Washington State Department of Health

Certificate of Need Application
Kidney Disease Treatment Facilities

Certificate of Need applications must be submitted with a fee in accordance with Washington Administrative Code (WAC) 246-310-990.

Application is made for a Certificate of Need in accordance with provisions in Revised Code of Washington (RCW) 70.38 and WAC 246-310, rules and regulations adopted by the Washington State Department of Health. I attest that the statements made in this application are correct to the best of my knowledge and belief.

Signature and Title of Responsible Officer: Evan Moore Director, Special Projects, North Star Division Email Address: evan.moore@davita.com	Date: June 1, 2018 Telephone Number: 1 (253) 733-4755
Legal Name of Applicant: Total Renal Care, Inc., a subsidiary of DaVita Inc. Address of Applicant: DaVita Inc. 2000 16th Street Denver, CO 80202	Estimated capital expenditure: $3,366,078
This application is submitted under (check **one** box only): [ ] Concurrent Review **Cycle 1** – Special Circumstances: [**x**] Concurrent Review **Cycle 1** – Nonspecial Circumstance [ ] Concurrent Review **Cycle 2** – Special Circumstances: [ ] Concurrent Review **Cycle 2** – Nonspecial Circumstance	

Identify the Planning Area for this project as defined in WAC 246-310-800(15). King County ESRD Planning Area, Sub Planning Area Eleven ("King 11")

DAVITA

AUBURN VALLEY DIALYSIS CENTER

CERTIFICATE OF NEED APPLICATION

EXECUTIVE SUMMARY

DaVita proposes to establish a new twenty-two (22) station facility in the King County ESRD Planning area, Sub Planning Area Eleven (hereafter, “King 11”). DaVita’s proposal for a twenty-two station facility in Auburn will provide ESRD patients and their families with important new access and provider choice in a planning area with high need for dialysis services. The Total Capital Expenditure as reflected in Table 10 will be $3,366,078 and will be financed through operational funds on-hand allocated for the project.

The proposed DaVita Auburn Valley Dialysis Center will occupy 11,500 rentable square feet located on 7.6 acres at the intersection of O Street and 115th St SW, Auburn, WA 98001.

This planning area, as defined by the Department of Health, is currently served by two approved facilities: Northwest Kidney Centers Auburn Kidney Center and Northwest Kidney Centers Federal Way East Kidney Center. The facility that DaVita proposes to establish will increase the total station count in the planning area by twenty-two (22) stations, and will support the broader community with a location that meets the needs of King County’s ESRD population.

TABLE OF CONTENTS:

Executive Summary	**1**
S E C T I O N 1	
Applicant Description	**3**
S E C T I O N 2	
Project Description	**8**
S E C T I O N 3	
Certificate of Need Review Criteria	**13**
A. Need	**13**
B. Financial Feasibility	**18**
C. Structure and Process Quality of Care	**23**
D. Cost Containment	**28**
Appendices	**30**

DAVITA
AUBURN VALLEY DIALYSIS CENTER
CERTIFICATE OF NEED APPLICATION

I. APPLICANT DESCRIPTION

1. Provide the legal name(s) and address(es)of the applicant(s).

The legal name of the applicant is Total Renal Care, Inc., a subsidiary of DaVita Inc. For ease of reference, both Total Renal Care, Inc. and its parent company generally will be referred to in this application as "DaVita." DaVita will be doing business for this project as DaVita Auburn Valley Dialysis Center. DaVita's address is DaVita Inc., 2000 16th Street, Denver, CO 80202.

We also provide the following additional information regarding DaVita:

- DaVita is a leading provider of dialysis services in the United States for patients suffering from chronic kidney failure, also known as End Stage Renal Disease, or ESRD. We currently operate or provide administrative services to more than 2,539 outpatient dialysis centers located in the United States, serving approximately 185,000 patients.
- Consistent with DaVita's mission statement to "Be the Provider, Partner and Employer of Choice," serving patients by providing quality clinical outcomes is paramount. DaVita has instituted a nationally recognized Dialysis Quality Outcomes program and maintains an aggressive Continuous Quality Improvement (CQI) program. The DaVita philosophy is patient-focused in serving the chronically ill dialysis patient by addressing all dimensions of the dialysis patient's illness state and by providing quality services through a clinical outcomes measurement and management approach to treating ESRD.
- DaVita is committed to serving the chronic kidney disease patient in union with nephrologist partners. The DaVita Auburn Valley Dialysis Center will continue to carry out this commitment through:
    - Serving patients where they live and work.
    - Providing the highest quality patient care – DaVita has more three, four, and five-star centers than in the history of the Five-Star rating program, and leads all dialysis providers (davita.com, News Release April 27, 2018 – Appendix 21).
    - Providing proven infrastructure and continuity to grow rapidly and cost effectively in an underserved community.
    - Supporting new patients – All DaVita dialysis centers within Washington State provide regular, in-center education and training with the goal to empower patients through information about their disease and ability to self-manage their care.
    - DaVita offers Kidney Smart, a non-branded, community-based education program for Chronic Kidney Disease (CKD) patients and their families.

