreign jurisdictions. Significant judgments and estimates are required in determining the consolidated income tax expense. Deferred income taxes arise from temporary differences between the tax basis of assets and liabilities and their reported amounts in the financial statements, which will result in taxable or deductible amounts in the future. In evaluating our ability to recover our deferred tax assets within the jurisdiction from which they arise, we consider all available positive and negative evidence, including scheduled reversals of deferred tax liabilities, projected future taxable income, tax-planning strategies, and results of recent operations, assumptions about the amount of future state, federal, and foreign pre-tax operating income

adjusted for items that do not have tax consequences. The assumptions about future taxable income require significant judgment and are consistent with the plans and estimates we are using to manage the underlying businesses. To the extent that recovery is not likely, a valuation allowance is established. The allowance is regularly reviewed and updated for changes in circumstances that would cause a change in judgment about the realizability of the related deferred tax assets.

Variable compensation accruals. We estimate variable compensation accruals quarterly based upon the amounts expected to be earned and paid out resulting from the achievement of certain teammate-specific and/or corporate financial and operating goals. Our estimates, which include compensation incentives for bonuses and other awards, including long-term incentive programs, are updated periodically based on changes in our economic condition or cash flows that could ultimately impact the actual final payment amount. Actual results reflected in each fiscal quarter may vary due to the subjectivity involved in anticipating fulfillment of specific and/or corporate goals, as well as the final determination and approval of amounts by our Board of Directors, as applicable.

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

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

Fair value estimates. We have recorded certain assets, liabilities and noncontrolling interests (temporary equity) subject to put provisions at fair value. The FASB defines fair value which is measured based upon certain valuation techniques that include inputs and assumptions that market participants would use in pricing assets, liabilities and noncontrolling interests subject to put provisions. We have measured the fair values of our applicable assets, liabilities and noncontrolling interests subject to put provisions based upon certain market inputs and assumptions that are either observable or unobservable in determining fair values and have also classified these assets, liabilities and noncontrolling interests subject to put provisions into the appropriate fair value hierarchy levels. The fair value of our investments available for sale are based upon quoted market prices from active markets and the fair value of our swap and cap agreements were based upon valuation models utilizing the income approach and commonly accepted valuation techniques that use inputs from closing prices for similar assets and liabilities in active markets as well as other relevant observable market inputs at quoted intervals such as current interest rates, forward yield curves, implied volatility and credit default swap pricing. The fair value of funds on deposit with third parties are based primarily on quoted close or bid market prices of the same or similar assets. The fair value of our contingent earn-out considerations were primarily based upon unobservable inputs including projected EBITDA, the estimated probabilities of achieving other performance targets and the estimated probability of the earn-out payments being made by using option pricing techniques and simulation models of expected EBITDA and operating income and other performance targets. For our noncontrolling interests subject to put provisions we have estimated the fair values based upon either the higher of a liquidation value of net assets or an average multiple of earnings based on historical earnings, patient mix and other performance indicators that can affect future results, as well as other factors. The estimate of the fair values of the noncontrolling interests subject to put provisions involves significant judgments and assumptions and may not be indicative of the actual values at which the noncontrolling interests may ultimately be settled, which could vary significantly from our current estimates. The estimated fair values of the noncontrolling interests subject to put provisions can also fluctuate and the implicit multiple of earnings at which these noncontrolling interests obligations may be settled will vary depending upon market conditions including potential purchasers' access to the capital markets, which can impact the level of competition for dialysis and non-dialysis related businesses, the economic performance of these businesses and the restricted marketability of the third-party owners' equity interests.

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

Medical liability claims associated with DMG. The medical groups are responsible for the medical services that associated physicians and contracted hospitals provide to assigned HMO enrollees. We provide medical services to health plan enrollees through a network of contracted providers under sub-capitation and FFS arrangements, company-operated clinics and staff physicians. Medical costs for professional and institutional services rendered by contracted providers are recorded as medical expenses and hospital

expenses, respectively, in the consolidated statements of income. Costs for operating medical clinics, including the salaries of medical and non-medical personnel and support costs, are recorded in clinic support and other operating costs.

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

Significant new accounting standards

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

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

Interest rate sensitivity

The tables below provide information about our financial instruments that are sensitive to changes in interest rates. The table below presents principal repayments and current weighted average interest rates on our debt obligations as of December 31, 2016. The variable rates presented reflect the weighted average LIBOR rates in effect for all debt tranches plus interest rate margins in effect as of December 31, 2016. The Term Loan A margin in effect at December 31, 2016 is 1.75%, and along with the revolving line of credit, is subject to adjustment depending upon changes in certain of our financial ratios, including a leverage ratio. Term Loan B currently bears interest at LIBOR plus an interest rate margin of 2.75%.

	Expected maturity date					Thereafter	Total	Average interest rate	Fair value
	2017	2018	2019	2020	2021				
	(dollars in millions)								
Long term debt:									
Fixed rate	$ 37	$ 25	$ 28	$ 26	$ 21	$ 4,735	$ 4,872	5.27%	$ 4,902
Variable rate	$ 128	$ 143	$ 720	$ 44	$ 3,279	$ 7	$ 4,321	3.68%	$ 4,383

	Notional amount	Contract maturity date					Pay fixed	Receive variable	Fair value
		2017	2018	2019	2020	2021			
	(dollars in millions)								
Cap agreements	$ 7,000	$ —	$ 3,500	$ —	$ 3,500	$ —		LIBOR above 3.5%	$ 9.9

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 December 31, 2016, our Term Loan A bears interest at LIBOR plus an interest rate margin of 1.75% and our Term Loan B debt bears interest at LIBOR plus an interest rate margin of 2.75%. LIBOR was greater than the 0.75% embedded LIBOR floor on Term Loan B, resulting in Term Loan B being subject to LIBOR-based interest rate volatility on the LIBOR variable component of our interest rate as of December 31, 2016. 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 $87.5 million on Term Loan A as a result of the interest rate cap agreements, as described below.

As of December 31, 2016, we maintain several interest rate cap agreements that were entered into in November 2014 with notional amounts totaling $3.5 billion. These previously forward 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. These cap agreements expire on June 30, 2018. As of December 31, 2016, the total fair value of these cap agreements was an

asset of approximately $0.1 million. During the year ended December 31, 2016, we recognized debt expense of $2.0 million from these caps. During the year ended December 31, 2016, we recorded a loss of $1.2 million in other comprehensive income due to a decrease in the unrealized fair value of these cap agreements.

As of December 31, 2016, we maintain several forward interest rate cap agreements that were entered into in October 2015 with notional amounts totaling $3.5 billion. These forward cap agreements will 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 December 31, 2016, the total fair value of these cap agreements was an asset of approximately $9.8 million. During the year ended December 31, 2016, we recorded a loss of $4.0 million in other comprehensive income due to a decrease in the unrealized fair value of these forward cap agreements.

Previously, we maintained several interest rate cap agreements with notional amounts totaling $2.7 billion on our Term Loan B debt. These agreements had the economic effect of capping the LIBOR variable component of our interest rate at a maximum of 2.50% on an equivalent amount of our Term Loan B. These interest rate cap agreements expired September 30, 2016. During the year ended December 31, 2016, we recognized debt expense of $1.8 million from these caps.

We also previously maintained several interest rate swap agreements. These agreements had the economic effect of modifying the LIBOR variable component of our interest rate on an equivalent amount of our Term Loan A to fixed rates ranging from 0.49% to 0.52%. These interest rate swap agreements required monthly interest payments and expired September 30, 2016. During the year ended December 31, 2016, we recognized debt expense of $0.3 million from these swaps and recorded a loss of $0.8 million in other comprehensive income due to a decrease in the unrealized fair value of these swap agreements.

Our overall weighted average effective interest rate on the senior secured credit facilities was 3.68%, based on the current margins in effect of 1.75% for Term Loan A and 2.75% for Term Loan B, as of December 31, 2016.

As of December 31, 2016, 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 1.75%. The capped portion of Term Loan A is $87.5 million. In addition, the uncapped portion of Term Loan A, which is subject to the variability of LIBOR, is $775 million. Interest rates on our senior notes are fixed by their terms.

Our overall weighted average effective interest rate during the year ended December 31, 2016 was 4.43% and as of December 31, 2016 was 4.52%.

As of December 31, 2016, we had undrawn revolving credit facilities totaling $1.0 billion of which approximately $95.2 million was committed for outstanding letters of credit. The remaining amount is unencumbered. In addition, DMG has an outstanding letter of credit of approximately $1.3 million which is secured 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 and working capital needs for the foreseeable future, including the next 12 months, under the terms of our debt agreements. Our primary sources of liquidity are cash from operations and cash from borrowings.

One mean of assessing exposure to debt-related interest rate changes is a duration-based analysis that measures the potential loss in net income resulting from a hypothetical increase in interest rates of 100 basis points across all variable rate maturities (referred to as a parallel shift in the yield curve). Under this model, with all else constant, it is estimated that such an increase would have reduced net income by approximately $11.6 million, $9.3 million, and $5.7 million, net of tax, for the years ended December 31, 2016, 2015, and 2014, respectively.

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.

We evaluate our exposure to foreign exchange risk through the judgment of our regional and corporate management teams. Through 2016, our international operations remained small relative to the size of our consolidated financial statements, constituting less than 4% of our consolidated assets as of December 31, 2016 and approximately 1% of our consolidated net revenues for the year ended December 31, 2016. In addition, our foreign currency translation losses have remained less than approximately 2% of our consolidated operating income for the year ended December 31, 2016.

Given the still small size of our international operations, management does not consider our exposure to foreign exchange risk to be significant to the consolidated enterprise. As such, through December 31, 2016 we have not engaged in transactions to hedge the exposure of our international transactions or net investments to foreign currency risk. However, we may do so in the future.

Item 8. Financial Statements and Supplementary Data.

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

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

None.

Item 9A. Controls and Procedures.

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

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

There has not been any change in our internal control over financial reporting that was identified during the evaluation that occurred during the fourth fiscal quarter and that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

Item 9B. Other Information.

None.

PART III

Item 10. Directors, Executive Officers and Corporate Governance.

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

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

The other information required to be disclosed by this item will appear in, and is incorporated by reference from, the sections entitled "Proposal No. 1. Election of Directors", "Corporate Governance", and "Security Ownership of Certain Beneficial Owners and Management" included in our definitive proxy statement relating to our 2017 annual stockholder meeting.

Item 11. Executive Compensation.

The information required by this item will appear in, and is incorporated by reference from, the sections entitled "Executive Compensation" and "Compensation Committee Interlocks and Insider Participations" included in our definitive proxy statement relating to our 2017 annual stockholder meeting. The information required by Item 407(e)(5) of Regulation S-K will appear in and is incorporated by reference from the section entitled "Compensation Committee Report" included in our definitive proxy statement relating to our 2017 annual stockholder meeting; however, this information shall not be deemed to be filed.

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

The following table provides information about our common stock that may be issued upon the exercise of stock-settled stock appreciation rights, restricted stock units and other rights under all of our existing equity compensation plans as of December 31, 2016, which consist of our 2011 Incentive Award Plan and our Employee Stock Purchase Plan. The material terms of these plans are described in Note 19 to the consolidated financial statements.

Plan category	Number of shares to be issued upon exercise of outstanding options, warrants and rights	Weighted average exercise price of outstanding options, warrants and rights	Number of shares remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a))	Total of shares reflected in columns (a) and (c)
	(a)	*(b)*	*(c)*	*(d)*
Equity compensation plans approved by shareholders	8,122,819	$ 58.62	37,789,231	45,912,050
Equity compensation plans not requiring shareholder approval	—	—	—	—
Total	8,122,819	$ 58.62	37,789,231	45,912,050

Other information required to be disclosed by Item 12 will appear in, and is incorporated by reference from, the section entitled "Security Ownership of Certain Beneficial Owners and Management" included in our definitive proxy statement relating to our 2017 annual stockholder meeting.

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

The information required by this item will appear in, and is incorporated by reference from, the section entitled "Certain Relationships and Related Transactions" and the section entitled "Corporate Governance" included in our definitive proxy statement relating to our 2017 annual stockholder meeting.

Item 14. Principal Accounting Fees and Services.

The information required by this item will appear in, and is incorporated by reference from, the section entitled "Ratification of Appointment of Independent Registered Public Accounting Firm" included in our definitive proxy statement relating to our 2017 annual stockholder meeting.

PART IV

Item 15. Exhibits, Financial Statement Schedules.

(a) Documents filed as part of this Report:

(1) Index to Financial Statements:

	Page
Management's Report on Internal Control Over Financial Reporting	F-1
Report of Independent Registered Public Accounting Firm	F-2
Report of Independent Registered Public Accounting Firm	F-3
Consolidated Statements of Income for the years ended December 31, 2016, 2015, and 2014	F-4
Consolidated Statements of Comprehensive Income for the years ended December 31, 2016, 2015, and 2014	F-5
Consolidated Balance Sheets as of December 31, 2016, and 2015	F-6
Consolidated Statements of Cash Flow for the years ended December 31, 2016, 2015, and 2014	F-7
Consolidated Statements of Equity for the years ended December 31, 2016, 2015, and 2014	F-8
Notes to Consolidated Financial Statements	F-10

(2) Index to Financial Statement Schedules:

Report of Independent Registered Public Accounting Firm	S-3
Schedule II—Valuation and Qualifying Accounts	S-4

(1) *Exhibits:*

2.1	Agreement and Plan of Merger, dated as of May 20, 2012, by and among DaVita Inc., Seismic Acquisition LLC, HealthCare Partners Holdings, LLC, and the Member Representative.(28)
2.2	Amendment, dated as of July 6, 2012, to the Agreement and Plan of Merger, dated as of May 20, 2012, by and among DaVita Inc., Seismic Acquisition LLC, HealthCare Partners Holdings, LLC, and the Member Representative.(29)
3.1	Restated Certificate of Incorporation of DaVita Inc., as filed with the Secretary of State of Delaware on November 1, 2016.(1)
3.2	Certificate of Ownership and Merger Merging DaVita Name Change, Inc. with and into DaVita Inc., as filed with Secretary of State of the State of Delaware on November 1, 2012.(31)
3.3	Amended and Restated Bylaws for DaVita Inc. dated as of September 7, 2016.(1)
4.1	Indenture, dated August 28, 2012, by and among DaVita Inc., the guarantors named therein and The Bank of New York Mellon Trust Company, N.A., as Trustee.(30)
4.2	Form of 5.750% Senior Notes due 2022 and related Guarantee (included in Exhibit 4.1).(30)
4.3	Indenture, dated June 13, 2014, by and among DaVita Inc., the guarantors named therein and The Bank of New York Mellon Trust Company, N.A., as Trustee. (34)
4.4	Form of 5.125% Senior Notes due 2024 and related Guarantee (included in Exhibit 4.3). (34)
4.5	Second Supplemental Indenture for the 5.750% Senior Notes due 2022, dated June 13, 2014, by and among DaVita Inc., the guarantors named therein and The Bank of New York Mellon Trust Company, N.A., as Trustee. (35)
4.6	Indenture for the 5.000% Senior Notes due 2025, dated April 17, 2015, by and among DaVita Inc., the guarantors named therein and The Bank of New York Mellon Trust Company, N.A., as Trustee. (22)
4.7	Form of 5.000% Senior Notes due 2025 and related Guarantee (included in Exhibit 4.6). (22)

10.1	Employment Agreement, dated as of October 31, 2005, effective October 24, 2005, by and between DaVita Inc. and Dennis Kogod.(6)*
10.2	Amendment to Mr. Kogod's Employment Agreement, effective December 12, 2008.(18)*
10.3	Second Amendment to Mr. Kogod's Employment Agreement, effective December 31, 2012.(18)*
10.4	Employment Agreement, effective September 22, 2005, by and between DaVita Inc. and James Hilger.(8)*
10.5	Separation Agreement, effective November 30, 2016, by and between DaVita Inc. and Mr. Kogod.✓*
10.6	Consulting Agreement, effective December 1, 2016, by and between DaVita Inc. and Mr. Kogod.✓*
10.7	Amendment to Mr. Hilger's Employment Agreement, effective December 12, 2008.(18)*
10.8	Second Amendment to Mr. Hilger's Employment Agreement, effective December 27, 2012.(33)*
10.9	Employment Agreement, effective July 25, 2008, between DaVita Inc. and Kent J. Thiry.(15)*
10.10	Employment Agreement, effective August 1, 2008, between DaVita Inc. and Allen Nissenson.(16)*
10.11	Employment Agreement, effective March 17, 2010, by and between DaVita Inc. and Javier Rodriguez.(20)*
10.12	Employment Agreement, effective November 1, 2016, by and between DaVita Inc. and Charles G. Berg.✓*
10.13	Employment Agreement, effective February 21, 2017, by and between DaVita Inc. and Joel Ackerman.✓*
10.14	Form of Indemnity Agreement.(12)*
10.15	Form of Indemnity Agreement.(7)*
10.16	DaVita Deferred Compensation Plan.✓*
10.17	Executive Incentive Plan (as Amended and Restated effective January 1, 2009).(19)*
10.18	Executive Retirement Plan.(18)*
10.19	DaVita Voluntary Deferral Plan.(5)*
10.20	Deferred Bonus Plan (Prosperity Plan).(17)*
10.21	Amendment No. 1 to Deferred Bonus Plan (Prosperity Plan).(18)*
10.22	Amended and Restated Employee Stock Purchase Plan.(13)*
10.23	Amended and Restated DaVita Inc. Severance Plan.(33)*
10.24	Change in Control Bonus Program.(18)*
10.25	Non-Management Director Compensation Philosophy and Plan.(14)*
10.26	Amended and Restated 2002 Equity Compensation Plan.(4)*
10.27	Amended and Restated 2002 Equity Compensation Plan.(11)*
10.28	Amended and Restated 2002 Equity Compensation Plan.(13)*
10.29	Amended and Restated 2002 Equity Compensation Plan.(18)*
10.30	DaVita Inc. 2002 Equity Compensation Plan.(21)*
10.31	Form of Non-Qualified Stock Option Agreement—Employee (DaVita Inc. 1999 Non-Executive Officer and Non-Director Equity Compensation Plan.(10)*
10.32	Form of Non-Qualified Stock Option Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(2)*
10.33	Form of Non-Qualified Stock Option Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(9)*
10.34	Form of Non-Qualified Stock Option Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(10)*
10.35	Form of Restricted Stock Units Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(2)*
10.36	Form of Restricted Stock Units Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(9)*

10.37	Form of Restricted Stock Units Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(10)*
10.38	Form of Restricted Stock Units Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(18)*
10.39	Form of Stock Appreciation Rights Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(9)*
10.40	Form of Stock Appreciation Rights Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(10)*
10.41	Form of Stock Appreciation Rights Agreement—Board (DaVita Inc. 2002 Equity Compensation Plan).(16)*
10.42	Form of Stock Appreciation Rights Agreement—Board members (DaVita Inc. 2011 Incentive Award Plan).(24)*
10.43	Form of Restricted Stock Units Agreement—Board (DaVita Inc. 2002 Equity Compensation Plan).(16)*
10.44	Form of Restricted Stock Units Agreement—Board members (DaVita Inc. 2011 Incentive Award Plan).(24)*
10.45	Form of Non-Qualified Stock Option Agreement—Board (DaVita Inc. 2002 Equity Compensation Plan).(16)*
10.46	Form of Stock Appreciation Rights Agreement—Executives (DaVita Inc. 2011 Incentive Award Plan).(24)*
10.47	Form of Restricted Stock Units Agreement—Executives (DaVita Inc. 2011 Incentive Award Plan).(24)*
10.48	Form of Restricted Stock Units Agreement (DaVita Inc. 2011 Incentive Award Plan). (33)*
10.49	Form of Stock Appreciation Rights Agreement (DaVita Inc. 2011 Incentive Award Plan). (33)*
10.50	Form of Long-Term Incentive Program Award Agreement (For 162(m) designated teammates) (DaVita Inc. 2011 Incentive Award Plan).(33)*
10.51	Form of Long-Term Incentive Program Award Agreement (DaVita Inc. 2011 Incentive Award Plan). (33)*
10.52	Credit Agreement, dated as of June 24, 2014, by and among DaVita Inc., the guarantors the guarantors party thereto, the lenders party thereto, JPMorgan Chase Bank, N.A., as Administrative Agent and Collateral Agent, Barclays Bank PLC, and Wells Fargo Bank, National Association as Co-Syndication Agents, Bank of America, N.A., Credit Suisse AG, Goldman Sachs Bank USA, JPMorgan Chase Bank, N.A., Morgan Stanley Senior Funding, Inc., and SunTrust Bank, as Co-Documentation Agents, Barclays Bank PLC, Wells Fargo Securities, LLC, Credit Suisse Securities (USA) LLC, Goldman Sachs Bank USA, J.P. Morgan Securities, LLC, Bank of America, N.A., Morgan Stanley Senior Funding, Inc., and SunTrust Robinson Humphrey, Inc. as Joint Lead Arrangers and Joint Bookrunners, The Bank of Nova Scotia, Credit Agricole Securities (USA) Inc., The Bank of Tokyo-Mitsubishi UFJ, Ltd., and Sumitomo Mitsui Banking Corporation, as Senior Managing Agents, HSBC Securities (USA) Inc., Fifth Third Bank, and Compass Bank as Managing Agents. (35)
10.53	Perfection Certificate executed as of October 20, 2010 and delivered in connection with the closing of the Credit Agreement filed as Exhibit 10.68.(26)**
10.54	Dialysis Organization Agreement between DaVita Inc. and Amgen USA Inc. dated December 20, 2007.(17)**
10.55	Dialysis Organization Agreement between DaVita Inc. and Amgen USA Inc. dated December 17, 2010.(23)**
10.56	Amended and Restated DaVita Inc. 2011 Incentive Award Plan.(35)*
10.57	Amendment No. 2 to Dialysis Organization Agreement between DaVita Inc. and Amgen USA Inc. effective as of July 1, 2011.(25)**
10.58	Form of Non-Competition and Non-Solicitation Agreement, dated as of May 20, 2012, between DaVita Inc. and Dr. Robert Margolis, Dr. William Chin, Dr. Thomas Paulsen, Mr. Zan Calhoun, and Ms. Lori Glisson.(28)
10.59	Form of Non-Competition and Non-Solicitation Agreement, dated as of May 20, 2012, between DaVita Inc. and Mr. Matthew Mazdyasni, Dr. Sherif Abdou, and Dr. Amir Bacchus.(28)
10.60	Escrow Agreement, dated as of August 28, 2012, by and among DaVita Inc., The Bank of New York Mellon Trust Company, N.A., as trustee, The Bank of New York Mellon Trust Company, N.A., as escrow agent and The Bank of New York Mellon Trust Company, N.A., as bank and securities intermediary.(30)
10.61	Form of 2014 Long Term Incentive Program Cash Performance Award Agreement under the DaVita Inc. 2011 Incentive Award Plan and Long-Term Incentive Program (for 162(m) designated teammates). (36) * **
10.62	Form of 2014 Long Term Incentive Program Cash Performance Award Agreement under the DaVita Inc. 2011 Incentive Award Plan and Long-Term Incentive Program. (36)* **

10.63	Form of 2014 Long Term Incentive Program Performance Stock Units Agreement under the DaVita Inc. 2011 Incentive Award Plan and Long-Term Incentive Program (for 162(m) designated teammates). (36) * **
10.64	Form of 2014 Long Term Incentive Program Restricted Stock Units Agreement under the DaVita Inc. 2011 Incentive Award Plan and Long-Term Incentive Program. (36)*
10.65	Form of 2014 Long Term Incentive Program Stock Appreciation Rights Agreement under the DaVita Inc. 2011 Incentive Award Plan and Long-Term Incentive Program. (36)*
10.66	Corporate Integrity Agreement, dated as of October 22, 2014, by and among the Office of Inspector General of The Department of Health and Human Services and DaVita Inc. (27)
12.1	Computation of Ratio of Earnings to Fixed Charges.✓
14.1	DaVita Inc. Corporate Governance Code of Ethics.(3)
21.1	List of our subsidiaries.✓
23.1	Consent of KPMG LLP, independent registered public accounting firm.✓
24.1	Powers of Attorney with respect to DaVita. (Included on Page II-1).
31.1	Certification of the Chief Executive Officer, dated February 24, 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 February 24, 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 February 24, 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 February 24, 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.✓

✓	Included in this filing.
*	Management contract or executive compensation plan or arrangement.
**	Portions of this exhibit are subject to a request for confidential treatment and have been redacted and filed separately with the SEC.
(1)	Filed on November 2, 2016 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2016.
(2)	Filed on November 8, 2004 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2004.
(3)	Filed on February 27, 2004 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 2003.
(4)	Filed on May 4, 2005 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2005.
(5)	Filed on November 8, 2005 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2005.
(6)	Filed on November 4, 2005 as an exhibit to the Company's Current Report on Form 8-K.
(7)	Filed on March 3, 2005 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 2004.
(8)	Filed on August 7, 2006 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ending June 30, 2006.
(9)	Filed on July 6, 2006 as an exhibit to the Company's Current Report on Form 8-K.
(10)	Filed on October 18, 2006 as an exhibit to the Company's Current Report on Form 8-K.
(11)	Filed on July 31, 2006 as an exhibit to the Company's Current Report on Form 8-K.
(12)	Filed on December 20, 2006 as an exhibit to the Company's Current Report on Form 8-K.

(13) Filed on June 4, 2007 as an exhibit to the Company's Current Report on Form 8-K.
(14) Filed on May 8, 2008 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2008.
(15) Filed on July 31, 2008 as an exhibit to the Company's Current Report on Form 8-K.
(16) Filed on November 6, 2008 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2008.
(17) Filed on February 29, 2008 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 2007.
(18) Filed on February 27, 2009 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 2008
(19) Filed on June 18, 2009 as an exhibit to the Company's Current Report on Form 8-K.
(20) Filed on April 14, 2010 as an exhibit to the Company's Current Report on Form 8-K.
(21) Filed on April 28, 2010 as Appendix A to the Company's Definitive Proxy Statement on Schedule 14A.
(22) Filed on April 17, 2015 as an exhibit to the Company's Current Report on Form 8-K.
(23) Filed on December 29, 2011 as an exhibit to the Company's Annual Report on Form 10-K/A for the year ended December 31, 2010.
(24) Filed on August 4, 2011 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2011.
(25) Filed on December 29, 2011 as an exhibit to the Company's Quarterly Report on Form 10-Q/A for the quarter ended June 30, 2011.
(26) Filed on January 17, 2012 as an exhibit to the Company's Quarterly Report on Form 10-Q/A for the quarter ended March 31, 2011.
(27) Filed on October 23, 2014 as an exhibit to the Company's Current Report on Form 8-K.
(28) Filed on May 21, 2012 as an exhibit to the Company's Current Report on Form 8-K.
(29) Filed on July 9, 2012 as an exhibit to the Company's Current Report on Form 8-K.
(30) Filed on August 28, 2012 as an exhibit to the Company's Current Report on Form 8-K.
(31) Filed on November 1, 2012 as an exhibit to the Company's Current Report on Form 8-K.
(32) Filed on August 7, 2013 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2013.
(33) Filed on February 28, 2013 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 2012.
(34) Filed on June 16, 2014 as an exhibit to the Company's Current Report on Form 8-K.
(35) Filed on August 1, 2014 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2014.
(36) Filed on November 6, 2014 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2014.

Item 16. Form 10-K Summary.

None.

DAVITA INC.
MANAGEMENT'S REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING

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

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

Based upon our evaluation under the COSO framework, we have concluded that the Company's internal control over financial reporting was effective as of December 31, 2016.

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

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Shareholders
DaVita Inc.:

We have audited the accompanying consolidated balance sheets of DaVita Inc. and subsidiaries as of December 31, 2016 and 2015, and the related consolidated statements of income, comprehensive income, equity, and cash flows for each of the years in the three-year period ended December 31, 2016. These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

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

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of DaVita Inc. and subsidiaries as of December 31, 2016 and 2015, and the results of their operations and their cash flows for each of the years in the three-year period ended December 31, 2016, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), DaVita Inc.'s internal control over financial reporting as of December 31, 2016, based on criteria established in *Internal Control – Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO), and our report dated February 24, 2017 expressed an unqualified opinion on the effectiveness of the Company's internal control over financial reporting.

/s/ KPMG LLP
Seattle, Washington

February 24, 2017

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Shareholders
DaVita Inc.:

We have audited DaVita Inc.'s internal control over financial reporting as of December 31, 2016, based on criteria established in *Internal Control – Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). DaVita Inc.'s management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Management's Report on Internal Control Over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit.

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

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

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

In our opinion, DaVita Inc. maintained, in all material respects, effective internal control over financial reporting as of December 31, 2016, based on criteria established in *Internal Control – Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of DaVita Inc. and subsidiaries as of December 31, 2016 and 2015, and the related consolidated statements of income, comprehensive income, equity, and cash flows for each of the years in the three-year period ended December 31, 2016, and our report dated February 24, 2017 expressed an unqualified opinion on those consolidated financial statements.

/s/ KPMG LLP
Seattle, Washington

February 24, 2017

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

	Year ended December 31,		
	2016	**2015**	**2014**
Patient service revenues	$ 10,354,161	$ 9,480,279	$ 8,868,338
Less: Provision for uncollectible accounts	(451,353)	(427,860)	(366,884)
Net patient service revenues	9,902,808	9,052,419	8,501,454
Capitated revenues	3,518,679	3,509,095	3,261,288
Other revenues	1,323,618	1,220,323	1,032,364
Total net revenues	14,745,105	13,781,837	12,795,106
Operating expenses and charges:			
Patient care costs and other costs	10,646,736	9,824,834	9,119,305
General and administrative	1,592,698	1,452,135	1,261,506
Depreciation and amortization	720,252	638,024	590,935
Provision for uncollectible accounts	11,677	9,240	14,453
Equity investment income	(13,044)	(18,325)	(23,234)
Goodwill and other asset impairment charges	296,408	210,234	—
Gain on changes in ownership interests, net	(404,165)	—	—
Settlement charge and loss contingency accrual	—	495,000	17,000
Total operating expenses and charges	12,850,562	12,611,142	10,979,965
Operating income	1,894,543	1,170,695	1,815,141
Debt expense	(414,382)	(408,380)	(410,294)
Debt redemption and refinancing charges	—	(48,072)	(97,548)
Other income, net	8,734	8,893	2,374
Income before income taxes	1,488,895	723,136	1,309,673
Income tax expense	455,813	295,726	446,343
Net income	1,033,082	427,410	863,330
Less: Net income attributable to noncontrolling interests	(153,208)	(157,678)	(140,216)
Net income attributable to DaVita Inc.	$ 879,874	$ 269,732	$ 723,114
Earnings per share:			
Basic net income per share attributable to DaVita Inc.	$ 4.36	$ 1.27	$ 3.41
Diluted net income per share attributable to DaVita Inc.	$ 4.29	$ 1.25	$ 3.33
Weighted average shares for earnings per share:			
Basic	201,641,173	211,867,714	212,301,827
Diluted	204,904,656	216,251,807	216,927,681

See notes to consolidated financial statements.

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

	Year ended December 31,		
	2016	2015	2014
Net income	$ 1,033,082	$ 427,410	$ 863,330
Other comprehensive income (losses), net of tax:			
Unrealized losses on interest rate swap and cap agreements:			
Unrealized losses on interest rate swap and cap agreements	(3,670)	(12,241)	(10,059)
Reclassifications of net swap and cap agreements realized losses into net income	2,566	3,111	10,608
Unrealized gains (losses) on investments:			
Unrealized gains (losses) on investments	1,427	(1,413)	238
Reclassification of net investment realized gains into net income	(423)	(377)	(207)
Foreign currency translation adjustments			
Foreign currency translation adjustments	(39,614)	(23,889)	(22,952)
Reclassification of foreign currency translation into net income	10,087	—	—
Other comprehensive loss	(29,627)	(34,809)	(22,372)
Total comprehensive income	1,003,455	392,601	840,958
Less: Comprehensive income attributable to noncontrolling interests	(153,398)	(157,678)	(140,216)
Comprehensive income attributable to DaVita Inc.	$ 850,057	$ 234,923	$ 700,742

See notes to consolidated financial statements.

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

	December 31, 2016	December 31, 2015
ASSETS		
Cash and cash equivalents	$ 913,187	$ 1,499,116
Short-term investments	310,198	408,084
Accounts receivable, less allowance of $252,056 and $264,144	1,917,302	1,724,228
Inventories	164,858	185,575
Other receivables	453,483	435,885
Other current assets	210,604	190,322
Income tax receivable	10,596	60,070
Total current assets	3,980,228	4,503,280
Property and equipment, net	3,175,367	2,788,740
Intangible assets, net	1,527,767	1,687,326
Equity investments	502,389	78,368
Long-term investments	103,679	89,122
Other long-term assets	44,510	73,560
Goodwill	9,407,317	9,294,479
	$ 18,741,257	$ 18,514,875
LIABILITIES AND EQUITY		
Accounts payable	$ 522,415	$ 513,950
Other liabilities	856,847	682,123
Accrued compensation and benefits	815,761	741,926
Medical payables	336,381	332,102
Current portion of long-term debt	165,041	129,037
Total current liabilities	2,696,445	2,399,138
Long-term debt	8,947,327	9,001,308
Other long-term liabilities	465,358	439,229
Deferred income taxes	809,128	726,962
Total liabilities	12,918,258	12,566,637
Commitments and contingencies		
Noncontrolling interests subject to put provisions	973,258	864,066
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; 194,554,491 and 217,120,346 shares issued and 194,554,491 and 209,754,247 shares outstanding, respectively)	195	217
Additional paid-in capital	1,027,182	1,118,326
Retained earnings	3,710,313	4,356,835
Treasury stock (7,366,099 shares at December 31, 2015)	—	(544,772)
Accumulated other comprehensive loss	(89,643)	(59,826)
Total DaVita Inc. shareholders' equity	4,648,047	4,870,780
Noncontrolling interests not subject to put provisions	201,694	213,392
Total equity	4,849,741	5,084,172
	$ 18,741,257	$ 18,514,875

See notes to consolidated financial statements.

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

	Year ended December 31,		
	2016	**2015**	**2014**
Cash flows from operating activities:			
Net income	$ 1,033,082	$ 427,410	$ 863,330
Adjustments to reconcile net income to net cash provided by operating activities:			
Settlement charge and loss contingency accrual	—	495,000	17,000
Depreciation and amortization	720,252	638,024	590,935
Goodwill and other asset impairment charges	296,408	210,234	—
Debt redemption and refinancing charges	—	48,072	97,548
Stock-based compensation expense	38,338	56,664	56,743
Tax benefits from stock award exercises	28,397	45,749	59,119
Excess tax benefits from stock award exercises	(13,251)	(28,157)	(45,271)
Deferred income taxes	52,010	61,744	210,955
Equity investment income, net	17,766	9,293	10,125
Gain on sales of business interests, net	(404,165)	—	—
Other non-cash charges, net	(7,338)	44,691	39,274
Changes in operating assets and liabilities, net of effect of acquisitions and divestitures:			
Accounts receivable	(152,240)	(202,867)	(40,676)
Inventories	22,920	(48,313)	(46,398)
Other receivables and other current assets	(54,038)	32,761	(61,674)
Other long-term assets	35,893	3,723	2,916
Accounts payable	11,897	30,998	(2,956)
Accrued compensation and benefits	68,272	54,950	97,261
Other current liabilities	176,494	113,470	83,590
Settlement payments	—	(493,775)	(410,356)
Income taxes	62,230	24,175	(60,475)
Other long-term liabilities	30,517	33,354	(1,583)
Net cash provided by operating activities	1,963,444	1,557,200	1,459,407
Cash flows from investing activities:			
Additions of property and equipment	(829,095)	(707,998)	(641,330)
Acquisitions	(563,856)	(96,469)	(272,094)
Proceeds from asset and business sales	64,725	19,715	8,791
Purchase of investments available-for-sale	(13,539)	(8,783)	(8,440)
Purchase of investments held-to-maturity	(1,133,192)	(1,709,883)	(472,628)
Proceeds from sale of investments available-for-sale	18,963	2,058	2,475
Proceeds from investments held-to-maturity	1,240,502	1,637,358	141,072
Purchase of intangible assets	—	—	(1,018)
Purchase of equity investments	(27,096)	(17,911)	(35,382)
Proceeds from sale of equity investments	40,920	—	—
Distributions received on equity investments	—	129	825
Net cash used in investing activities	(1,201,668)	(881,784)	(1,277,729)
Cash flows from financing activities:			
Borrowings	51,991,490	54,541,988	60,038,508
Payments on long-term debt and other financing costs	(52,115,932)	(53,922,290)	(60,046,487)
Deferred financing and debt redemption and refinancing costs	(188)	(76,672)	(122,988)
Purchase of treasury stock	(1,097,822)	(549,935)	—
Distributions to noncontrolling interests	(192,401)	(174,635)	(149,339)
Stock award exercises and other share issuances, net	23,543	26,155	19,500
Excess tax benefits from stock award exercises	13,251	28,157	45,271
Contributions from noncontrolling interests	47,590	54,644	64,655
Proceeds from sales of additional noncontrolling interests	—	—	3,777
Purchases of noncontrolling interests	(21,512)	(66,382)	(17,876)
Net cash used in financing activities	(1,351,981)	(138,970)	(164,979)
Effect of exchange rate changes on cash and cash equivalents	4,276	(2,571)	2,293
Net (decrease) increase in cash and cash equivalents	(585,929)	533,875	18,992
Cash and cash equivalents at beginning of the year	1,499,116	965,241	946,249
Cash and cash equivalents at end of the year	$ 913,187	$ 1,499,116	$ 965,241

See notes to consolidated financial statements.