- DaVita offers access to a national non-profit kidney disease advocacy program: Dialysis Patient Citizens.
- DaVita dialysis centers offer a renal focused pharmacy service, DaVita Rx, that has demonstrated a reduction in the number of annual hospitalizations in ESRD patients enrolled in the program.
- DaVita's Guest Services Program provides assistance in locating other dialysis facilities for patients wishing to travel or relocate.
- DaVita will contribute to the community through increased taxes, thereby increasing the community's ability to provide support services for the ESRD patient population.

2. Identify the legal structure of the applicant (LLC, PLLC, etc) and provide the UBI number.

Total Renal Care, Inc. is a subsidiary of DaVita Inc., a publicly held, for-profit Delaware corporation. Total Renal Care's UBI number is 601-134-681.

3. Contact person for this application

Evan Moore – Director, Special Projects
DaVita Inc. – North Star Division Office
32275 32nd Ave S.
Federal Way, WA 98001
Phone Number: (253) 733-4755
Email: evan.moore@davita.com

4. Provide the name, title, address, telephone number, and email address of the consultant authorized to speak on your behalf related to the screening of this application (if any).

Not Applicable

5. Provide an organizational chart that clearly identifies the business structure of the applicant(s).

DaVita is governed by its Board of Directors. Board of Director meetings are held quarterly. Organization charts are included as Appendix 1.

6. Identify all healthcare facilities owned, operated by, or managed by the applicant. This should include all facilities in Washington State as well as out-of-state facilities, and should identify the license/accreditation status of each facility.

All DaVita facilities nationally, and their CMS license and accreditation status, are listed in Appendix 2. All applicable state regulatory agencies are listed in Appendix 13.

State licensure and accreditation is not required for outpatient dialysis facilities in Washington State. However, to establish and maintain federal Medicare certification, each DaVita facility undergoes the process established by the state in which the facility operates. Medicare certification is established through surveys conducted by the Department of Health Facility and Licensing Division. All operating Washington State DaVita facilities are Medicare certified except for Lynnwood Dialysis Center, which has requested initial certification survey by CMS. All operating DaVita facilities listed in Appendix 2 are Medicare certified or awaiting survey as noted.

DaVita owns, operates or has been approved to operate forty-two (42) dialysis facilities in Washington State. Facilities in Washington State include:

Battle Ground Dialysis Center 720 West Main St. Battle Ground, WA 98604 (360) 687-4677 Medicare Certified	**Olympia Dialysis Center** 335 Cooper Point Rd NW, Ste 105 Olympia, WA 98502 (360) 357-6198 Medicare Certified
Belfair Dialysis Center 23961 NE State Route 3, Suite B Belfair, WA 98528 (360) 275-0141 Medicare Certified	**Olympic View Dialysis Center** 125 16th Ave E., 5th Floor Seattle, WA 98112 (206) 323-8900 Medicare Certified
Bellevue Dialysis Center 3535 Factoria Blvd SE, Ste 150 Bellevue, WA 98006 (425) 641-6514 Medicare Certified	**Parkland Dialysis Center** 331 140th Street South Tacoma, WA 98444 (253) 536-5961 Medicare Certified
Cascade Dialysis Center 145 Cascade Place, Ste 100 Burlington, WA 98223 (360) 707-5373 Medicare Certified	**Pilchuck Dialysis Center** 1250 State Avenue Marysville, WA 98270 (360) 651-0780 Medicare Certified
Cooks Hill Dialysis Center 1821 Cooks Hill Road Centralia, WA 98531 Medicare Certified	**Puyallup Community Dialysis Center** 716 South Hill Park Drive, Suite C Puyallup, WA 98373 (253) 845-2127 Medicare Certified