DAVITA INC.
CONSOLIDATED STATEMENTS OF EQUITY
(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				Treasury stock				
		Shares	Amount	Additional paid-in capital	Retained earnings	Shares	Amount	Accumulated other comprehensive income (loss)	Total	
Balance at December 31, 2013	$ 697,300	213,163	$ 213	$ 1,070,922	$ 3,363,989	$ —	$ —	$ (2,645)	$ 4,432,479	$ 173,062
Comprehensive income:										
Net income	88,425				723,114				723,114	51,791
Other comprehensive loss								(22,372)	(22,372)	
Stock purchase shares issued		298	—	19,010					19,010	
Stock unit shares issued		304	1	(28)					(27)	
Stock-settled SAR shares issued		1,876	2	(2)					—	
Stock-settled stock-based compensation expense				54,969					54,969	
Excess tax benefits from stock awards exercised				45,271					45,271	
Distributions to noncontrolling interests	(93,884)									(55,455)
Contributions from noncontrolling interests	41,876									22,779
Sales and assumptions of additional noncontrolling interests	25,220			355					355	4,165
Purchases from noncontrolling interests	(6,111)			(5,357)					(5,357)	(6,544)
Other reclassification				210					210	
Changes in fair value of noncontrolling interests	77,139			(77,139)					(77,139)	
Balance at December 31, 2014	$ 829,965	215,641	$ 216	$ 1,108,211	$ 4,087,103	$ —	$ —	$ (25,017)	$ 5,170,513	$ 189,798
Comprehensive income:										
Net income	96,510				269,732				269,732	61,168
Other comprehensive loss								(34,809)	(34,809)	
Stock purchase shares issued		—	—	(6,079)		414	30,608		24,529	
Stock unit shares issued		348	—	—					—	
Stock-settled SAR shares issued		1,131	1	(1)					—	
Stock-settled stock-based compensation expense				56,899					56,899	
Excess tax benefits from stock awards exercised				28,157					28,157	
Distributions to noncontrolling interests	(103,355)									(71,280)
Contributions from noncontrolling interests	25,795									28,849
Sales and assumptions of additional noncontrolling interests	10,654									6,875
Purchases from noncontrolling interests	(8,538)			(55,826)					(55,826)	(2,018)
Changes in fair value of noncontrolling interests	13,035			(13,035)					(13,035)	
Purchase of treasury stock						(7,780)	(575,380)		(575,380)	
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

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

	Non-controlling interests subject to put provisions	DaVita Inc. Shareholders' Equity								Non-controlling interests not subject to put provisions
		Common stock				Treasury stock				
		Shares	Amount	Additional paid-in capital	Retained earnings	Shares	Amount	Accumulated other comprehensive income (loss)	Total	
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	
Distributions to noncontrolling interests	(111,092)									(81,309)
Contributions from noncontrolling interests	33,517									14,073
Sales and assumptions of additional noncontrolling interests	28,874			3,423					3,423	2,585
Purchases from noncontrolling interests	(6,660)			(13,105)					(13,105)	(1,747)
Changes in fair value of noncontrolling interests	65,855			(65,855)					(65,855)	
Reclassifications and expirations of noncontrolling interests subject to 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

See notes to consolidated financial statements.

1. Organization and summary of significant accounting policies

Organization

DaVita Inc. operates two major divisions, DaVita Kidney Care (Kidney Care) and DaVita Medical Group (DMG, formerly known as HealthCare Partners or HCP). Kidney Care is comprised of the Company's U.S. dialysis and related lab services, its ancillary services and strategic initiatives, including its international operations, and its corporate administrative support. The Company's largest line of business is its U.S. dialysis and related lab services business, which operates kidney dialysis centers in the U.S. for patients suffering from chronic kidney failure also known as end stage renal disease (ESRD). As of December 31, 2016, the Company operated or provided administrative services through a network of 2,350 U.S. outpatient dialysis centers in 46 states and the District of Columbia, serving approximately 187,700 patients. The Company's DMG division is a patient- and physician-focused integrated healthcare delivery and management company that provides medical services to members primarily through capitation contracts with some of the nation's leading health plans.

In addition, as of December 31, 2016, the Company operated or provided administrative services to 154 outpatient dialysis centers serving approximately 15,100 patients located in 11 countries outside of the U.S.

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

Basis of presentation

These consolidated financial statements are prepared in accordance with United States generally accepted accounting principles (U.S. GAAP). The financial statements include DaVita Inc. and its subsidiaries, partnerships and other entities in which it maintains a majority voting interest or other controlling financial interest (collectively, the Company). All significant intercompany transactions and balances have been eliminated. Non-marketable equity investments are recorded under the equity or cost method of accounting based upon whether the Company has significant influence over the investee. For the Company's international subsidiaries, local currencies are considered their functional currencies. Translation adjustments result from translating the Company's international subsidiaries' financial statements from their functional currencies into the Company's reporting currency (USD). Prior year balances and amounts have been reclassified to conform to the current year presentation.

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

Use of estimates

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

The most significant assumptions and estimates underlying these financial statements and accompanying notes involve revenue recognition and accounts receivable, contingencies, impairments of long-lived assets and goodwill, valuation adjustments, accounting for income taxes, quarterly, annual and long-term variable compensation accruals, consolidation of variable interest entities, purchase accounting valuation estimates, other fair value estimates, stock-based compensation and medical liability claims. Specific estimating risks and contingencies are further addressed within these notes to the consolidated financial statements.

Patient service net revenues and accounts receivable

U.S. dialysis and related lab services

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

Revenues associated with Medicare and Medicaid programs are recognized based on: (a) the payment rates that are established by statute or regulation for the portion of payment rates paid by the government payor (e.g., 80% for Medicare patients) and (b) for the portion not paid by the primary government payor, estimates of the amounts ultimately collectible from other government programs paying secondary coverage (e.g., Medicaid secondary coverage), the patient's commercial health plan secondary coverage, or the patient. The Company's reimbursements from Medicare are subject to certain variations under Medicare's single bundled payment rate system, whereby reimbursements can be adjusted for certain patient characteristics and other factors. The Company's revenue recognition will depend upon its ability to effectively capture, document and bill for Medicare's base payment rate as well as these other variable factors.

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

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

Under Medicare's bundled payment rate system, services covered by Medicare are subject to estimating risk, whereby reimbursements from Medicare can vary significantly depending upon certain patient characteristics and other variable factors. Even with the bundled payment rate system, Medicare payments for bad debt claims as established by cost reports require evidence of collection efforts. As a result, billing and collection of Medicare bad debt claims can be delayed significantly and final payment is subject to audit.

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

The Company's range of revenue estimating risk for the dialysis and related lab services segment is generally expected to be within 1% of its revenue. Changes in revenue estimates for prior periods are not material.

Other patient service revenues

Patient service revenues earned by DMG are recognized in the period services are provided, net of an estimated contractual allowance and are mainly attributable to primary care physician services and certain other specialty care services provided to patients.

Capitated revenue

DMG capitated revenue

The Company's associated medical groups are licensed to contract with health maintenance organizations (HMOs), to provide physician services in California under capitation contracts, and to provide both hospital and physician services under global risk capitation contracts in Florida and Nevada. DMG's revenues consist primarily of fees for medical services provided by these medical group entities' payments from capitated contracts with various HMOs and revenues under risk-sharing programs. Capitation revenue under HMO contracts is prepaid monthly based on the number of enrollees electing physicians affiliated with one of the medical group entities as their healthcare provider, regardless of the level of actual medical services utilized. Capitation revenue is reported as revenue in the month in which enrollees are entitled to receive healthcare. A portion of the capitation revenue pertaining to Medicare enrollees is subject to possible retroactive premium risk adjustments based on their individual acuity. Due to lack of sufficient data to

project the amount of such retroactive adjustments, the Company records any corresponding retroactive revenues in the year of receipt.

Depending on the applicable state regulation regarding global risk capitation, revenues may be received by the Company or by an independent hospital with which the Company contracts under various managed care-related administrative services agreements. In the Florida and Nevada service markets, the global capitation revenue is recorded by the Company with the corresponding cost of medical care reported by the Company as patient care costs. In California, the Company receives professional capitation and either the health plan retains the capitated revenues in a shared risk pool or the independent hospitals receive the institutional capitation revenues. The revenues are used to pay medical claims for the related enrollees. The Company is entitled to any residual amounts and bears the risk of any deficits. In all cases, an estimate is made for the cost of medical services that have been incurred and where no medical claim has been received (IBNR). DMG enters into contracts with health plans allowing it to recognize revenue under global capitation arrangements for both professional and institutional services. DMG has converted three separate contracts to global risk in California and is in the approval and implementation process to convert more.

Under risk-sharing programs, the medical groups share in the risk for hospitalization services and earn additional incentive revenues or incur penalties based on the utilization of hospital services. Estimated shared-risk receivables from the HMOs are recorded based upon hospital utilization and associated costs incurred by assigned HMO enrollees, including an estimate of IBNR compared to budgeted funding. Differences between actual contract settlements and estimated receivables or payables are recorded in the year of final settlement. The medical groups also receive other incentive payments from health plans based on specified performance and quality criteria. These amounts are accrued when earned and the amounts can be reasonably estimated, and are included in DMG's capitated revenues.

Other capitated revenues

One of the Company's subsidiaries operates Medicare Advantage ESRD Special Needs Plans in partnerships with payors that work with CMS to provide full service healthcare to ESRD patients. The Company is at risk for all medical costs of the program in excess of the capitation payments.

Other revenues

Other revenues consist of the non-patient service revenues associated with the ancillary services and strategic initiatives, management and administrative support services that are provided to outpatient dialysis centers that the Company does not own or in which the Company owns a noncontrolling interest, retail pharmacies and medical consulting services. The Company also provides administrative and management support services to certain other non-dialysis joint ventures in which the Company owns a noncontrolling interest. Management fees are principally determined as a percentage of the managed operations' revenues or cash collections and in some cases an additional component based upon a percentage of operating income. Management fees are included in net revenues when earned and represent less than 1% of total consolidated operating revenues. Revenues related to medical consulting services are recognized in the period services are provided.

Allowance for uncollectible accounts

Net revenue recognition and allowances for uncollectible billings require the use of estimates of the amounts that will ultimately be realized considering, among other items, retroactive adjustments that may be associated with regulatory reviews, audits, billing reviews and other matters. The Company's policy is to write off any uncollectible accounts receivable balance only after all collection efforts have been exhausted or when write off is mandated by federal or state policies or required by certain payor contracts. It is also the Company's policy to write off any accounts receivable balance associated with any payors or patients when the Company receives notification of a bankruptcy filing.

Other income

Other income includes interest income on cash investments, gains (losses) on foreign currency translation adjustments and other non-operating gains from investment transactions, as well as realized foreign currency transaction gains and losses.

Cash and cash equivalents

Cash equivalents are short-term highly liquid investments with maturities of three months or less at date of purchase.

Inventories

Inventories are stated at the lower of cost (first-in, first-out) or market and consist principally of pharmaceuticals and dialysis-related supplies. Rebates related to inventory purchases are recorded when earned and are based on certain qualification requirements which are dependent on a variety of factors including future pricing levels by the manufacturer and data submission.

Funds on deposit with a third party

The Company's DMG business has established a risk sharing arrangement with a California hospital, wherein the Company shares in any surplus or deficit. One of the terms of this agreement is the establishment of a segregated investment fund to ensure adequate cash to pay IBNR. The Company and the hospital monitor the reserve balance to maintain the adequacy of funds on deposit. The Company has $75,877 in such funds as of December 31, 2016, included in other current assets on the consolidated balance sheet.

Property and equipment

Property and equipment is stated at cost less accumulated depreciation and amortization and is further reduced by any impairments. Maintenance and repairs are charged to expense as incurred. Depreciation and amortization expenses are computed using the straight-line method over the useful lives of the assets estimated as follows: buildings, 20 to 40 years; leasehold improvements, the shorter of their economic useful life or the expected lease term; and equipment and information systems, principally three to eight years. Disposition gains and losses are included in current operating expenses.

Amortizable intangibles

Amortizable intangible assets and liabilities include customer relationships, trade names, provider networks, supply agreements, practice management tools, non-competition and similar agreements, lease agreements and hospital acute services contracts, each of which have finite useful lives. Amortization expense is computed using the straight-line method over the useful lives of the assets estimated as follows: customer relationships, principally ten to twenty years; provider networks and practice management tools, two to fifteen years; trade names, principally four years; non-competition and similar agreements, two to ten years; and lease agreements and hospital acute service contracts, over the term of the lease or contract period, respectively.

Equity investments

Equity investments that do not have readily determinable fair values are carried on the cost or equity method, as applicable. The Company classifies its cost and equity method investments as "Equity investments" on its balance sheet. See Note 8 to these consolidated financial statements for further details.

Investments in debt and equity securities

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

Goodwill

Goodwill represents the difference between the fair value of businesses acquired and the fair value of the identifiable tangible and intangible net assets acquired. Goodwill is not amortized, but is assessed at the reporting unit for impairment as circumstances warrant and at least annually. An impairment charge is recorded to the extent the carrying amount of goodwill exceeds its implied fair value. The Company operates several reporting units for goodwill impairment assessments. See Note 10 to these consolidated financial statements for further details.

Impairment of long-lived assets

Long-lived assets, including property and equipment, equity investments in non-consolidated businesses, and amortizable intangible assets are reviewed for possible impairment whenever significant events or changes in circumstances indicate that an impairment may have occurred, including changes in the Company's business strategy and plans, changes in the quality or structure of its relationships with its partners or deteriorating operating performance of individual outpatient dialysis centers or other operations. An impairment is indicated when the sum of the expected future undiscounted net cash flows identifiable to an asset group is less than

its carrying amount. Impairment losses are measured based upon the difference between the actual or estimated fair values, which are based on market values, net realizable values or projections of discounted net cash flows, as appropriate, and the carrying amount of the asset group. Impairment charges are included in operating expenses. Indefinite-lived intangible assets are reviewed for possible impairment at least annually or whenever significant events or changes in circumstances indicate that an impairment may have occurred.

Self insurance

The Company's Kidney Care division records insurance liabilities for professional and general liability and workers' compensation in excess of certain individual and or aggregate amounts not covered by third-party carriers. The Company's Kidney Care division estimates the self-insured retention portion of professional and general liability and workers' compensation risks using third-party actuarial calculations that are based upon historical claims experience and expectations for future claims. In addition, DMG has purchased external primary professional and general liability insurance from California Medical Group Insurance (CMGI) in which the Company owns an equity interest of 67%.

Medical liability costs

The medical groups are responsible for integrated care that the associated physicians and contracted hospitals provide to assigned HMO enrollees. The Company provides integrated care to health plan enrollees through a network of contracted providers under sub-capitation and direct patient service arrangements, company-operated clinics and staff physicians. Medical costs for professional and institutional services rendered by contracted providers are recorded as patient care costs in the consolidated statements of income. Costs for operating medical clinics, including the salaries of medical and non-medical personnel and support costs, are also recorded in patient care costs.

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

Income taxes

Federal and state income taxes are computed at currently enacted tax rates less tax credits using the asset and liability method. Deferred taxes are adjusted both for items that do not currently have tax consequences and for the cumulative effect of any changes in tax rates from those previously used to determine deferred tax assets or liabilities. Tax provisions include amounts that are currently payable, changes in deferred tax assets and liabilities that arise because of temporary differences between the timing of when items of income and expense are recognized for financial reporting and income tax purposes, changes in the recognition of tax positions and any changes in the valuation allowance caused by a change in judgment about the realizability of the related deferred tax assets. A valuation allowance is established when necessary to reduce deferred tax assets to amounts expected to be realized.

The Company uses a recognition threshold of more-likely-than-not and a measurement attribute on all tax positions taken or expected to be taken in a tax return in order to be recognized in the financial statements. Once the recognition threshold is met, the tax position is then measured to determine the actual amount of benefit to recognize in the financial statements.

Stock-based compensation

The Company's stock-based compensation 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. Stock-based compensation to be settled in shares is recorded to the Company's shareholders' equity, while stock-based compensation to be settled in cash is recorded to a liability.

Interest rate swap and cap agreements

The Company often carries a combination of interest rate caps, forward interest rate caps, or interest rate swaps on portions of its variable rate debt as a means of hedging its exposure to changes in LIBOR interest rates as part of its overall interest rate risk management strategy. These interest rate caps and swaps are not held for trading or speculative purposes and are typically designated as qualifying cash flow hedges. See Note 14 to these consolidated financial statements for further details.

Noncontrolling interests

Noncontrolling interests represent third-party equity ownership interests in entities which are consolidated by the Company for financial statement reporting purposes. As of December 31, 2016, third parties held noncontrolling equity interests in 490 consolidated legal entities.

Fair value estimates

The Company currently measures the fair value of certain assets, liabilities (including contingent earn-out consideration) and noncontrolling interests subject to put provisions (temporary equity) based upon valuation techniques that include observable or unobservable market inputs and assumptions that market participants would use in pricing these assets, liabilities and temporary equity. The Company has also classified its assets, liabilities and temporary equity into the appropriate fair value hierarchy levels as defined by the Financial Accounting Standards Board (FASB). See Note 24 to the consolidated financial statements for further details.

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 U.S. 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 consolidated financial statements and related disclosures. The Company has not yet selected a transition method nor determined the effect of these ASUs on its ongoing financial reporting. The Company expects to adopt these ASU's effective January 1, 2018.

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 consolidated financial statements.

In February 2016, the FASB issued ASU No. 2016-02, *Leases (Topic 842)*. The amendments in this ASU revise the accounting related to lessee accounting. Under the new guidance, lessees will be required to recognize a lease liability and a right-of-use asset for 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 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 consolidated balance sheet but will not have a material impact on its results of operations or liquidity. The Company continues to evaluate the effect that the implementation of this ASU will have on its 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 are effective for the Company beginning on January 1, 2017 to be applied prospectively. The adoption of this ASU is not expected to have a material impact on the Company's consolidated financial statements.

In 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, and classification on the statement of cash flows. The amendments in this ASU are effective for the Company beginning January 1, 2017. The method of adoption differs for each of the topics covered by the ASU. The Company expects that the primary effect of this ASU will be the presentation of excess tax benefits or deficiencies within the Company's consolidated statement of income as a component of income tax expense rather than within additional paid-in capital on its consolidated balance sheet. In addition, these amounts will be presented as an operating activity on the consolidated statement of cash flows rather than as a financing activity. 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 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 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 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 is permitted after January 1, 2017. The Company is evaluating the effect that the implementation of this ASU will have on its consolidated financial statements, related disclosures and timing of implementation.

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 interest 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 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 (SSARs), stock options and unvested stock units (under the treasury stock method) as well as shares held in escrow that the Company expects will remain outstanding.

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

	Year ended December 31,		
	2016	2015	2014
	(shares in thousands)		
Basic:			
Net income attributable to DaVita Inc. for basic earnings per share calculation	$ 879,874	$ 269,732	$ 723,114
Weighted average shares outstanding during the period	203,835	214,062	214,496
Contingently returnable shares held in escrow for the DaVita HealthCare Partners merger	(2,194)	(2,194)	(2,194)
Weighted average shares for basic earnings per share calculation	201,641	211,868	212,302
Basic net income per share attributable to DaVita Inc.	$ 4.36	$ 1.27	$ 3.41
Diluted:			
Net income attributable to DaVita Inc. for diluted earnings per share calculation	$ 879,874	$ 269,732	$ 723,114
Weighted average shares outstanding during the period	203,835	214,062	214,496
Assumed incremental shares from stock plans	1,070	2,190	2,432
Weighted average shares for diluted earnings per share calculation	204,905	216,252	216,928
Diluted net income per share attributable to DaVita Inc.	$ 4.29	$ 1.25	$ 3.33
Anti-dilutive stock-settled awards excluded from calculation(1)	2,523	1,365	1,715

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

3. Accounts receivable

For both years ending December 31, 2016 and 2015, approximately 81% of the Company's consolidated net accounts receivable is related to patient and other services, and approximately 19% is related to capitated health plans.

Approximately 16% and 18% of the Company's net patient services accounts receivable balances as of December 31, 2016 and 2015, respectively, were more than six months old, and there were no significant balances over one year old. Accounts receivable are principally from Medicare and Medicaid programs and commercial insurance plans.

Accounts receivable are reduced by an allowance for doubtful accounts. In evaluating the ultimate collectability of its accounts receivable, the Company analyzes its historical cash collection experience and trends for each payor 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 it to determine its current provision for uncollectible accounts and the adequacy of its allowance for doubtful accounts.

For receivables associated with dialysis and related lab services covered by government payors, like 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. The majority of the Company's capitated health plans accounts receivable is one to three months old with collections occurring on a periodic basis throughout the duration of the corresponding plan year.

(dollars in thousands, except per share data)

Approximately 1% of the Company's U.S. dialysis and related lab services net accounts receivable are associated with patient pay and it is the Company's policy to reserve 100% of the outstanding accounts receivable balances for dialysis services when those amounts due are outstanding for more than three months and to reserve 100% of the outstanding patient pay accounts receivable balances for DMG's services when those amounts due have been outstanding for more than twelve months.

During the year ended December 31, 2016, the Company's allowance for doubtful accounts decreased by $12,088. The decrease in 2016 was primarily due to an increase in the write-offs of patient pay billings in the Company's U.S. dialysis business. The decrease was also due to a reduction in accounts receivable older than six months. During the year ended December 31, 2015, the Company's allowance for doubtful accounts increased by $21,470. The increase in 2015 was primarily due to an increase in the provision for uncollectible accounts due to an increase in the write-offs of Medicare secondary billings.

4. Other receivables

Other receivables were comprised of the following:

	December 31,	
	2016	2015
Supplier rebates and non-trade receivables	$ 347,123	$ 316,644
Medicare bad debt claims	104,658	105,714
Operating advances under management and administrative services agreements	1,702	13,527
	$ 453,483	$ 435,885

Operating advances under management and administrative services agreements are generally unsecured.

5. Other current assets

Other current assets were comprised of the following:

	December 31,	
	2016	2015
Prepaid expenses	$ 131,833	$ 105,216
Funds on deposit with third parties	75,877	82,679
Other	2,894	2,427
	$ 210,604	$ 190,322

6. Property and equipment

Property and equipment were comprised of the following:

	December 31,	
	2016	2015
Land	$ 59,013	$ 42,080
Buildings	491,301	437,283
Leasehold improvements	2,598,471	2,289,425
Equipment and information systems, including internally developed software	2,378,303	2,080,446
New center and capital asset projects in progress	480,439	336,513
	6,007,527	5,185,747
Less accumulated depreciation	(2,832,160)	(2,397,007)
	$ 3,175,367	$ 2,788,740

Depreciation expense on property and equipment was $545,734, $475,484 and $428,309 for 2016, 2015 and 2014, respectively.

Interest on debt incurred during the development of new centers and other capital asset projects is capitalized as a component of the asset cost based on the respective in-process capital asset balances. Interest capitalized was $12,990, $9,723 and $7,888 for 2016, 2015 and 2014, respectively.

(dollars in thousands, except per share data)

7. Intangibles

Intangible assets other than goodwill were comprised of the following:

	December 31,	
	2016	2015
Customer relationships	$ 1,568,161	$ 1,575,865
Trade names	190,761	170,883
Provider network and practice management tools	187,318	183,724
Noncompetition and other agreements	512,505	510,521
Lease agreements	7,624	7,306
Indefinite-lived assets	1,546	9,310
Other	583	408
	2,468,498	2,458,017
Less accumulated amortization	(940,731)	(770,691)
	$ 1,527,767	$ 1,687,326

Amortization expense from amortizable intangible assets, other than lease agreements, was $174,518, $166,537 and $167,956 for 2016, 2015 and 2014, respectively. Lease agreement intangible assets and liabilities were amortized to rent expense in the amounts of $(923), $(1,613) and $(1,798) for 2016, 2015 and 2014, respectively.

During the year ended December 31, 2016, the Company did not recognize impairment charges on any intangible assets other than goodwill. During the year ended December 31, 2015, the Company recognized a $17,400 impairment charge on an indefinite-lived intangible asset of its DMG Nevada reporting unit.

Amortizable intangible liabilities were comprised of the following:

	December 31,	
	2016	2015
Lease agreements (net of accumulated amortization of $8,485 and $6,936)	7,420	8,969
	$ 7,420	$ 8,969

There was no amortization benefit recognized from the alliance and product supply agreement in 2016 as it expired in September 2015. Amortization benefit related to this agreement was $3,997 for 2015 and $5,330 for 2014 related to this agreement. Lease agreement intangible liabilities are classified in other long-term liabilities and amortized to rent expense.

Scheduled amortization charges from amortizable intangible assets and liabilities as of December 31, 2016 were as follows:

	Customer relationships	Trade names	Provider network and practice management tools	Noncompetition and other agreements	Lease agreements	Other
2017	82,669	47,046	26,941	30,156	(1,228)	102
2018	82,664	47,046	26,881	19,519	(892)	102
2019	82,625	11,008	22,492	15,796	(832)	87
2020	82,609	3,800	581	10,437	(678)	44
2021	82,609	633	97	7,005	(606)	—
Thereafter	821,282	—	—	21,990	(3,184)	—

(dollars in thousands, except per share data)

8. Equity 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 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 or equity method investments as equity investments on its balance sheet.

As described in Note 21, the Company deconsolidated its Asia Pacific dialysis business (APAC JV) effective as of August 1, 2016, 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.

During the year ended December 31, 2016, the Company recorded an impairment of $14,993 related to a minority equity investment in one of its international reporting units.

Equity investments in nonconsolidated businesses were $502,389 and $78,368 at December 31, 2016 and 2015, respectively. The increase in equity investments was primarily related to the APAC JV, as discussed above. During 2016, 2015 and 2014, the Company recognized equity investment income of $13,044, $18,325 and $23,234, respectively, relating to equity investments in nonconsolidated businesses under the equity method of accounting.

9. Investments in debt and equity securities

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

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

	December 31, 2016			December 31, 2015		
	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	$ 256,827	$ —	$ 256,827	$ 406,884	$ —	$ 406,884
Investments in mutual funds and common stock	50,000	47,404	97,404	—	33,482	33,482
Cash surrender value of life insurance policies	—	59,646	59,646	—	56,840	56,840
	$ 306,827	$ 107,050	$ 413,877	$ 406,884	$ 90,322	$ 497,206
Short-term investments	$ 306,827	$ 3,371	$ 310,198	$ 406,884	$ 1,200	$ 408,084
Long-term investments	—	103,679	103,679	—	89,122	89,122
	$ 306,827	$ 107,050	$ 413,877	$ 406,884	$ 90,322	$ 497,206

The cost of certificates of deposit, commercial paper and money market funds at December 31, 2016 and 2015 approximate their fair value. As of December 31, 2016 and 2015, available for sale investments included $3,701 and $2,589, respectively, of gross pre-tax unrealized gains. During 2016 and 2015 the Company recorded gross pre-tax unrealized gains (losses) of $1,802 and $(1,974), respectively, in other comprehensive income associated with changes in the fair value of these investments. During 2016, the Company sold investments in mutual funds and common stock for net proceeds of $14,971, and recognized a pre-tax gain of $690, or $423 after tax, that was previously recorded in other comprehensive income. During 2015, the Company sold investments in mutual funds and common stock for net proceeds of $1,295, and recognized a pre-tax gain of $618, or $377 after tax, that was previously recorded in other comprehensive income.

Investments in mutual funds classified as available for sale are held within trusts 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. See Note 16 for further details.

(dollars in thousands, except per share data)

10. Goodwill

Changes in the carrying value of 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, 2015	$ 5,610,643	$ 3,562,534	$ 242,118	$ 9,415,295
Acquisitions	21,910	29,910	45,273	$ 97,093
Divestitures	(3,370)	(5,411)	—	$ (8,781)
Goodwill impairment charges	—	(188,769)	(4,065)	$ (192,834)
Foreign currency and other adjustments	—	—	(16,294)	$ (16,294)
Balance at December 31, 2015	$ 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
Balance at December 31, 2016:				
Goodwill	$ 5,691,587	$ 3,833,711	$ 358,112	$ 9,883,410
Accumulated impairment charges	—	(441,769)	(34,324)	$ (476,093)
	$ 5,691,587	$ 3,391,942	$ 323,788	$ 9,407,317

Each of the Company's operating segments described in Note 25 to these consolidated financial statements represents an individual reporting unit for goodwill impairment testing purposes, 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 services 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.

During the fourth quarter of 2015, the Company recognized impairment charges of $188,769 on goodwill of certain DMG reporting units based on assessments performed after circumstances indicated it had become more likely than not that the goodwill of certain DMG reporting units had become impaired. These circumstances included under-performance of the business in recent quarters as well as changes in other market conditions, including government reimbursement cuts and the Company's expected ability to mitigate them.

Based on continuing developments at the Company's DMG reporting units during 2016, including the Medicare Advantage final benchmark rates for 2017 announced on April 4, 2016, further changes in expectations concerning future government reimbursement rates and the Company's expected ability to mitigate them, as well as medical cost and utilization trends, underperformance of certain at-risk units in recent quarters and other market conditions, the Company performed additional goodwill impairment assessments for certain at-risk DMG reporting units during each of the first three quarters of 2016 and as of their November 1 annual assessment date.

In addition, during the quarter ended December 31, 2016, the Company determined that circumstances indicated it had become more likely than not that the goodwill of the Company's vascular access reporting unit had become impaired. These circumstances included changes in future governmental reimbursement and the Company's expected ability to mitigate them. Specifically, on November 2, 2016, CMS released the 2017 Physician Fee Schedule Final Rule and the Ambulatory Surgical Center Payment Final

(dollars in thousands, except per share data)

Rule which reflected significant changes in reimbursement structure for this business unit. Accordingly, the Company performed the required valuations to estimate the fair value of the net assets and implied goodwill of this reporting unit with the assistance of a third-party valuation firm.

As a result of the assessments described above, the Company has recognized the goodwill impairment charges below:

	Year ended December 31,		
Reporting unit	2016	2015	2014
DMG Nevada	$ 161,800	$ 181,253	$ —
DMG Florida	91,200	5,800	—
DMG Arizona	—	1,716	—
Vascular access	28,415	—	—
International operations	—	4,065	1,000
Total	$ 281,415	$ 192,834	$ 1,000

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:

	Goodwill balance as of December 31, 2016	Carrying amount coverage(1)	Sensitivities	
Reporting unit			Operating income(2)	Discount rate(3)
DMG Nevada	$ 261,204	11.4%	-2.2%	-3.9%
DMG Florida	$ 442,835	7.1%	-1.7%	-3.2%
DMG New Mexico	$ 70,926	2.6%	-1.5%	-2.2%
DMG Washington	$ 244,502	3.7%	-1.8%	-3.4%
Vascular access	$ 34,696	4.3%	-2.7%	-5.3%

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

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

Except as described above, none of the Company's various other reporting units were considered at risk of goodwill impairment as of December 31, 2016. Since the dates of the Company's last annual goodwill impairment tests, there have been certain developments, events, changes in operating performance and other changes in key circumstances that have affected the Company's businesses. However, except as further described above, these did not cause management to believe it is more likely than not that the fair value of any of the Company's other reporting units would be less than their respective carrying amount.

11. Other liabilities

Other liabilities were comprised of the following:

	December 31,	
	2016	2015
Payor refunds and retractions	$ 277,482	$ 153,104
Contingent earn-out consideration	7,217	29,050
Insurance and self-insurance accruals	80,437	80,355
Accrued interest	82,234	81,585
Other medical payables	36,645	53,687
Accrued non-income tax liabilities	27,759	29,291
Other	345,073	255,051
	$ 856,847	$ 682,123

(dollars in thousands, except per share data)

12. Medical payables

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

The following table shows the components of changes in the healthcare costs payable for the year ended December 31, 2016 and 2015:

	December 31,	
	2016	2015
Healthcare costs payable, beginning of the year	$ 212,641	$ 214,405
Add: Components of incurred healthcare costs		
Current year	1,673,742	1,587,036
Prior years	(141)	1,523
Total incurred healthcare costs	1,673,601	1,588,559
Less: Claims paid		
Current year	1,473,723	1,397,378
Prior years	198,244	192,945
Total claims paid	1,671,967	1,590,323
Healthcare costs payable, end of the year	$ 214,275	$ 212,641

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 healthcare cost estimates occur that the Company believes significantly impacts its current year operating results, the Company discloses that amount as unfavorable (favorable) development of prior-year's healthcare cost estimates. Actual claim payments for prior year services have not been materially different from the Company's year-end estimates.

13. Income taxes

The Company accounts for income taxes under the asset and liability method, which requires the recognition of deferred tax assets and liabilities for the expected future tax consequences of events that have been included in the financial statements. Under this method, deferred tax assets and liabilities are determined on the basis of the differences between the financial statements and tax basis of assets and liabilities using enacted tax rates in effect for the year in which the differences are expected to reverse.

Income before income taxes consisted of the following:

	Year ended December 31,		
	2016	2015	2014
Domestic	$ 1,144,544	$ 764,998	$ 1,341,208
International	344,351	(41,862)	(31,535)
	$ 1,488,895	$ 723,136	$ 1,309,673

(dollars in thousands, except per share data)

Income tax expense (benefit) consisted of the following:

	Year ended December 31,		
	2016	2015	2014
Current:			
Federal	$ 337,178	$ 183,263	$ 188,302
State	48,771	30,766	30,789
International	1,928	856	1,687
Total current income tax	$ 387,877	$ 214,885	$ 220,778
Deferred:			
Federal	93,214	88,718	192,267
State	(27,764)	(8,307)	32,360
International	2,486	430	938
Total deferred income tax	$ 67,936	$ 80,841	$ 225,565
	$ 455,813	$ 295,726	$ 446,343

The reconciliation between the U.S. federal income tax rate and the Company's effective tax rate is as follows:

	Year ended December 31,		
	2016	2015	2014
Federal income tax rate	35.0%	35.0%	35.0%
State income taxes, net of federal benefit	1.2	2.5	3.5
International rate differential	0.2	(1.1)	(0.2)
Gain on APAC JV ownership changes	(9.8)	—	—
Goodwill impairments	6.7	11.7	—
Changes in deferred tax valuation allowances	0.6	2.6	0.6
Other	0.2	1.5	(0.8)
Impact of noncontrolling interests primarily attributable to non-tax paying entities	(3.5)	(11.3)	(4.0)
Effective tax rate	30.6%	40.9%	34.1%

The Company has indefinitely reinvested $381,523 of undistributed earnings of its foreign operations outside of the United States as of December 31, 2016. Included in this undistributed earnings amount is a non-taxable gain on the APAC JV ownership changes in the amount of $374,374. No deferred tax liability has been recognized for the remittance of such earnings to the U.S. since it is the Company's intention to utilize these earnings in its foreign operations. The determination of the amount of deferred taxes on these earnings is not practicable since the computation would depend on a number of factors that cannot be known unless a decision is made to repatriate the earnings.

(dollars in thousands, except per share data)

Deferred tax assets and liabilities arising from temporary differences were as follows:

	December 31,	
	2016	2015
Receivables	$ 19,283	$ 43,393
Accrued liabilities	318,596	272,080
Net operating loss carryforwards	130,456	130,977
Other	147,487	114,805
Deferred tax assets	615,822	561,255
Valuation allowance	(56,016)	(57,811)
Net deferred tax assets	559,806	503,444
Intangible assets	(1,025,488)	(927,761)
Property and equipment	(230,870)	(205,071)
Investments in partnerships	(95,936)	(83,584)
Other	(16,640)	(13,990)
Deferred tax liabilities	(1,368,934)	(1,230,406)
Net deferred tax liabilities	$ (809,128)	$ (726,962)

At December 31, 2016, the Company had federal net operating loss carryforwards of approximately $155,790 that expire through 2035, although a substantial amount expire by 2028. The Company also had state net operating loss carryforwards of $836,774 that expire through 2036 and international net operating loss carryforwards of $97,281, some of which have an indefinite life. The utilization of a portion of these losses may be limited in future years based on the profitability of certain entities. The valuation allowance net decrease of $1,795 is primarily due to an increase related to the realizability of losses in certain foreign and state jurisdictions of $8,339 and a decrease relating to the APAC JV ownership changes of $10,134.

Unrecognized tax benefits

A reconciliation of the beginning and ending liability for unrecognized tax benefits that do not meet the more-likely-than-not threshold were as follows:

	Year ended December 31,	
	2016	2015
Beginning balance	$ 39,011	$ 31,877
Additions for tax positions related to current year	9,714	6,131
Additions for tax positions related to prior years	—	2,999
Reductions related to lapse of applicable statute	(1,277)	(1,996)
Reductions related to settlements with taxing authorities	(23,382)	—
Ending balance	$ 24,066	$ 39,011

As of December 31, 2016, the Company's total liability for unrecognized tax benefits relating to tax positions that do not meet the more-likely-than-not threshold is $24,066, all of which would impact the Company's effective tax rate if recognized. This balance represents a decrease of $14,945 from the December 31, 2015 balance of $39,011, primarily due to the positive settlement of an IRS and state audit.

The Company recognizes accrued interest and penalties related to unrecognized tax benefits in its income tax expense. At December 31, 2016 and 2015, the Company had approximately $2,595 and $9,918, respectively, accrued for interest and penalties related to unrecognized tax benefits, net of federal tax benefit.

The Company and its subsidiaries file U.S. federal and state income tax returns and various international income tax returns. The Company is no longer subject to U.S. federal and state examinations by tax authorities for years before 2013 and 2008, respectively.

(dollars in thousands, except per share data)

14. Long-term debt

Long-term debt was comprised of the following:

	December 31,	
	2016	2015
Senior Secured Credit Facilities:		
Term Loan A	$ 862,500	$ 925,000
Term Loan B	3,412,500	3,447,500
Senior notes	4,500,000	4,500,000
Acquisition obligations and other notes payable	117,547	70,645
Capital lease obligations	299,682	283,185
Total debt principal outstanding	9,192,229	9,226,330
Discount and deferred financing costs	(79,861)	(95,985)
	9,112,368	9,130,345
Less current portion	(165,041)	(129,037)
	$ 8,947,327	$ 9,001,308

Scheduled maturities of long-term debt at December 31, 2016 were as follows:

2017	165,041
2018	167,684
2019	747,871
2020	69,508
2021	3,300,437
Thereafter	4,741,688

Term Loans

Total outstanding borrowings under Term Loan A and Term Loan B can consist of various individual tranches that can range in maturity from one month to twelve months (currently all tranches are one month in duration). For Term Loan A and Term Loan B, each tranche bears interest at a London Interbank Offered Rate (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. At December 31, 2016, the overall weighted average interest rate for Term Loan A was determined based upon the LIBOR interest rates in effect for all of the individual tranches plus the interest rate margin of 1.75%. At December 31, 2016, Term Loan B bears interest at LIBOR (floor of 0.75%) plus a margin of 2.75%. The Company is subject to LIBOR-based interest rate volatility on Term Loan B as the LIBOR-based component of the interest rate exceeded the floor of 0.75% as of December 31, 2016. The overall weighted average interest rate for Term Loan B was determined based upon the LIBOR interest rates in effect for all individual tranches plus the interest rate margin. The Company has several interest rate cap agreements that have the economic effect of capping the LIBOR variable component of the Company's interest rate at a maximum of 3.50% on $3,500,000 of outstanding principal debt. The remaining $775,000 outstanding principal balance of Term Loan A would still be subject to LIBOR-based interest rate volatility. In addition, the Company maintains several forward interest rate cap agreements with notional amounts totaling $3,500,000, which will be effective June 29, 2018. The cap agreements 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 the Company's debt. See below for further details. The Company is restricted from paying dividends under the terms of its senior secured credit facilities.

During the year ended December 31, 2016, the Company made mandatory principal payments under its then existing senior secured credit facilities totaling $62,500 on Term Loan A and $35,000 on Term Loan B.

Revolving lines of credit

The Company has an undrawn revolving line under the senior secured credit facilities totaling $1,000,000, of which approximately $95,629 was committed for outstanding letters of credit. In addition, the Company has approximately $1,286 of committed outstanding letters of credit related to DMG, which is backed by a certificate of deposit.

Senior Notes

The Company's senior notes as of December 31, 2016 consisted of $1,500,000 of 5.0% Senior Notes due 2025, $1,750,000 5 1/8% senior notes due 2024 and $1,250,000 of 5 3/4% senior notes due 2022 (collectively Senior Notes).

The Senior Notes are unsecured obligations, rank equally in right of payment with the Company's existing and future unsecured senior indebtedness, and are guaranteed by substantially all of the Company's direct and indirect wholly-owned domestic subsidiaries and require semi-annual interest payments. The Company may redeem some or all of the Senior Notes at any time on or after certain specific dates and at certain specific redemption prices as outlined in each senior note agreement. The Company is restricted from paying dividends under the indentures governing its Senior Notes.

In April 2015, the Company issued $1,500,000 5.0% Senior Notes due 2025 (5.0% Senior Notes). The 5.0% Senior Notes pay interest on May 1 and November 1 of each year beginning November 1, 2015. The 5.0% Senior Notes are unsecured senior obligations, rank equally in right of payment with the Company's existing and future unsecured senior indebtedness, and are guaranteed by certain of the Company's domestic subsidiaries. The Company may redeem up to 35% of the 5.0% Senior Notes at any time prior to May 1, 2018 at a certain specified price from the proceeds of one or more equity offerings. In addition, the Company may redeem some or all of the 5.0% Senior Notes at any time prior to May 1, 2020 at make-whole redemption rates and on or after such date at certain specified redemption prices. The net proceeds from the 5.0% Senior Notes offering were used to repurchase all of the $775,000 aggregate outstanding principal balances of the 6 5/8% Senior Notes due 2020 (6 5/8% Senior Notes) through a combination of a tender offer and a redemption process and to pay fees and expenses. The remaining net offering proceeds were used for general corporate purposes, acquisitions and share repurchases. As a result of these transactions, the Company incurred $48,072 in debt redemption charges consisting of tender and redemption premiums as well as the write-off of deferred financing costs associated with the repurchase of the 6 5/8% Senior Notes.

Interest rate swaps and cap agreements

During the year ended December 31, 2016 the Company had several interest rate swap agreements as a means of hedging its exposure to and volatility from variable-based interest rate changes as part of its overall interest rate risk management strategy. These agreements were not held for trading or speculative purposes and had the economic effect of converting the LIBOR variable component of the Company's Term Loan A interest rate to a fixed rate. These swap agreements were designated as cash flow hedges, and as a result, hedge-effective gains or losses resulting from changes in the fair values of these swaps were reported in other comprehensive income until such time as the hedged forecasted cash flows occurred, at which time the amounts were reclassified into net income. Net amounts paid or received for each specific swap tranche that had settled were reflected as adjustments to debt expense. In addition, the Company has entered into several interest rate cap agreements and several 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. These cap agreements are also designated as cash flow hedges and, as a result, changes in the fair values of these cap agreements are reported in other comprehensive income. The amortization of the original cap premium is recognized as a component of debt expense on a straight-line basis over the term of the cap agreements. The swap and cap agreements do not contain credit-risk contingent features.

As of December 31, 2016, the Company maintains interest rate cap agreements that were entered into in November 2014 with notional amounts totaling $3,500,000. These previously forward 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. These cap agreements expire on June 30, 2018. As of December 31, 2016, the total fair value of these cap agreements was an asset of approximately $116. During the year ended December 31, 2016, the Company recognized debt expense of $2,070 from these caps. During the year ended December 31, 2016, the Company recorded a loss of $1,196 in other comprehensive income due to a decrease in the unrealized fair value of these cap agreements.

As of December 31, 2016, the Company 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 December 31, 2016, the total fair value of these cap agreements was an asset of approximately $9,813. During the year ended December 31, 2016, the Company recorded a loss of $4,002 in other comprehensive income due to a decrease in the unrealized fair value of these cap agreements.

Previously, the Company maintained several interest rate cap agreements with notional amounts totaling $2,735,000 on the Company's Term Loan B debt. These agreements had the economic effect of capping the LIBOR variable component of the Company's interest rate at a maximum of 2.50% on an equivalent amount of the Company's Term Loan B. During the year ended

(dollars in thousands, except per share data)

December 31, 2016, the Company recognized debt expense of $1,829 from these caps. The cap agreements expired on September 30, 2016.

The Company also previously maintained several interest rate swap agreements. These agreements had the economic effect of modifying the LIBOR variable component of the Company's interest rate on an equivalent amount of the Company's Term Loan A to fixed rates ranging from 0.49% to 0.52%. These interest rate swap agreements required monthly interest payments and expired on September 30, 2016. During the year ended December 31, 2016, the Company recognized debt expense of $299 from these swaps, and recorded a loss of $815 in other comprehensive income due to a decrease in the unrealized fair value of these swap agreements.

The following table summarizes the Company's derivative instruments as of December 31, 2016 and 2015:

	Interest rate swap and cap agreements (liabilities and assets)			
	December 31, 2016		December 31, 2015	
Derivatives designated as hedging instruments	Balance sheet location	Fair value	Balance sheet location	Fair value
Interest rate swap agreements		$ —	Other short-term assets	$ 516
Interest rate cap agreements	Other long-term assets	$ 9,929	Other long-term assets	$ 15,127

The following table summarizes the effects of the Company's interest rate swap and cap agreements for the years ended December 31, 2016, 2015 and 2014:

	Amount of losses recognized in OCI on interest rate swap and cap agreements			Location of (losses) gains reclassified from accumulated OCI into income	Amount of gains reclassified from accumulated OCI into income		
	Years ended December 31,				Years ended December 31,		
Derivatives designated as cash flow hedges	2016	2015	2014		2016	2015	2014
Interest rate swap agreements	$ (815)	$ (3,971)	$ (8,390)	Debt expense	$ 299	$ 2,664	$ 12,279
Interest rate cap agreements	(5,198)	(16,114)	(8,119)	Debt expense	3,899	2,439	5,130
Tax benefit (expense)	2,343	7,844	6,450		(1,632)	(1,992)	(6,801)
Total	$ (3,670)	$ (12,241)	$ (10,059)		$ 2,566	$ 3,111	$ 10,608

As of December 31, 2016, 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 an interest rate cap if LIBOR should rise above 3.50%. Term Loan A bears interest at LIBOR plus an interest rate margin of 1.75%. The capped portion of Term Loan A is $87.5 million. In addition, the uncapped portion of Term Loan A, which is subject to the variability of LIBOR, is $775 million. See above for further details. Interest rates on the Company's Senior Notes are fixed by their terms.

The Company's overall weighted average effective interest rate on the senior secured credit facilities was 3.68%, based upon the current margins in effect of 1.75% for Term Loan A and 2.75% for Term Loan B, as of December 31, 2016.

The Company's overall weighted average effective interest rate for the year ended December 31, 2016 was 4.43% and as of December 31, 2016 was 4.52%.

Debt expense

Debt expense consisted of interest expense of $394,279, $389,755 and $385,750 and the amortization and accretion of debt discounts and premiums, amortization of deferred financing costs and the amortization of interest rate cap agreements of $20,103, $18,625 and $24,544 for 2016, 2015 and 2014, respectively. The interest expense amounts are net of capitalized interest.

15. Leases

The majority of the Company's facilities are leased under non-cancelable operating leases ranging in terms from five to fifteen years and which contain renewal options of five to ten years at the fair rental value at the time of renewal. The Company's leases are

(dollars in thousands, except per share data)

generally subject to periodic consumer price index increases or contain fixed escalation clauses. The Company also leases certain facilities and equipment under capital leases.

Future minimum lease payments under non-cancelable operating and capital leases are as follows:

	Operating leases	Capital leases
2017	$ 473,302	$ 37,758
2018	442,959	34,442
2019	401,242	35,292
2020	354,559	35,575
2021	310,704	31,133
Thereafter	1,244,309	232,191
	$ 3,227,075	406,391
Less portion representing interest		(106,709)
Total capital lease obligations, including current portion		$ 299,682

Rent expense under all operating leases for 2016, 2015, and 2014 was $563,204, $514,287 and $460,093, respectively. Rent expense is recorded on a straight-line basis over the term of the lease for leases that contain fixed escalation clauses or include abatement provisions. Leasehold improvement incentives are deferred and amortized to rent expense over the term of the lease. The net book value of property and equipment under capital leases was $263,995 and $261,960 at December 31, 2016 and 2015, respectively. Capital lease obligations are included in long-term debt. See Note 14 to these consolidated financial statements.

16. Employee benefit plans

The Company has a savings plan for substantially all of its non-DMG employees which has been established pursuant to the provisions of Section 401(k) of the Internal Revenue Code (IRC). The plan allows for employees to contribute a percentage of their base annual salaries on a tax-deferred basis not to exceed IRC limitations. The Company does not provide any matching contributions for its non-DMG employees.

The Company also has various savings plans covering substantially all of its DMG employees which have been established pursuant to the provisions of Section 401(k) of the IRC. These plans provide for multiple employer matching contributions up to 4% of employee contributions. The Company made matching contributions in 2016, 2015 and 2014 totaling approximately $11,266, $8,324 and $7,400, respectively.

The Company also maintains a voluntary compensation deferral plan, the DaVita Voluntary Deferral Plan. This plan is non-qualified and permits certain employees whose annualized base salary equals or exceeds a minimum annual threshold amount as set by the Company to elect to defer all or a portion of their annual bonus payment and up to 50% of their base salary into a deferral account maintained by the Company. Total contributions to this plan in 2016, 2015 and 2014 were $5,344, $4,234 and $3,772, respectively. Deferred amounts are generally paid out in cash at the participant's election either in the first or second year following retirement or in a specified future period at least three to four years after the deferral election was effective. During 2016, 2015 and 2014 the Company distributed $916, $1,270 and $1,111, respectively, to participants in this plan. Participants are credited with their proportional amount of annual earnings from the plan. The assets of this plan are held in a rabbi trust and as such are subject to the claims of the Company's general creditors in the event of its bankruptcy. As of December 31, 2016 and 2015, the total fair value of assets held in this plan's trust were $30,191 and $23,800, respectively.

The Company also maintains two separate non-qualified voluntary compensation deferral plans for its DMG business, the HealthCare Partners, LLC Deferred Compensation Plan and the HealthCare Partners Medical Group, Inc. Deferred Compensation Plan 2. As of December 31, 2016 and 2015, the total fair value of the assets held in these plans' trusts were $14,036 and $8,578, respectively.

The Company also maintains an Executive Retirement Plan for certain members of management. This plan is non-qualified and contributions to the plan were made at the discretion of DVA Renal Healthcare based upon a pre-determined percentage of a participant's base salary. Effective November 2005, all contributions to this plan were discontinued and the balance of the plan assets will be paid out upon termination or retirement of each individual participant. During 2016 and 2015 the Company distributed $149

and $25, respectively, to participants in this plan. During 2014 the Company did not make any distributions to participants under this plan. As of December 31, 2016 and 2015, the total fair value of assets held under this plan's trust was $1,005 and $1,104, respectively.

The Company also maintains a frozen non-qualified trust-owned life insurance deferred compensation plan, the HealthCare Partners Medical Group, Inc. Deferred Compensation Plan, for certain key employees of DMG. The total cash surrender value of all of the life insurance policies totaled approximately $59,646 and $56,840 at December 31, 2016 and 2015, respectively, and is included in long-term investments. In addition, the total deferred compensation liabilities owed to the participants totaled approximately $54,486 and $52,128 at December 31, 2016 and 2015, respectively, and are included in other long-term liabilities. During 2016, 2015 and 2014, the Company did not make any contributions on behalf of its participants.

The fair value of all of the assets held in plan trusts as of December 31, 2016, and 2015 totaled $45,233 and $33,482, respectively. The assets of these plans are available for sale and as such are recorded at fair market value with changes in the fair market values being recorded in other comprehensive income. Any fair market value changes to the corresponding liability balance are recorded as compensation expense. See Note 9 to these consolidated financial statements.

Most of the Company's outstanding employee stock plan awards include a provision accelerating the vesting of the award in the event of a change of control. The Company also maintains a change of control protection program for its employees who do not have a significant number of stock awards, which has been in place since 2001, and which provides for cash bonuses to employees in the event of a change of control. Based on the market price of the Company's common stock and shares outstanding on December 31, 2016, these cash bonuses would total approximately $492,645 if a change of control transaction occurred at that price and the Company's Board of Directors did not modify the program. This amount has not been accrued at December 31, 2016, and would only be accrued upon a change of control. These change of control provisions may affect the price an acquirer would be willing to pay for the Company.

17. Contingencies

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

The Company operates in a highly regulated industry and is a party to various lawsuits, claims, 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. While these accruals reflect the Company's best estimate of the probable loss for those matters as the dates of those accruals, the recorded amounts may differ materially from the actual amount of the losses for those matters. 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

Vainer Private Civil Suit: As previously disclosed, the Company received a subpoena for documents from the Office of Inspector General (OIG) for the U.S. Department of Health and Human Services (HHS) 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 False Claims Act (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. It is the Company's understanding that this inquiry is civil in nature. The Company understands further that certain other providers that operate dialysis clinics in New York may have received a similar request for documents. 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 U.S. Department of Justice (DOJ), including a settlement payment of an immaterial amount.

Swoben Private Civil Suit: In April 2013, HealthCare Partners (HCP), now known as the Company's DaVita Medical Group (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 program, referred to as HCC and RAF scores. The complaint sought monetary damages and civil penalties as well as costs and expenses. The DOJ reviewed these allegations and in January 2013 declined to intervene in the case. 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.

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 has been advised by an attorney with the United States Attorney's Office for the Central District of California that the qui tam is related to the investigation concerning the medical necessity of patient transportation, which was the basis for the subpoenas. The relator alleges 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 alleges that two of its purported clinical staff caused the submission of a small number of those claims through improper certifications of medical necessity. The Company is investigating these allegations and intends to defend accordingly. The DOJ has declined to intervene.

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 OIG. 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 Medicare Advantage service providers' risk adjustment practices and data, including identification and verification of patient diagnoses and

factors used in making the diagnoses. The subpoena requests documents and information for the period from January 1, 2008 through December 31, 2013, for certain Medicare Advantage plans for which JSA provided services. It also requests information regarding JSA's communications about patient diagnoses as they relate to certain Medicare Advantage plans generally, and more specifically as related to two Florida physicians with whom JSA previously contracted. 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 Medicare Advantage 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 Medicare Advantage 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.

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 alleges 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 the third quarter of 2016 the Company recorded an accrual of a non-material amount for potential damages and liabilities. In January 2017, the Company finalized and executed a settlement agreement with the relator and the government for an immaterial amount.

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. It appears the government is conducting an FCA investigation concerning allegations that DaVita Rx presented or caused to be presented false claims for payment to the government for prescription medications, 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. 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. As of December 31, 2016, the Company recorded estimated accruals totaling $38,330 for potential damages and liabilities associated with write-offs and discounts of patient co-payment obligations, and credits to payors for returns of prescriptions drugs, related to DaVita Rx that were identified during the course of this internal compliance review. Upon completion of its review, the Company filed a self-disclosure with the OIG in early 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 Company may accrue additional reserves for refunds and related damages and potential liabilities arising out of this review. The Company does not

know if the U.S. Attorney's Office, which is part of the DOJ, knew when it served the CID on the Company that it was already in the process of developing a self-disclosure to the OIG. 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 and is producing the requested information.

Solari Post-Acquisition Matter: In 2016, HCP Nevada disclosed to the OIG for the Department of Health and Human Services (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. The Company recorded an estimated accrual of $16,000 for potential damages and liabilities associated with this matter. 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 may accrue additional reserves for potential damages and liabilities related to this matter. 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 intends to cooperate with the government in this investigation.

Although the Company cannot predict whether or when proceedings might be initiated or when these matters may be resolved (other than as 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 of Georgia Securities Laws 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 the Company's 2016 proxy statement 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 January 2017, the Company reached a resolution of its claims with the government for $538,000, which the Company expects to recognize in its first quarter 2017 financial statements.

* * *

Other than as described above, the Company cannot predict the ultimate outcomes of the various legal proceedings and regulatory matters to which the Company is or may be subject from time to time, including those described in this Note 17, 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 or reputation.

18. Noncontrolling interests subject to put provisions and other commitments

Noncontrolling interests subject to put provisions

The Company has potential obligations to purchase the equity interests held by third parties in several of its majority-owned joint ventures and other nonconsolidated entities. These obligations are in the form of put provisions 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 interests obligations may be settled will vary significantly depending upon market conditions including potential purchasers' access to the capital markets, which can impact the level of competition for dialysis and non-dialysis related businesses, the economic performance of these businesses and the restricted marketability of the third-party owners' equity interests. The amount of noncontrolling interests subject to put provisions that employ a contractually predetermined multiple of earnings rather than fair value are immaterial.

Additionally, the Company has certain other potential commitments to provide operating capital to several dialysis centers that are wholly-owned by third parties or centers in which the Company owns a noncontrolling equity interest as well as to physician-owned vascular access clinics or medical practices that the Company operates under management and administrative service agreements of approximately $1,500.

Certain consolidated joint ventures are originally contractually scheduled to dissolve after terms ranging from 10 to 50 years. Accordingly, the noncontrolling interests in these joint ventures are considered mandatorily redeemable instruments, for which the classification and measurement requirements have been indefinitely deferred. Future distributions upon dissolution of these entities would be valued below the related noncontrolling interest carrying balances in the consolidated balance sheet.

Other commitments

In January 2017, the Company entered into a six year Sourcing and Supply Agreement with Amgen USA Inc. (Amgen) that expires on December 31, 2022, replacing the Company's prior agreement that was to expire in 2018. Under terms of the agreement,

the Company will purchase EPO in amounts necessary to meet no less than 90% of its requirements for ESAs from Amgen. The actual amount of EPO that the Company will purchase will depend upon the amount of EPO administered during dialysis as prescribed by physicians and the overall number of patients that the Company serves.

In 2010, the Company entered into an agreement with Fresenius Medical Care (FMC) which committed the Company to purchase a certain amount of dialysis equipment, parts and supplies from FMC through 2013. This agreement has been subsequently extended through December 31, 2017. During 2016, 2015 and 2014, the Company purchased $164,766, $154,566 and $154,266, respectively, of certain equipment, parts and supplies from FMC.

In 2014, the Company entered into an agreement with Baxter Healthcare (Baxter) which committed the Company to purchase a certain amount of its hemodialysis non-equipment product supplies, such as dialyzers, at fixed prices through 2018. During 2016, 2015 and 2014, the Company purchased $162,109, $112,931 and $112,645 of hemodialysis product supplies from Baxter under this agreement.

Certain DMG entities are required to maintain minimum cash balances in order to comply with regulatory requirements in conjunction with medical claim reserves. As of December 31, 2016, this minimum cash balance was approximately $60,796.

Other than operating leases disclosed in Note 15 to the consolidated financial statements, the letters of credit disclosed in Note 14 to the consolidated financial statements, and the arrangements as described above, the Company has no off balance sheet financing arrangements as of December 31, 2016.

19. Long-term incentive compensation and shareholders' equity

Long-term incentive compensation

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

Stock-based compensation to be settled in shares is recorded to the Company's shareholders' equity, while stock-based compensation to be settled in cash is recorded to a liability. Shares issued upon exercise of stock awards have generally been issued from treasury shares.

Long-term incentive compensation plans

The Company's 2011 Incentive Award Plan (the 2011 Plan) is the Company's omnibus equity compensation plan and provides for grants of stock-based awards to employees, directors and other individuals providing services to the Company, except that incentive stock options may only be awarded to employees. The 2011 Plan authorizes the Company to award stock options, stock appreciation rights, restricted stock units, restricted stock, and other stock-based or performance-based awards, and is designed to enable the Company to grant equity and cash awards that qualify as performance-based compensation under Section 162(m) of the Internal Revenue Code. The 2011 Plan mandates a maximum award term of five years and stipulates that stock appreciation rights and stock options be granted with prices not less than fair market value on the date of grant. The 2011 Plan also requires that full value share awards such as restricted stock units reduce shares available under the 2011 Plan at a ratio of 3.5:1. The Company's nonqualified stock appreciation rights and stock units awarded under the 2011 Plan generally vest over 36 to 48 months from the date of grant. At December 31, 2016, there were 7,337,266 stock-settled stock appreciation rights, 785,553 stock-settled stock units, 33,000 cash-settled stock appreciation rights and 1,600 cash-settled stock units outstanding, and 30,543,883 shares available for future grants, under the 2011 Plan.

(dollars in thousands, except per share data)

A combined summary of the status of the Company's stock-settled awards under the 2011 Plan, including base shares for stock-settled stock appreciation rights and stock-settled stock unit awards is as follows:

	Year ended December 31, 2016				
	Stock appreciation rights			Stock units	
	Awards	Weighted average exercise price	Weighted average remaining contractual life	Awards	Weighted average remaining contractual life
Outstanding at beginning of year	8,533,561	$ 59.05		765,060	
Granted	1,280,034	73.40		328,457	
Exercised	(2,031,593)	45.35		(280,197)	
Cancelled	(444,736)	66.50		(27,767)	
Outstanding at end of period	7,337,266	$ 64.90	2.2	785,553	1.9
Exercisable at end of period	3,026,721	$ 56.83	1.1	—	—
Weighted-average fair value of grants in 2016	$ 13.74			$ 70.99	
Weighted-average fair value of grants in 2015	$ 17.97			$ 80.25	
Weighted-average fair value of grants in 2014	$ 16.41			$ 72.24	

Range of SSAR base prices	Awards outstanding	Weighted average exercise price	Awards exercisable	Weighted average exercise price
$30.01–$40.00	16,000	39.89	16,000	39.89
$40.01–$50.00	267,621	44.44	267,621	44.44
$50.01–$60.00	3,489,398	57.53	2,420,035	56.84
$60.01–$70.00	1,306,049	67.46	232,816	65.04
$70.01–$80.00	1,581,487	74.76	50,806	70.44
$80.01–$90.00	676,711	83.60	39,443	81.51
Total	7,337,266	$ 64.90	3,026,721	$ 56.83

The Company granted 9,600 cash-settled stock-based awards during 2016. Liability-classified awards contributed $376, $(236) and $1,774 to stock-based compensation expense for the years ended December 31, 2016, 2015 and 2014, respectively. As of December 31, 2016 the Company had 34,600 liability-classified stock-based awards outstanding, 5,000 of which were vested, and a total stock-based compensation liability balance of $124.

For the years ended December 31, 2016, 2015, and 2014, the aggregate intrinsic value of stock-based awards exercised was $73,001, $116,933 and $151,342, respectively. At December 31, 2016, the aggregate intrinsic value of stock awards outstanding was $79,717 and the aggregate intrinsic value of stock awards exercisable was $23,566.

Estimated fair value of stock-based compensation awards

The Company has estimated the grant-date fair value of stock-settled stock appreciation rights awards using the Black-Scholes-Merton valuation model and stock-settled stock unit awards at intrinsic value on the date of grant, except for portions of the Company's performance stock unit awards for which a Monte Carlo simulation was used to estimate the grant-date fair value. The following assumptions were used in estimating these values and determining the related stock-based compensation attributable to the current period:

Expected term of the awards: The expected term of awards granted represents the period of time that they are expected to remain outstanding from the date of grant. The Company determines the expected term of its stock awards based on its historical experience with similar awards, considering the Company's historical exercise and post-vesting termination patterns, and the terms expected by peer companies in near industries.

Expected volatility: Expected volatility represents the volatility anticipated over the expected term of the award. The Company determines the expected volatility for its awards based on the volatility of the price of its common stock over the most recent

(dollars in thousands, except per share data)

retrospective period commensurate with the expected term of the award, considering the volatility expectations implied by the market price of its exchange-traded options and the volatilities expected by peer companies in near industries.

Expected dividend yield: The Company has not paid dividends on its common stock and does not currently expect to pay dividends during the term of stock awards granted.

Risk-free interest rate: The Company bases the expected risk-free interest rate on the implied yield currently available on stripped interest coupons of U.S. Treasury issues with a remaining term equivalent to the expected term of the award.

A summary of the weighted average valuation inputs described above used for estimating the grant-date fair value of stock-settled stock appreciation rights awards granted in the periods indicated is as follows:

	Year ended December 31,		
	2016	2015	2014
Expected term	4.2 years	4.1 years	4.2 years
Expected volatility	21.0%	24.6%	25.8%
Expected dividend yield	0.0%	0.0%	0.0%
Risk-free interest rate	1.0%	1.5%	1.5%

The Company estimates expected forfeitures based upon historical experience with separate groups of employees that have exhibited similar forfeiture behavior in the past. Stock-based compensation expense is recorded only for awards that are expected to vest.

Employee stock purchase plan

The Employee Stock Purchase Plan entitles qualifying employees to purchase up to $25 of the Company's common stock during each calendar year. The amounts used to purchase stock are accumulated through payroll withholdings or through optional lump sum payments made in advance of the first day of the purchase right period. This compensatory plan allows employees to purchase stock for the lesser of 100% of the fair market value on the first day of the purchase right period or 85% of the fair market value on the last day of the purchase right period. Purchase right periods begin on January 1 and July 1, and end on December 31. Contributions used to purchase the Company's common stock under this plan for the 2016, 2015 and 2014 participation periods were $23,902, $24,523 and $19,010, respectively. Shares purchased pursuant to the plan's 2016, 2015 and 2014 participation periods were 438,002, 413,859 and 297,954, respectively. At December 31, 2016, there were 7,484,395 shares remaining available for future grants under this plan, which includes an additional 7,500,000 shares approved by stockholders on June 20, 2016.

The fair value of employees' purchase rights was estimated as of the beginning dates of the purchase right periods using the Black-Scholes-Merton valuation model with the following weighted average assumptions for purchase right periods in 2016, 2015 and 2014, respectively: expected volatility of 22%, 26% and 27%; risk-free interest rate of 0.8%, 0.2% and 0.2%, and no dividends. Using these assumptions, the weighted average estimated fair value of these purchase rights was $16.73, $18.76 and $16.40 for 2016, 2015 and 2014, respectively.

Long-term incentive compensation expense and proceeds

For the years ended December 31, 2016, 2015 and 2014, the Company recognized $73,337, $130,682 and $118,970, respectively, in total long-term incentive program (LTIP) expense, of which $38,338, $56,664 and $56,743, respectively, was stock-based compensation expense for stock appreciation rights, stock units and discounted employee stock plan purchases, which are primarily included in general and administrative expenses. The estimated tax benefits recorded for stock-based compensation in 2016, 2015 and 2014 were $12,731, $19,689 and $20,351, respectively. As of December 31, 2016, there was $92,987 total estimated unrecognized compensation cost for outstanding LTIP awards, including $59,016 related to stock-based compensation arrangements under the Company's equity compensation and stock purchase plans. The Company expects to recognize the performance-based cash component of these LTIP costs over a weighted average remaining period of 1.0 year and the stock-based component of these LTIP costs over a weighted average remaining period of 1.4 years.

For the years ended December 31, 2016, 2015 and 2014, the Company received $28,397, $45,749 and $59,119, respectively, in actual tax benefits upon the exercise of stock awards. Since the Company issues stock-settled stock appreciation rights rather than stock options, it does not receive cash proceeds from stock option exercises.

(dollars in thousands, except per share data)

Stock repurchases

During the years ended December 31, 2016 and 2015, the Company repurchased a total of 16,649,090 shares and 7,779,958 shares of its common stock for $1,072,377 and $575,380, or an average price of $64.41 and $73.96 per share, respectively, pursuant to previously announced authorizations by the Board of Directors. The Company has not repurchased any additional shares of its common stock from January 1, 2017 through February 24, 2017.

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 is 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 December 31, 2016, there was $677,104 available under the current Board authorizations for additional share repurchases. Although these share repurchase authorizations have no 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.

Charter documents & Delaware law

The Company's charter documents include provisions that may deter hostile takeovers, delay or prevent changes of control or changes in management, or limit the ability of stockholders to approve transactions that they may otherwise determine to be in their best interests. These include provisions prohibiting stockholders from acting by written consent, requiring 90 days advance notice of stockholder proposals or nominations to the Board of Directors and granting the Board of Directors the authority to issue up to five million shares of preferred stock and to determine the rights and preferences of the preferred stock without the need for further stockholder approval.

The Company is also subject to Section 203 of the Delaware General Corporation Law which, subject to exceptions, would prohibit the Company 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 restrictions may discourage, delay or prevent a change in the control of the Company.

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:

	Year ended December 31,		
	2016	2015	2014
Net income attributable to DaVita Inc.	$ 879,874	$ 269,732	$ 723,114
Increase in paid-in capital for sales of noncontrolling interest	—	—	355
Decrease in paid-in capital for the purchase of noncontrolling interests	(13,105)	(55,826)	(5,357)
Net transfer to noncontrolling interests	(13,105)	(55,826)	(5,002)
Change from net income attributable to DaVita Inc. and transfers to noncontrolling interests	$ 866,769	$ 213,906	$ 718,112

The Company acquired additional ownership interests in several existing majority-owned joint ventures for $21,512 in 2016 and $66,382 in 2015 in cash, and $17,876 in cash and deferred purchase price of $136 in 2014.

(dollars in thousands, except per share data)

20. Other comprehensive (loss) income

Charges and credits to other comprehensive (loss) income have been as follows:

	Interest rate swap and cap agreements	Investment securities	Foreign currency translation adjustments	Accumulated other comprehensive income (loss)
Balance at December 31, 2013	$ (2,344)	$ 3,120	$ (3,421)	$ (2,645)
Unrealized (losses) gains	(16,509)	425	(22,952)	(39,036)
Related income tax	6,450	(187)	—	6,263
	(10,059)	238	(22,952)	(32,773)
Reclassification from accumulated other comprehensive losses (income) into net income	17,409	(340)	—	17,069
Related income tax	(6,801)	133	—	(6,668)
	10,608	(207)	—	10,401
Balance at December 31, 2014	$ (1,795)	$ 3,151	$ (26,373)	$ (25,017)
Unrealized losses	(20,085)	(1,974)	(23,889)	(45,948)
Related income tax	7,844	561	—	8,405
	(12,241)	(1,413)	(23,889)	(37,543)
Reclassification from accumulated other comprehensive losses (income) into net income	5,103	(618)	—	4,485
Related income tax	(1,992)	241	—	(1,751)
	3,111	(377)	—	2,734
Balance at December 31, 2015	$ (10,925)	$ 1,361	$ (50,262)	$ (59,826)
Unrealized (losses) gains	(6,013)	1,802	(39,614)	(43,825)
Related income tax	2,343	(565)	—	1,778
	(3,670)	1,237	(39,614)	(42,047)
Reclassification from accumulated other comprehensive losses (income) into net income	4,198	(690)	10,087	13,595
Related income tax	(1,632)	267	—	(1,365)
	2,566	(423)	10,087	12,230
Balance at December 31, 2016	$ (12,029)	$ 2,175	$ (79,789)	$ (89,643)

The reclassification of net swap and cap realized losses into income are recorded as debt expense in the corresponding consolidated statements of income. See Note 14 to these 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 9 to these consolidated financial statements for further details.

21. Acquisitions and divestitures

Change in ownership interests in Asia Pacific joint venture

On August 1, 2016, the Company consummated an agreement with Khazanah Nasional Berhad (Khazanah) and Mitsui and Co., Ltd (Mitsui) whereby Khazanah and Mitsui subscribed to invest a total of $300,000 over three years in exchange for a 40% total equity interest in the Company's APAC JV. Khazanah and Mitsui each made related initial investments of $50,000 in this business on August 1, 2016.

Based on the governance structure and voting rights put in place upon the formation of the APAC JV, certain key decisions affecting the JV's operations are no longer at the unilateral discretion of the Company, but rather are shared with the noncontrolling investors. As a result, the Company deconsolidated its Asia Pacific dialysis business in the third quarter and recognized a non-cash non-taxable gain of $374,374 on its retained investment, net of contingent obligations. This retained interest was adjusted to the Company's proportionate share of the estimated fair value of the business, as implied by the Khazanah and

(dollars in thousands, except per share data)

Mitsui investment and adjusted for certain time value of money and uncertainty discounts. Subsequent to the deconsolidation, the Company's retained interest in the APAC JV is accounted for under the equity method.

The calculation of the Company's non-cash gain on its retained investment in the APAC JV is based upon the best information available to management and will be finalized when certain information arranged to be obtained has been received, including issuance of the final valuation report by an independent third party and certain post-closing adjustments subject to audit of the APAC JV's financial statements.

Sales of Tandigm Health and DMG Arizona ownership interests

Effective June 30, 2016, the Company sold a portion of DMG's ownership interest in the Tandigm Health (Tandigm) joint venture, reducing its ownership from fifty percent to nineteen percent and resulting in a gain of $40,280. In addition, on June 1, 2016, the Company sold its DMG Arizona business, resulting in a loss of $10,489.

Acquisition of TEC

On March 1, 2016, the Company completed its acquisition of The Everett Clinic (TEC) pursuant to an agreement and plan of merger dated November 23, 2015, whereby TEC became a 100% consolidated subsidiary of DMG. TEC has 500 providers in primary and specialty care locations throughout Snohomish County, Washington who care for more than 315,000 patients. The total consideration paid at closing for all outstanding common units of TEC was approximately $393,687, net of cash acquired, plus the assumption of certain liabilities totaling approximately $7,284.

The initial purchase price allocation for the acquisition of TEC 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. The fair values of property and equipment and intangible assets were valued by an independent third party and are pending issuance of the final valuation report. Certain income tax amounts are pending issuance of final tax returns.

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

Current assets, net of cash acquired	$	91,591
Property and equipment		108,533
Covenant not-to-compete		3,200
Amortizable intangible and other long-term assets		30,850
Goodwill		244,502
Liabilities assumed		(50,940)
Long-term deferred income taxes		(16,880)
Noncontrolling interests		(9,885)
	$	400,971

Amortizable intangible assets acquired in this acquisition have a weighted average estimated useful life of six years. None of the goodwill recognized in this acquisition is expected to be deductible for tax purposes.

The noncontrolling interests assumed as part of the acquisition are stated at estimated fair value based on the estimated fair value of the underlying assets and liabilities of each non-wholly-owned entity.

The operating results of TEC are included in the Company's consolidated financial statements from March 1, 2016.

Other routine acquisitions

During 2016, the Company acquired eight dialysis centers in the U.S., 21 dialysis centers outside the U.S., and other medical businesses for a total of $170,169 in net cash, earn-outs of $1,511, and deferred purchase price and liabilities assumed of $18,373. During 2015, the Company acquired dialysis-related and other ancillary businesses consisting of six dialysis centers in the U.S., 21 dialysis centers outside the U.S., three vascular access centers, and other medical businesses for a total of $96,469 in net cash and deferred purchase price and earn-outs of $8,395. During 2014, the Company acquired dialysis-related and other ancillary businesses consisting of 18 dialysis centers in the U.S., seven dialysis centers outside the U.S. and other medical businesses for a total of $272,094 in net cash and deferred purchase price of $23,781. The assets and liabilities for all acquisitions were recorded at their

(dollars in thousands, except per share data)

estimated fair values at the dates of the acquisitions and are included in the Company's financial statements and operating results from the effective dates of the acquisitions. For several of the 2016 acquisitions, certain income tax amounts are pending final evaluation and quantification of any pre-acquisition tax contingencies. In addition, valuation of medical claims liabilities and certain other working capital items relating to several of these acquisitions are pending final quantification.

The following table summarizes the assets acquired and liabilities assumed in the above described transactions and recognized at their acquisition dates at estimated fair values, as well as the estimated fair value of the noncontrolling interests assumed in these transactions:

	Year ended December 31,		
	2016	2015	2014
Current assets	$ 3,996	$ 3,843	$ 915
Property and equipment	9,407	12,436	5,999
Customer relationships	—	—	74,515
Non-compete agreements	5,395	8,959	16,585
Amortizable intangible and other long-term assets	986	4,345	4,193
Goodwill	203,326	97,093	221,514
Long-term deferred income taxes	597	(1,467)	—
Noncontrolling interests assumed	(30,337)	(18,905)	(25,963)
Liabilities assumed	(3,317)	(1,440)	(1,883)
Aggregate purchase cost	$ 190,053	$ 104,864	$ 295,875

Amortizable intangible assets acquired during 2016, 2015 and 2014 had weighted-average estimated useful lives of seven, eight and ten years, respectively. The majority of the intangible assets acquired relate to non-compete agreements and customer relationships. The weighted-average amortization period for customer relationships was ten years for 2014. The weighted-average amortization period for non-compete agreements was seven years for 2016, and eight years for both 2015 and 2014. The total amount of goodwill deductible for tax purposes associated with these acquisitions for 2016, 2015, and 2014 was approximately $173,718, $73,733 and $175,247, respectively.

Other pending transactions

On August 9, 2016, the Company entered into an amendment to its agreement to acquire Colorado-based Renal Ventures Limited, LLC (Renal Ventures). As a result of the amended agreement, the Company will acquire a 100 percent interest in all 38 outpatient dialysis centers owned by Renal Ventures, including one new center under construction, and a fifty-one percent interest in one vascular access clinic. The purchase price will be approximately $360,000 in cash, subject to, among other things, adjustments for certain items such as working capital. The transaction is subject to approval by the Federal Trade Commission (FTC), including Hart-Scott-Rodino antitrust clearance. The Company anticipates that it will be required by the FTC to divest some outpatient dialysis centers as a condition of the transaction. The Company expects the transaction to close in mid 2017.

Pro forma financial information (unaudited)

The following summary, prepared on a pro forma basis, combines the results of operations as if all acquisitions in 2016 and 2015 had been consummated as of the beginning of 2015, including the impact of certain adjustments such as amortization of intangibles, interest expense on acquisition financing and income tax effects.

	Year ended December 31,	
	2016	2015
	(unaudited)	
Pro forma net revenues	$ 14,875,592	$ 14,342,138
Pro forma net income attributable to DaVita Inc.	884,284	280,124
Pro forma basic net income per share attributable to DaVita Inc.	4.39	1.32
Pro forma diluted net income per share attributable to DaVita Inc.	4.32	1.30

(dollars in thousands, except per share data)

Contingent earn-out obligations

The Company has several contingent earn-out obligations associated with acquisitions that could result in the Company paying the former shareholders of acquired companies a total of up to approximately $19,557 if certain EBITDA, operating income performance targets or quality margins are met over the next one to eight years.

Contingent earn-out obligations are remeasured to fair value at each reporting date until the contingencies are resolved with changes in the liability due to the remeasurement recorded in earnings. See Note 24 to these consolidated financial statements for further details. As of December 31, 2016, the Company has estimated the fair value of these contingent earn-out obligations to be $9,977, of which a total of $7,217 is included in other liabilities and the remaining $2,760 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 year ended December 31, 2016:

Beginning balance January 1, 2016	$	34,135
Contingent earn-out obligations associated with acquisitions		1,511
Remeasurement of fair value		(4,132)
Payments of contingent earn-out obligations		(21,537)
	$	9,977

22. Variable interest entities

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

Under U.S. GAAP, 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 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 the entities to accomplish their operational and strategic objectives. A number of these entities are subject to nominee share ownership or share transfer restriction agreements that effectively transfer the majority of the economic risks and rewards of their ownership to the Company. In other cases the Company's management agreements with these entities include both financial terms and protective and participating rights to the entities' operating, strategic and non-clinical governance 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 its related party nominee owners that effectively indemnify these parties from the economic losses from, or entitle the Company to the economic benefits of, these entities.