Chinook Kidney Center	**Rainier View Dialysis Center**
1351 Aaron Drive Richland, WA 99352 (509) 943-4598 Medicare Certified	1822 - 112th Street East, STE A Tacoma, WA 98445 (253) 539-5659 Medicare Certified
Downtown Spokane Renal Center	**Redondo Heights Dialysis Center**
601 W. 5th Avenue, Suite 101 Spokane, WA 99204 (509) 363-0700 Medicare Certified	27320 Pacific Highway South Federal Way, WA 98003 (253) 529-7825 Medicare Certified
East Wenatchee Dialysis Center	**Renton Dialysis Center**
300 N. Colorado Avenue East Wenatchee, WA 98802 (509) 886-4950 Medicare Certified	4110-E NE 4th St Renton, WA 98059 (425) 226-2408 Medicare Certified
Echo Valley Dialysis Center	**Seaview Dialysis Center**
198 Ponderosa Rd. #A Colville, WA 99114 (509) 684-2285 Medicare Certified	101 18th Street SE Seaview, WA 98631 (360) 642-3442 Medicare Certified
Wapato Dialysis Center (CN Approved)	**Spokane Valley Renal Center**
502 W. 1st Street Wapato, WA 98951 Facility Under Construction	12610 E. Maribeau Pkwy, Suite 100 Spokane, WA 99216 (509) 228-9933 Medicare Certified
Ellensburg Dialysis Center	**Tacoma Dialysis Center**
2101 W Dolarway Rd, STE 1 Ellensburg, WA 98926 (509) 925-2333 Medicare Certified	3401 South 19th Street Tacoma, WA 98405 (253) 573-1600 Medicare Certified
Everett Dialysis Center	**Tumwater Dialysis Center**
8130 Evergreen Way Everett, WA 98203 (425) 353-6036 Medicare Certified	855 Trosper Rd SW, STE 110 Tumwater, WA 98512 (360) 352-7522 Medicare Certified

Federal Way Community Dialysis Center	**Union Gap Dialysis Center**
1015 S 348th St Federal Way, WA 98003 (253) 661-9055 Medicare Certified	1236 Ahtanum Ridge Dr. Union Gap, WA 98903-1813 (509) 469-6292 Medicare Certified
Graham Dialysis Center	**Vancouver Dialysis Center**
10219 196th Street Ct. E., Ste C Graham, WA 98338 (253) 875-5382 Medicare Certified	9120 NE Vancouver Mall Drive, Ste 160 Vancouver, WA 98662 (360) 891-5777 Medicare Certified
Kennewick Dialysis Center	**Wenatchee Valley Dialysis Center**
3208 W 19th Ave, Ste 101 Kennewick, WA 99336 (509) 585-5535 Medicare Certified	116 Olds Station Rd Wenatchee, WA 98801 (509) 664-3487 Medicare Certified
Kent Dialysis Center	**Westwood Dialysis Center**
21851 84th Ave S Kent, WA 98032 (253) 872-5474 Medicare Certified	2615 SW Trenton Street Seattle, WA 98126 (206) 938-6738 Medicare Certified
Lakewood Community Dialysis Center	**Whidbey Island Dialysis Center**
5919 Lakewood Towne Center Blvd SW Lakewood, WA 98499 (253) 512-2400 Medicare Certified	32650 State Route 20, Bldg. D, Ste 101 Oak Harbor, WA 98277 (360) 240-1596 Medicare Certified
Lynnwood Dialysis Center (CN Approved)	**Yakima Dialysis Center**
13619 Mukilteo Speedway, #D-1 Lynnwood, WA 98087 Awaiting CMS Certification Survey	1221 N. 16th Ave. Yakima WA 98902-1347 (509) 457-8333 Medicare Certified
Mid-Columbia Kidney Center	**Zillah Dialysis Center**
6825 Burden Boulevard, Suite A Pasco, WA 99301 (509) 545-0205 Medicare Certified	823 Zillah West Road, Ste 300 Zillah, WA 98953 (509) 829-0209 Medicare Certified

Mill Creek Dialysis Center	**Mount Baker Kidney Center**
18001 Bothell Everett Hwy, Ste 112 Bothell, WA 98012 (425) 481-5258 Medicare Certified	410 Birchwood Avenue, Ste 100 Bellingham, WA 98225 (360) 734-4243 Medicare Certified
Mt. Adams Kidney Center	**North Spokane Renal Center**
3220 Picard Place Sunnyside, WA 98944 (509) 837-2013 Medicare Certified	7407 N. Division St., Suite F Spokane, WA 99208 (509) 465-4779 Medicare Certified

II. Project Description

1. Provide the name and address of the existing facility.

Not applicable.