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 December 31, 2016, these consolidated financial statements include total assets of VIEs of $747,574 and total liabilities and noncontrolling interests of VIEs to third parties of $425,034.

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 related liabilities recorded in accrued compensation and benefits and other long-term liabilities. See Note 16 to these consolidated financial statements for disclosures on the assets of these consolidated non-qualified deferred compensation plans.

(dollars in thousands, except per share data)

23. Concentrations

Approximately 64%, 66% and 67% of total U.S. dialysis services revenues in 2016, 2015 and 2014, respectively, are from government-based programs, principally Medicare and Medicaid. Related net accounts receivable and other receivables from Medicare, including Medicare-assigned plans, and Medicaid, including Medicaid-assigned plans, were approximately $831,445 and $830,060, as of December 31, 2016 and 2015, respectively.

Approximately 72%, 70% and 71% of DMG's revenues in 2016, 2015 and 2014, respectively, are from government-based programs, principally Medicare and Medicaid. Approximately 63%, 61% and 64% for 2016, 2015 and 2014, respectively, of DMG's capitated medical revenues are associated with three health plans. In addition, approximately $289,798 and $231,278 at December 31, 2016 and 2015, respectively, of DMG's capitated accounts receivables are associated with three health plans.

One commercial payor, Humana, accounted for approximately 11% of total consolidated net revenues.

There is no single commercial payor that accounted for more than 10% of total consolidated accounts receivable at December 31, 2016 and 2015.

24. Fair values of financial instruments

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

The following tables summarize the Company's assets, liabilities and temporary equity measured at fair value on a recurring basis as of December 31, 2016 and 2015:

	Total	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
December 31, 2016				
Assets				
Available for sale securities	$ 47,404	$ 47,404	$ —	$ —
Cash surrender value of life insurance policies	$ 59,646	$ —	$ 59,646	$ —
Interest rate cap agreements	$ 9,929	$ —	$ 9,929	$ —
Funds on deposit with third parties	$ 75,877	$ 75,877	$ —	$ —
Liabilities				
Contingent earn-out obligations	$ 9,977	$ —	$ —	$ 9,977
Temporary equity				
Noncontrolling interests subject to put provisions	$ 973,258	$ —	$ —	$ 973,258
December 31, 2015				
Assets				
Available for sale securities	$ 33,482	$ 33,482	$ —	$ —
Cash surrender value of life insurance policies	$ 56,840	$ —	$ 56,840	$ —
Interest rate cap agreements	$ 15,127	$ —	$ 15,127	$ —
Interest rate swap agreements	$ 516	$ —	$ 516	$ —
Funds on deposit with third parties	$ 82,679	$ 82,679	$ —	$ —
Liabilities				
Contingent earn-out obligations	$ 34,135	$ —	$ —	$ 34,135
Temporary equity				
Noncontrolling interests subject to put provisions	$ 864,066	$ —	$ —	$ 864,066

Available for sale securities represent investments in various open-ended registered investment companies, or mutual funds, and are recorded at fair value estimated based upon quoted prices reported by each mutual fund. See Note 9 to these 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 16 to these consolidated financial statements for further discussion.

The interest rate swap and cap agreements are recorded at fair value based upon valuation models utilizing the income approach and commonly accepted valuation techniques that use inputs from closing prices for similar assets and liabilities in active markets as well as other relevant observable market inputs at quoted intervals such as current interest rates, forward yield curves, implied volatility and credit default swap pricing. The Company does not believe the ultimate amount that could be realized upon settlement of these interest rate swap and cap agreements would be materially different from the fair values currently reported. See Note 14 to these consolidated financial statements for further discussion.

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

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

See Note 18 to these 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 consolidated financial statements at December 31, 2016 and 2015 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 $4,217,348 as of December 31, 2016, and the fair value was approximately $4,336,969 based upon quoted market prices. The fair value of the Company's Senior Notes was approximately $4,530,875 at December 31, 2016 based upon quoted market prices, as compared to the carrying amount of $4,500,000.

25. Segment reporting

The Company operates two major divisions, DaVita Kidney Care (Kidney Care) and DaVita Medical Group (DMG). The Kidney Care division is comprised of the Company's U.S. dialysis and related lab services business, various 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 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 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 health operations in the European and Middle Eastern, Latin American, and Asian 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 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 all of the Company's various operating lines of business. These corporate administrative support costs are reduced by internal management fees received from the Company's ancillary lines of business and were increased by the reduction of a tax asset associated with the DMG acquisition escrow provisions.

(dollars in thousands, except per share data)

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

	Year ended December 31,		
	2016	2015	2014
Segment revenues:			
U.S. dialysis and related lab services			
Patient service revenues:			
External sources	$ 9,482,648	$ 8,980,515	$ 8,513,089
Intersegment revenues	68,774	53,476	37,112
Total dialysis and related lab services revenues	9,551,422	9,033,991	8,550,201
Less: Provision for uncollectible accounts	(429,882)	(406,530)	(353,028)
Net dialysis and related lab services patient service revenues	9,121,540	8,627,461	8,197,173
Other revenues(1)	16,649	13,971	13,498
Total net dialysis and related lab services revenues	9,138,189	8,641,432	8,210,671
DMG			
DMG revenues:			
Capitated revenues	$ 3,430,576	$ 3,436,705	$ 3,190,903
Net patient service revenues	621,583	317,950	219,306
Other revenues(2)	61,040	82,470	91,374
Intersegment capitated and other revenues	215	136	716
Total revenues	$ 4,113,414	$ 3,837,261	$ 3,502,299
Other - Ancillary services and strategic initiatives			
Net patient service revenues	$ 228,459	$ 160,484	$ 122,087
Capitated revenues	88,103	72,390	70,385
Other external sources	1,245,929	1,123,882	927,492
Intersegment revenues	58,881	25,674	19,535
Total ancillary services and strategic initiatives revenues	1,621,372	1,382,430	1,139,499
Total net segment revenues	14,872,975	13,861,123	12,852,469
Elimination of intersegment revenues	(127,870)	(79,286)	(57,363)
Consolidated net revenues	$ 14,745,105	$ 13,781,837	$ 12,795,106
Segment operating margin (loss):			
U.S. dialysis and related lab services	$ 1,777,014	$ 1,259,632	$ 1,637,626
DMG	(104,233)	33,929	214,983
Other—Ancillary services and strategic initiatives	266,323	(103,901)	(24,456)
Total segment margin	1,939,104	1,189,660	1,828,153
Reconciliation of segment operating margin to consolidated income from continuing operations before income taxes:			
Corporate administrative support(3)	(44,561)	(18,965)	(13,012)
Consolidated operating income	1,894,543	1,170,695	1,815,141
Debt expense	(414,382)	(408,380)	(410,294)
Debt refinancing and redemption charges	—	(48,072)	(97,548)
Other income	8,734	8,893	2,374
Consolidated income from continuing operations before income taxes	$ 1,488,895	$ 723,136	$ 1,309,673

(1) Includes management fees for providing management and administrative services to dialysis centers in which the Company owns a noncontrolling interest or which are wholly-owned by third parties.

(2) Includes medical consulting service fees and management fees for providing management and administrative services to unconsolidated joint ventures, as well as revenue related to the maintenance of existing physician networks.

(3) Corporate administrative support costs in 2016 also include $30,934 of an adjustment to reduce a tax asset associated with the DMG acquisition escrow provisions.

(dollars in thousands, except per share data)

Depreciation and amortization expense by segment is as follows:

	December 31,		
	2016	2015	2014
U.S. dialysis and related lab services	$ 482,768	$ 438,238	$ 402,767
DMG	210,755	174,118	169,485
Other - Ancillary services and strategic initiatives	26,729	25,668	18,683
	$ 720,252	$ 638,024	$ 590,935

Summary of assets by segment is as follows:

	December 31,	
	2016	2015
Segment assets		
U.S. dialysis and related lab services (including equity investments of $66,924 and $29,801, respectively)	$ 11,438,100	$ 11,591,507
DMG (including equity investments of $10,350 and $22,714, respectively)	6,213,091	6,150,666
Other - Ancillary services and strategic initiatives(1) (including equity investments of $425,115 and $20,853, respectively)	1,090,066	772,702
Consolidated assets	$ 18,741,257	$ 18,514,875

(1) Includes approximately $96,396 and $ 69,519 in 2016 and 2015, respectively, of net property and equipment related to the Company's international operations.

Expenditures for property and equipment by segment is as follows:

	December 31,		
	2016	2015	2014
U.S. dialysis and related lab services	$ 675,994	$ 584,513	$ 560,610
DMG	84,399	66,800	27,885
Other - Ancillary services and strategic initiatives	68,702	56,685	52,835
	$ 829,095	$ 707,998	$ 641,330

26. Supplemental cash flow information

The table below provides supplemental cash flow information:

	Year ended December 31,		
	2016	2015	2014
Cash paid:			
Income taxes	$ 339,411	$ 156,075	$ 238,615
Interest	406,987	405,120	351,967
Non-cash investing and financing activities:			
Fixed assets under capital lease obligations	28,127	74,035	72,389

(dollars in thousands, except per share data)

27. Selected quarterly financial data (unaudited)

	2016				2015			
	December 31	September 30	June 30	March 31	December 31	September 30	June 30	March 31
Net revenues	$ 3,715,742	$ 3,730,576	$ 3,717,651	$ 3,581,136	$ 3,533,589	$ 3,525,665	$ 3,434,618	$ 3,287,965
Operating income (loss)	$ 381,428	$ 819,156	$ 329,070	$ 364,889	$ 244,935	$ 509,368	$ 480,548	$ (64,156)
Income (loss) before income taxes	$ 278,072	$ 716,451	$ 229,391	$ 264,981	$ 146,307	$ 408,371	$ 330,539	$ (162,081)
Net income (loss) attributable to DaVita Inc.	$ 157,726	$ 571,332	$ 53,382	$ 97,434	$ (6,000)	$ 215,872	$ 170,477	$ (110,617)
Basic net income (loss) per share attributable to DaVita Inc.	$ 0.81	$ 2.80	$ 0.26	$ 0.48	$ (0.03)	$ 1.02	$ 0.80	$ (0.52)
Diluted net income (loss) per share attributable to DaVita Inc.	$ 0.80	$ 2.76	$ 0.26	$ 0.47	$ (0.03)	$ 1.00	$ 0.78	$ (0.52)

28. Consolidating financial statements

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

Consolidating Statements of Income

	DaVita Inc.	Guarantor Subsidiaries	Non-Guarantor Subsidiaries	Consolidating Adjustments	Consolidated Total
For the twelve months ended December 31, 2016					
Patient services revenues	$ —	$ 6,766,138	$ 3,761,590	$ (173,567)	$ 10,354,161
Less: Provision for uncollectible accounts	—	(278,761)	(172,592)	—	(451,353)
Net patient service revenues	—	6,487,377	3,588,998	(173,567)	9,902,808
Capitated revenues	—	1,795,673	1,723,279	(273)	3,518,679
Other revenues	767,791	2,089,749	125,203	(1,659,125)	1,323,618
Total net revenues	767,791	10,372,799	5,437,480	(1,832,965)	14,745,105
Operating expenses and charges	524,108	9,735,334	4,424,085	(1,832,965)	12,850,562
Operating income	243,683	637,465	1,013,395	—	1,894,543
Debt expense	(407,925)	(358,535)	(50,710)	402,788	(414,382)
Other income, net	396,797	6,196	8,529	(402,788)	8,734
Income tax expense	79,301	210,338	166,174	—	455,813
Equity earnings in subsidiaries	726,620	651,832	—	(1,378,452)	—
Net income	879,874	726,620	805,040	(1,378,452)	1,033,082
Less: Net income attributable to noncontrolling interests	—	—	—	(153,208)	(153,208)
Net income attributable to DaVita Inc.	$ 879,874	$ 726,620	$ 805,040	$ (1,531,660)	$ 879,874

(dollars in thousands, except per share data)

Consolidating Statements of Income

	DaVita Inc.	Guarantor Subsidiaries	Non-Guarantor Subsidiaries	Consolidating Adjustments	Consolidated Total
For twelve months ended December 31, 2015					
Patient services revenues	$ —	$ 6,578,185	$ 3,047,048	$ (144,954)	$ 9,480,279
Less: Provision for uncollectible accounts	—	(285,454)	(142,406)	—	(427,860)
Net patient service revenues	—	6,292,731	2,904,642	(144,954)	9,052,419
Capitated revenues	—	1,776,311	1,733,027	(243)	3,509,095
Other revenues	727,887	1,875,133	32,137	(1,414,834)	1,220,323
Total net revenues	727,887	9,944,175	4,669,806	(1,560,031)	13,781,837
Operating expenses and charges	488,595	9,565,667	4,116,911	(1,560,031)	12,611,142
Operating income	239,292	378,508	552,895	—	1,170,695
Debt (expense) and refinancing charges	(449,598)	(340,176)	(42,500)	375,822	(456,452)
Other income, net	365,752	11,562	7,401	(375,822)	8,893
Income tax expense	81,221	173,063	41,442	—	295,726
Equity earnings in subsidiaries	195,507	318,676	—	(514,183)	—
Net income	269,732	195,507	476,354	(514,183)	427,410
Less: Net income attributable to noncontrolling interests	—	—	—	(157,678)	(157,678)
Net income attributable to DaVita Inc.	$ 269,732	$ 195,507	$ 476,354	$ (671,861)	$ 269,732
For the year ended December 31, 2014					
Patient services revenues	$ —	$ 6,246,683	$ 2,739,204	$ (117,549)	$ 8,868,338
Less: Provision for uncollectible accounts	—	(238,600)	(128,284)	—	(366,884)
Net patient service revenues	—	6,008,083	2,610,920	(117,549)	8,501,454
Capitated revenues	—	1,681,668	1,579,804	(184)	3,261,288
Other revenues	684,066	1,639,828	24,155	(1,315,685)	1,032,364
Total net revenues	684,066	9,329,579	4,214,879	(1,433,418)	12,795,106
Operating expenses and charges	443,951	8,269,025	3,700,407	(1,433,418)	10,979,965
Operating income	240,115	1,060,554	514,472	—	1,815,141
Debt (expense) and refinancing charges	(502,762)	(363,623)	(43,449)	401,992	(507,842)
Other income, net	385,532	11,731	7,103	(401,992)	2,374
Income tax expense	46,856	397,268	2,219	—	446,343
Equity earnings in subsidiaries	647,085	335,691	—	(982,776)	—
Net income	723,114	647,085	475,907	(982,776)	863,330
Less: Net income attributable to noncontrolling interests	—	—	—	(140,216)	(140,216)
Net income attributable to DaVita Inc.	$ 723,114	$ 647,085	$ 475,907	$ (1,122,992)	$ 723,114

(dollars in thousands, except per share data)

Consolidating Statements of Comprehensive Income

	DaVita Inc.	Guarantor Subsidiaries	Non-Guarantor Subsidiaries	Consolidating Adjustments	Consolidated Total
For the year ended December 31, 2016					
Net income	$ 879,874	$ 726,620	$ 805,040	$ (1,378,452)	$ 1,033,082
Other comprehensive loss	(290)	—	(29,337)	—	(29,627)
Total comprehensive income	879,584	726,620	775,703	(1,378,452)	1,003,455
Less: Comprehensive income attributable to noncontrolling interest	—	—	—	(153,398)	(153,398)
Comprehensive income attributable to DaVita Inc.	$ 879,584	$ 726,620	$ 775,703	$ (1,531,850)	$ 850,057
For the year ended December 31, 2015					
Net income	$ 269,732	$ 195,507	$ 476,354	$ (514,183)	$ 427,410
Other comprehensive loss	(10,920)	—	(23,889)	—	(34,809)
Total comprehensive income	258,812	195,507	452,465	(514,183)	392,601
Less: Comprehensive income attributable to noncontrolling interest	—	—	—	(157,678)	(157,678)
Comprehensive income attributable to DaVita Inc.	$ 258,812	$ 195,507	$ 452,465	$ (671,861)	$ 234,923
For the year ended December 31, 2014					
Net income	$ 723,114	$ 647,085	$ 475,907	$ (982,776)	$ 863,330
Other comprehensive income (losses)	580	—	(22,952)	—	(22,372)
Total comprehensive income	723,694	647,085	452,955	(982,776)	840,958
Less: Comprehensive income attributable to noncontrolling interest	—	—	—	(140,216)	(140,216)
Comprehensive income attributable to DaVita Inc.	$ 723,694	$ 647,085	$ 452,955	$ (1,122,992)	$ 700,742

(dollars in thousands, except per share data)

Consolidating Balance Sheets

	DaVita Inc.	Guarantor Subsidiaries	Non-Guarantor Subsidiaries	Consolidating Adjustments	Consolidated Total
As of December 31, 2016					
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. shareholders' 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
As of December 31, 2015					
Cash and cash equivalents	$ 1,186,636	$ 109,357	$ 203,123	$ —	$ 1,499,116
Accounts receivable, net	—	929,390	794,838	—	1,724,228
Other current assets	431,504	769,947	78,485	—	1,279,936
Total current assets	1,618,140	1,808,694	1,076,446	—	4,503,280
Property and equipment, net	268,066	1,575,890	944,784	—	2,788,740
Intangible assets, net	540	1,634,920	51,866	—	1,687,326
Investments in subsidiaries	8,893,079	1,597,185	—	(10,490,264)	—
Intercompany receivables	3,474,133	—	701,814	(4,175,947)	—
Other long-term assets and investments	74,458	53,346	113,246	—	241,050
Goodwill	—	7,834,257	1,460,222	—	9,294,479
Total assets	$ 14,328,416	$ 14,504,292	$ 4,348,378	$ (14,666,211)	$ 18,514,875
Current liabilities	$ 185,217	$ 1,730,123	$ 483,798	$ —	$ 2,399,138
Intercompany payables	—	2,750,102	1,425,845	(4,175,947)	—
Long-term debt and other long-term liabilities	8,730,673	1,130,988	305,838	—	10,167,499
Noncontrolling interests subject to put provisions	541,746	—	—	322,320	864,066
Total DaVita Inc. shareholders' equity	4,870,780	8,893,079	1,597,185	(10,490,264)	4,870,780
Noncontrolling interests not subject to put provisions	—	—	535,712	(322,320)	213,392
Total equity	4,870,780	8,893,079	2,132,897	(10,812,584)	5,084,172
Total liabilities and equity	$ 14,328,416	$ 14,504,292	$ 4,348,378	$ (14,666,211)	$ 18,514,875

(dollars in thousands, except per share data)

Consolidating Statements of Cash Flows

	DaVita Inc.	Guarantor Subsidiaries	Non-Guarantor Subsidiaries	Consolidating Adjustments	Consolidated Total
For the year ended December 31, 2016					
Cash flows from operating activities:					
Net income	$ 879,874	$ 726,620	$ 805,040	$ (1,378,452)	$ 1,033,082
Changes in operating assets and liabilities and non-cash items included in net income	(614,642)	335,166	(168,614)	1,378,452	930,362
Net cash provided by operating activities	265,232	1,061,786	636,426	—	1,963,444
Cash flows from investing activities:					
Additions of property and equipment, net	(139,303)	(382,305)	(307,487)	—	(829,095)
Acquisitions	—	(472,413)	(91,443)	—	(563,856)
Proceeds from asset sales, net of cash divested	—	70,342	(5,617)	—	64,725
Investments and other items	153,031	(29,038)	2,565	—	126,558
Net cash provided by (used in) investing activities	13,728	(813,414)	(401,982)	—	(1,201,668)
Cash flows from financing activities:					
Long-term debt and related financing costs, net	(92,460)	(27,830)	(4,152)	—	(124,442)
Intercompany borrowing	237,988	(249,182)	11,194	—	—
Other items	(1,061,203)	(21,525)	(144,811)	—	(1,227,539)
Net cash used in financing activities	(915,675)	(298,537)	(137,769)	—	(1,351,981)
Effect of exchange rate changes on cash	—	—	4,276	—	4,276
Net (decrease) increase in cash and cash equivalents	(636,715)	(50,165)	100,951	—	(585,929)
Cash and cash equivalents at beginning of the year	1,186,636	109,357	203,123	—	1,499,116
Cash and cash equivalents at the end of the year	$ 549,921	$ 59,192	$ 304,074	$ —	$ 913,187
For the year ended December 31, 2015					
Cash flows from operating activities:					
Net income	$ 269,732	$ 195,507	$ 476,354	$ (514,183)	$ 427,410
Changes in operating assets and liabilities and non-cash items included in net income	(146,531)	688,106	74,032	514,183	1,129,790
Net cash provided by operating activities	123,201	883,613	550,386	—	1,557,200
Cash flows from investing activities:					
Additions of property and equipment, net	(115,269)	(319,695)	(273,034)	—	(707,998)
Acquisitions	—	(76,983)	(19,486)	—	(96,469)
Proceeds from asset sales	—	19,715	—	—	19,715
Investments and other items	(74,474)	(2,144)	(20,414)	—	(97,032)
Net cash used in investing activities	(189,743)	(379,107)	(312,934)	—	(881,784)
Cash flows from financing activities:					
Long-term debt and related financing costs, net	640,009	(11,953)	(8,358)	—	619,698
Intercompany borrowing	486,588	(394,735)	(91,853)	—	—
Other items	(572,295)	(66,382)	(119,991)	—	(758,668)
Net cash provided by (used in) financing activities	554,302	(473,070)	(220,202)	—	(138,970)
Effect of exchange rate changes on cash	—	—	(2,571)	—	(2,571)
Net increase in cash and cash equivalents	487,760	31,436	14,679	—	533,875
Cash and cash equivalents at beginning of the year	698,876	77,921	188,444	—	965,241
Cash and cash equivalents at the end of the year	$ 1,186,636	$ 109,357	$ 203,123	$ —	$ 1,499,116

(dollars in thousands, except per share data)

Consolidating Statements of Cash Flows

	DaVita Inc.	Guarantor Subsidiaries	Non-Guarantor Subsidiaries	Consolidating Adjustments	Consolidated Total
For the year ended December 31, 2014					
Cash flows from operating activities:					
Net income	$ 723,114	$ 647,085	$ 475,907	$ (982,776)	$ 863,330
Changes in operating assets and liabilities and non-cash items included in net income	(597,992)	120,772	90,521	982,776	596,077
Net cash provided by operating activities	125,122	767,857	566,428	—	1,459,407
Cash flows from investing activities:					
Additions of property and equipment, net	(51,374)	(312,191)	(277,765)	—	(641,330)
Acquisitions	—	(228,569)	(43,525)	—	(272,094)
Proceeds from asset sales	—	8,791	—	—	8,791
Investments and other items	(333,803)	(316)	(38,977)	—	(373,096)
Net cash used in investing activities	(385,177)	(532,285)	(360,267)	—	(1,277,729)
Cash flows from financing activities:					
Long-term debt and related financing costs, net	4,513	(12,545)	43	—	(7,989)
Intercompany borrowing	410,437	(282,461)	(127,976)	—	—
Other items	(58,207)	(14,099)	(84,684)	—	(156,990)
Net cash provided by (used in) financing activities	356,743	(309,105)	(212,617)	—	(164,979)
Effect of exchange rate changes on cash	—	—	2,293	—	2,293
Net increase (decrease) in cash and cash equivalents	96,688	(73,533)	(4,163)	—	18,992
Cash and cash equivalents at beginning of the year	602,188	151,454	192,607	—	946,249
Cash and cash equivalents at the end of the year	$ 698,876	$ 77,921	$ 188,444	$ —	$ 965,241

(dollars in thousands, except per share data)

29. Supplemental data (unaudited)

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

Condensed Consolidating Statements of Income

	Consolidated Total	Physician Groups	Unrestricted Subsidiaries	Company and Restricted Subsidiaries(1)
For the year ended December 31, 2016				
Patient services revenues	$ 10,354,161	$ 449,473	$ —	$ 9,904,688
Less: Provision for uncollectible accounts	(451,353)	(12,696)	—	(438,657)
Net patient service revenues	9,902,808	436,777	—	9,466,031
Capitated revenues	3,518,679	1,617,794	—	1,900,885
Other revenues	1,323,618	32,938	—	1,290,680
Total net revenues	14,745,105	2,087,509	—	12,657,596
Operating expenses and charges	12,850,562	2,035,001	110	10,815,451
Operating income	1,894,543	52,508	(110)	1,842,145
Debt expense	(414,382)	(10,140)	—	(404,242)
Other income, net	8,734	576	—	8,158
Income tax expense	455,813	10,643	(44)	445,214
Net income	1,033,082	32,301	(66)	1,000,847
Less: Net income attributable to noncontrolling interests	(153,208)	—	—	(153,208)
Net income attributable to DaVita Inc.	$ 879,874	$ 32,301	$ (66)	$ 847,639

Condensed Consolidating Statements of Comprehensive Income

	Consolidated Total	Physician Groups	Unrestricted Subsidiaries	Company and Restricted Subsidiaries(1)
For the year ended December 31, 2016				
Net income (losses)	$ 1,033,082	$ 32,301	$ (66)	$ 1,000,847
Other comprehensive losses	(29,627)	—	—	(29,627)
Total comprehensive income (losses)	1,003,455	32,301	(66)	971,220
Less: Comprehensive income attributable to noncontrolling interest	(153,398)	—	—	(153,398)
Comprehensive income (losses) attributable to DaVita Inc.	$ 850,057	$ 32,301	$ (66)	$ 817,822

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

(dollars in thousands, except per share data)

Condensed Consolidating Balance Sheets

	Consolidated Total	Physician Groups	Unrestricted Subsidiaries	Company and Restricted Subsidiaries(1)
As of December 31, 2016				
Cash and cash equivalents	$ 913,187	$ 104,691	$ —	$ 808,496
Accounts receivable, net	1,917,302	207,430	—	1,709,872
Other current assets	1,149,739	15,124	—	1,134,615
Total current assets	3,980,228	327,245	—	3,652,983
Property and equipment, net	3,175,367	1,378	—	3,173,989
Amortizable intangibles, net	1,527,767	4,858	—	1,522,909
Other long-term assets	650,578	78,215	2,714	569,649
Goodwill	9,407,317	16,405	—	9,390,912
Total assets	$ 18,741,257	$ 428,101	$ 2,714	$ 18,310,442
Current liabilities	$ 2,696,445	$ 223,302	$ —	$ 2,473,143
Payables to parent	—	56,699	2,714	(59,413)
Long-term debt and other long-term liabilities	10,221,813	44,094	—	10,177,719
Noncontrolling interests subject to put provisions	973,258	—	—	973,258
Total DaVita Inc. shareholders' equity	4,648,047	104,006	—	4,544,041
Noncontrolling interests not subject to put provisions	201,694	—	—	201,694
Shareholders' equity	4,849,741	104,006	—	4,745,735
Total liabilities and shareholder's equity	$ 18,741,257	$ 428,101	$ 2,714	$ 18,310,442

Condensed Consolidating Statements of Cash Flows

	Consolidated Total	Physician Groups	Unrestricted Subsidiaries	Company and Restricted Subsidiaries(1)
For the year ended December 31, 2016				
Cash flows from operating activities:				
Net income	$ 1,033,082	$ 32,301	$ (66)	$ 1,000,847
Changes in operating and intercompany assets and liabilities and non-cash items included in net income	930,362	131,863	66	798,433
Net cash provided by operating activities	1,963,444	164,164	—	1,799,280
Cash flows from investing activities:				
Additions of property and equipment	(829,095)	(863)	—	(828,232)
Acquisitions and divestitures, net	(563,856)	—	—	(563,856)
Proceeds from asset sales	64,725	—	—	64,725
Investments and other items	126,558	(3,014)	—	129,572
Net cash used in investing activities	(1,201,668)	(3,877)	—	(1,197,791)
Cash flows from financing activities:				
Long-term debt and related financing costs, net	(124,442)	(4)	—	(124,438)
Intercompany	—	(143,837)	—	143,837
Other items	(1,227,539)	—	—	(1,227,539)
Net cash used in financing activities	(1,351,981)	(143,841)	—	(1,208,140)
Effect of exchange rate changes on cash	4,276	—	—	4,276
Net increase (decrease) in cash	(585,929)	16,446	—	(602,375)
Cash at beginning of the year	1,499,116	88,245	—	1,410,871
Cash at the end of the year	$ 913,187	$ 104,691	$ —	$ 808,496

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

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, we have duly caused this Annual Report on Form 10-K to be signed on our behalf by the undersigned, thereunto duly authorized, in the City of Denver, State of Colorado, on February 24, 2017.

DAVITA INC.

By: /s/ KENT J. THIRY
Kent J. Thiry
Chairman and Chief Executive Officer

KNOW ALL MEN BY THESE PRESENT, that each person whose signature appears below constitutes and appoints Kent J. Thiry, James K. Hilger, and Kathleen Waters, and each of them his or her true and lawful attorneys-in-fact and agents with full power of substitution and resubstitution, for him or her and in his or her name, place and stead, in any and all capacities, to sign any and all amendments to this Annual Report on Form 10-K, and to file the same, with all exhibits thereto, and other documents in connection therewith, with the Securities and Exchange Commission, granting unto said attorneys-in-fact and agents, and each of them, full power and authority to do and perform each and every act and thing requisite or necessary to be done in and about the premises, as fully to all intents and purposes as he or she might or could do in person, hereby ratifying and confirming all that said attorneys-in-fact and agents or any of them, or their or his or her substitute or substitutes, may lawfully do or cause to be done by virtue hereof.

Pursuant to the requirements of the Securities Exchange Act of 1934, this Annual Report on Form 10-K has been signed by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/s/ KENT J. THIRY Kent J. Thiry	Chairman and Chief Executive Officer (Principal Executive Officer)	February 24, 2017
/s/ JAMES K. HILGER James K. Hilger	Interim Chief Financial Officer and Chief Accounting Officer (Principal Accounting Officer)	February 24, 2017
/s/ PAMELA M. ARWAY Pamela M. Arway	Director	February 24, 2017
/s/ CHARLES G. BERG Charles G. Berg	Director	February 24, 2017
/s/ CAROL A. DAVIDSON Carol A. Davidson	Director	February 24, 2017
/s/ BARBARA J. DESOER Barbara J. Desoer	Director	February 24, 2017
/s/ PASCAL DESROCHES Pascal. Desroches	Director	February 24, 2017
/s/ PAUL J. DIAZ Paul J. Diaz	Director	February 24, 2017
/s/ PETER T. GRAUER Peter T. Grauer	Director	February 24, 2017
/s/ JOHN M. NEHRA John M. Nehra	Director	February 24, 2017
/s/ WILLIAM L. ROPER William L. Roper	Director	February 24, 2017

Signature	Title	Date
/S/ ROGER J. VALINE Roger J. Valine	Director	February 24, 2017
/S/ PHYLLIS R. YALE Phyllis R. Yale	Director	February 24, 2017

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Shareholders
DaVita Inc.:

Under date of February 24, 2017, we reported on the consolidated balance sheets of DaVita Inc. and subsidiaries as of December 31, 2016 and 2015, and the related consolidated statements of income, comprehensive income, equity, and cash flows for each of the years in the three-year period ended December 31, 2016, which are included in the Annual Report on Form 10-K. In connection with our audits of the aforementioned consolidated financial statements, we also audited the related Schedule II – Valuation and Qualifying Accounts included in the Annual Report on Form 10-K. This financial statement schedule is the responsibility of the Company's management. Our responsibility is to express an opinion on this financial statement schedule based on our audits.

In our opinion, such financial statement schedule, when considered in relation to the basic consolidated financial statements taken as a whole, presents fairly, in all material respects, the information set forth therein.

/s/ KPMG LLP

Seattle, Washington
February 24, 2017

DAVITA INC.
SCHEDULE II—VALUATION AND QUALIFYING ACCOUNTS

Description	Balance at beginning of year	Acquisitions	Amounts charged to income	Amounts written off	Balance at end of year
			(in thousands)		
Allowance for uncollectible accounts:					
Year ended December 31, 2014	$ 237,143	$ —	$ 381,337	$ 375,806	$ 242,674
Year ended December 31, 2015	$ 242,674	$ —	$ 437,100	$ 415,630	$ 264,144
Year ended December 31, 2016	$ 264,144	$ —	$ 463,030	$ 475,118	$ 252,056

EXHIBIT INDEX

2.1	Agreement and Plan of Merger, dated as of May 20, 2012, by and among DaVita Inc., Seismic Acquisition LLC, HealthCare Partners Holdings, LLC, and the Member Representative.(28)
2.2	Amendment, dated as of July 6, 2012, to the Agreement and Plan of Merger, dated as of May 20, 2012, by and among DaVita Inc., Seismic Acquisition LLC, HealthCare Partners Holdings, LLC, and the Member Representative.(29)
3.1	Restated Certificate of Incorporation of DaVita Inc., as filed with the Secretary of State of Delaware on November 1, 2016.(1)
3.2	Certificate of Ownership and Merger Merging DaVita Name Change, Inc. with and into DaVita Inc., as filed with Secretary of State of the State of Delaware on November 1, 2012.(31)
3.3	Amended and Restated Bylaws for DaVita Inc. dated as of September 7, 2016.(1)
4.1	Indenture, dated August 28, 2012, by and among DaVita Inc., the guarantors named therein and The Bank of New York Mellon Trust Company, N.A., as Trustee.(30)
4.2	Form of 5.750% Senior Notes due 2022 and related Guarantee (included in Exhibit 4.1).(30)
4.3	Indenture, dated June 13, 2014, by and among DaVita Inc., the guarantors named therein and The Bank of New York Mellon Trust Company, N.A., as Trustee. (34)
4.4	Form of 5.125% Senior Notes due 2024 and related Guarantee (included in Exhibit 4.3). (34)
4.5	Second Supplemental Indenture for the 5.750% Senior Notes due 2022, dated June 13, 2014, by and among DaVita Inc., the guarantors named therein and The Bank of New York Mellon Trust Company, N.A., as Trustee. (35)
4.6	Indenture for the 5.000% Senior Notes due 2025, dated April 17, 2015, by and among DaVita Inc., the guarantors named therein and The Bank of New York Mellon Trust Company, N.A., as Trustee. (22)
4.7	Form of 5.000% Senior Notes due 2025 and related Guarantee (included in Exhibit 4.6). (22)
10.1	Employment Agreement, dated as of October 31, 2005, effective October 24, 2005, by and between DaVita Inc. and Dennis Kogod.(6)*
10.2	Amendment to Mr. Kogod's Employment Agreement, effective December 12, 2008.(18)*
10.3	Second Amendment to Mr. Kogod's Employment Agreement, effective December 31, 2012.(18)*
10.4	Employment Agreement, effective September 22, 2005, by and between DaVita Inc. and James Hilger.(8)*
10.5	Separation Agreement, effective November 30, 2016, by and between DaVita Inc. and Mr. Kogod.✓*
10.6	Consulting Agreement, effective December 1, 2016, by and between DaVita Inc. and Mr. Kogod.✓*
10.7	Amendment to Mr. Hilger's Employment Agreement, effective December 12, 2008.(18)*
10.8	Second Amendment to Mr. Hilger's Employment Agreement, effective December 27, 2012.(33)*
10.9	Employment Agreement, effective July 25, 2008, between DaVita Inc. and Kent J. Thiry.(15)*
10.10	Employment Agreement, effective August 1, 2008, between DaVita Inc. and Allen Nissenson.(16)*
10.11	Employment Agreement, effective March 17, 2010, by and between DaVita Inc. and Javier Rodriguez.(20)*
10.12	Employment Agreement, effective November 1, 2016, by and between DaVita Inc. and Charles G. Berg.✓*
10.13	Employment Agreement, effective February 21, 2017, by and between DaVita Inc. and Joel Ackerman.✓*
10.14	Form of Indemnity Agreement.(12)*
10.15	Form of Indemnity Agreement.(7)*
10.16	DaVita Deferred Compensation Plan.✓*
10.17	Executive Incentive Plan (as Amended and Restated effective January 1, 2009).(19)*
10.18	Executive Retirement Plan.(18)*
10.19	DaVita Voluntary Deferral Plan.(5)*

10.20	Deferred Bonus Plan (Prosperity Plan).(17)*
10.21	Amendment No. 1 to Deferred Bonus Plan (Prosperity Plan).(18)*
10.22	Amended and Restated Employee Stock Purchase Plan.(13)*
10.23	Amended and Restated DaVita Inc. Severance Plan.(33)*
10.24	Change in Control Bonus Program.(18)*
10.25	Non-Management Director Compensation Philosophy and Plan.(14)*
10.26	Amended and Restated 2002 Equity Compensation Plan.(4)*
10.27	Amended and Restated 2002 Equity Compensation Plan.(11)*
10.28	Amended and Restated 2002 Equity Compensation Plan.(13)*
10.29	Amended and Restated 2002 Equity Compensation Plan.(18)*
10.30	DaVita Inc. 2002 Equity Compensation Plan.(21)*
10.31	Form of Non-Qualified Stock Option Agreement—Employee (DaVita Inc. 1999 Non-Executive Officer and Non-Director Equity Compensation Plan.(10)*
10.32	Form of Non-Qualified Stock Option Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(2)*
10.33	Form of Non-Qualified Stock Option Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(9)*
10.34	Form of Non-Qualified Stock Option Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(10)*
10.35	Form of Restricted Stock Units Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(2)*
10.36	Form of Restricted Stock Units Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(9)*
10.37	Form of Restricted Stock Units Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(10)*
10.38	Form of Restricted Stock Units Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(18)*
10.39	Form of Stock Appreciation Rights Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(9)*
10.40	Form of Stock Appreciation Rights Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(10)*
10.41	Form of Stock Appreciation Rights Agreement—Board (DaVita Inc. 2002 Equity Compensation Plan).(16)*
10.42	Form of Stock Appreciation Rights Agreement—Board members (DaVita Inc. 2011 Incentive Award Plan).(24)*
10.43	Form of Restricted Stock Units Agreement—Board (DaVita Inc. 2002 Equity Compensation Plan).(16)*
10.44	Form of Restricted Stock Units Agreement—Board members (DaVita Inc. 2011 Incentive Award Plan).(24)*
10.45	Form of Non-Qualified Stock Option Agreement—Board (DaVita Inc. 2002 Equity Compensation Plan).(16)*
10.46	Form of Stock Appreciation Rights Agreement—Executives (DaVita Inc. 2011 Incentive Award Plan).(24)*
10.47	Form of Restricted Stock Units Agreement—Executives (DaVita Inc. 2011 Incentive Award Plan).(24)*
10.48	Form of Restricted Stock Units Agreement (DaVita Inc. 2011 Incentive Award Plan). (33)*
10.49	Form of Stock Appreciation Rights Agreement (DaVita Inc. 2011 Incentive Award Plan). (33)*
10.50	Form of Long-Term Incentive Program Award Agreement (For 162(m) designated teammates) (DaVita Inc. 2011 Incentive Award Plan).(33)*
10.51	Form of Long-Term Incentive Program Award Agreement (DaVita Inc. 2011 Incentive Award Plan). (33)*