2. Provide the name and address of the proposed facility.

The new DaVita Auburn Valley Dialysis Center will provide kidney dialysis services for residents of the King 11 ESRD planning area. The location is:

DaVita Auburn Valley Dialysis Center
The intersection of O Street and 115th St SW
King County Parcel ID #0301500090, #0301500280, and #0301500110
Auburn, WA 98001

3. Provide a detailed project description of the proposed project.

This project will add twenty-two (22) new stations to the service area, thereby fully meeting the 2018-2022 projected need for King 11 and providing meaningful new access and provider choice for the planning area's dialysis patients.

DaVita Auburn Valley Dialysis Center will be located in King 11, which has experienced an annualized 13.33% ESRD population growth rate over the past 3 years, per the NWRN modality reports. Prior to relocation of stations to Northwest Kidney Centers (hereafter, "NKC") Federal Way East, NKC Auburn, historically the sole dialysis facility in the planning area, was at 5.96 patients per station as of 12/31/2017, or 99.33% six-shift utilization, leaving great need for additional stations to provide access in a rapidly growing planning area. Northwest Kidney Centers was approved under CN #1596 to add two net stations with the opening of NKC Federal Way East, which did not open within the timeline represented in its application. DaVita Auburn Valley Dialysis Center would thereby provide significant new access, and the only access east of WA-167, that is sorely needed in the King 11 planning area. The current King 11 ESRD population, continued service area growth, and high-utilization existing facilities support additional capacity and provider choice via DaVita Auburn Valley Dialysis Center.

Patients of DaVita Auburn Valley Dialysis Center will also gain access to DaVita national programs. The proposed dialysis center will offer a renal focused pharmacy service, DaVita Rx. A study conducted by the American Journal of Kidney Diseases compared the outcomes of hemodialysis patients enrolled in this program and matched control patients, and the results indicated that DaVita RX patients demonstrated an increase in medication adherence associated with a total reduction in the number of deaths and annual hospitalizations[1]. Patients and their families will also have access to the Guest Services Program that provides assistance in locating other dialysis facilities for patients wishing to travel or relocate. Additionally, the Kidney Smart Education Program, which is described in Appendix 18, offers robust education for those in the community whose disease may not have yet progressed to ESRD, generating greater awareness of how best to self-manage their care and what treatment options are available to discuss with their nephrologists.

4. Identify any affiliates for this project, as defined in WAC 246-310-800(1).

This question is not applicable, as DaVita Inc., through its wholly-owned subsidiary Total Renal Care, Inc., will be the sole owner of DaVita Auburn Valley Dialysis Center. It therefore has no affiliates for this project.

5. Provide an estimated timeline for project implementation.

The table below outlines the anticipated dates of approval, design completion, construction commencement and completion, and preparation for survey based on an approval date, assuming all variables operate according to historical trends. DaVita continues to refine and streamline the facility development process.

[1] Weinhandl, Eric D., Thomas J. Arneson and Wendy L St. Peter. "Clinical Outcomes Associated With Receipt of Integrated Pharmacy Services by Hemodialysis Patients: A Quality Improvement Report." American Journal of Kidney Diseases 62 (2013): 557-567.

Table 1 DaVita Auburn Valley Dialysis Center Anticipated Dates of Commencement & Completion of Project	
Event	**Anticipated Date**
Project Approval	*December 19, 2018*
Design Complete	April 1, 2019
Construction Commenced	January 17, 2020
Construction Completed	February 17, 2021
Facility Prepared for Survey/ "Operational"	May 3, 2021

6. Identify the date the facility is expected to be operational as defined in WAC 246-310-800(12).

DaVita expects that Auburn Valley Dialysis Center will be operational and prepared for survey as defined in WAC 246-310-800(12) by **May 3, 2021,** based on a December 19, 2018 project approval date.

7. Provide a detailed description of the services represented by this project. For existing facilities, this should include a discussion of existing services and how these would or would not change as a result of the project.

DaVita Auburn Valley Dialysis Center will provide twenty-two (22) total chronic dialysis stations, offering services to:

- Hemodialysis patients who dialyze in the chronic setting,
- Hemodialysis patients requiring isolation,
- Hemodialysis patients requiring dialysis in a permanent bed station,
- Hemodialysis patients requiring treatment shifts that begin after 5:00 PM.

Additional services provided will include:

- Treatment for visiting hemodialysis patients from other areas outside King 11, and
- Community education for patients recently diagnosed with Chronic Kidney Disease (CKD).