10.52	Credit Agreement, dated as of June 24, 2014, by and among DaVita Inc., the guarantors the guarantors party thereto, the lenders party thereto, JPMorgan Chase Bank, N.A., as Administrative Agent and Collateral Agent, Barclays Bank PLC, and Wells Fargo Bank, National Association as Co-Syndication Agents, Bank of America, N.A., Credit Suisse AG, Goldman Sachs Bank USA, JPMorgan Chase Bank, N.A., Morgan Stanley Senior Funding, Inc., and SunTrust Bank, as Co-Documentation Agents, Barclays Bank PLC, Wells Fargo Securities, LLC, Credit Suisse Securities (USA) LLC, Goldman Sachs Bank USA, J.P. Morgan Securities, LLC, Bank of America, N.A., Morgan Stanley Senior Funding, Inc., and SunTrust Robinson Humphrey, Inc. as Joint Lead Arrangers and Joint Bookrunners, The Bank of Nova Scotia, Credit Agricole Securities (USA) Inc., The Bank of Tokyo-Mitsubishi UFJ, Ltd., and Sumitomo Mitsui Banking Corporation, as Senior Managing Agents, HSBC Securities (USA) Inc., Fifth Third Bank, and Compass Bank as Managing Agents. (35)
10.53	Perfection Certificate executed as of October 20, 2010 and delivered in connection with the closing of the Credit Agreement filed as Exhibit 10.68.(26)**
10.54	Dialysis Organization Agreement between DaVita Inc. and Amgen USA Inc. dated December 20, 2007.(17)**
10.55	Dialysis Organization Agreement between DaVita Inc. and Amgen USA Inc. dated December 17, 2010.(23)**
10.56	Amended and Restated DaVita Inc. 2011 Incentive Award Plan.(35)*
10.57	Amendment No. 2 to Dialysis Organization Agreement between DaVita Inc. and Amgen USA Inc. effective as of July 1, 2011.(25)**
10.58	Form of Non-Competition and Non-Solicitation Agreement, dated as of May 20, 2012, between DaVita Inc. and Dr. Robert Margolis, Dr. William Chin, Dr. Thomas Paulsen, Mr. Zan Calhoun, and Ms. Lori Glisson.(28)
10.59	Form of Non-Competition and Non-Solicitation Agreement, dated as of May 20, 2012, between DaVita Inc. and Mr. Matthew Mazdyasni, Dr. Sherif Abdou, and Dr. Amir Bacchus.(28)
10.60	Escrow Agreement, dated as of August 28, 2012, by and among DaVita Inc., The Bank of New York Mellon Trust Company, N.A., as trustee, The Bank of New York Mellon Trust Company, N.A., as escrow agent and The Bank of New York Mellon Trust Company, N.A., as bank and securities intermediary.(30)
10.61	Form of 2014 Long Term Incentive Program Cash Performance Award Agreement under the DaVita Inc. 2011 Incentive Award Plan and Long-Term Incentive Program (for 162(m) designated teammates). (36) * **
10.62	Form of 2014 Long Term Incentive Program Cash Performance Award Agreement under the DaVita Inc. 2011 Incentive Award Plan and Long-Term Incentive Program. (36)* **
10.63	Form of 2014 Long Term Incentive Program Performance Stock Units Agreement under the DaVita Inc. 2011 Incentive Award Plan and Long-Term Incentive Program (for 162(m) designated teammates). (36) * **
10.64	Form of 2014 Long Term Incentive Program Restricted Stock Units Agreement under the DaVita Inc. 2011 Incentive Award Plan and Long-Term Incentive Program. (36)*
10.65	Form of 2014 Long Term Incentive Program Stock Appreciation Rights Agreement under the DaVita Inc. 2011 Incentive Award Plan and Long-Term Incentive Program. (36)*
10.66	Corporate Integrity Agreement, dated as of October 22, 2014, by and among the Office of Inspector General of The Department of Health and Human Services and DaVita Inc. (27)
12.1	Computation of Ratio of Earnings to Fixed Charges.✓
14.1	DaVita Inc. Corporate Governance Code of Ethics.(3)
21.1	List of our subsidiaries.✓
23.1	Consent of KPMG LLP, independent registered public accounting firm.✓
24.1	Powers of Attorney with respect to DaVita. (Included on Page II-1).
31.1	Certification of the Chief Executive Officer, dated February 24, 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 February 24, 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 February 24, 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 February 24, 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.✓

✓	Included in this filing.
*	Management contract or executive compensation plan or arrangement.
**	Portions of this exhibit are subject to a request for confidential treatment and have been redacted and filed separately with the SEC.
(37)	Filed on November 2, 2016 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2016.
(38)	Filed on November 8, 2004 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2004.
(39)	Filed on February 27, 2004 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 2003.
(40)	Filed on May 4, 2005 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2005.
(41)	Filed on November 8, 2005 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2005.
(42)	Filed on November 4, 2005 as an exhibit to the Company's Current Report on Form 8-K.
(43)	Filed on March 3, 2005 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 2004.
(44)	Filed on August 7, 2006 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ending June 30, 2006.
(45)	Filed on July 6, 2006 as an exhibit to the Company's Current Report on Form 8-K.
(46)	Filed on October 18, 2006 as an exhibit to the Company's Current Report on Form 8-K.
(47)	Filed on July 31, 2006 as an exhibit to the Company's Current Report on Form 8-K.
(48)	Filed on December 20, 2006 as an exhibit to the Company's Current Report on Form 8-K.
(49)	Filed on June 4, 2007 as an exhibit to the Company's Current Report on Form 8-K.
(50)	Filed on May 8, 2008 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2008.
(51)	Filed on July 31, 2008 as an exhibit to the Company's Current Report on Form 8-K.
(52)	Filed on November 6, 2008 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2008.
(53)	Filed on February 29, 2008 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 2007.
(54)	Filed on February 27, 2009 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 2008
(55)	Filed on June 18, 2009 as an exhibit to the Company's Current Report on Form 8-K.
(56)	Filed on April 14, 2010 as an exhibit to the Company's Current Report on Form 8-K.
(57)	Filed on April 28, 2010 as Appendix A to the Company's Definitive Proxy Statement on Schedule 14A.
(58)	Filed on April 17, 2015 as an exhibit to the Company's Current Report on Form 8-K.
(59)	Filed on December 29, 2011 as an exhibit to the Company's Annual Report on Form 10-K/A for the year ended December 31, 2010.
(60)	Filed on August 4, 2011 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2011.
(61)	Filed on December 29, 2011 as an exhibit to the Company's Quarterly Report on Form 10-Q/A for the quarter ended June 30, 2011.
(62)	Filed on January 17, 2012 as an exhibit to the Company's Quarterly Report on Form 10-Q/A for the quarter ended March 31, 2011.
(63)	Filed on October 23, 2014 as an exhibit to the Company's Current Report on Form 8-K.
(64)	Filed on May 21, 2012 as an exhibit to the Company's Current Report on Form 8-K.
(65)	Filed on July 9, 2012 as an exhibit to the Company's Current Report on Form 8-K.
(66)	Filed on August 28, 2012 as an exhibit to the Company's Current Report on Form 8-K.
(67)	Filed on November 1, 2012 as an exhibit to the Company's Current Report on Form 8-K.
(68)	Filed on August 7, 2013 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2013.

(69) Filed on February 28, 2013 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 2012.
(70) Filed on June 16, 2014 as an exhibit to the Company's Current Report on Form 8-K.
(71) Filed on August 1, 2014 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2014.
(72) Filed on November 6, 2014 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2014.

Exhibit 10.5

SEPARATION AGREEMENT AND RELEASE

This Separation Agreement and Release ("Agreement") is made and entered into by and between DaVita Healthcare Partners Inc. and/or any of its parents, subsidiaries, successors and assigns (collectively "DaVita" or the "Company") and Dennis Kogod ("Kogod").

WHEREAS, DaVita and Kogod wish to provide for the termination of their employment relationship, all roles in which Kogod serves as an officer, board member or other non-employment role with DaVita (the "Non-Employment Roles"), and all agreements (including the October 31, 2005 Employment Agreement and any amendments thereto) except as otherwise noted herein, that exist and may have existed between them, and fully and finally resolve any and all matters arising out of Kogod's employment by DaVita or the termination of his employment, without any admission of any kind by either party; and

WHEREAS, the parties wish to document their understanding and agreement with respect to the terms of Kogod's separation from employment with DaVita.

NOW, THEREFORE, in consideration of the provisions and agreements set forth hereinafter, and for good and valuable consideration, the sufficiency of which is acknowledged by both parties, the parties agree as follows:

1. Employment Termination. DaVita will eliminate Kogod's position, CEO of DaVita International, as part of a reorganization of the Company effective November 30, 2016. The Company will continue to employ Kogod as CEO of DaVita International until November 30, 2016 (the "Termination Date"). Until the Termination Date, Kogod's job duties and responsibilities, pay, and entitlement to health and welfare benefits shall remain the same as of the date of his execution of this Agreement. However, during this time, Kogod may not bind the Company or DaVita International to any contract or make any representation or commitment on behalf of the Company or DaVita International that would tend to bind the Company or DaVita International without prior written authorization from the Chief Executive Officer of DaVita. In addition, during this time if requested to do so by the Company, Kogod will submit his written and signed resignation from any Non-Employment Roles or, in lieu thereof, the Company may remove Kogod from all such roles at any time(s) prior to the Termination Date. Prior to the date of any such resignation or removal from the Non-Employment Roles, Kogod shall cooperate with the Company to take such action as might be necessary to complete any pending or essential matters that need to be accomplished prior to the Termination Date and/or to provide for a smooth transition out of the Non-Employment Roles. The parties will announce the termination of Kogod's employment consistent with applicable regulations.

2. Consulting. Kogod agrees to provide consulting services to DaVita from the termination of his employment until November 30, 2019. The terms of Kogod's provision of consulting services to DaVita are outlined in the Consulting Agreement attached hereto as Exhibit A. Notwithstanding anything to the contrary in this Agreement, the Consulting Agreement or any other writing of any kind whatsoever, upon Kogod's commencement of the consulting services under the Consulting Agreement, those services will not be deemed to be a simultaneous commencement of or remaining in service with the Company by Kogod for

purposes of the definition of "Termination of Services" under Section 2.53 of the 2011 DaVita HealthCare Partners Inc. Incentive Award Plan, as amended and restated on June 17, 2014 (the "Plan"). Without limiting the generality of the foregoing, and for the avoidance of doubt, any rights that Kogod might have under any equity-based or cash-based awards made to Kogod by the Company pursuant to the Plan prior to the Termination Date, including without limitation, to exercise any such award (other than awards that have vested prior to the Termination Date) or to continue to have such awards vest or to otherwise derive value of any kind therefrom, will cease as of the Termination Date, and any unvested portions thereof shall be forfeited. Any exercise of any vested but unexercised awards under the Plan are subject to pre-clearance by the Chief Legal Officer of the Company and the other usual requirements under the Company's Insider Trading Policy, and must occur no later than 90 days after the Termination Date, provided that no exercises may occur during the Company's regular third quarter trading blackout that begins at the close of the New York Stock Exchange on September 23, 2016 and is expected to end in or about the first week of November, unless prior to the beginning of such trading blackout Kogod establishes a 10b5-1 trading plan that complies with the DaVita Insider Trading Policy with respect to any desired exercise of any award during the blackout period, and provided further that any exercise dates under such trading plan during the trading blackout or after must occur no later than 90 days after the Termination Date.

3. Consideration. In consideration for Kogod's execution and non-revocation of this Agreement and the promises and covenants contained herein, DaVita shall pay Kogod a lump sum of One Million Five Hundred Thousand Dollars ($1,500,000) (less standard federal and state withholdings and authorized deductions), to be reported on an IRS Form W-2, within 10 business days of Kogod's execution of this Agreement, provided he does not revoke the Agreement as set forth in paragraph 12.

4. Return of Company Property. Kogod agrees to return all of DaVita's proprietary or confidential information, emails, documents, and property, including but not limited to cellular phones, credit cards, calling cards, keys, computers, employment badges and any company-provided hardware and software to DaVita on or before the Termination Date.

5. Non-Required Benefits. Kogod acknowledges that by accepting the provisions of this Agreement, Kogod is receiving certain benefits to which he would not otherwise be entitled.

6. Release. In consideration of the obligations of DaVita under this Agreement, Kogod, for himself and his heirs, executors, administrators, attorneys, successors, and assigns, hereby releases DaVita and its parents, subsidiaries, divisions, affiliates, related entities, its and their joint ventures and joint venturers, insurers, insurance policies and benefit plans, each of the past and present shareholders, officers, directors, agents, employees (including, but not limited to, Kent Thiry), representatives, administrators, fiduciaries and attorneys of the foregoing entities and plans, and the predecessors, successors, transferees and assigns of each of the persons and entities described in this sentence ("Released Parties"), from any and all claims of any kind, known or unknown, that arose on or before the date Kogod signed this Agreement.

The claims Kogod is releasing include, without limitation, any and all claims arising out of or related to his employment with DaVita.

The claims Kogod is releasing also include, without limitation, claims of wrongful termination, claims of constructive discharge, claims arising out of agreements, representations or policies related to his employment, claims arising under federal, state or local laws or ordinances prohibiting discrimination, harassment, or retaliation for whistleblowing or requiring accommodation on the basis of age, race, color, national origin, religion, sex, disability, marital status, sexual orientation or any other protected status, claims of failure to accommodate a disability or religious practice, claims for violation of public policy, claims of retaliation, claims under the federal false claims act and/or any state false claims act relating in any manner to information Kogod learned while employed by DaVita, claims of failure to assist Kogod in applying for future position openings, claims of failure to hire Kogod for future position openings, claims for wages or compensation of any kind (including overtime claims), claims of willful withholding of wages, claims of tortious interference with contract or expectancy, claims of fraud or negligent misrepresentation, claims of breach of privacy, defamation claims, claims of intentional or negligent infliction of emotional distress, claims of unfair labor practices, claims arising out of any claimed right to stock or to the receipt of any equity grant or for the issuance, vesting or derivation of any value of stock or other equity or cash in connection with any award made under the Plan (other than the right to exercise vested but unexercised equity awards as provided under paragraph 2 above), claims for attorneys' fees or costs, claims that he may have or assert based on alleged acts or omissions by DaVita, and any other claims that are based on any alleged legal obligations of DaVita.

Kogod understands and agrees that this Agreement is a full and final release covering all known and unknown, suspected or unsuspected injuries, debts, claims or damages which have arisen or may have arisen from any matters, acts, omissions or dealings released. As to such released matters, Kogod expressly waives any and all rights or benefits which he may now have, or in the future may have, under the terms of California Civil Code Section 1542 and any similar law of any state or territory in the United States. Said section provides as follows:

> A GENERAL RELEASE DOES NOT EXTEND TO CLAIMS WHICH THE CREDITOR DOES NOT KNOW OR SUSPECT TO EXIST IN HIS OR HER FAVOR AT THE TIME OF EXECUTING THE RELEASE, WHICH IF KNOWN BY HIM OR HER MUST HAVE MATERIALLY AFFECTED HIS OR HER SETTLEMENT WITH THE DEBTOR.

Kogod fully understands that if any fact with respect to any matter covered in this Agreement is found hereinafter to be other than or different from the facts now believed by him to be true, he expressly accepts and assumes that this Agreement shall be and remain effective, notwithstanding such difference in facts.

7. Waiver of Rights. Kogod specifically waives any rights or claims that Kogod may have under the California Labor Code, the California Fair Employment and Housing Act, the California Family Rights Act, the Nevada Revised Statutes, the Nevada Fair Employment Practices Act, the Colorado Civil Rights Act, the Colorado Revised Statutes, the Civil Rights Act of 1964 (including Title VII of that Act), the Americans with Disabilities Act of 1990 (ADA), the Family and Medical Leave Act, the Age Discrimination in Employment Act (ADEA), the Worker Adjustment and Retraining Notification Act (WARN), the Employee Retirement Income Security Act of 1974 (ERISA), the National Labor Relations Act (NLRA), the Consolidated

Omnibus Budget Reconciliation Act of 1985 (COBRA), the Sarbanes-Oxley Act of 2002, the Dodd-Frank Act of 2010 (all as amended), and all similar federal, state and local laws.

8. Remedies for Breach of Release and Waiver of Rights. Kogod acknowledges and agrees that if he breaches the provisions in paragraphs 6 and/or 7, then, to the fullest extent permitted by law, DaVita will be entitled to apply for and receive an injunction to restrain any violation of the release and/or waiver of rights and DaVita will not be obligated to make any additional payments or provide any additional benefits under this Agreement, subject to an arbitrator subsequently ruling otherwise pursuant to the dispute resolution mechanism set forth in paragraph 19 below.

9. Waiver of Reinstatement Rights. To the extent permitted by law, Kogod further waives, releases, and discharges DaVita and the Released Parties from any reinstatement rights which Kogod has or could have, and Kogod acknowledges that he has not suffered any on-the job injury for which he has not already filed a claim.

10. No Pending Actions. Kogod represents and warrants that as of the date of his signing this Agreement, he has not initiated any complaint, charge, administrative proceeding, lawsuit or arbitration seeking damages or equitable relief for any of the claims Kogod is releasing in this Agreement, including, without limitation, any administrative or civil actions pending with respect to DaVita and/or any alleged or perceived violation by DaVita or the Released Parties with respect to Kogod.

11. Protected Rights. Kogod expressly acknowledges that this Release does not relinquish any protected rights he may have under Title VII of the Civil Rights Act of 1964, the Equal Pay Act ("EPA"), the Americans with Disabilities Act ("ADA"), Older Workers Benefit Protection Act ("OWBPA") or the Age Discrimination in Employment Act ("ADEA") to file a charge, testify, assist or participate in any manner in an investigation, hearing or proceeding conducted by the Equal Employment Opportunity Commission or the Office of Federal Contract Compliance. However, Kogod may not recover additional compensation or damages as a result of that participation.

Kogod agrees that he will not file or permit any other person to file a claim on Kogod's behalf, with any judicial body, administrative agency or arbitrator, any claim or cause of action herein released.

The foregoing notwithstanding, nothing herein shall prohibit or restrict Kogod from communicating directly with, or responding to any inquiry from, cooperating with, or providing testimony before, the Securities and Exchange Commission (SEC), Department of Justice (DOJ), Office of the Inspector General (OIG), or any other governmental or self-regulatory authority about a possible violation of law.

This Agreement does not waive Kogod's vested rights, if any, to receive pension or medical benefits pursuant to any formally-adopted written benefit plan, unemployment compensation benefits or workers' compensation benefits, nor does it waive Kogod's rights that he cannot waive, including claims for indemnification, and any claim that the Company has failed to make any payments or to provide any of the payments or benefits described in paragraph 3 of this Agreement.

12. Notice of Rights of Review and Revocation. Kogod acknowledges receipt of this Agreement as notice in writing from DaVita advising him to consult with an attorney prior to executing this Agreement and further acknowledges that he has been provided the right to consider this Agreement, including the release contained herein, for a period of twenty-one (21) days following the date of such receipt prior to executing same. The parties acknowledge that Kogod has seven (7) days from the date of execution of this Agreement to revoke same, and that this entire Agreement shall not be effective or enforceable in whole or in part until the revocation period has expired. If Kogod chooses to revoke this Agreement within seven (7) days of execution, such revocation shall apply to the entire Agreement, and it is understood and agreed that such revocation shall render this entire Agreement null and void. To be effective, the rescission must be in writing and delivered by hand or mailed to Timothy J. Long, Orrick Herrington & Sutcliffe, LLP, 777 S. Figueroa Street, Suite 3200, Los Angeles, CA 90017. If mailed, the rescission must be (a) postmarked within the seven-day revocation period; (b) properly addressed to Timothy J. Long and (c) sent by certified mail, return receipt requested. If Kogod accepts this Agreement, the signed Agreement must be postmarked or returned by the close of the twenty-first day of the consideration period, to Timothy J. Long at the address stated herein.

13. Cooperation/Full Disclosure. Kogod agrees, upon request of DaVita, to cooperate with DaVita in the transition of his duties.

Kogod will fully cooperate with DaVita in the investigation, prosecution and/or defense of any claims or concerns regarding the business of DaVita about which he has relevant knowledge, including by providing truthful information and testimony as reasonably requested by DaVita. Such assistance shall include, but is not limited to, participating in interviews with representatives of DaVita, attending, as a witness, depositions, trials, or other similar proceedings without requiring a subpoena, and producing and/or providing any documents or names of other persons with relevant information.

Kogod also acknowledges his obligation to raise any and all compliance concerns prior to the Termination Date. Kogod shall fill out DaVita's form Compliance Questionnaire and be available to participate in an exit interview with DaVita's Corporate Compliance Department or its designee if Kogod is asked by DaVita to do so prior to the Termination Date. In the event an interview is desired, at the sole discretion of DaVita, DaVita will contact Kogod to establish a mutually agreeable time for the interview. Kogod agrees to answer any questions fully and completely, and a failure to do so is a material breach of this Agreement. If Kogod is aware of a compliance-related issue, he acknowledges his obligation to raise the concern(s) in the form Compliance Questionnaire and the exit interview (if any), and that failure to do so is a material breach of this Agreement.

14. Duty to DaVita. Kogod acknowledges his duty of loyalty to DaVita including, but not limited to, a duty not to improperly profit from or improperly seek to profit from knowledge he has acquired while in a position of trust at DaVita, to the detriment of DaVita.

15. No Future Employment. Kogod represents and confirms that, after the Termination Date, Kogod has no interest in future employment with DaVita or its parents, subsidiaries, successors or affiliates, and that DaVita and its parents, subsidiaries and affiliates

have no obligation to assist Kogod in identifying or applying for positions with DaVita. Kogod agrees not to apply for future employment with DaVita or its parents, subsidiaries or affiliates and agrees that DaVita and its parents, subsidiaries and affiliates have no obligation to consider Kogod for future employment.

16. Kogod's Representations and Warranties. Kogod expressly represents and warrants that he is the sole owner of the actual or alleged claims, demands, rights, causes of action, and other matters that are released by Kogod herein; that the same have not been transferred or assigned or caused to be transferred or assigned to any other person, firm, corporation or other legal entity; and that Kogod has the full right and power to grant, execute and deliver the releases, undertakings, and agreements contained herein. Kogod further represents and warrants that he is unaware of any lien that has been noticed or filed and that would attach to any payment or benefit to be made or given by DaVita pursuant to this Agreement. Kogod agrees to indemnify DaVita and the Released Parties, including payment of any attorneys' fees and costs, and hold DaVita and the Released Parties harmless from and against any and all damages which may be suffered by them in the event that any of the foregoing representations and warranties are untrue in whole or part, and any and all claims based on or arising from any such assignment or transfer, or any attempted assignment or transfer, of any matters released herein. Kogod also represents that the total payment fully and adequately compensates him for anything he is releasing and anything that is owed to him (including wages and benefits) and that he is not owed any other sums.

17. Entire Agreement. The parties agree that, except as otherwise stated herein, this Agreement supersedes any prior arrangements, agreements or contracts, whether written, oral or implied (in law or fact), between them on the subject matter contained herein and contains the entire understanding and agreement between the parties and cannot be amended, modified or supplemented in any respect, except by a subsequent written agreement executed by both parties.

18. Choice of Law. This Agreement shall be governed by the laws of the State of Colorado, without regard to conflict of law principles.

19. Enforcement of Agreement by Arbitration. Any dispute over the terms of or obligations under this Agreement shall be resolved by final and binding arbitration before JAMS in Denver, Colorado, except that the Company may seek judicial intervention to obtain temporary injunctive relief to restrain any violation of the releases provided in this Agreement and/or waiver of rights pursuant to paragraph 8 above. The parties agree that the venue for any such court action will be Denver, Colorado. The arbitrator (or the Court) shall be obligated to follow substantive Colorado law. Kogod and DaVita agree to waive any and all rights to a jury trial or a bench trial in connection with the resolution of any dispute under this Agreement. The prevailing party shall be entitled to reasonable attorneys' fees and/or costs incurred to enforce this Agreement.

20. Severability. If any provision of this Agreement or the application thereof is held invalid, such invalidation shall not affect other provisions or applications of this Agreement and to this end, the provisions of this Agreement are declared to be severable; provided that if the release and covenants not to sue provided for in paragraphs 6 and 10 or any parts thereof are declared or adjudged invalid or unenforceable for any reason, the entire Agreement shall be a nullity and all consideration provided in this Agreement shall be returned. Each party agrees, at

the other party's option, to execute a release, waiver, and/or covenant that is legal and enforceable to effectuate the terms of this Agreement.

21. Section 409A. For purposes of this Agreement and the Second Agreement, all references to "termination of employment" and correlative phrases shall be construed to require a "separation from service" (as defined under Section 409A of the Internal Revenue Code of 1986, as amended (the "Code"). For purposes of the rules under Section 409A of the Code, each payment made under this Agreement and the Second Agreement shall be treated as a separate payment, and the right to a series of installment payments under this Agreement is to be treated as a right to a series of separate payments. It is intended that the payments satisfy, to the greatest extent possible, the exemptions from the application of Section 409A of the Code. Notwithstanding anything to the contrary in this Agreement or the Second Agreement, if DaVita determines (i) that on the date that Kogod's employment with the Company terminates or at such other times that DaVita determines to be relevant, Kogod is a "specified employee" (within the meaning of Section 409A of the Code) of Da Vita and (ii) that any payments to be provided to Kogod pursuant to this Agreement are or may become subject to the additional tax under Section 409A(a)(1)(B) of the Code or any other taxes or penalties imposed under Section 409A of the Code if provided at the time otherwise required under this Agreement, then such payments shall be delayed until the date that is six months after the date of Kogod's "separation from service" (as such term is defined under Section 409A of the Code) with Da Vita, or, if earlier, the date of Kogod's death. Any payments delayed pursuant to this paragraph shall be made in lump sum on the first day of the seventh month following Kogod's "separation from service" (as such term is defined under Section 409A of the Code), or, if earlier, the date of Kogod's death. In addition, to the extent that any benefits are provided in-kind or through reimbursement, (i) the amount eligible for reimbursement or payment in one calendar year may not affect the amount eligible for reimbursement or payment in any other calendar year, and (ii) the right to any reimbursement or in-kind benefit is not subject to liquidation or exchange for another benefit. Notwithstanding any other provision to the contrary, in no event shall any payment under this Agreement that constitutes "deferred compensation" for purposes of Section 409A of the Code be subject to offset by any other amount unless otherwise permitted by Section 409A of the Code.

22. Counterparts and Copies. This Agreement may be signed in any number of copies and counterparts, each of which shall be deemed an original when signed and shall constitute the same instrument. Fully executed photocopies of the Agreement shall be treated as originals.

WHEREFORE, the parties execute this Agreement effective the date set forth below.

DaVita Healthcare Partners, Inc.

/s/ Kent J. Thiry	/s/ Dennis L. Kogod
Kent J. Thiry Chief Executive Officer	Dennis L. Kogod
Dated: October 17, 2016	Dated: October 17, 2016

Exhibit 10.6

EXHIBIT A

CONSULTING AGREEMENT

The following confirms the agreement (the "Consulting Agreement") between DaVita Healthcare Partners Inc. and/or any of its parents, subsidiaries, successors and assigns (collectively "DaVita" or the "Company") and Dennis L. Kogod ("Kogod") with respect to the provision of consulting services to DaVita.

1. **Term of Consulting Agreement.** This Consulting Agreement is effective as of December 1, 2016 and will continue for three (3) years, until November 30, 2019 unless terminated earlier pursuant to paragraph 10 of this Consulting Agreement.

2. **Services, Obligations and Cooperation.** Kogod and DaVita agree to the following with respect to the services, obligation and coordination under the Consulting Agreement: (a) In Year One of this Consulting Agreement, Kogod shall provide no more than 100 hours per month of consulting services to DaVita under this Consulting Agreement as Advisor to DaVita's Chief Executive Officer, or his/her designee. In Years Two and Three of this Consulting Agreement, the cap on consulting services shall be reduced to 90 hours per month. Kogod shall include in the monthly time record all time he spends attending to administrative functions, which will count towards his consulting services. If Kogod does not work 100 hours (or, as applicable, 90 hours) in any given month, the difference between hours worked and 100 hours (or, as applicable, 90 hours) shall not carry over to the following month, unless Kogod and DaVita agree otherwise. Kogod shall maintain a record of the hours he works each month and shall send the log to DaVita's Chief Executive Officer no later than five (5) business days after the end of each month. The parties agree that the spirit and intent of this Consulting Agreement is for Kogod to provide 100 hours (or, as applicable, 90 hours) of substantive consulting services to DaVita, but recognize that this will require substantial travel in addition to the substantive consulting services. As such, DaVita agrees to pay Kogod $350 per hour for his travel time, which will be limited to 40 hours per month. However, if travel exceeds 40 hours per month, then each travel hour in excess of 40 shall be treated as consulting services, thereby counting towards the 100 (or 90) hour monthly consulting services maximum. For purposes of recording Kogod's travel hours, travel time shall be measured from the scheduled airline departure time to landing, including any lay-overs and travel delays. Travel time is not be considered part of the 100 hours (or, as applicable, 90 hours) required under this section unless the travel time exceeds 40 hours per month, as discussed above.

(b) Kogod shall give DaVita five (5) business days' notice of any days on which he cannot perform work, including travel or phone calls, provided that Kogod has not previously agreed to a commitment to DaVita pursuant to Section 2(d)-(e).

(c) In this role, Kogod shall report to DaVita's Chief Executive Officer or his/her designee and attend meetings called by him/her and/or DaVita's senior management, with reasonable notice as set forth below. Kogod understands and agrees that in performing services under this Consulting Agreement he may be required to travel internationally, with reasonable notice as set forth below. DaVita will pay for Kogod to travel on a commercial airline, first

class, and to stay in executive level accommodations consistent with similarly situated DaVita executives. Kogod shall seek reimbursement for other reasonable expenses he incurs in connection with performing these consulting services. None of the travel costs will be imputed to Kogod as income. Kogod will not be permitted to use the fractionally-owned or chartered corporate aircraft. Kogod shall also provide Quarterly Financial Disclosure Certifications to the Company in the form of Exhibit 1 attached hereto.

(d) DaVita shall give Kogod no fewer than six (6) business days' notice for any domestic travel that DaVita requires of Kogod and ten (10) business days' notice for any international travel that DaVita requires of Kogod.

(e) DaVita shall give Kogod no fewer than five (5) business days' notice of any conference call or in person meeting in which his participation is required. DaVita shall give Kogod no fewer than five (5) business days' notice of any one on one or other similar regular calls with international management team members.

(f) DaVita and Kogod agree and understand that the notice provisions in Sections 2(b), (d) and (e) may not always be possible in the event of an emergency or urgent business situation. If a legitimately urgent or emergent situation arises, both parties agree to act reasonably to accommodate the request by the other party that would be less than the required time of the notice provisions in Sections 2(b), (d) and (e).

(g) DaVita shall not require Kogod to attend any meeting of the Board of Directors.

(h) Kogod shall utilize his expertise, experience and professional judgment in performing such consulting services.

(i) Kogod acknowledges his duty of loyalty to DaVita including, but not limited to, a duty not to improperly profit from or improperly seek to profit from knowledge he has acquired while in a position of trust at DaVita, to the detriment of DaVita.

(j) Kogod shall fully cooperate with DaVita in the investigation, prosecution and/or defense of any claims or concerns regarding the business of DaVita about which he has relevant knowledge, including by providing truthful information and testimony as reasonably requested by DaVita.

3. **Compensation**. For the duration of this Consulting Agreement, and in consideration for this Consulting Agreement, DaVita shall pay Kogod One Million Two Hundred Thousand Dollars ($1,200,000) per year, to be reported on an IRS Form 1099 and paid out monthly. In addition, and subject to executing a Second Agreement attached hereto as Exhibit 2, no later than January 15, 2017, DaVita shall pay Kogod a lump sum of One Million Eight Hundred Thousand Dollars ($1,800,000), to be reported on an IRS Form 1099. The payment of this lump sum shall be conditioned solely on Kogod executing the Second Agreement and once paid, shall not be subject to later recapture or repayment, even if Kogod should later breach this Consulting Agreement or the Third Agreement (see paragraph 4 below).

4. **Additional Consideration**. Upon expiration or termination of this Consulting Agreement, Kogod shall sign a Third Agreement attached hereto as Exhibit 3. As good and

valuable consideration for Kogod's execution of the Third Agreement, as well as the post-consulting noncompetition and nonsolicitation provisions set out in paragraphs 7 and 8 herein, DaVita shall pay Kogod a lump sum of One Hundred Thousand Dollars ($100,000), to be reported on an IRS Form 1099.

5. **Independent Contractor Status**. It is the express intention of the parties to this Consulting Agreement that Kogod is an independent contractor, and is not an employee, agent, joint venturer or partner of DaVita. Nothing in this Consulting Agreement shall be interpreted or construed as creating or establishing an employment relationship between DaVita and Kogod. Both parties understand and agree that Kogod may perform services for others during the term of this Consulting Agreement.

6. **Taxes.** Kogod and DaVita agree that all tax obligations, if any, which may arise from the payments set forth above shall be the sole obligation of Kogod, and that Kogod defends and indemnifies DaVita against any and all costs, penalties, taxes or other payments made or required as a result of the allocation of those payments, if any, or the reporting of those payments. Kogod agrees to notify DaVita promptly of any claims made for costs, penalties or taxes related to those payments. Kogod acknowledges that DaVita makes no representations as to the tax consequences or characterization of the nature of the payment made pursuant to this Consulting Agreement. Kogod is solely responsible for all taxes, withholdings and other similar statutory obligations; and Kogod agrees to defend, indemnify and hold DaVita harmless from any and all claims made by any entity on account of an alleged failure by Kogod to satisfy any such tax or withholding obligations.

7. **Noncompete.** Kogod agrees that, during the term of this Consulting Agreement and for a period of eight (8) months following the expiration this Consulting Agreement, he will not perform or engage in any activities that would be competitive with DaVita, including providing any services for (whether as an owner, partner, investor, director, officer, representative, manager, employee, principal, agent, advisor, or consultant) any business which provides dialysis services in the United States, Australia, Brazil, China (PRC), Colombia, Germany, India, Indonesia, Malaysia, the Netherlands, the Philippines, Poland, Portugal, Saudi Arabia, Singapore, Spain, Taiwan, the United Arab Emirates, and United Kingdom. Kogod agrees that this provision is only as wide in scope, geographic reach and duration as necessary to safeguard DaVita's business, including its trade secret information. Additionally, Kogod agrees that this provision does not impose undue hardship on him. If any court of competent jurisdiction shall determine that any portion of this provision is invalid in any respect, the parties agree that such court may limit this provision in geographic scope, in duration, or in any other manner which the court determines such that the provision shall be enforceable against Kogod.

8. **Non-Solicitation of Employees.** Kogod understands and acknowledges that DaVita has expended and continues to expend significant time and expense in recruiting and training its employees and that the loss of employees would cause significant and irreparable harm to DaVita. Kogod agrees that he will not directly or indirectly solicit, hire, recruit, attempt to hire or recruit, or induce the termination of employment of any employee employed by DaVita during the term of this Consulting Agreement and for a period of one (1) year following the expiration of this Consulting Agreement.

9. **Confidential Information.** Kogod understands and acknowledges that DaVita has and will continue to spend significant time, effort and money to develop proprietary information which is vital to DaVita's business. In connection with performing services under this Consulting Agreement, Kogod will have access to DaVita's confidential, proprietary and trade secret information including but not limited to information and strategy relating to the Company's products and services including customer lists and files, product description and pricing, information and strategy regarding profits, costs, marketing, purchasing, sales, customers, suppliers, contract terms, employees, salaries; product development plans; business, acquisition and financial plans and forecasts and marketing and sales plans and forecasts (collectively called "Company Confidential Information"). Kogod will not, throughout the duration of this Consulting Agreement and after, directly or indirectly disclose to any other person or entity, or use for his own benefit or for the benefit of others besides the Company, any Company Confidential Information. Upon termination of this Consulting Agreement, Kogod agrees to promptly return all Company Confidential Information.

10. **Termination of Consulting Agreement.** DaVita shall have the right to terminate this Consulting Agreement for any reason, including for convenience. In the event of termination of this Consulting Agreement by DaVita for any reason except Cause, as defined below, the full unpaid balance of payment described in paragraph 3 above shall be paid to Kogod at the time of termination. Kogod agrees, however, that the noncompetition and nonsolicitation provisions set out in paragraphs 7 and 8 herein shall continue in force and effect for the anticipated duration of these provisions – i.e., three (3) years and eight months from the effective date of this Consulting Agreement.

For purposes of this Agreement, "Cause" shall mean the occurrence of any of the following events, as determined in the good faith reasonable judgment of the Board: (i) any violation by Kogod of any securities law or regulation; (ii) Kogod's conviction for, indictment for, or plea of nolo contendere to fraud, theft, embezzlement, or any crime involving moral turpitude that is injurious to DaVita; (iii) Kogod's failure to adequately perform the consulting services under this Agreement as determined by the Board, which failure continues for a period of more than 15 business days after the Board has given written notice thereof to Kogod, which written notice shall set forth in reasonable detail the manner in which Kogod's performance of the consulting services is not adequate; (iv) Kogod's breach, non-performance or non-observance of any of the material terms of this Agreement; provided, that, if such breach, non-performance or non-observance of any such material term is capable of cure, it continues without cure beyond a period of 15 business days immediately after written notice thereof by the Board to Kogod, which written notice shall set forth in reasonable detail the facts or circumstances constituting or giving rise to such breach, non-performance or non-observance; (v) any gross negligence or willful misconduct by Kogod in the performance of his consulting services; (vi) egregious conduct by Kogod that brings the Company or any of its subsidiaries or affiliates into public disgrace or disrepute; (vii) any act of unlawful discrimination, including sexual harassment, by Kogod; or (viii) exclusion or notice of exclusion of Kogod from participating in any federal health care program.

If the Company determines that it has Cause to terminate this agreement, Kogod shall have the right to request a hearing, with an arbitrator agreed upon by the parties, to determine whether Cause exists. There shall be no discovery prior to the hearing. The parties shall share

the cost of the arbitrator and shall bear their own attorneys' fees and costs. The decision of the arbitrator following the hearing shall be final.

11. **Entire Agreement**. The parties agree that, except as otherwise stated herein, this Consulting Agreement supersedes any prior arrangements, agreements or contracts, whether written, oral or implied (in law or fact), between them on the subject matter contained herein and contains the entire understanding and agreement between the parties and cannot be amended, modified or supplemented in any respect, except by a subsequent written agreement executed by both parties.

12. **Choice of Law.** This Consulting Agreement shall be governed by the laws of the State of Colorado, without regard to conflict of law principles.

13. **Enforcement of Consulting Agreement by Arbitration.** Any dispute over the terms of or obligations under this Consulting Agreement shall be resolved by final and binding arbitration before JAMS in Denver, Colorado. The arbitrator shall be obligated to follow substantive Colorado law. Kogod and DaVita agree to waive any and all rights to a jury trial or a bench trial in connection with the resolution of any dispute under this Consulting Agreement, except as described herein. The prevailing party shall be entitled to reasonable attorneys' fees and/or costs incurred to enforce this Consulting Agreement. Expressly excluded from the provisions of this paragraph are actions by either party for temporary restraining orders or preliminary injunctions in cases where such temporary equitable relief would otherwise be authorized by law.

14. **Severability.** If any provision of this Consulting Agreement or the application thereof is held invalid, such invalidation shall not affect other provisions or applications of this Consulting Agreement and to this end, the provisions of this Consulting Agreement are declared to be severable. Each party agrees, at the other party's option, to execute a release, waiver, and/or covenant that is legal and enforceable to effectuate the terms of this Consulting Agreement.

WHEREFORE, the parties execute this Consulting Agreement effective the date set forth below.

DaVita Healthcare Partners, Inc.

/s/ Ken J. Thiry	/s/ Dennis L. Kogod
Kent J. Thiry Chief Executive Officer	Dennis L. Kogod
Date: October 17, 2016	Date: October 17, 2016

EXHIBIT 2

SECOND AGREEMENT

1. I, Dennis L. Kogod, for myself and my heirs, executors, administrators, attorneys, successors, and assigns, in consideration for the payments provided pursuant to the Separation and Release Agreement with DaVita Healthcare Partners Inc. ("DaVita" or the "Company") (dated _October 17, _____, 2016) (the "Original Agreement"), which I expressly agree are more than I would otherwise be entitled, hereby release DaVita and its parents, subsidiaries, divisions, affiliates, related entities, its and their joint ventures and joint venturers, insurers, insurance policies and benefit plans, each of the past and present shareholders, officers, directors, agents, employees (including, but not limited to, Kent Thiry), representatives, administrators, fiduciaries and attorneys of the foregoing entities and plans, and the predecessors, successors, transferees and assigns of each of the persons and entities described in this sentence, from any and all claims of any kind, known or unknown, that arose on or before the time I signed this Second Agreement.

2. The claims I am releasing include, without limitation, any and all claims arising out of or related to my employment with DaVita and my consulting for DaVita. The claims I am releasing include, without limitation, claims of wrongful termination, claims of constructive discharge, claims arising out of agreements, representations or policies related to his employment, claims arising under federal, state or local laws or ordinances prohibiting discrimination, or harassment, or whistleblowing or requiring accommodation on the basis of age, race, color, national origin, religion, sex, disability, marital status, sexual orientation or any other protected status, claims of failure to accommodate a disability or religious practice, claims for violation of public policy, claims of retaliation, claims under the federal false claims act and/or any state false claims act relating in any manner to information I learned while employed by DaVita, claims of failure to assist in applying for future position openings, claims of failure to hire for future position openings, claims for wages or compensation of any kind (including overtime claims), claims of willful withholding of wages, claims of tortious interference with contract or expectancy, claims of fraud or negligent misrepresentation, claims of breach of privacy, defamation claims, claims of intentional or negligent infliction of emotional distress, claims of unfair labor practices, claims arising out of any claimed right to stock or stock options, claims for attorneys' fees or costs, claims that he may have or assert based on alleged acts or omissions by DaVita, and any other claims that are based on any alleged legal obligations of DaVita.

3. I understand and agree that this Second Agreement is a full and final release covering all known and unknown, suspected or unsuspected injuries, debts, claims or damages which have arisen or may have arisen from any matters, acts, omissions or dealings released. As to such released matters, I expressly waive any and all rights or benefits which I may now have, or in the future may have, under the terms of California Civil Code Section 1542 and any similar law of any state or territory in the United States. Said section provides as follows:

> A GENERAL RELEASE DOES NOT EXTEND TO CLAIMS WHICH THE CREDITOR DOES NOT KNOW OR SUSPECT

TO EXIST IN HIS OR HER FAVOR AT THE TIME OF EXECUTING THE RELEASE, WHICH IF KNOWN BY HIM OR HER MUST HAVE MATERIALLY AFFECTED HIS OR HER SETTLEMENT WITH THE DEBTOR.

4. I fully understand that, if any fact with respect to any matter covered in this Second Agreement is found hereinafter to be other than or different from the facts now believed by me to be true, I expressly accept and assume that this Second Agreement shall be and remain effective, notwithstanding such difference in facts.

5. I specifically waive any rights or claims that I may have under the California Labor Code, the California Fair Employment and Housing Act, the California Family Rights Act, the Nevada Revised Statutes, the Nevada Fair Employment Practices Act, the Colorado Civil Rights Act, the Colorado Revised Statutes, the Civil Rights Act of 1964 (including Title VII of that Act), the Americans with Disabilities Act of 1990 (ADA), the Family and Medical Leave Act, the Worker Adjustment and Retraining Notification Act (WARN), the Employee Retirement Income Security Act of 1974 (ERISA), the National Labor Relations Act (NLRA), the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Sarbanes-Oxley Act of 2002, the Dodd-Frank Act of 2010, and all similar federal, state and local laws.

6. The foregoing notwithstanding, this Second Agreement does not waive my vested rights, if any, to receive pension or medical benefits pursuant to any formally-adopted written benefit plan, unemployment compensation benefits or workers' compensation benefits. Nor does it waive my rights that I cannot waive, including claims for indemnification.

7. I represent and warrant that as of the date of his signing this Second Agreement, I have not initiated any complaint, charge, administrative proceeding, lawsuit or arbitration seeking damages or equitable relief for any of the claims I released in the Original Agreement, including, without limitation, any administrative or civil actions with respect to my employment and/or any alleged or perceived violation by DaVita or the Released Parties with respect to me.

8. I acknowledge that I have fulfilled my obligation to inform DaVita completely, forthrightly and fully of all allegations, perceived allegations, facts, and incidents or other information of which I may be aware about alleged or perceived violations by DaVita of any federal, state or local law or regulation, or DaVita's Corporate Integrity Agreement, Code of Conduct, Business Conduct Standards, or any other conduct prescribed by legal or regulatory authority or by DaVita.

9. I have returned all of DaVita's proprietary and confidential information, emails, documents, and property, including but not limited to cellular phones, credit cards, calling cards, keys, computers, employment badges and any company-provided hardware and software ("Company Property") to DaVita. I have not made any images and/or copies of Company Property, nor have I disclosed, provided, and/or shared any Company Property with any third party.

10. I acknowledge receipt of this Second Agreement as notice in writing from DaVita advising me to consult with an attorney prior to executing this Second Agreement and further acknowledge that I have been provided the right to consider this Second Agreement.

11. I understand that I will not be entitled to receive the One Million Eight Hundred Thousand Dollars ($1,800,000) lump-sum payment provided for in paragraph 3 of the Consulting Agreement until after this Second Agreement has been executed and returned.

12. This Second Agreement shall be governed by the laws of the State of Colorado.

DaVita Healthcare Partners, Inc.

/s/ Kent J. Thiry	/s/ Dennis L. Kogod
Kent J. Thiry Chief Executive Officer	Dennis L. Kogod
Date: January 13, 2017	Date: January 13, 2017

EXHIBIT 3

THIRD AGREEMENT

1. I, Dennis L. Kogod, for myself and my heirs, executors, administrators, attorneys, successors, and assigns, in consideration for the payments provided pursuant to the Separation and Release Agreement with DaVita Healthcare Partners Inc. ("DaVita" or the "Company") (dated August 18, 2016) (the "Original Agreement"), which I expressly agree are more than I would otherwise be entitled, hereby release DaVita and its parents, subsidiaries, divisions, affiliates, related entities, its and their joint ventures and joint venturers, insurers, insurance policies and benefit plans, each of the past and present shareholders, officers, directors, agents, employees (including, but not limited to, Kent Thiry), representatives, administrators, fiduciaries and attorneys of the foregoing entities and plans, and the predecessors, successors, transferees and assigns of each of the persons and entities described in this sentence, from any and all claims of any kind, known or unknown, that arose on or before the time I signed this Third Agreement.

2. The claims I am releasing include, without limitation, any and all claims arising out of or related to my employment with DaVita and my consulting for DaVita. The claims I am releasing include, without limitation, claims of wrongful termination, claims of constructive discharge, claims arising out of agreements, representations or policies related to his employment, claims arising under federal, state or local laws or ordinances prohibiting discrimination, or harassment, or whistleblowing or requiring accommodation on the basis of age, race, color, national origin, religion, sex, disability, marital status, sexual orientation or any other protected status, claims of failure to accommodate a disability or religious practice, claims for violation of public policy, claims of retaliation, claims under the federal false claims act and/or any state false claims act relating in any manner to information I learned while employed by DaVita, claims of failure to assist in applying for future position openings, claims of failure to hire for future position openings, claims for wages or compensation of any kind (including overtime claims), claims of willful withholding of wages, claims of tortious interference with contract or expectancy, claims of fraud or negligent misrepresentation, claims of breach of privacy, defamation claims, claims of intentional or negligent infliction of emotional distress, claims of unfair labor practices, claims arising out of any claimed right to stock or stock options, claims for attorneys' fees or costs, claims that he may have or assert based on alleged acts or omissions by DaVita, and any other claims that are based on any alleged legal obligations of DaVita.

3. I understand and agree that this Third Agreement is a full and final release covering all known and unknown, suspected or unsuspected injuries, debts, claims or damages which have arisen or may have arisen from any matters, acts, omissions or dealings released. As to such released matters, I expressly waive any and all rights or benefits which I may now have, or in the future may have, under the terms of California Civil Code Section 1542 and any similar law of any state or territory in the United States. Said section provides as follows:

> A GENERAL RELEASE DOES NOT EXTEND TO CLAIMS WHICH THE CREDITOR DOES NOT KNOW OR SUSPECT TO EXIST IN HIS OR HER FAVOR AT THE TIME OF

EXECUTING THE RELEASE, WHICH IF KNOWN BY HIM OR HER MUST HAVE MATERIALLY AFFECTED HIS OR HER SETTLEMENT WITH THE DEBTOR.

4. I fully understand that if any fact with respect to any matter covered in this Third Agreement is found hereinafter to be other than or different from the facts now believed by me to be true, I expressly accept and assume that this Third Agreement shall be and remain effective, notwithstanding such difference in facts.

5. I specifically waive any rights or claims that I may have under the California Labor Code, the California Fair Employment and Housing Act, the California Family Rights Act, the Nevada Revised Statutes, the Nevada Fair Employment Practices Act, the Colorado Civil Rights Act, the Colorado Revised Statutes, the Civil Rights Act of 1964 (including Title VII of that Act), the Americans with Disabilities Act of 1990 (ADA), the Family and Medical Leave Act, the Worker Adjustment and Retraining Notification Act (WARN), the Employee Retirement Income Security Act of 1974 (ERISA), the National Labor Relations Act (NLRA), the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Sarbanes-Oxley Act of 2002, the Dodd-Frank Act of 2010, and all similar federal, state and local laws.

6. The foregoing notwithstanding, this Third Agreement does not waive my vested rights, if any, to receive pension or medical benefits pursuant to any formally-adopted written benefit plan, unemployment compensation benefits or workers' compensation benefits. Nor does it waive my rights that I cannot waive, including claims for indemnification.

7. I represent and warrant that as of the date of his signing this Third Agreement, I have not initiated any complaint, charge, administrative proceeding, lawsuit or arbitration seeking damages or equitable relief for any of the claims I released in the Original Agreement, including, without limitation, any administrative or civil actions with respect to my employment and/or any alleged or perceived violation by DaVita or the Released Parties with respect to me.

8. I acknowledge that I have fulfilled my obligation to inform DaVita completely, forthrightly and fully of all allegations, perceived allegations, facts, and incidents or other information of which I may be aware about alleged or perceived violations by DaVita of any federal, state or local law or regulation, or DaVita's Corporate Integrity Agreement, Code of Conduct, Business Conduct Standards, or any other conduct prescribed by legal or regulatory authority or by DaVita.

9. I have returned all of DaVita's proprietary and confidential information, emails, documents, and property, including but not limited to cellular phones, credit cards, calling cards, keys, computers, employment badges and any company-provided hardware and software ("Company Property") to DaVita. I have not made any images and/or copies of Company Property, nor have I disclosed, provided, and/or shared any Company Property with any third party.

10. I acknowledge receipt of this Third Agreement as notice in writing from DaVita advising me to consult with an attorney prior to executing this Third Agreement and further acknowledge that I have been provided the right to consider this Third Agreement.

11. I understand that I will not be entitled to receive any payments or benefits under paragraph 4 of the Consulting Agreement until after this Third Agreement has been executed and returned.

12. This Third Agreement shall be governed by the laws of the State of Colorado.

DaVita Healthcare Partners, Inc.

Kent J. Thiry Chief Executive Officer	Dennis L. Kogod
Date: _____	Date: _____

Exhibit 10.12

EMPLOYMENT AGREEMENT

This Employment Agreement (this "Agreement") is made effective as of November 1, 2016 (the "Effective Date"), by and between DaVita Inc. ("Parent") and HealthCare Partners, LLC, one of its controlled affiliates ("Employer", and collectively with Parent, "DaVita") and Charles G. Berg ("Employee").

In consideration of the mutual covenants and agreements hereinafter set forth and for other good and valuable consideration, the parties hereto, intending to be legally bound hereby, agree as follows:

Section 1. Employment and Duties. Employer hereby employs Employee to serve as Executive Chair for DaVita Medical Group ("Executive Chair"). Employee accepts such employment on the terms and conditions set forth in this Agreement. Employee shall report to the Chief Executive Officer of Parent. Employee agrees to devote approximately half of his business time to the business of Employer and shall not engage in any other business activities during the term of this Agreement that would reasonably be anticipated to materially interfere with Employee's performance of his duties under this Agreement. Notwithstanding the foregoing, Employer agrees that Employee may continue his work with Justworks, Inc. and Consonance Capital Partners during the term of this Agreement. Employee shall at all times observe and abide by the Employer's policies and procedures as in effect from time to time.

Section 2. Compensation. In consideration of the services to be performed by Employee hereunder, Employee shall receive the following compensation and benefits:

2.1 Base Salary. Employer shall pay Employee a base salary of one million five hundred thousand dollars ($1,500,000) per annum, less standard withholdings and authorized deductions. Employee shall be paid consistent with Employer's payroll schedule.

2.2 Benefits. Employee and/or his family, as the case may be, shall be eligible for participation in and shall receive all benefits under Employer's health and welfare benefit plans (including, without limitation, medical, prescription, dental, disability, and life insurance) under the same terms and conditions applicable to most executives at similar levels of compensation and responsibility.

2.3 Discretionary Performance Bonus. Employee shall be eligible to receive a discretionary performance bonus (the "Discretionary Bonus") between zero ($0) and one million five hundred thousand dollars ($1,500,000), less standard withholdings and authorized deductions. The amount of the Discretionary Bonus could exceed $1,500,000 depending on performance. The amount of the Discretionary Bonus, if any, will be based on Employee's performance and will be decided by the Chief Executive Officer and/or the Board of Directors or the Compensation Committee of the Board in his/her/its sole discretion.

2.4 Sign-On Bonus: Employer will pay Employee five hundred thousand dollars ($500,000), less standard withholdings and authorized deductions (the "Sign-On Bonus"), within ten (10) days after Employee's first date of employment with Employer.

2.5 Vacation. Employee shall have vacation, subject to the approval of his direct supervisor.

2.6 Employee's Position on Board of Directors. While this Agreement is in effect, Employee shall not be entitled to any fees, compensation, other remuneration, dividends, distributions, or other property or financial benefit in connection with Employee's position as a Director of Parent.

2.7 Compensation or other Property Received in Connection with Director, Officer, Shareholder or Similar Position. All fees, compensation, other remuneration, dividends, distributions, or other property or financial benefit received by Employee in connection with Employee's position as a director, officer, member, shareholder, partner or any other similar position of any controlled or uncontrolled direct or indirect subsidiary or affiliate of Employer, or other contractual obligor to Employer or any of its subsidiaries or affiliates the obligations of which constitute revenue to Employer or any of its subsidiaries or affiliates and of which Employee beneficially owns or has the right to acquire, directly or indirectly, 10% or more of the equity interests or has the power to vote 10% or more of the voting interests, shall belong to Employer and shall be immediately remitted to Employer. Notwithstanding the foregoing, this provision shall not apply to any amounts payable to, earned by, received by or otherwise due to Employee as employment compensation from Employer or any of its subsidiaries or affiliates, or any dividends or other distributions received by Employee in Employee's capacity as a stockholder of Parent.

2.8 Indemnification. Parent agrees to indemnify Employee against and in respect of any and all claims, actions, or demands, to the extent permitted by and in accordance with Parent's Certificate of Incorporation, Parent's By-laws and applicable law. Parent shall maintain a directors' and officers' liability insurance policy covering Employee in his capacity as an employee (in addition to his capacity as a member of the Board of Directors of Parent) to the extent Parent provides such coverage to its executive officers. Notwithstanding any provision of this Agreement to the contrary, the obligations under this Section 2.8 (Indemnification) will survive termination of this Agreement or Employee's employment for any reason.

2.9 Reimbursement. Employer also agrees to reimburse Employee in accordance with Employer's reimbursement policies for travel and entertainment expenses, as well as other business-related expenses, incurred in the performance of his duties hereunder.

2.10 Changes to Benefit Plans. Employer reserves the right to modify, suspend, or discontinue any and all of its health and welfare benefit plans, practices, policies, and programs at any time without recourse by Employee so long as such action is taken generally with respect to all other similarly-situated peer executives and does not single out Employee.

2.11 Possible Recoupment of Certain Compensation. Notwithstanding any other provision in this Agreement to the contrary, Employee shall be subject to the written policies of the Board of Directors applicable to executives of the Employer, including without limitation any Board policy relating to recoupment or "claw back" of compensation, as they exist from time to time during the Employee's employment by the Employer and thereafter.

Section 3. Provisions Relating to Termination of Employment.

3.1 Term. The term of this Agreement will be until October 15, 2017 (the "Term"), unless the parties mutually agree to extend the Term. Notwithstanding the Term, Employer and Employee shall have the right to terminate this Agreement at any point during the Term in accordance with the terms of this Section 3 (Provisions Relating to Termination of Employment).

3.2 Termination for Material Cause. Employer may terminate Employee's employment without advance notice for Material Cause (as defined below). Upon termination for Material Cause, Employee shall (i) be entitled to receive the Base Salary and benefits as set forth in Section 2.1 (Base Salary), Section 2.2 (Benefits), and Section 2.9 (Reimbursement) respectively, through the effective date of such termination and (ii) not be entitled to receive any other compensation, benefits, or payments of any kind, except as otherwise required by law or by the terms of any benefit or retirement plan or other arrangement that would, by its terms, apply. Employee acknowledges and agrees that he will not be eligible for any severance payments or benefits under the DaVita Inc. Severance Plan and/or any other severance plan adopted by Employer (including its subsidiaries and affiliates).

3.3 Other Termination. Employer may terminate the employment of Employee for any reason or for no reason at any time upon at least thirty (30) days' advance written notice. Upon termination pursuant to this Section 3.3 (Other Termination), Employee shall (i) be entitled to receive the Base Salary and benefits as set forth in Section 2.1 (Base Salary), Section 2.2 (Benefits), and Section 2.9 (Reimbursement) respectively, through the effective date of such termination and (ii) not be entitled to receive any other compensation, benefits, or payments of any kind, except as otherwise required by law or by the terms of any benefit or retirement plan or other arrangement that would, by its terms, apply. Employee acknowledges and agrees that he will not be eligible for any severance payments or benefits under the DaVita Inc. Severance Plan and/or any other severance plan adopted by Employer (including its subsidiaries and affiliates).

3.4. Voluntary Resignation. Employee may resign from Employer at any time upon at least thirty (30) days' advance written notice. If Employee resigns from Employer, Employee shall (i) be entitled to receive the base salary and benefits as set forth in Section 2.1 (Base Salary), Section 2.2 (Benefits), and Section 2.9 (Reimbursement) respectively, through the effective date of such termination and (ii) not be entitled to receive any other compensation, benefits, or payments of any kind, except as otherwise required by law or by the terms of any benefit or retirement plan or other arrangement that would, by its terms, apply. In the event Employee resigns from Employer at any time, Employer shall have the right to make such resignation effective as of any date before the expiration of the required notice period.

3.5 Disability. Upon thirty (30) days' advance notice (which notice may be given before the completion of the periods described herein), Employer may terminate Employee's employment for Disability (as defined below).

3.6 Definitions. For the purposes of this Agreement, the following terms shall have the meanings indicated:

(a) "Disability" shall mean the inability, for a period of six (6) months, to adequately perform Employee's regular duties, with or without reasonable accommodation, due to a physical or mental illness, condition, or disability.

(b) "Material Cause" shall mean any of the following: (i) conviction of a felony or plea of no contest to a felony; (ii) any act of fraud or dishonesty in connection with the performance of his duties; (iii) repeated failure or refusal by Employee to follow policies or directives reasonably established by the Chief Executive Officer of Parent that goes uncorrected for a period of ten (10) consecutive days after written notice has been provided to Employee; (iv) a material breach of this Agreement that goes uncorrected after a period of ten (10) consecutive days after written notice has been provided to Employee; (v) any gross or willful misconduct or gross negligence by Employee in the performance of his duties; (vi) egregious conduct by Employee that brings Employer or any of its subsidiaries or affiliates into public disgrace or disrepute; (vii) an act of unlawful discrimination, including sexual harassment; (viii) a violation of the duty of loyalty or of any fiduciary duty; or (ix) exclusion or notice of exclusion of Employee from participating in any federal health care program.

3.7 Notice of Termination. Any purported termination of Employee's employment by Employer or by Employee shall be communicated by a written Notice of Termination to the other party hereto in accordance with Section 5.3 (Notice) hereof. A "Notice of Termination" shall mean a written notice that indicates the specific termination provision in this Agreement.

3.8 Effect of Termination. Upon termination, this Agreement shall be of no further force and effect and neither party shall have any further right or obligation hereunder; provided, however, that no termination shall modify or affect the rights and obligations of the parties that have accrued prior to termination; and provided further, that the rights and obligations of the parties under Section 2.8 (Indemnification), Section 3 (Provisions Relating to Termination of Employment), Section 4 (Noncompetition, Nonsolicitation, and Confidentiality Agreement), and Section 5 (Miscellaneous) shall survive termination of this Agreement.

3.9 Payments and benefits under this Agreement are intended to be exempt from, or comply with, the applicable requirements of Section 409A of the Internal Revenue Code, and this Agreement shall be construed and interpreted in accordance with such intent. Notwithstanding any provision herein to the contrary, in the event that any payment to be made to Employee hereunder (whether pursuant to this Section 3 (Provisions Relating to Termination of Employment) or any other Section) as a result of Employee's termination of employment is determined to constitute "deferred compensation" subject to Section 409A of the Internal Revenue Code, and Employee is a "Key Employee" under the DaVita Inc. Key Employee Policy

for 409A Arrangements at the time of Employee's termination of employment, all such deferred compensation payments payable during the first six (6) months following Employee's termination of employment shall be delayed and paid in a lump sum during the seventh calendar month following the calendar month during which Employee's termination of employment occurs.

Section 4: Covenant Not to Compete, Covenant Not to Solicit, and Confidentiality.

4.1 Covenant Not to Compete. Employee recognizes and agrees that his covenant not to compete is necessary to insure continuation of the business and reputation of the Employer and that irreparable harm and damage will be done to the Employer if Employee competes with the Employer in certain specified areas. Employee acknowledges that he will be privy to confidential information to which Employee might not otherwise be exposed.

Employee covenants and agrees that during the term of this Agreement and for six (6) months following the termination of this Agreement (the "Restricted Period"), he shall not, as an employee, independent contractor, consultant, or in any other form, provide any of the same or similar services that Employee performed under this Agreement for any other individual, partnership, limited liability company, corporation, independent practice association, management services organization, or any other entity (collectively, "Person") that competes in any material way with the Employer or any of its subsidiaries or affiliates within the DaVita Medical Group organization anywhere in the states where Employer operates as of the date of termination of Employee's employment.

Employee understands and acknowledges that the provisions of this Section 4 (Covenant Not to Compete, Covenant Not to Solicit, and Confidentiality), are designed to preserve the business and goodwill of the Employer. Accordingly, if Employee breaches any such obligation, in addition to any other remedies available under this Agreement, at law or in equity, the Employer shall be entitled to enforce this Section 4 (Covenant Not to Compete, Covenant Not to Solicit, and Confidentiality) by injunctive relief and by specific performance of this Section 4 (Covenant Not to Compete, Covenant Not to Solicit, and Confidentiality), such relief to be without the necessity of posting a bond, cash or otherwise. Additionally, nothing in this Section 4.1 (Covenant Not to Compete) shall limit the Employer's right to recover any other damages to which it is entitled as a result of Employee's breach. If any provision of the restrictive covenants contained in this Agreement is held by a court of competent jurisdiction to be unenforceable due to the excessive time period, geographic area, or restricted activity, the restrictive covenant shall be reformed to comply with the time period, geographic area, or restricted activity that would be held enforceable.

Notwithstanding the foregoing, this Section 4.1 (Covenant Not to Compete) will only apply if Employee is no longer serving on the Parent's Board of Directors during the time period covered by the covenant not to compete (i.e., during the term of this Agreement and for six (6) months following the termination of this Agreement), and the Restricted Period will continue to run during any time period after the termination of this Agreement when Employee is serving on the Board of Directors.

4.2 Covenant Not to Solicit. Employee agrees that during the term of this Agreement, and for a period of one (1) year after the termination of this Agreement, Employee will not contact, communicate with, or correspond with any director, officer, employee, representative, agent or independent contractor of the Parent and its subsidiaries and affiliates (including Employer), in any manner that will interfere with or attempt to disrupt the relationship between the Employer and any such director, officer, employee, representative, agent or independent contractor, including but not limited to the solicitation or encouragement of any employee to leave the employ of the Employer for any reason, or employ any such person in any manner whatsoever, without the prior written consent of the Employer; provided, however, that nothing herein shall prohibit Employee from making a general employment solicitation to the public that does not target any employee or independent contractor of Employer or its subsidiaries and then having contact with and/or employing such employee or independent contractor who responds to such general solicitation or who otherwise independently contacts Employee.

4.3 Confidentiality. Employee agrees that all data and information about the Employer's business, legal affairs, plans, finances, plants, equipment, processes and methods of operation disclosed to, acquired by or developed by Employee during performance of the work hereunder is and shall remain the exclusive property of the Employer. Except for such information and data that has entered the public domain through no fault of Employee or to have been in Employee's possession prior to disclosure to Employee by the Employer and/or the performance of Employee's services hereunder, Employee shall during the term of the Agreement and thereafter in perpetuity maintain as confidential and not disclose to third parties or otherwise use, and will enjoin Employee's employees, agents or subcontractors (as applicable) from using, such information except as duly authorized in the conduct of the Employer's business or as otherwise authorized in advance in writing signed by the Employer's Chief Executive Officer (or his successor). Employee agrees that such data and information shall be used by Employee solely for the purpose of performing services for the Employer and not for the benefit of any other person or entity whatsoever.

Section 5. Miscellaneous.

5.1 Entire Agreement; Amendment. This Agreement represents the entire understanding of the parties hereto with respect to the employment of Employee and supersedes all prior agreements with respect thereto. This Agreement may not be altered or amended except in writing executed by both parties hereto.

5.2 Assignment; Benefit. This Agreement is personal and may not be assigned by Employee. This Agreement may be assigned by Employer and shall inure to the benefit of and be binding upon the successors and assigns of Employer.

5.3 Notice. Notices and all other communications provided for in this Agreement shall be in writing and shall be deemed to have been duly given when delivered by (i) personal delivery, (ii) a nationally-recognized, next-day courier service, or (iii) first-class registered or certified mail, postage prepaid addressed to Employer at its principal office and to Employee at the address listed on Employee's invoices, provided that all notices to Employer shall be directed to the attention of the Chief Executive Officer, or to such other address as either party may have furnished to the other in writing in accordance herewith, except that notice of change of address shall be effective only upon receipt.

5.4 Arbitration. Any disagreement, dispute or claim arising out of or relating to this Agreement which cannot be settled by the parties hereto shall be resolved by arbitration in accordance with the following provisions: (a) the forum for arbitration shall be Denver, Colorado, (b) governing law shall be the laws of the State of Colorado, (c) the number of arbitrators shall be one (1), who shall be a retired judge; (d) arbitration shall be administered by JAMS; (e) the rules of arbitration shall be as determined by JAMS, as modified by any other instructions that the parties hereto may agree upon at the time; (f) the award rendered by arbitration shall be final and binding upon the parties hereto, and judgment on the award may be entered in any court of competent jurisdiction in the United States; (g) Employer and Employee shall each pay fifty percent (50%) of the fees and costs charged by the arbitrator and/or JAMS. Notwithstanding the foregoing, Employer and/or Parent shall be entitled to seek equitable relief from a court of competent jurisdiction for any alleged violation of Section 4 (Covenant Not to Compete, Covenant Not to Solicit, and Confidentiality).

5.5 Waiver of Jury Trial. Each of the parties hereto hereby irrevocably waives to the fullest extent permitted by applicable law any right he or it may have to a trial by jury with respect to any action directly or indirectly arising out of, under or in connection with this Agreement. Each of the parties hereto hereby (a) certifies that no representative of any other party has represented, expressly or otherwise, that such other party would not, in the event of any such action, seek to enforce the foregoing wavier; and (b) acknowledges that it has been induced to enter into this Agreement and the transactions, as applicable, by, among other things, the mutual waivers and certifications in this Section 5.5 (Waiver of Jury Trial).

5.6 Construction. Each party has cooperated in the drafting and preparation of this Agreement. Hence, in any construction to be made of this Agreement, the same shall not be construed against any party on the basis that the party was the drafter. The captions of this Agreement are not part of the provisions hereof and shall have no force or effect.

5.7 Execution. This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument. Photographic or facsimile copies of such signed counterparts may be used in lieu of the originals for any purpose.

5.8 Legal Counsel. Employee and Employer recognize that this is a legally binding contract and acknowledge and agree that they have had the opportunity to consult with legal counsel of their choice.

5.9 Waiver. The waiver by any party of a breach of any provision of this Agreement by the other shall not operate or be construed as a waiver of any other or subsequent breach of such or any provision.

5.10 Invalidity of Provision. In the event that any provision of this Agreement is determined to be illegal, invalid, or void for any reason, the remaining provisions hereof shall continue in full force and effect.

5.11 Approval by DaVita Inc. as to Form. The parties acknowledge and agree that this Agreement shall take effect and be legally binding upon the parties only upon full execution hereof by the parties and upon approval by DaVita Inc. as to the form of hereof.

The remainder of this page is left blank intentionally.

IN WITNESS WHEREOF, the parties hereto have entered into this Agreement effective as of the date and year first written above.

DAVITA INC.

By: /s/ Kent J. Thiry
Date: November 2, 2016

EMPLOYEE / CHARLES G. BERG

By: /s/ Charles G. Berg
Date: November 2, 2016

HEALTHCARE PARTNERS, LLC

By: /s/ Kent J. Thiry
Date: November 2, 2016

Approved by DaVita Inc. as to Form:

/s/ Kathleen A. Waters
Kathleen A. Waters
Chief Legal Officer

Exhibit 10.13

EMPLOYMENT AGREEMENT

This Employment Agreement (this "Agreement") is made effective as of January 3, 2017 (the "Effective Date"), by and between DaVita Inc. ("Parent") and one of its controlled affiliates, TRC Total Renal Care, Inc. ("Employer," and collectively with Parent, "DaVita") and Joel Ackerman ("Employee").

In consideration of the mutual covenants and agreements hereinafter set forth and for other good and valuable consideration, the parties hereto, intending to be legally bound hereby, agree as follows:

Section 1. Employment and Duties. Employer and Employee expect that Employee's employment will commence on or about February 21, 2017. Employee will serve initially in the position of Senior Vice President, Finance until the close of business on the first business day following the day on which Parent files its Annual Report on Form 10-K for the year ended December 31, 2016 with the Securities and Exchange Commission, when Employee will begin serving in the position of Chief Financial Officer, provided that if Employee commences employment on or after the first business day following the day on which the Parent files such Form 10-K, he shall immediately begin serving in the position of Chief Financial Officer. Employee accepts such employment on the terms and conditions set forth in this Agreement. Employee shall report to Parent's Chief Executive Officer and shall perform the duties of Chief Financial Officer or any additional or different duties that are similar to or consistent with that position. Initially, Employee shall work out of New York, New York, although the location is subject to change to suit business needs, provided however, that relocation of the office more than thirty-five (35) miles from its current location shall constitute "Good Reason" for Employee to resign as set forth below in this Agreement. Employee agrees to devote substantially all of his time, energy, and ability to the business of Employer on a full-time basis and shall not engage in any other business activities during the term of this Agreement, including but not limited to providing consulting services to any investment firm, such as a hedge fund, provided however, Employee may pursue other normal charitable activities so long as such activities do not interfere with his ability to perform his duties. Employee agrees that he shall not serve on the board of directors, advisory board, or similar oversight body of any other not-for-profit or for-profit company, entity or institution without the express written approval of the Chief Executive Officer or the Board of Directors. Notwithstanding the foregoing, Employer agrees that Employee may continue his role on the Board of Directors of Kindred Healthcare, Champions Oncology and One Acre Fund. Employee shall at all times observe and abide by the Employer's policies and procedures as in effect from time to time.

Section 2. Compensation. In consideration of the services to be performed by Employee hereunder, Employee shall receive the following compensation and benefits:

2.1 Base Salary. Employer shall pay Employee a base salary of $700,000 per annum, less standard withholdings and authorized deductions. Employee shall be paid consistent with Employer's payroll schedule. The base salary will be reviewed from time to time. Employer, in its sole discretion, may increase the base salary as a result of any such review. Employer may not reduce Employee's base salary unless the Employee authorizes it in writing or the Employer is reducing the base salary of other similarly-situated executives by a similar percentage.

2.2 Benefits. Employee and/or his family, as the case may be, shall be eligible for participation in and shall receive all benefits under Employer's health and welfare benefit plans (including, without limitation, medical, prescription, dental, disability, and life insurance) under the same terms and conditions applicable to most executives at similar levels of compensation and responsibility.

2.3 Sign-On Bonus. Employer will pay Employee a sign-on bonus of two hundred thousand dollars ($200,000), less standard withholdings and authorized deductions, within twenty-one (21) days after Employee's first date of employment with Employer.

2.4 Performance Bonus.

(a) Employee shall be eligible to receive an annual cash bonus under the short-term incentive program approved by the Parent's Board of Directors and applicable to the company's executive officers exposed to the requirements of Section 162(m) of the Internal Revenue Code (the "Short-Term Incentive Program", or "STI Program"). Under the STI Program, the actual annual cash bonus amount payable to Employee for any one year (the "Bonus") is primarily contingent on the level of the Employer's achievement on the performance metrics specified in the Short-Term Incentive Program for that year. For fiscal year 2017, the Bonus payable to Employee in cash under the STI Program will be an amount between zero and $1,500,000. Employee shall not be eligible for any Bonus for fiscal year 2016.

(b) For Employee and other senior executives subject to the STI Program, the amounts of annual Bonuses earned are objectively and formulaically driven, further subject to negative discretion (i.e., further downward adjustment) in the sole discretion of the Board of Directors or the Compensation Committee of the Board of Directors.

(c) Subject to the terms of Section 3.3 (Other Termination), Employee must be employed by Employer (or an affiliate) on the date any Bonus is paid to be eligible to receive such Bonus and, if Employee is not employed by Employer (or an affiliate) on the date any Bonus is paid for any reason whatsoever, Employee shall not be entitled to receive such Bonus.

2.5 Vacation. Employee shall have vacation, subject to the approval of his direct manager.

2.6 Stock Appreciation Rights. Parent shall issue a grant to Employee of stock-settled Stock Appreciation Rights ("SSARs") with a value of two million dollars ($2,000,000) as customarily determined by Parent. This grant shall have a five-year term and vest 50% on the third and fourth anniversaries of the grant date. The base price of the award shall be the closing price as reported on the New York Stock Exchange on the start date of Employee's employment, or the date the SSAR grant has been formally approved by the appropriate authorized body or Officer, whichever date is later. The terms of the SSAR grant will be reflected in a separate agreement to be signed by Parent and Employee, which may include, among other terms, a noncompetition agreement.

2.7 Performance Stock Units and/or Restricted Stock Units. In early 2017, at the time when Parent makes grants to its other similarly-situated senior officers, Parent will grant Employee one million dollars ($1,000,000) in value of Employer's Performance Stock Units ("PSUs") and/or Restricted Stock Units ("RSUs"), with value determined similarly to such other senior officers, subject to the following time vesting conditions: such PSUs and/or RSUs shall vest fifty percent (50%) each on approximately the third and fourth anniversaries of the grant date**.** The composition of the grant (i.e., the number of PSUs and/or RSUs) will be determined by Parent in its sole discretion. Parent will determine, in its sole discretion, the performance targets for any PSU grant. The terms of the PSU and/or RSU grant(s) will be reflected in a separate Performance Stock Units Agreement and/or Restricted Stock Units Agreement to be signed by Parent and Employee, and each agreement may include, among other terms, a noncompetition agreement.

2.8 Management Share Ownership Policy. Employee shall review and understand the terms of the Management Share Ownership Policy with respect to all equity-based awards to the extent it applies to Employee.

2.9 Return of Compensation or other Property Received in Connection with Director, Officer, Shareholder or Similar Position. All fees, compensation, other remuneration, dividends, distributions, or other property or financial benefit received by Employee in connection with Employee's position as a director, officer, member, shareholder, partner or any other similar position of any controlled or uncontrolled direct or indirect subsidiary or affiliate of Employer, or other contractual obligor to Employer or any of its subsidiaries or affiliates the obligations of which constitute revenue to Employer or any of its subsidiaries or affiliates and of which Employee beneficially owns or has the right to acquire, directly or indirectly, 10% or more of the equity interests or has the power to vote 10% or more of the voting interests, shall belong to Employer and shall be immediately remitted to Employer. Notwithstanding the foregoing, this provision shall not apply to any amounts payable to, earned by, received by or otherwise due to Employee as employment compensation from Employer or any of its subsidiaries or affiliates, or any dividends or other distributions received by Employee in Employee's capacity as a stockholder of Parent.

2.10 Indemnification. In the event that the Employee is made a party or threatened to be made a party to any action, suit, or proceeding, whether civil, criminal, administrative, or investigative, by reason of the fact that he is or was a Director or officer of the Parent or Employer, or while a director or officer of the Parent or Employer is or was serving at the request of the Parent or Employer as a Director, officer, employee, or agent of another corporation or of a partnership, joint venture, trust or other enterprise, the Employee shall be indemnified and held harmless by the Parent and Employer to the fullest extent permitted under applicable law and the Parent's bylaws, and as specifically set forth in the Parent's bylaws, as the same exist or may hereafter be amended by Parent.