Out of an abundance of caution, DaVita also notes that, while there are no plans to offer such services from its operational date, Auburn Valley Dialysis Center will be built to accommodate Continuous Ambulatory Peritoneal Dialysis (CAPD) patients, Continuous Cyclic Peritoneal Dialysis (CCPD) patients, Home Hemodialysis (HHD) patients, and training and support for CAPD, CCPD, and HHD patient, should patient need exist in King 11 in the future to offer these services.

8. Provide a general description of the types of patients to be served by the facility at project completion.

DaVita Auburn Valley Dialysis Center will serve patients requiring in-center hemodialysis (both chronic and acute). In addition, it will serve patients requiring isolation, those requiring dialysis in a horizontal position, and those requiring treatment shifts beginning after 5:00 PM. Finally, it will serve visiting hemodialysis patients and recently diagnosed CKD patients.

9. Provide a copy of the letter of intent that was already submitted according to WAC 246-310-080.

A copy of the letter of intent is included in Appendix 5.

10. Provide single-line drawings (approximately to scale) of the facility, both before and after project completion. Reference WAC 246-310-800(11) for the definition of maximum treatment area square footage. Ensure that stations are clearly labeled with their square footage identified, and specifically identify future expansion stations (if applicable)

A single line drawing, showing DaVita Auburn Valley Dialysis Center both before and after project completion, is included as Appendix 16. Note that up to three hundred (300) square feet is allocated for future expansion stations per WAC 246-310-800(11)(c) on the proposed line drawing.

11. Provide the gross and net square feet of this facility. Treatment area and non-treatment area should be identified separately.

The DaVita Auburn Valley Dialysis Center will consist of, after project completion, 11,500 gross square feet and 11,500 net square feet. The treatment area consists of 5,810 square feet, and non-treatment area of 5,690 square feet. Auburn Valley Dialysis Center space allocations are included in Table 2 below. Note that the space allocations include usable (net) square footage, not gross square footage.

Table 2
Auburn Valley Dialysis Center
Square Footage Allocation

Category	After Completion
Treatment Floor Area	
Chronic Dialysis Stations	1,600
Isolation Station	143
Permanent Bed Station	100
Expansion Stations	160
Nurse Station/Meds Area	370
Patient Prep	237
Circulation	2,784
Lab Prep	332
Storage	88
Treatment Floor Area Total	*5,810*
Non-Treatment Floor Area	
Water Room	419
Re-Use	0
Bio-Med	143

Staff Bathroom/Lounge	349
Janitorial/Electric	182
Business Office/ Medical Records	346
Reception	949
Conference Room	300
Home Training, PD & HHD nurses	0*
Patient Bathrooms	145
Storage/Med Waste/Wheelchair	1,040
Staff Offices	1,090
HVAC/Circulation	622
Clean Supplies/Kidney Care Training	106
Non-Treatment Floor Area Total	*5,690*
Total Space (NET)	**11,500**

*Future space allocations for Home Training, PD & HHD nurses are primarily allocated to Storage and Staff Offices categories under non-treatment floor area.

In Table 3, below, is calculated the maximum treatment area square footage of 6,475 square feet. Treatment floor area at project completion will be 5,810 square feet, below the maximum allowable square footage.

Table 3

Maximum treatment floor area square footage: WAC 246-310-800(11)

Area Type	Number of Stations	Sq Ft Per Station	Total Square Feet
(a) General Use	20	150	3,000
(b) Permanent Bed	1	200	200
(b) Isolation	1	200	200
(c) Expansion	2	150	300
Other Treatment Floor Space	*75% * sum of (a), (b) and (c)*		2,775.0
Total			**6,475.0**

12. Confirm that the facility will be certified by Medicare and Medicaid. Provide the existing facility's Medicare and Medicaid numbers.

DaVita Auburn Valley Dialysis Center will be certified by Medicare and Medicaid upon completion. DaVita's track record of certification by Medicare and Medicaid (for 40 current facilities in Washington, with one additional awaiting survey and one under construction) should provide the Department of Health confidence both in DaVita's intent to achieve certification by Medicare and Medicaid and its track record of providing high quality care borne out via successful survey.

III. Certificate of Need Review Criteria

A. Need (WAC 246-310-210 and 246-310-800 to 246-310-833)

1. List all other dialysis facilities currently operating in the planning area, as defined in WAC 246-310-800(15).

WAC 246-310-800(15) defines the King 11 ESRD planning area zip codes. Table 4 provides a list of all currently approved dialysis facilities operating in the King 11 planning area.