2.11 Reimbursement. Employer also agrees to reimburse Employee in accordance with Employer's reimbursement policies for travel and entertainment expenses, as well as other business-related expenses, incurred in the performance of his duties hereunder.

2.12 Changes to Benefit Plans. Employer reserves the right to modify, suspend, or discontinue any and all of its health and welfare benefit plans, practices, policies, and programs at any time without recourse by Employee so long as such action is taken generally with respect to all other similarly-situated peer executives and does not single out Employee.

2.13 Possible Recoupment of Certain Compensation. Notwithstanding any other provision in this Agreement to the contrary, Employee shall be subject to the written policies of the Board of Directors applicable to executives of the Employer, including without limitation any Board policy relating to recoupment or "claw back" of compensation, as they exist from time to time during the Employee's employment by the Employer and thereafter.

Section 3. Provisions Relating to Termination of Employment.

3.1 Employment Is At-Will. Employee's employment with Employer is "at will" and is terminable by Employer or by Employee at any time and for any reason or no reason, subject to the notice requirements set forth below.

3.2 Termination for Material Cause. Employer may terminate Employee's employment for Material Cause (as defined below). Upon termination for Material Cause, Employee shall (i) be entitled to receive the Base Salary and benefits as set forth in Section 2.1 (Base Salary) and Section 2.2 (Benefits), respectively, through the effective date of such termination and (ii) not be entitled to receive any other compensation, benefits, or payments of any kind, except as otherwise required by law or by the terms of any benefit or retirement plan or other arrangement that would, by its terms, apply.

3.3 Other Termination.

(a) Employer may terminate the employment of Employee for any reason or for no reason at any time upon at least thirty (30) days' advance written notice. If prior to the first anniversary of the date Employee commences employment, Employee resigns for "Good Reason," or Employer terminates the employment of Employee for reasons other than for death, Material Cause, or Disability, and contingent upon Employee's execution of the Employer's standard Severance and General Release Agreement within twenty-eight days of the termination of Employee's employment, Employee shall be entitled to the benefits set forth in the DaVita Inc. Severance Plan, pursuant to the terms and conditions of that plan as they exist at the time of the termination of Employee's employment.

(b) If on, or after, the first anniversary of date Employee's employment commences, Employee resigns for "Good Reason," or Employer terminates Employee's employment for any reasons other than death, Material Cause, or Disability, Employee shall be entitled to receive: (i) the benefits set forth in the DaVita Inc. Severance Plan, pursuant to the terms and conditions of that plan as they exist at the time of termination of Employee's employment; (b) a bonus in the amount Employee received for the previous year pro-rated based on the number of months served in the year that Employee's employment is terminated; and (c) any amounts due Employee under any stock option, stock grant, or any other compensation plan, in the accordance of the terms of such plan(s). Moreover, if the Employee timely and properly elects health continuation coverage under COBRA, the Employer shall pay for the employer portion of the cost of health continuation coverage for Employee and his dependents. Employer shall make such payments until the earliest of: (i) the eighteen-month anniversary of the Termination Date; (ii) the date the Employee is no longer eligible to receive COBRA continuation coverage; and (iii) the date on which the Employee receives/becomes eligible to receive substantially similar coverage from another employer or other source.

(c) For purposes of this provision, an Employee's employment has been terminated when Employee is no longer providing services for Employer after a specific date or the level of bona fide services that Employee would perform (as an employee or independent contractor) after a specific date would permanently decrease to no more than 20% of the average level of bona fide services performed over the immediately preceding thirty-six month period (or the full period of service if Employee was employed for less than thirty-six months).

3.4. Change in Control Termination. Notwithstanding any other provision contained herein, if the Employee's employment hereunder is terminated by the Employee for Good Reason or by the Employer without Material Cause (other than on account of the Employee's death or Disability), in each case at the time of, or within twelve (12) months following, a Change in Control, the Employee shall be entitled to receive the following:

(a) a lump sum payment equal to two (2) times the sum of the Employee's Base Salary and an amount equal to the bonus received for the year previous to the year in which the Termination Date occurs; and

(b) if the Employee timely and properly elects health continuation coverage under COBRA, the Employer shall pay for the employer portion of the cost of health continuation coverage for Employee and his dependents. Employer shall make such payments until the earliest of: (i) the eighteen-month anniversary of the Termination Date; (ii) the date the Employee is no longer eligible to receive COBRA continuation coverage; and (iii) the date on which the Employee receives/becomes eligible to receive substantially similar coverage from another employer or other source.

3.5 Voluntary Resignation. Employee may resign from Employer at any time upon at least thirty (30) days' advance written notice. If Employee resigns from Employer, Employee shall (i) be entitled to receive the base salary and benefits as set forth in Section 2.1 (Base Salary) and Section 2.2 (Benefits), respectively, through the effective date of such termination and (ii) not be entitled to receive any other compensation, benefits, or payments of any kind, except as otherwise required by law or by the terms of any benefit or retirement plan or other arrangement that would, by its terms, apply. In the event Employee resigns from Employer at any time, Employer shall have the right to make such resignation effective as of any date before the expiration of the required notice period.

3.6 Disability. Upon thirty (30) days' advance notice (which notice may be given before the completion of the periods described herein), Employer may terminate Employee's employment for Disability (as defined below).

3.7 Definitions. For the purposes of this Agreement, the following terms shall have the meanings indicated:

(a) "Disability" shall mean the inability, for a period of six (6) months, to adequately perform Employee's regular duties, with or without reasonable accommodation, due to a physical or mental illness, condition, or disability.

(b) "Material Cause" shall mean any of the following: (i) conviction of a felony or plea of no contest to a felony; (ii) any act of fraud or dishonesty in connection with the performance of his duties; (iii) repeated failure or refusal by Employee to follow policies or directives reasonably established by the Chief Executive Officer of Parent or his/her designee that goes uncorrected for a period of ten (10) consecutive days after written notice has been provided to Employee; (iv) a material breach of this Agreement; (v) any gross or willful misconduct or gross negligence by Employee in the performance of his duties; (vi) egregious conduct by Employee that brings Employer or any of its subsidiaries or affiliates into public disgrace or disrepute; (vii) an act of unlawful discrimination, including sexual harassment; (viii) a violation of the duty of loyalty or of any fiduciary duty; or (ix) exclusion or notice of exclusion of Employee from participating in any federal health care program.

Termination of the Employee's employment shall not be deemed to be for Material Cause unless and until the Employer delivers to the Employee a copy of a written notice finding that the Employee has engaged in the conduct described in any of (i)-(viii) above. Except for a failure, breach, or refusal which, by its nature, cannot reasonably be expected to be cured, the Employee shall have fourteen (14) calendar days from the delivery of written notice by the Employer within which to cure any acts constituting Material Cause; provided however, that, if the Employer reasonably expects irreparable injury from a delay of fourteen (14) calendar days, the Employer may give the Employee notice of such shorter period within which to cure as is reasonable under the circumstances, which may include the termination of the Employee's employment without notice and with immediate effect.

(c) "Good Reason" shall mean the occurrence of any of the following, in each case during the Employment Term without the Employee's written consent:

i. a material reduction in the Employee's Base Salary other than a general reduction in Base Salary that affects all similarly situated executives in substantially the same proportions; or

ii. a relocation of the Employee's principal place of employment by more than thirty-five (35) miles; or

iii. any material breach by the Employer of any material provision of this Agreement; or

iv. the Employer's failure to obtain an agreement from any successor to the Employer to assume and agree to perform this Agreement in the same manner and to the same extent that the Employer would be required to perform if no succession had taken place, except where such assumption occurs by operation of law; or

v. a material, adverse change in the Employee's title, authority, duties, or responsibilities (other than temporarily while the Employee is physically or mentally incapacitated or as required by applicable law) taking into account the Employer's size, status as a public company, and capitalization as of the date of this Agreement.

The Employee cannot terminate his employment for Good Reason unless he has provided written notice to the Employer of the existence of the circumstances providing grounds for termination for Good Reason within sixty (60) days of the initial existence of such grounds and the Employer has had at least sixty (60) days from the date on which such notice is provided to cure such circumstances. If the Executive does not terminate his employment for Good Reason within ninety (90) days after the first occurrence of the applicable grounds, then the Executive will be deemed to have waived his right to terminate for Good Reason with respect to such grounds.

(d) "Change in Control" shall mean (i) any transaction or series of transactions in which any person or group (within the meaning of Rule 13d-5 under the Exchange Act and Sections 13(d) and 14(d) of the Exchange Act) becomes the direct or indirect "beneficial owner" (as defined in Rule 13d-3 under the Exchange Act), by way of a stock issuance, tender offer, merger, consolidation, other business combination or otherwise, of greater than 50% of the total voting power (on a fully diluted basis as if all convertible securities had been converted and all warrants and options had been exercised) entitled to vote in the election of directors of Parent (including any transaction in which Parent becomes a wholly-owned or majority-owned subsidiary of another corporation), (ii) any merger or consolidation or reorganization in which Parent does not survive, (iii) any merger or consolidation in which Parent survives, but the shares of Parent's Common Stock outstanding immediately prior to such merger or consolidation represent 40% or less of the voting power of Parent after such merger or consolidation, and (iv) any transaction in which more than 40% of Parent's assets are sold. However, despite the occurrence of any of the above-directed events, a Change of Control will not have occurred if Kent Thiry remains the Chief Executive Officer or Executive Chair of Parent for at least one (1) year after the Change of Control or becomes the Chief Executive Officer or Executive Chair of the surviving company with which Parent merged or consolidated and remains in that position for at least one (1) year after the Change of Control.

3.8 Notice of Termination. Any purported termination of Employee's employment by Employer or by Employee shall be communicated by a written Notice of Termination to the other party hereto in accordance with Section 5 (Miscellaneous) hereof. A "Notice of Termination" shall mean a written notice that indicates the specific termination provision in this Agreement.

3.9 Effect of Termination. Upon termination, this Agreement shall be of no further force and effect and neither party shall have any further right or obligation hereunder; provided, however, that no termination shall modify or affect the rights and obligations of the parties that have accrued prior to termination; and provided further, that the rights and obligations of the parties under Section 3 (Provisions Relating to Termination of Employment), Section 4 (Noncompetition, Nonsolicitation, Confidentiality and Intellectual Property Agreement), and Section 5 (Miscellaneous) shall survive termination of this Agreement.

3.10 Notwithstanding any provision herein to the contrary, in the event that any payment to be made to Employee hereunder (whether pursuant to this Section 3 (Provisions Relating to Termination of Employment) or any other Section) as a result of Employee's termination of employment is determined to constitute "deferred compensation" subject to Section 409A of the Internal Revenue Code, and Employee is a "Key Employee" under the DaVita Inc. Key Employee Policy for 409A Arrangements at the time of Employee's termination of employment, all such deferred compensation payments payable during the first six (6) months following Employee's termination of employment shall be delayed and paid in a lump sum during the seventh calendar month following the calendar month during which Employee's termination of employment occurs.

Section 4: Noncompetition, Nonsolicitation, Confidentiality and Intellectual Property Agreement. Employee, contemporaneously herewith, shall enter into a Noncompetition, Nonsolicitation, Confidentiality and Intellectual Property Agreement, the terms of which are incorporated herein and made a part hereof as though set forth in this Agreement.

Section 5. Miscellaneous.

5.1 Arbitration. Any disagreement, dispute or claim arising out of or relating to this Agreement and/or Employee's employment with DaVita which cannot be settled by the parties hereto shall be resolved by arbitration in accordance with the following provisions: (a) the forum for arbitration shall be Denver, Colorado, (b) governing law shall be the laws of the State of Colorado, (c) the number of arbitrators shall be one (1), who shall be a retired judge; (d) arbitration shall be administered by JAMS; (e) the rules of arbitration shall be as determined by JAMS, as modified by any other instructions that the parties hereto may agree upon at the time; (f) the award rendered by arbitration shall be final and binding upon the parties hereto, and judgment on the award may be entered in any court of competent jurisdiction in the United States; (g) DaVita and Employee shall each pay fifty percent (50%) of the fees and costs charged by the arbitrator and/or JAMS. Notwithstanding the foregoing, DaVita shall be entitled to seek equitable relief from a court of competent jurisdiction for any alleged violation of Section 4 (Noncompetition, Nonsolicitation, Confidentiality and Intellectual Property Agreement).

5.2 Waiver of Jury Trial. Each of the parties hereto hereby irrevocably waives to the fullest extent permitted by applicable law any right he or it may have to a trial by jury with respect to any action directly or indirectly arising out of, under or in connection with this Agreement and/or Employee's employment with DaVita. Each of the parties hereto hereby (a) certifies that no representative of any other party has represented, expressly or otherwise, that such other party would not, in the event of any such action, seek to enforce the foregoing wavier; and (b) acknowledges that it has been induced to enter into this Agreement and the transactions, as applicable, by, among other things, the mutual waivers and certifications in this Section 5.2 (Waiver of Jury Trial).

5.3 Entire Agreement; Amendment. This Agreement represents the entire understanding of the parties hereto with respect to the employment of Employee and supersedes all prior agreements with respect thereto. This Agreement may not be altered or amended except in writing executed by both parties hereto.

5.4 Assignment; Benefit. This Agreement is personal and may not be assigned by Employee. This Agreement may be assigned by Employer and shall inure to the benefit of and be binding upon the successors and assigns of Employer.

5.5. Applicable Law. This Agreement shall be governed by the laws of the State of Colorado, without regard to the principles of conflicts of laws.

5.6 Notice. Notices and all other communications provided for in this Agreement shall be in writing and shall be deemed to have been duly given when delivered by (i) personal delivery, (ii) a nationally-recognized, next-day courier service, or (iii) first-class registered or certified mail, postage prepaid addressed to Employer at its principal office and to Employee at the address listed on Employee's invoices, provided that all notices to Employer shall be directed to the attention of the Chief Executive Officer, or to such other address as either party may have furnished to the other in writing in accordance herewith, except that notice of change of address shall be effective only upon receipt.

5.7 Construction. Each party has cooperated in the drafting and preparation of this Agreement. Hence, in any construction to be made of this Agreement, the same shall not be construed against any party on the basis that the party was the drafter. The captions of this Agreement are not part of the provisions hereof and shall have no force or effect.

5.8 Execution. This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument. Photographic, electronic or facsimile copies of such signed counterparts may be used in lieu of the originals for any purpose.

5.9 Legal Counsel. Employee and Employer recognize that this is a legally binding contract and acknowledge and agree that they have had the opportunity to consult with legal counsel of their choice.

5.10 Waiver. The waiver by any party of a breach of any provision of this Agreement by the other shall not operate or be construed as a waiver of any other or subsequent breach of such or any provision.

5.11 Invalidity of Provision. In the event that any provision of this Agreement is determined to be illegal, invalid, or void for any reason, the remaining provisions hereof shall continue in full force and effect.

5.12 Approval by DaVita Inc. as to Form. The parties acknowledge and agree that this Agreement shall take effect and be legally binding upon the parties only upon full execution hereof by the parties and upon approval by DaVita Inc. as to the form of hereof.

The remainder of this page is left blank intentionally.

IN WITNESS WHEREOF, the parties hereto have entered into this Agreement effective as of the date and year first written above.

DAVITA INC.

By /s/ Kent Thiry
Kent Thiry

Date: 01/04/17

EMPLOYEE

By /s/ Joel Ackerman
Joel Ackerman

Date: 01/04/17

Approved by DaVita Inc. as to Form:

/s/ Kathleen A. Waters
Name: Kathleen A. Waters
Title: Chief Legal Officer

EXHIBIT 10.16

DAVITA DEFERRED COMPENSATION PLAN

EFFECTIVE JANUARY 1, 2015

TABLE OF CONTENTS

		Page
ARTICLE I DEFINITIONS		1
ARTICLE II PARTICIPATION		5
ARTICLE III DEFERRAL ELECTIONS		6
3.1	Elections to Defer Compensation	6
3.2	Timing of Deferral Elections; Effect of Participant Election(s)	6
3.3	Investment Elections	7
3.4	Distribution Elections	8
ARTICLE IV ACCOUNTS		9
4.1	Deferral Accounts	9
4.2	Trust	9
4.3	Statement of Accounts	9
4.4	Vesting of Deferral Accounts	9
ARTICLE V DISTRIBUTIONS		10
5.1	Termination Distributions	10
5.2	Disability Distributions	10
5.3	Death Benefits	10
5.4	Scheduled In-Service Distributions	10
5.5	Hardship Distribution	11
5.6	Acceleration of Distributions Following a Change of Control	12
5.7	Form of Distribution	12
ARTICLE VI BENEFICIARY DESIGNATIONS AND OTHER PAYEES		13
6.1	Beneficiaries	13
6.2	Payments to Minors	13
6.3	Payments on Behalf of Persons Under Incapacity	13
ARTICLE VII LEAVE OF ABSENCE		13
7.1	Paid Leave of Absence	13
7.2	Unpaid Leave of Absence	14
ARTICLE VIII ADMINISTRATION		14
8.1	Committee	14

		Page
8.2	Claims Procedure	14
8.3	Review Procedures	15
ARTICLE IX MISCELLANEOUS		15
9.1	Termination of Plan	15
9.2	Amendment	15
9.3	Unsecured General Creditor	15
9.4	Restriction Against Assignment	16
9.5	Withholding	16
9.6	Code Section 409A	16
9.7	Effect of Payment	16
9.8	Errors in Account Statements, Deferrals or Distributions	16
9.9	Domestic Relations Orders	17
9.10	Employment Not Guaranteed	17
9.11	No Guarantee of Tax Consequences	17
9.12	Successors of the Company	17
9.13	Notice	17
9.14	Headings	17
9.15	Gender, Singular and Plural	17
9.16	Governing Law	17

DAVITA DEFERRED COMPENSATION PLAN

DaVita HealthCare Partners Inc., a Delaware corporation (the "**Company**"), hereby establishes the DaVita Deferred Compensation Plan (the "**Plan**"), effective January 1, 2015, (the "**Effective Date**"), for the purpose of providing a select group of management or highly compensated employees of the Company the opportunity to defer the receipt of Compensation otherwise payable to such employees in accordance with the terms of the Plan. The Plan is intended to, and shall be interpreted to, comply in all respects with Code Section 409A and those provisions of ERISA applicable to an unfunded plan maintained primarily to provide deferred compensation for a select group of management or highly compensated employees.

This Plan is considered a complete restatement of the DaVita Voluntary Deferral Plan and will apply to deferrals for 2015 and future years. Deferrals for 2014 and prior years shall be governed by the DaVita Voluntary Deferral Plan in effect on December 31, 2014.

ARTICLE I
DEFINITIONS

1.1 "**Account**" or "**Accounts**" shall mean the bookkeeping account or accounts established under this Plan pursuant to Article 4 and maintained by the Company in the names of the respective Participants, to which all amounts deferred under the Plan and earnings on such amounts shall be credited, and from which all amounts distributed under the Plan shall be debited.

1.2 "**Annual Incentive**" means a Participant's annual bonus payment, if any, that is earned in the same Plan Year as the Participant's Base Salary but is payable (if not deferred under this Plan) in the following Plan Year.

1.3 "**Base Salary**" shall mean a Participant's annual base salary, excluding incentive and discretionary bonuses, commissions, reimbursements and other non-regular remuneration, received from the Company prior to reduction for any salary deferrals under benefit plans sponsored by the Company, including but not limited to, plans established under Code Section 125 or Code Section 401(k).

1.4 "**Beneficiary**" or "**Beneficiaries**" shall mean the person, persons or entity designated as such pursuant to Section 7.1.

1.5 "**Board**" shall mean the Board of Directors of the Company.

1.6 "**Code**" shall mean the Internal Revenue Code of 1986, as amended, as interpreted by Treasury regulations and applicable authorities promulgated thereunder.

1.7 "**Committee**" shall mean the person or persons appointed by the Board to administer the Plan in accordance with Article 9.

1.8 "**Compensation**" shall mean all amounts eligible for deferral for a particular Plan Year under Section 3.1.

1.9 "**Deferral Account**" shall mean an Account maintained for each Participant that is credited with Participant deferrals pursuant to Section 4.1.

1.10 "**Disability**" or "**Disabled**" shall mean (consistent with the requirements of Code Section 409A) that the Participant is (a) unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or can be expected to last for a continuous period of not less than 12 months, or (b) by reason of any medically determinable physical or mental impairment which can be expected to result in death or can be expected to last for a continuous period of not less than 12 months, receiving income replacement benefits for a period of not less than three months under an accident and health plan covering employees of the Participant's Employer. For purposes of this Plan, a Participant shall be deemed Disabled if determined to be totally disabled by the Social Security Administration. A Participant shall also be deemed Disabled if determined to be disabled in accordance with the applicable disability insurance program of such Participant's Employer, provided that the definition of "disability" applied under such disability insurance program complies with the requirements of this Section.

1.11 "**Distributable Amount**" shall mean the vested balance in the applicable Account as determined under Article 4.

1.12 "**Eligible Executive**" shall mean a highly compensated or management level employee of an Employer selected by the Committee to be eligible to participate in the Plan.

1.13 "**Employer(s)**" shall be defined as follows:

(a) Except as otherwise provided in part (b) of this Section, the term "Employer" shall mean the Company and/or any of its subsidiaries (now in existence or hereafter formed or acquired) that have been selected by the Committee to participate in the Plan and have adopted the Plan as a participating Employer**.**

(b) For the purpose of determining whether a Participant has experienced a Separation from Service, the term "Employer" shall mean:

(1) The entity for which the Participant performs services and with respect to which the legally binding right to compensation deferred under this Plan arises; and

(2) All other entities with which the entity described above would be aggregated and treated as a single employer under Code Section 414(b) (controlled group of corporations) and Code Section 414(c) (a group of trades or businesses, whether or not incorporated, under common control), as applicable. In order to identify the group of entities described in the preceding sentence, the Committee shall use an ownership threshold of at least 50% as a substitute for the 80% minimum ownership threshold that appears in, and otherwise must be used when applying, the applicable provisions of (A) Code Section 1563 for determining a controlled group of corporations under Code Section 414(b), and (B) Treas. Reg. §1.414(c)-2 for determining the trades or businesses that are under common control under Code Section 414(c).

1.14 "**ERISA**" shall mean the Employee Retirement Income Security Act of 1974, as amended, including Department of Labor and Treasury regulations and applicable authorities promulgated thereunder.

1.15 "**Financial Hardship**" shall mean a severe financial hardship to the Participant resulting from an illness or accident of the Participant, the Participant's spouse, or a dependent (as defined in Code Section 152, without regard to Code Sections 152(b)(1), (b)(2), and (d)(1)(B))) of the Participant, loss of the Participant's property due to casualty, or other similar extraordinary and unforeseeable circumstances arising as a result of events beyond the control of the Participant, but shall in all events correspond to the meaning of the term "unforeseeable emergency" under Code Section 409A. No Financial Hardship shall be deemed to exist to the extent that the financial hardship is or may be relieved (a) through reimbursement or compensation by insurance or otherwise, (b) by borrowing from commercial sources on reasonable commercial terms to the extent that this borrowing would not itself cause a severe financial hardship, (c) by cessation of deferrals under the Plan, or (d) by liquidation of the Participant's other assets to the extent that this liquidation would not itself cause severe financial hardship. The Committee shall determine whether the circumstances of the Participant constitute a Financial Hardship.

1.16 "**Fund**" or "**Funds**" shall mean one or more of the investments selected by the Committee pursuant to Section 3.3 of the Plan.

1.17 "**Hardship Distribution**" shall mean an accelerated distribution of benefits or a cancellation of deferral elections pursuant to Section 5.5 to a Participant (including terminated Participants with Account balances) who has suffered a Financial Hardship.

1.18 "**Interest Rate**" shall mean, for each Fund, the rate of return derived from the net gain or loss on the assets of such Fund, as determined by the Committee.

1.19 "**Participant**" shall mean any Eligible Executive who becomes a Participant in this Plan in accordance with Article 2.

1.20 "**Participant Election(s)**" shall mean the forms or procedures by which a Participant makes elections with respect to (a) voluntary deferrals of his/her Compensation, (b) the Funds, which shall act as the basis for crediting of interest on Account balances, and (c) the form and timing of distributions from Accounts. Participant Elections may take the form of an electronic communication followed by appropriate confirmation according to specifications established by the Committee.

1.21 "**Payment Date**" shall mean the date by which a total distribution of the Distributable Amount shall be made or the date by which installment payments of the Distributable Amount shall commence, which shall be a date in January of the Plan Year following the Plan Year in which occurs the event triggering the distribution or, in the case of a Scheduled In-Service Distribution, in January of the Plan Year indicated by the Participant for the elected Scheduled In-Service Distribution. Notwithstanding the foregoing:

(a) The Payment Date shall not be before the earliest date on which benefits may be distributed under Code Section 409A without violation of the provisions thereof, as reasonably determined by the Committee.

(b) The Payment Date for a Scheduled In-Service Distribution may not be earlier than two years after the Plan Year to which the deferral election applies.

(c) To the extent required under Code Section 409A, any amount that otherwise would be payable to a Participant who is a "specified employee" of the Company, as determined by the Company in accordance with Code Section 409A, during the six-month period following such Participant's Separation from Service, shall be suspended until the lapse of such six-month period (or, if earlier, the date of death of the Participant). The amount that otherwise would be payable to such Participant during such period of suspension, together with interest on such suspended amount credited pursuant to the rules of the Plan, shall be paid in a single payment within 30 days following the end of such six-month period (or, if such day is not a business day, on the next succeeding business day) or within 30 days following the death of the Participant during such six-month period, provided that the death of the Participant during such six-month period shall not cause the acceleration of any amount that otherwise would be payable on any date during such six-month period following the date of the Participant's death.

1.22 "**Performance-Based Compensation**" shall mean compensation the entitlement to or amount of which is contingent on the satisfaction of pre-established organizational or individual performance criteria relating to a performance period of at least 12 consecutive months, as determined by the Committee in accordance with Treas. Reg. §1.409A-1(e).

1.23 "**Plan Year**" shall mean the calendar year.

1.24 "**Separation from Service**" shall mean a Separation from Services provided by a Participant to his or her Employer, whether voluntarily or involuntarily, other than by reason of death or Disability, as determined by the Committee in accordance with Treas. Reg. §1.409A-1(h). For a Participant who provides services to an Employer as an employee, a Separation from Service shall occur when such Participant has experienced a termination of employment with the Employer. A Participant shall be considered to have experienced a termination of employment when the facts and circumstances indicate that the Participant and his or her Employer reasonably anticipate that either (i) no further services will be performed for the Employer after a certain date, or (ii) that the level of bona fide services the Participant will perform for the Employer after such date (whether as an employee or as an independent contractor) will permanently decrease to no more than 20% of the average level of bona fide services performed by such Participant (whether as an employee or an independent contractor) over the immediately preceding 36-month period (or the full period of services to the employer if the Participant has been providing services to the Employer less than 36 months).

If a Participant is on military leave, sick leave, or other bona fide leave of absence, the employment relationship between the Participant and the Employer shall be treated as continuing intact, provided that the period of such leave does not exceed 6 months, or if longer, so long as the Participant retains a right to reemployment with the Employer under an applicable statute or by contract. If the period of a military leave, sick leave, or other bona fide leave of absence exceeds 6 months and the Participant does not retain a right to reemployment under an applicable statute or by contract, the employment relationship shall be considered to be terminated for purposes of this Plan as of the first day immediately following the end of such 6-month period. In applying the provisions of this paragraph, a leave of absence shall be considered a bona fide leave of absence only if there is a reasonable expectation that the Participant will return to perform services for the Employer.

1.25 "**Scheduled In-Service Distribution**" shall mean a scheduled in-service distribution date elected by the Participant for distribution of amounts from a specified Deferral Account, including earnings thereon, which distribution shall be made provided that the Participant has not experienced a Separation from Service, as provided under Section 5.4.

1.26 "**Years of Service**" shall mean the cumulative consecutive years of continuous full-time employment with the Employer (including approved leaves of absence of six months or less or legally protected leaves of absence), beginning on the date the Participant first began service with the Employer, and counting each anniversary thereof. A partial year of employment shall not be treated as a Year of Service.

ARTICLE II
PARTICIPATION

2.1 Enrollment Requirements; Commencement of Participation

(a) As a condition to participation, each Eligible Executive shall complete, execute and return to the Committee the appropriate Participant Elections, as well as such other documentation and information as the Committee reasonably requests, by the deadline(s) established by the Committee. In addition, the Committee shall establish from time to time such other enrollment requirements as it determines, in its sole discretion, are necessary.

(b) Each Eligible Executive shall commence participation in the Plan on the date that the Committee determines that the Eligible Executive has met all enrollment requirements set forth in this Plan and required by the Committee, including returning all required documents to the Committee within the specified time period.

(c) If an Eligible Executive fails to meet all requirements established by the Committee within the period required, that Eligible Executive shall not be eligible to participate in the Plan during such Plan Year.

ARTICLE III
DEFERRAL ELECTIONS

3.1 Elections to Defer Compensation. Elections to defer Compensation shall take the form of a flat dollar amount or a whole percentage (less applicable payroll withholding requirements for Social Security and income taxes and employee benefit plans, as determined in the sole and absolute discretion of the Committee) of up to a maximum of:

(1) 50% of Base Salary; and

(2) 100% of Annual Incentives.

3.2 Timing of Deferral Elections; Effect of Participant Election(s).

(a) General Timing Rule for Deferral Elections. Except as otherwise provided in this Section 3.2, in order for a Participant to make a valid election to defer Compensation, the Participant must submit Participant Election(s) on or before the deadline established by the Committee, which shall be no later than the December 31st preceding the Plan Year in which such Compensation will be earned.

Any deferral election made in accordance with this Section 3.2(a) shall be irrevocable; provided, however, that if the Committee permits Participants to make a deferral election by the deadline described above for an amount that qualifies as Performance-Based Compensation, the Committee may permit a Participant to subsequently change his or her deferral election for such compensation by submitting new Participant Election(s) in accordance with Section 3.2(c) below.

(b) Timing of Deferral Elections for New Plan Participants. An Eligible Executive who first becomes eligible to participate in the Plan on or after the beginning of a Plan Year, as determined in accordance with Treas. Reg. §1.409A-2(a)(7)(ii) and the "plan aggregation" rules provided in Treas. Reg. §1.409A-1(c)(2), may be permitted to make an election to defer the portion of Compensation attributable to services to be performed after such election, provided that the Participant submits Participant Election(s) on or before the deadline established by the Committee, which in no event shall be later than thirty (30) days after the Participant first becomes eligible to participate in the Plan.

If a deferral election made in accordance with this Section 3.2(c) relates to compensation earned based upon a specified performance period, the amount eligible for deferral shall be equal to (i) the total amount of compensation for the performance period, multiplied by (ii) a fraction, the numerator of which is the number of days remaining in the service period after the Participant's deferral election is made, and the denominator of which is the total number of days in the performance period.

Any deferral election made in accordance with this Section 3.2(c) shall become irrevocable no later than the 30th day after the date the Participant first becomes eligible to participate in the Plan.

(c) Timing of Deferral Elections for Performance-Based Compensation. Subject to the limitations described below, the Committee may determine that an irrevocable deferral election for an amount that qualifies as Performance-Based Compensation may be made by submitting Participant Election(s) on or before the deadline established by the Committee, which in no event shall be later than six (6) months before the end of the performance period.

In order for a Participant to be eligible to make a deferral election for Performance-Based Compensation in accordance with the deadline established pursuant to this Section 3.2(d), the Participant must have performed services continuously from the later of (i) the beginning of the performance period for such compensation, or (ii) the date upon which the performance criteria for such compensation are established, through the date upon which the Participant makes the deferral election for such compensation. In no event shall a deferral election submitted under this Section 3.2(d) be permitted to apply to any amount of Performance-Based Compensation that has become readily ascertainable.

(d) Duration of Compensation Deferral Election. A deferral election made for any Plan Year shall be applicable only for that Plan Year; provided, however, that the Committee may permit a Participant to elect, pursuant to procedures established by the Committee, to have his or her deferral election continue in effect for future Plan Years, until terminated or changed by the Participant prior to the beginning of a Plan Year.

3.3 Investment Elections.

(a) Participant Designation. At the time of entering the Plan and/or of making a deferral election under the Plan, the Participant shall designate, on a Participant Election provided by the Committee, the Funds in which the Participant's Accounts shall be deemed to be invested for purposes of determining the amount of earnings and losses to be credited to each Account. The Participant may specify that all or any percentage of his or her Accounts shall be deemed to be invested, in whole percentage increments, in one or more of the Funds selected as alternative investments under the Plan from time to time by the Committee pursuant to subsection (b) of this Section. If a Participant fails to make an election among the Funds as described in this Section, the Participant's Account balance shall automatically be allocated into the default Fund selected by the Committee. A Participant may change any designation made under this Section as permitted by the Committee by filing a revised election, on a Participant Election provided by the Committee. Notwithstanding the foregoing, the Committee, in its sole discretion, may impose limitations on the frequency with which one or more of the Funds elected in accordance with this Section may be added or deleted by such Participant; furthermore, the Committee, in its sole discretion, may impose limitations on the frequency with which the Participant may change the portion of his or her Account balance allocated to each previously or newly elected Fund.

(b) Investment Funds. The Committee, in its sole discretion, may select each of the types of commercially available investments communicated to the Participant pursuant to subsection (a) of this Section to be the Funds. The Interest Rate of each such commercially available investment shall be used to determine the amount of earnings or losses to be credited to the Participant's Account under Article IV. The Participant's choice among investments shall be solely for purposes of calculation of the Interest Rate on Accounts. The Company and the Employers shall have no obligation to set aside or invest amounts as directed by the Participant and, if the Company and/or the Employer elects to invest amounts as directed by the Participant, the Participant shall have no more right to such investments than any other unsecured general creditor.

3.4 Distribution Elections.

(a) Initial Election. At the time of making a deferral election under the Plan, the Participant shall designate the time and form of distribution of deferrals made pursuant to such election (together with any earnings credited thereon) from among the alternatives specified under Article VI for the applicable distribution. A new distribution election may be made at the time of subsequent deferral elections with respect to deferrals in Plan Years beginning after the election is made, in accordance with the Participant Election forms.

(b) Modification of Election. A distribution election with respect to previously deferred amounts may only be changed under the terms and conditions specified in Code Section 409A and this Section. Except as permitted under Code Section 409A, no acceleration of a distribution is permitted. A subsequent election that delays payment or changes the form of payment shall be permitted only if all of the following requirements are met:

(1) the new election does not take effect until at least twelve (12) months after the date on which the new election is made;

(2) except for payments to be made upon Disability, death or Financial Hardship, the new election delays payment for at least five (5) years from the date that payment would otherwise have been made, absent the new election; and

(3) in the case of payments made according to a Scheduled In-Service Distribution, the new election is made not less than twelve (12) months before the date on which payment would have been made (or, in the case of installment payments, the first installment payment would have been made) absent the new election.

Only one subsequent election to modify any initial distribution election for any Plan Year's deferrals (either a Scheduled In-Service Distribution, or any other distribution election) is permitted for any Participant and Participants may make a subsequent election only while employed by the Employer. A Beneficiary of a deceased Participant is not permitted to make a subsequent election under this Section. For purposes of application of the above change limitations, installment payments shall be treated as a single payment under Code Section 409A. Election changes made pursuant to this Section shall be made in accordance with rules established by the Committee and shall comply with all requirements of Code Section 409A and applicable authorities.

ARTICLE IV
ACCOUNTS

4.1 Deferral Accounts. The Committee shall establish and maintain such Deferral Accounts as are necessary for each Participant under the Plan. Each Participant's Deferral Account shall be further divided into separate subaccounts ("Fund Subaccounts"), each of which corresponds to a Fund designated pursuant to Section 3.3. A Participant's Deferral Account shall be credited as follows:

(a) As soon as reasonably possible after amounts are withheld and deferred from a Participant's Compensation, the Committee shall credit the Fund Subaccounts of the Participant's Deferral Account with an amount equal to Compensation deferred by the Participant in accordance with the designation under Section 3.3; that is, the portion of the Participant's deferred Compensation designated to be deemed to be invested in a Fund shall be credited to the Fund Subaccount to be invested in that Fund;

(b) Each business day, each Fund Subaccount of a Participant's Deferral Account shall be credited with earnings or losses in an amount equal to that determined by multiplying the balance credited to such Fund Subaccount as of the prior day, less any distributions valued as of the end of the prior day, by the Interest Rate for the corresponding Fund as determined by the Committee pursuant to Section 3.3(b); and

(c) In the event that a Participant elects for a given Plan Year's deferral of Compensation a Scheduled In-Service Distribution, all amounts attributed to the deferral of Compensation for such Plan Year shall be accounted for in a manner which allows separate accounting for the deferral of Compensation and investment gains and losses associated with amounts allocated to each such separate Scheduled In-Service Distribution.

4.2 Trust. The Company shall be responsible for the payment of all benefits under the Plan. At its discretion, the Company may establish one or more grantor trusts for the purpose of providing for payment of benefits under the Plan. Such trust or trusts may be irrevocable, but the assets thereof shall be subject to the claims of the Company's creditors. Benefits paid to the Participant from any such trust or trusts shall be considered paid by the Company for purposes of meeting the obligations of the Company under the Plan.

4.3 Statement of Accounts. The Committee shall provide each Participant with electronic statements at least quarterly setting forth the Participant's Account balance as of the end of each applicable period.

4.4 Vesting of Deferral Accounts . The Participant shall be vested at all times in amounts credited to the Participant's Deferral Account(s).

ARTICLE V
DISTRIBUTIONS

5.1 Distributions Upon Separation from Service.

(a) Timing and Form of Distributions Upon Separation from Service. Except as otherwise provided herein, in the event of a Participant's Separation from Service, the Distributable Amount credited to the Participant's Deferral Accounts shall be paid or commence to be paid to the Participant in the form of cash or other property on the Payment Date following the Participant's Separation from Service, in one lump sum payment unless the Participant has made a distribution election on a timely basis to receive substantially equal annual installments over a period of up to twenty (20) years; provided, however, that if distributions to the Participant have commenced as of the Participant's Separation from Service pursuant to a Scheduled In-Service Distribution election, then those Scheduled In-Service Distributions shall continue in effect.

(b) Small Benefit Exception. Notwithstanding any distribution election to the contrary, if on commencement of benefits payable from an Account by reason of a Participant's Separation from Service, the Distributable Amount from such Account is less than or equal to $20,000, the total Distributable Amount from such Account shall be paid in one lump sum payment of cash or other property on the scheduled Payment Date.

5.2 Disability Distributions. Except as otherwise provided herein, in the event of a Participant's Disability prior to Separation from Service, the Distributable Amount credited to the Participant's Deferral Accounts and Company Contribution Account shall be paid to the Participant in one lump sum payment of cash or other property on the Payment Date following the Participant's Disability.

5.3 Death Benefits.

(a) Prior to Commencement of Benefits. In the event that the Participant dies prior to commencement of a benefit described in this Article VI, the Participant's Beneficiary shall receive a death benefit equal to the Distributable Amount credited to the Participant's Deferral Accounts in one lump sum payment of cash or property on the Payment Date following the Participant's death.

(b) After Commencement of Benefits. In the event that the Participant dies after commencement of a benefit described in this Article VI, such Participant's remaining benefits shall be paid to the Participant's Beneficiary in one lump sum payment of cash or property on the Payment Date following the Participant's death.

5.4 Scheduled In-Service Distributions.

(a) Scheduled In-Service Distribution Election. Participants who have not had a Separation from Service from the Employer shall be entitled to elect to receive a Scheduled In-Service Distribution from a Deferral Account. If a Participant has a Separation from Service with the Employer prior to commencement of payment of the Scheduled In-Service Distribution,

distribution will not be made pursuant to this subsection (a) but will instead be made pursuant to Section 5.1(a) above. In the case of a Participant who has elected to receive a Scheduled In-Service Distribution, such Participant shall receive the Distributable Amount, with respect to the specified deferrals, including earnings thereon, which have been elected by the Participant to be subject to such Scheduled In-Service Distribution election. The Committee shall determine the earliest commencement date that may be elected by the Participant for each Scheduled In-Service Distribution and such date shall be indicated on the Participant Election. The Participant may elect to receive the Scheduled In-Service Distribution in a single lump sum or in substantially equal annual installments over a period of up to twenty (20) years. A Participant may delay and change the form of a Scheduled In-Service Distribution, provided such extension complies with the requirements of Section 3.4.

(b) Small Benefit Exception. Notwithstanding any Scheduled In-Service Distribution election to the contrary, if on commencement of a Scheduled In-Service Distribution, the balance of such Scheduled In-Service Distribution is less than or equal to $20,000, the Scheduled In-Service Distribution amount from such Account shall be paid in one lump sum payment of cash or other property on the Scheduled In-Service Distribution date.

(c) Relationship to Other Benefits. In the event that distribution of a Participant's Account is triggered under Section 5.1, 5.2, or 5.3 prior to commencement of a Scheduled In-Service Distribution, the amounts subject to such Scheduled In-Service Distribution shall not be distributed under this Section 5.4, but rather shall be distributed in accordance with the other applicable Section of this Article V.

5.5 Hardship Distribution. Upon a finding that the Participant has suffered a Financial Hardship, in accordance with Code Section 409A, the Committee may, at the request of the Participant, accelerate distribution of benefits and/or approve cancellation of deferral elections under the Plan, subject to the following conditions:

(a) The request to take a Hardship Distribution shall be made by filing a form provided by and filed with the Committee prior to the end of any calendar month.

(b) Upon a finding that the Participant has suffered a Financial Hardship under Code Section 409A, the Committee may, at the request of the Participant, accelerate distribution of benefits and/or approve cancellation of current deferral elections under the Plan in the amount reasonably necessary to alleviate such Financial Hardship. The amount distributed pursuant to this Section with respect to the Financial Hardship shall not exceed the amount necessary to satisfy such Financial Hardship, plus amounts necessary to pay taxes reasonably anticipated as a result of the distribution, after taking into account the extent to which such hardship is or may be relieved through reimbursement or compensation by insurance or otherwise or by liquidation of the Participant's assets (to the extent the liquidation of such assets would not itself cause severe financial hardship).

(c) The amount (if any) determined by the Committee as a Hardship Distribution shall be paid in a single cash lump sum as soon as practicable after the end of the calendar month in which the Hardship Distribution determination is made by the Committee.

5.6 Acceleration of Distributions Following a Change of Control. Notwithstanding any other provision of this Plan, upon the occurrence of a Change of Control of the Company, all Accounts under this Plan will be distributed in one lump sum payment of cash or property on the first day of the month following fifteen (15) months after the Change of Control; provided, however, that a Participant may make a subsequent election under Section 3.4(b) to delay such distribution within 90 days after the Change of Control. For purposes of this Section, "Change of Control" means

(a) any transactions or series of transactions in which any person or group (within the meaning of Rule 13d-5 under the Exchange Act and Sections 13(d) and 14(d) under the Exchange Act) becomes the direct or indirect "beneficial owner" (as defined in Rule 13d-3 under the Exchange Act), by way of stock issuance, tender offer, merger, consolidation, other business combination or otherwise, of greater than 50% of the total voting power (on a fully diluted basis as if all convertible securities had been converted and all warrants and options had been exercised) entitled to vote in the election of directors of the Company (including any transaction in which the Company becomes a wholly-owned or majority-owned subsidiary of another corporation), or

(b) any merger or consolidation or reorganization in which the Company does not survive, or

(c) any merger or consolidation in which the Company survives, but the shares of the Company's common stock outstanding immediately prior to such merger or consolidation represent 50% or less of the voting power of the Company after such merger or consolidation, or

(d) (iv) any transaction in which more than 50% of the Company's assets are sold;

provided, however, that no transaction contemplated by clauses (a) though (d) above shall constitute a Change of Control if both (i) the person acting as the Chief Executive Officer of the Company for six months prior to such transaction becomes the Chief Executive Officer or Executive Chairman of the board of directors of the entity that has acquired control of the Company as a result of such transaction (the "Acquiror") immediately after such transaction and remains the Chief Executive Officer or Executive Chairman of the board for not less than one year following the transaction and (ii) a majority of the Acquiror's board of directors immediately after such transaction consist of persons who were directors of the Company immediately prior to such transaction.

Notwithstanding the above, no transaction shall be considered a Change of Control under this Plan unless such transaction constitutes a change in the ownership or effective control of the Company or a change in the ownership of a substantial portion of the assets of the Company, in each case within the meaning of Code Section 409A.

5.7 Form of Distribution. Generally, distributions from the Plan shall be made in the form of cash, unless the Committee determines that such distributions shall be made in property.

ARTICLE VI
BENEFICIARY DESIGNATIONS AND OTHER PAYEES

6.1 Beneficiaries.

(a) Beneficiary Designation. The Participant shall have the right, at any time, to designate any person or persons as Beneficiary (both primary and contingent) to whom payment under the Plan shall be made in the event of the Participant's death. No consent of the Participant's spouse or any other person is required for the Participant to name a Beneficiary. The Beneficiary designation shall be effective when it is submitted to and acknowledged by the Committee during the Participant's lifetime in the format prescribed by the Committee._

(b) Absence of Valid Designation. If a Participant fails to designate a Beneficiary, as provided above, or if every person designated as Beneficiary predeceases the Participant or dies prior to complete distribution of the Participant's benefits, then the Participant's estate shall be deemed to be the Beneficiary and the Committee shall direct the distribution of such benefits to the Participant's estate.

6.2 Payments to Minors. In the event any amount is payable under the Plan to a minor, payment shall not be made to the minor, but instead such payment shall be made (a) to that person's living parent(s) to act as custodian, (b) if that person's parents are then divorced, and one parent is the sole custodial parent, to such custodial parent, to act as custodian, or (c) if no parent of that person is then living, to a custodian selected by the Committee to hold the funds for the minor under the Uniform Transfers or Gifts to Minors Act in effect in the jurisdiction in which the minor resides. If no parent is living and the Committee decides not to select another custodian to hold the funds for the minor, then payment shall be made to the duly appointed and currently acting guardian of the estate for the minor or, if no guardian of the estate for the minor is duly appointed and currently acting within sixty (60) days after the date the amount becomes payable, payment shall be deposited with the court having jurisdiction over the estate of the minor.

6.3 Payments on Behalf of Persons Under Incapacity. In the event that any amount becomes payable under the Plan to a person who, in the sole judgment of the Committee, is considered by reason of physical or mental condition to be unable to give a valid receipt therefore, the Committee may direct that such payment be made to any person found by the Committee, in its sole judgment, to have assumed the care of such person. Any payment made pursuant to such determination shall constitute a full release and discharge of any and all liability of the Committee and the Company under the Plan.

ARTICLE VII
LEAVE OF ABSENCE

7.1 Paid Leave of Absence. If a Participant is authorized by the Participant's Employer to take a paid leave of absence from the employment of the Employer, and such leave of absence does not constitute a Separation from Service, (a) the Participant shall continue to be considered eligible for the benefits provided under the Plan, and (b) deferrals shall continue to be withheld during such paid leave of absence in accordance with Article III.

7.2 Unpaid Leave of Absence. If a Participant is authorized by the Participant's Employer to take an unpaid leave of absence from the employment of the Employer for any reason, and such leave of absence does not constitute a Separation from Service, such Participant shall continue to be eligible for the benefits provided under the Plan. During the unpaid leave of absence, the Participant shall not be allowed to make any additional deferral elections. However, if the Participant returns to employment, the Participant may elect to defer for the Plan Year following his or her return to employment and for every Plan Year thereafter while a Participant in the Plan, provided such deferral elections are otherwise allowed and a Participant Election is delivered to and accepted by the Committee for each such election in accordance with Article III above.

ARTICLE VIII
ADMINISTRATION

8.1 Committee. The Plan shall be administered by a Committee appointed by the Board, which shall have the exclusive right and full discretion (a) to appoint agents to act on its behalf, (b) to select and establish Funds, (c) to interpret the Plan, (d) to decide any and all matters arising hereunder (including the right to remedy possible ambiguities, inconsistencies, or admissions), (e) to make, amend and rescind such rules as it deems necessary for the proper administration of the Plan and (f) to make all other determinations and resolve all questions of fact necessary or advisable for the administration of the Plan, including determinations regarding eligibility for benefits payable under the Plan. All interpretations of the Committee with respect to any matter hereunder shall be final, conclusive and binding on all persons affected thereby. No member of the Committee or agent thereof shall be liable for any determination, decision, or action made in good faith with respect to the Plan. The Company will indemnify and hold harmless the members of the Committee and its agents from and against any and all liabilities, costs, and expenses incurred by such persons as a result of any act, or omission, in connection with the performance of such persons' duties, responsibilities, and obligations under the Plan, other than such liabilities, costs, and expenses as may result from the bad faith, willful misconduct, or criminal acts of such persons.

8.2 Claims Procedure. Any Participant, former Participant or Beneficiary may file a written claim with the Committee setting forth the nature of the benefit claimed, the amount thereof, and the basis for claiming entitlement to such benefit. The Committee shall determine the validity of the claim and communicate a decision to the claimant promptly and, in any event, not later than ninety (90) days after the date of the claim. The claim may be deemed by the claimant to have been denied for purposes of further review described below in the event a decision is not furnished to the claimant within such ninety (90) day period. If additional information is necessary to make a determination on a claim, the claimant shall be advised of the need for such additional information within forty-five (45) days after the date of the claim. The claimant shall have up to one hundred eighty (180) days to supplement the claim information, and the claimant shall be advised of the decision on the claim within forty-five (45) days after the earlier of the date the supplemental information is supplied or the end of the one hundred eighty (180) day period. Every claim for benefits which is denied shall be denied by written notice setting forth in a manner calculated to be understood by the claimant (a) the specific reason or reasons for the denial, (b) specific reference to any provisions of the Plan (including

any internal rules, guidelines, protocols, criteria, etc.) on which the denial is based, (c) description of any additional material or information that is necessary to process the claim, and (d) an explanation of the procedure for further reviewing the denial of the claim and shall include an explanation of the claimant's right to pursue legal action in the event of an adverse determination on review.

8.3 Review Procedures. Within sixty (60) days after the receipt of a denial on a claim, a claimant or his/her authorized representative may file a written request for review of such denial. Such review shall be undertaken by the Committee and shall be a full and fair review. The claimant shall have the right to review all pertinent documents. The Committee shall issue a decision not later than sixty (60) days after receipt of a request for review from a claimant unless special circumstances, such as the need to hold a hearing, require a longer period of time, in which case a decision shall be rendered as soon as possible but not later than one hundred twenty (120) days after receipt of the claimant's request for review. The decision on review shall be in writing and shall include specific reasons for the decision written in a manner calculated to be understood by the claimant with specific reference to any provisions of the Plan on which the decision is based and shall include an explanation of the claimant's right to pursue legal action in the event of an adverse determination on review.

ARTICLE IX
MISCELLANEOUS

9.1 Termination of Plan. The Company may terminate the Plan at any time. In the event of a Plan termination, no new deferral elections shall be permitted. However, after the Plan termination the Account balances of such Participants shall continue to be credited with deferrals attributable to any deferral election that was in effect prior to the Plan termination to the extent necessary to comply with Code Section 409A, and additional amounts shall continue to be credited or debited to such Participants' Account balances pursuant to Article IV. In addition, following a Plan termination, Participant Account balances shall remain in the Plan and shall not be distributed until such amounts become eligible for distribution in accordance with the other applicable provisions of the Plan. Notwithstanding the preceding sentence, to the extent permitted by Treas. Reg. §1.409A-3(j)(4)(ix) or as otherwise permitted under Code Section 409A, the Employer may provide that upon termination of the Plan, all Account balances of the Participants shall be distributed, subject to and in accordance with any rules established by such Employer deemed necessary to comply with Code Section 409A.

9.2 Amendment. The Company may, at any time, amend or modify the Plan in whole or in part. Notwithstanding the foregoing, no amendment or modification shall be effective to decrease the value of a Participant's vested Account balance in existence at the time the amendment or modification is made.

9.3 Unsecured General Creditor. The benefits paid under the Plan shall be paid from the general assets of the Company, and the Participant and any Beneficiary or their heirs or successors shall be no more than unsecured general creditors of the Company with no special or prior right to any assets of the Company for payment of any obligations hereunder. It is the intention of the Company that this Plan be unfunded for purposes of ERISA and the Code.

9.4 Restriction Against Assignment. The Company shall pay all amounts payable hereunder only to the person or persons designated by the Plan and not to any other person or entity. No part of a Participant's Accounts shall be liable for the debts, contracts, or engagements of any Participant, Beneficiary, or their successors in interest, nor shall a Participant's Accounts be subject to execution by levy, attachment, or garnishment or by any other legal or equitable proceeding, nor shall any such person have any right to alienate, anticipate, sell, transfer, commute, pledge, encumber, or assign any benefits or payments hereunder in any manner whatsoever. No part of a Participant's Accounts shall be subject to any right of offset against or reduction for any amount payable by the Participant or Beneficiary, whether to the Company or any other party, under any arrangement other than under the terms of this Plan.

9.5 Withholding. The Participant shall make appropriate arrangements with the Company for satisfaction of any federal, state or local income tax withholding requirements, Social Security and other employee tax or other requirements applicable to the granting, crediting, vesting or payment of benefits under the Plan. There shall be deducted from each payment made under the Plan or any other Compensation payable to the Participant (or Beneficiary) all taxes that are required to be withheld by the Company in respect to such payment or this Plan. To the extent permissible under Code Section 409A, the Company shall have the right to reduce any payment (or other Compensation) by the amount of cash sufficient to provide the amount of said taxes.

9.6 Code Section 409A. The Company intends that the Plan comply with the requirements of Code Section 409A (and all applicable Treasury Regulations and other guidance issued thereunder) and shall be operated and interpreted consistent with that intent.

9.7 Effect of Payment. Any payment made in good faith to a Participant or the Participant's Beneficiary shall, to the extent thereof, be in full satisfaction of all claims against the Committee, its members, the Employer and the Company.

9.8 Errors in Account Statements, Deferrals or Distributions. In the event an error is made in an Account statement, such error shall be corrected on the next statement following the date such error is discovered. In the event of an operational error, including, but not limited to, errors involving deferral amounts, overpayments or underpayments, such operational error shall be corrected in a manner consistent with and as permitted by any correction procedures established under Code Section 409A. If any portion of a Participant's Account(s) under this Plan is required to be included in income by the Participant prior to receipt due to a failure of this Plan to comply with the requirements of Code Section 409A, the Committee may determine that such Participant shall receive a distribution from the Plan in an amount equal to the lesser of (i) the portion of his or her Account required to be included in income as a result of the failure of the Plan to comply with the requirements of Code Section 409A, or (ii) the unpaid vested Account balance.

9.9 Domestic Relations Orders. Notwithstanding any provision in this Plan to the contrary, in the event that the Committee receives a domestic relations order, as defined in Code Section 414(p)(1)(B), pursuant to which a court has determined that a spouse or former spouse of a Participant has an interest in the Participant's benefits under the Plan, the Committee shall have the right to immediately distribute the spouse's or former spouse's vested interest in the Participant's benefits under the Plan to such spouse or former spouse to the extent necessary to fulfill such domestic relations order, provided that such distribution is in accordance with the requirements of Code Section 409A.

9.10 Employment Not Guaranteed. Nothing contained in the Plan nor any action taken hereunder shall be construed as a contract of employment or as giving any Participant any right to continue the provision of services in any capacity whatsoever to the Employer.

9.11 No Guarantee of Tax Consequences. The Employer, Company, Board and Committee make no commitment or guarantee to any Participant that any federal, state or local tax treatment will apply or be available to any person eligible for benefits under the Plan and assume no liability whatsoever for the tax consequences to any Participant.

9.12 Successors of the Company. The rights and obligations of the Company under the Plan shall inure to the benefit of, and shall be binding upon, the successors and assigns of the Company.

9.13 Notice. Any notice or filing required or permitted to be given to the Company or the Participant under this Agreement shall be sufficient if in writing and hand-delivered, or sent by registered or certified mail, in the case of the Company, to the principal office of the Company, directed to the attention of the Committee, and in the case of the Participant, to the last known address of the Participant indicated on the employment records of the Company. Such notice shall be deemed given as of the date of delivery or, if delivery is made by mail, as of the date shown on the postmark on the receipt for registration or certification. Notices to the Company may be permitted by electronic communication according to specifications established by the Committee.

9.14 Headings. Headings and subheadings in this Plan are inserted for convenience of reference only and are not to be considered in the construction of the provisions hereof.

9.15 Gender, Singular and Plural. All pronouns and any variations thereof shall be deemed to refer to the masculine, feminine, or neuter, as the identity of the person or persons may require. As the context may require, the singular may be read as the plural and the plural as the singular.

9.16 Governing Law. The Plan is intended to be an unfunded plan maintained primarily to provide deferred compensation benefits for a select group of "management or highly compensated employees" within the meaning of Sections 201, 301 and 401 of ERISA and therefore to be exempt from Parts 2, 3 and 4 of Title I of ERISA. To the extent any provision of, or legal issue relating to, this Plan is not fully preempted by federal law, such issue or provision shall be governed by the laws of the State of Delaware.

IN WITNESS WHEREOF, the undersigned duly authorized officer of the Company has approved the adoption of this Plan on behalf of the Company.

DAVITA HEALTHCARE PARTNERS INC.

By:	/s/ Cynthia Baxter
Title:	VP, of Compensation and Benefits
Date:	11/26/14

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.

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

Exhibit 21.1

SUBSIDIARIES OF THE COMPANY
(as of December 31, 2015)

Name	Jurisdiction of Organization
Afton Dialysis, LLC	Delaware
Ahern Dialysis, LLC	Delaware
Alamosa Dialysis, LLC	Delaware
Andrews Dialysis, LLC	Delaware
Animas Dialysis, LLC	Delaware
Argyle Dialysis, LLC	Delaware
Astro, Hobby, West Mt. Renal Care Limited Partnership	Delaware
Athio Dialysis, LLC	Delaware
Austin Dialysis Centers, L.P.	Delaware
Babler Dialysis, LLC	Delaware
Bagby Dialysis, LLC	Delaware
Baker Dialysis, LLC	Delaware
Bannon Dialysis, LLC	Delaware
Barnell Dialysis, LLC	Delaware
Bastrop Dialysis, LLC	Delaware
Beachside Dialysis, LLC	Delaware
Beck Dialysis, LLC	Delaware
Bedell Dialysis, LLC	Delaware
Bellevue Dialysis, LLC	Delaware
Beverly Hills Dialysis Partnership	California
Bidwell Dialysis, LLC	Delaware
Birch Dialysis, LLC	Ohio
Bladon Dialysis, LLC	Delaware
Bogachiel Dialysis, LLC	Delaware
Bollinger Dialysis, LLC	Delaware
Borrego Dialysis, LLC	Delaware
Brache Dialysis, LLC	Delaware
Bridges Dialysis, LLC	Delaware
Bronson Dialysis, LLC	Delaware
Brook Dialysis, LLC	Delaware
Cagles Dialysis, LLC	Delaware
Canoe Dialysis, LLC	Delaware
Capes Dialysis, LLC	Delaware
Capital Dialysis Partnership	California
Carroll County Dialysis Facility, Inc.	Maryland
Caverns Dialysis, LLC	Delaware
Central Carolina Dialysis Centers, LLC	Delaware
Central Georgia Dialysis, LLC	Delaware
Central Kentucky Dialysis Centers, LLC	Delaware
Chadron Dialysis, LLC	Delaware
Cheraw Dialysis, LLC	Delaware
Chicago Heights Dialysis, LLC	Delaware
Churchill Dialysis, LLC	Delaware
Clark Dialysis, LLC	Delaware
Clifton Dialysis, LLC	Delaware

Name	Jurisdiction of Organization
Clinica Medica DaVita Londrina Servicos de Nefrologia Ltda.	Brazil
Clyfee Dialysis, LLC	Delaware
Cobbles Dialysis, LLC	Delaware
Columbus-RNA-DaVita, LLC	Delaware
Continental Dialysis Center of Springfield-Fairfax, Inc.	Virginia
Continental Dialysis Center, Inc.	Virginia
Coral Dialysis, LLC	Delaware
Couer Dialysis, LLC	Delaware
Croft Dialysis, LLC	Delaware
Crossings Dialysis, LLC	Delaware
Cuivre Dialysis, LLC	Delaware
Curlew Dialysis, LLC	Delaware
Dallas-Fort Worth Nephrology, L.P.	Delaware
Davis Dialysis, LLC	Delaware
DaVita - Riverside, LLC	Delaware
DaVita - West, LLC	Delaware
DaVita APAC Holding B.V.	Netherlands
DaVita Brasil Participacoes e Servicos de Gestao Ltda.	Brazil
DaVita Care (Saudi Arabia)	Saudi Arabia
DaVita Deutschland AG	Germany
DaVita Deutschland Beteiligungs GmbH & Co. KG	Germany
DaVita Germany GmbH	Germany
DaVita Health Plan of California, Inc. (fka DaVita Healthcare Partners Plan, Inc.)	Delaware
DaVita Hospice Nevada, LLC (fka Las Vegas Solari Hospice Care LLC)	Delaware
DaVita Medical ASC-LB California, LLC (fka HealthCare Partners ASC-LB, LLC)	California
DaVita Medical Colorado, LLC (fka HealthCare Partners Colorado, LLC)	Colorado
DaVita Medical Florida, Inc. (fka JSA Healthcare Corporation)	Delaware
DaVita Medical Florida, LLC (fka JSA Care Partners, LLC)	Florida
DaVita Medical Group Colorado Springs, LLC (fka Colorado Springs Health Partners, LLC)	Colorado
DaVita Medical Group New Mexico, LLC (fka ABQ Health Partners, LLC)	Delaware
DaVita Medical Group South Florida, LLC (fka HealthCare Partners South Florida, LLC)	Florida
DaVita Medical Holding Company, New Mexico, LLC (fka Medical Group Holding Company, LLC)	New Mexico
DaVita Medical Holdings California, LLC (fka HealthCare Partners Holdings, LLC)	California
DaVita Medical Holdings Florida, Inc. (fka JSA Holdings, Inc.)	Delaware
DaVita Medical IPA Nevada, LLC (fka JSA P5 Nevada, L.L.C.)	Nevada
DaVita Medical Management Services Nevada, LLC (fka HealthCare Partners Nevada, LLC)	Nevada
DaVita Medical Nevada, LLC (fka JSA Healthcare Nevada, L.L.C.)	Nevada
DaVita Medical RE, LLC (fka Healthcare Partners RE LLC)	Delaware
DaVita Medical Services, LLC (fka HealthCare Partners Services, LLC)	Delaware
DaVita Medical Services, LLC (fka HealthCare Partners, LLC)	California
DaVita of New York, Inc.	New York
DaVita Rx, LLC	Delaware
DaVita S.A.S.	Colombia
DaVita Sp. z o.o.	Poland
Dawson Dialysis, LLC	Delaware

Name	Jurisdiction of Organization
DC Healthcare International, Inc.	Delaware
Dialysis Holdings, Inc.	Delaware
Dialysis of Northern Illinois, LLC	Delaware
Dialysis Specialists of Dallas, Inc.	Texas
DNP Management Company, LLC	Delaware
Downriver Centers, Inc.	Michigan
Dresher Dialysis, LLC	Delaware
Dunes Dialysis, LLC	Delaware
Duston Dialysis, LLC	Delaware
DV Care Netherlands B.V.	Netherlands
DV Care Netherlands C.V.	Netherlands
DVA Healthcare - Southwest Ohio, LLC	Tennessee
DVA Healthcare of Maryland, Inc.	Maryland
DVA Healthcare of Massachusetts, Inc.	Massachusetts
DVA Healthcare of Pennsylvania, LLC	Pennsylvania
DVA Healthcare Procurement Services, Inc.	California
DVA Healthcare Renal Care, Inc.	Nevada
DVA Holdings Pte. Ltd.	Singapore
DVA Laboratory Services, Inc.	Florida
DVA of New York, Inc.	New York
DVA Renal Healthcare, Inc.	Tennessee
Dworsher Dialysis, LLC	Delaware
East End Dialysis Center, Inc.	Virginia
Edisto Dialysis, LLC	Delaware
Elberton Dialysis Facility, Inc.	Georgia
Eldrist Dialysis, LLC	Delaware
Elgin Dialysis, LLC	Delaware
Etowah Dialysis, LLC	Delaware
Eufaula Dialysis, LLC	Delaware
EURODIAL - Centro de Nefrologia e Dialise de Leiria S.A.	Portugal
Everett MSO, Inc.	Washington
Falcon, LLC	Delaware
Farragut Dialysis, LLC	Delaware
Fields Dialysis, LLC	Delaware
Flagler Dialysis, LLC	Delaware
Flamingo Park Kidney Center, Inc.	Florida
Flandrau Dialysis, LLC	Delaware
Flor Dialysis, LLC	Delaware
Fort Dialysis, LLC	Delaware
Foss Dialysis, LLC	Delaware
Freehold Artificial Kidney Center, L.L.C.	New Jersey
Garner Dialysis, LLC	Delaware
Garrett Dialysis, LLC	Delaware
Gate Dialysis, LLC	Delaware
Genesis KC Development, LLC	Delaware

Name	Jurisdiction of Organization
Gertrude Dialysis, LLC	Delaware
Geyser Dialysis, LLC	Delaware
Glassland Dialysis, LLC	Delaware
Glosser Dialysis, LLC	Delaware
Goodale Dialysis, LLC	Delaware
Greater Las Vegas Dialysis, LLC	Delaware
Greater Los Angeles Dialysis Centers, LLC	Delaware
Greenspoint Dialysis, LLC	Delaware
Gulch Dialysis, LLC	Delaware
Harmony Dialysis, LLC	Delaware
Hawn Dialysis, LLC	Delaware
Hazelton Dialysis, LLC	Delaware
Headlands Dialysis, LLC	Delaware
Heideck Dialysis, LLC	Delaware
Helmer Dialysis, LLC	Delaware
Hills Dialysis, LLC	Delaware
Holten Dialysis, LLC	Delaware
Honeyman Dialysis, LLC	Delaware
Houston Kidney Center/Total Renal Care Integrated Service Network Limited Partnership	Delaware
Hugo Dialysis, LLC	Delaware
IDC -International Dialysis Centers, Lda	Portugal
Infomasi Ekuiti Sdn. Bhd.	Malaysia
Iroquois Dialysis, LLC	Delaware
ISD I Holding Company, Inc.	Delaware
ISD Las Vegas, LLC	Delaware
ISD Renal, Inc.	Delaware
ISD Summit Renal Care, LLC	Ohio
Jacinto Dialysis, LLC	Delaware
Jericho Dialysis, LLC	Delaware
Kadden Dialysis, LLC	Delaware
Kamakee Dialysis, LLC	Delaware
Kamiah Dialysis, LLC	Delaware
Kavett Dialysis, LLC	Delaware
Kerricher Dialysis, LLC	Delaware
Kidney Care Services, LLC	Delaware
Kidney Center South LLC	Delaware
Kidney HOME Center, LLC	Delaware
Knickerbocker Dialysis, Inc.	New York
Lassen Dialysis, LLC	Delaware
Lees Dialysis, LLC	Delaware
Liberty RC, Inc.	New York
Lifeline Pensacola, LLC	Delaware
Lifeline Vascular Associates of Allen Park, LLC	Delaware
Lifeline Vascular Center of South Orlando, LLC	Delaware
Lifeline Vascular Center-Albany, LLC	Delaware

Name	Jurisdiction of Organization
Lifeline Vascular Center-Orlando, LLC	Delaware
Lincoln Park Dialysis Services, Inc.	Illinois
Little Rock Dialysis Centers, LLC	Delaware
Livingston Dialysis, LLC	Delaware
Llano Dialysis, LLC	Delaware
Lory Dialysis, LLC	Delaware
Lourdes Dialysis, LLC	Delaware
Lyndale Dialysis, LLC	Delaware
Lynwick Dialysis, LLC	Delaware
Madigan Dialysis, LLC	Delaware
Magoffin Dialysis, LLC	Delaware
Manchester Dialysis, LLC	Delaware
Manito Dialysis, LLC	Delaware
Maple Grove Dialysis, LLC	Delaware
Margette Dialysis, LLC	Delaware
Mashero Dialysis, LLC	Delaware
Mason-Dixon Dialysis Facilities, Inc.	Maryland
Mazonia Dialysis, LLC	Delaware
Meadows Dialysis, LLC	Delaware
Memorial Dialysis Center, L.P.	Delaware
Meridian Dialysis, LLC	Delaware
Mermet Dialysis, LLC	Delaware
Milo Dialysis, LLC	Delaware
Minam Dialysis, LLC	Delaware
Mocca Dialysis, LLC	Delaware
Montauk Dialysis, LLC	Delaware
Mulgee Dialysis, LLC	Delaware
MVZ DaVita Alzey GmbH	Germany
MVZ DaVita Aurich GmbH	Germany
MVZ DaVita Bad Duben GmbH	Germany
MVZ DaVita Dormagen GmbH	Germany
MVZ DaVita Duisburg GmbH	Germany
MVZ DaVita Elsterland GmbH	Germany
MVZ DaVita Emden GmbH	Germany
MVZ DaVita Gera GmbH	Germany
MVZ DaVita Monchengladbach GmbH	Germany
MVZ DaVita Neuss GmbH	Germany
MVZ DaVita Niederrhein GmbH	Germany
MVZ DaVita Nierenzentrum am Schloss Britz GmbH	Germany
MVZ DaVita Rhein-Ruhr GmbH	Germany
MVZ DaVita Salzgitter-Seesen GmbH	Germany
MVZ DaVita Sud-Niedersachsen GmbH	Germany
Myrtle Dialysis, LLC	Delaware
Nansen Dialysis, LLC	Delaware
Navarro Dialysis, LLC	Delaware

Name	Jurisdiction of Organization
Nephrology Medical Associates of Georgia, LLC	Georgia
Neptune Artificial Kidney Center, L.L.C.	New Jersey
Norbert Dialysis, LLC	Delaware
Norte Dialysis, LLC	Delaware
North Atlanta Dialysis Center, LLC	Delaware
North Colorado Springs Dialysis, LLC	Delaware
North Puget Sound Oncology Equipment Leasing Company, LLC	Washington
Northridge Medical Services Group, Incorporated	California
Noster Dialysis, LLC	Delaware
Odiorne Dialysis, LLC	Delaware
Ohio River Dialysis, LLC	Delaware
Olive Dialysis, LLC	Delaware
Open Access Lifeline, LLC	Delaware
Paladina Health, LLC	Delaware
Palo Dialysis, LLC	Delaware
Patient Pathways, LLC	Delaware
Pedernales Dialysis, LLC	Delaware
Physicians Choice Dialysis Of Alabama, LLC	Delaware
Physicians Choice Dialysis, LLC	Delaware
Physicians Dialysis Acquisitions, Inc.	Delaware
Physicians Dialysis of Lancaster, LLC	Pennsylvania
Physicians Dialysis Ventures, LLC	Delaware
Physicians Dialysis, Inc.	Delaware
Physicians Management, LLC	Delaware
Pible Dialysis, LLC	Delaware
Pine Dialysis, LLC	Delaware
Pittsburgh Dialysis Partners, LLC	Delaware
Platte Dialysis, LLC	Delaware
Pokagon Dialysis, LLC	Delaware
Portola Dialysis, LLC	Delaware
Powerton Dialysis, LLC	Delaware
Prairie Dialysis, LLC	Delaware
Primrose Dialysis, LLC	Delaware
Prineville Dialysis, LLC	Delaware
Prings Dialysis, LLC	Delaware
Pyramid Dialysis, LLC	Delaware
Randolph Dialysis, LLC	Delaware
Rayburn Dialysis, LLC	Delaware
Red Willow Dialysis, LLC	Delaware
Redcliff Dialysis, LLC	Delaware
Refuge Dialysis, LLC	Delaware
Renal Life Link, Inc.	Delaware
Renal Treatment Centers - California, Inc.	Delaware
Renal Treatment Centers - Hawaii, Inc.	Delaware
Renal Treatment Centers - Illinois, Inc.	Delaware

Name	Jurisdiction of Organization
Renal Treatment Centers - Mid-Atlantic, Inc.	Delaware
Renal Treatment Centers - Northeast, Inc.	Delaware
Renal Treatment Centers - Southeast, LP	Delaware
Renal Treatment Centers - West, Inc.	Delaware
Renal Treatment Centers, Inc.	Delaware
Ridgely Dialysis, LLC	Delaware
River Valley Dialysis, LLC	Delaware
RMS Lifeline Inc.	Delaware
Rocky Mountain Dialysis Services, LLC	Delaware
Roushe Dialysis, LLC	Delaware
Rusk Dialysis, LLC	Delaware
Sahara Dialysis, LLC	Delaware
SAKDC-DaVita Dialysis Partners, L.P.	Delaware
Sandlin Dialysis, LLC	Delaware
Sapelo Dialysis, LLC	Delaware
Shelby Dialysis, LLC	Delaware
Shelling Dialysis, LLC	Delaware
Sherman Dialysis, LLC	Delaware
Shetek Dialysis, LLC	Delaware
Shining Star Dialysis, Inc.	New Jersey
Shoals Dialysis, LLC	Delaware
Shone Dialysis, LLC	Delaware
Shoshone Dialysis, LLC	Delaware
Sierra Rose Dialysis Center, LLC	Delaware
Silverwood Dialysis, LLC	Delaware
Simeon Dialysis, LLC	Delaware
Skagit Dialysis, LLC	Delaware
Smithgall Dialysis, LLC	Delaware
South Central Florida Dialysis Partners, LLC	Delaware
South Fork Dialysis, LLC	Delaware
Southcrest Dialysis, LLC	Delaware
Southwest Atlanta Dialysis Centers, LLC	Delaware
Sprague Dialysis, LLC	Delaware
Star Dialysis, LLC	Delaware
Starks Dialysis, LLC	Delaware
Stearns Dialysis, LLC	Delaware
Storrie Dialysis, LLC	Delaware
Sunapee Dialysis, LLC	Delaware
Taum Dialysis, LLC	Delaware
Tel-Huron Dialysis, LLC	Delaware
The DaVita Collection, Inc.	California
THP Services, Inc.	California
Tolowa Dialysis, LLC	Delaware
Total Acute Kidney Care, Inc.	Florida
Total Renal Care Of North Carolina, LLC	Delaware

Name	Jurisdiction of Organization
Total Renal Care Texas Limited Partnership	Delaware
Total Renal Care, Inc.	California
Total Renal Laboratories, Inc.	Florida
Total Renal Research, Inc.	Delaware
Trailstone Dialysis, LLC	Delaware
Transmountain Dialysis, L.P.	Delaware
TRC - Four Corners Dialysis Clinics, L.L.C.	New Mexico
TRC - Indiana, LLC	Indiana
TRC - Petersburg, LLC	Delaware
TRC EL Paso Limited Partnership	Delaware
TRC of New York, Inc.	New York
TRC West, Inc.	Delaware
TRC-Georgetown Regional Dialysis, LLC	District Of Columbia
Tree City Dialysis, LLC	Delaware
Tross Dialysis, LLC	Delaware
Tunnel Dialysis, LLC	Delaware
Tyler Dialysis, LLC	Delaware
Ukiah Dialysis, LLC	Delaware
Unicoi Dialysis, LLC	Delaware
USC-DaVita Dialysis Center, LLC	California
UT Southwestern DVA Healthcare, L.L.P.	Texas
VillageHealth DM, LLC	Delaware
Volo Dialysis, LLC	Delaware
Wakoni Dialysis, LLC	Delaware
Walcott Dialysis, LLC	Delaware
Walker Dialysis, LLC	Delaware
Walton Dialysis, LLC	Delaware
Wayside Dialysis, LLC	Delaware
Weldon Dialysis, LLC	California
Williston Dialysis, LLC	Delaware

Exhibit 23.1

Consent of Independent Registered Public Accounting Firm

The Board of Directors and Shareholders
DaVita HealthCare Partners Inc.:

We consent to the incorporation by reference in the registration statements on Forms S-8 (No. 333-213119, No. 333-190434, No. 333-169467, No. 333-158220, No. 333-144097, No. 333-86550, and No. 333-30736), on Form S-4 (No. 333-182572), and on Forms S-3 (333-203394, No. 333-196630, No. 333-183285, and No. 333-169690) of DaVita Inc. of our reports dated February 24, 2017, with respect to the consolidated balance sheets of DaVita Inc. as of December 31, 2016 and 2015, and the related consolidated statements of income, comprehensive income, equity, and cash flows for each of the years in the three-year period ended December 31, 2016, the related financial statement schedule, and the effectiveness of internal control over financial reporting as of December 31, 2016, which reports appear in the December 31, 2016 annual report on Form 10-K of DaVita Inc.

/s/ KPMG LLP

Seattle, Washington
February 24, 2017

Exhibit 31.1

SECTION 302 CERTIFICATION

I, Kent J. Thiry, certify that:

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

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

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

4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and we 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: February 24, 2017

Exhibit 31.2

SECTION 302 CERTIFICATION

I, James K. Hilger, certify that:

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

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

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

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

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

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

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

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

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

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

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

/S/ JAMES K. HILGER

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

Date: February 24, 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 Annual Report of DaVita HealthCare Partners Inc. (the "Company") on Form 10-K for the year ending December 31, 2016 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

February 24, 2017

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 Annual Report of DaVita HealthCare Partners Inc. (the "Company") on Form 10-K for the year ending December 31, 2016 as filed with the Securities and Exchange Commission on the date hereof (the "Periodic Report"), I, James K. Hilger, Interim Chief Financial Officer and Chief Accounting Officer of the Company, certify, pursuant to 18.U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, that:

1. The Periodic Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

2. The information contained in the Periodic Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/S/ JAMES K. HILGER
James K. Hilger
Interim Chief Financial Officer and
Chief Accounting Officer

February 24, 2017