Table 4		
Existing Dialysis Facilities in King 11	**Provider**	**Approved Stations**
NKC AUBURN 502520	NKC	12
NKC Federal Way East	NKC	14

2. Provide utilization data for the facilities listed above according to the most recent NWRN modality report.

WAC 246-310-812(3) requires that projected station need must be based on 4.8 resident in-center patients per station in in urban areas, and 3.2 patients per station in designated rural counties. The applicable utilization standard for King 11 is 4.8 patients per station, therefore WAC 246-310-812(5) applies, and all certificate of need counted stations at each facility in the planning area must be operating at 4.5 in-center patients per station as of the letter of intent submission date, have been in operation for three or more years, or have not met the timeline presented in their Certificate of Need application. The relevant data for this analysis is the quarterly facility utilization report prepared by the Northwest Renal Network (hereafter "NWRN"). Table 5 provides current utilization levels for all existing King 11 dialysis facilities.

Table 5	Quarterly Utilization of Existing Stations			
Existing Dialysis Facilities in King 11	Provider	Approved Stations (as of 12/31/2017)	NWRN 12/31/2017	
			Patients	Patients Per Station
NKC AUBURN 502520	NKC	12 (24)	143	11.92
NKC Federal Way East	NKC	14 (0)	0	0

*note, at the time, NKC Auburn had not relocated its stations and was operating with 24 approved stations, or 5.96 patients per station.

WAC 246-310-812(5)(b) provides that [the department will consider the 4.5 in-center patients per station standard met for those facilities when] "Certificate of need approved stations for a facility have not become operational within the timeline as represented in the approved application." NKC Auburn Kidney Center, with

24 stations, has historically been the sole dialysis facility in the King 11 planning area. Under CN #1593, Northwest Kidney Centers was approved to relocate twelve (12) stations from NKC Auburn to a new facility, NKC Federal Way East, and add two additional stations to NKC Federal Way East. In its application, NKC represented the following: "This project will commence immediately upon CN approval (assuming Q1 2017). The proposed facility will be operational by January 1, 2018."[2] CN approval was on February 21, 2017[3]. Therefore, the approval was within the first quarter (hereafter, "Q1") of 2017, as NKC projected, and NKC Federal Way East should have become operational by January 1, 2018 per the timeline represented in the application. It did not.

NKC claimed in its progress reports that it would open by February, 2018.[4] This would not have been operational within the timeline claimed in its application. And yet NKC did not meet the February timeline, either, despite clear patient need for the additional stations provided by CN #1596. NKC staff informed DaVita staff, on March 2, 2018, that the facility was not yet open, and it would be another one to two weeks before it was.

NKC Federal Way East did not open in the timeline presented in its application. According to WAC 246-310-812(5), NKC Federal Way East is therefore seen to meet the 4.5 patients per standard, regardless of its census. As NKC Auburn would appropriately be at 5.96 patients per station, or 99.31% six-shift utilization, with 24 chairs as of 12/31/2017, both facilities with approved stations in the King 11 planning area meet the 4.5 patients per station utilization standard.

Finally, it is worth noting the exceptional utilization and patient demand seen in King 11 at NKC Auburn. If all 24 operational stations as of 12/31/2017 are allocated just to NKC Auburn, in addition to the two (2) stations granted under CN #1593 to be added to NKC Federal Way East as a partial relocation and expansion, a 26-station NKC Auburn with all approved stations in the planning area would have operated at 5.50 patients per station as of 12/31/2017, well in excess of the 4.5 patients per station threshold.

3. Complete the quantitative station need methodology outlined in WAC 246-310-812.

WAC 246-310-812 outlines the applicable standards and methodology to determine planning area need. WAC 246-310-800(15) defines a "planning area" as an individual geographic area designated by the department for which kidney dialysis station need projections are calculated. The 6 year in-center hemodialysis patient historical volume for the King 11 ESRD planning area zip codes is represented below in Table 6, per data from the year-end NWRN modality reports.

[2] See application, page 11.
[3] See decision page 1, dated February 21, 2017.
[4] See June 2017 Progress Report.

Table 6						
Planning Area In-Center Hemodialysis Patients Projected by Year						
King 11	2012	2013	2014	2015	2016	2017
98001	24	25	26	32	34	31
98002	39	33	35	42	57	67
98010	4	2	3	4	5	5
98047	11	7	12	9	8	7
98092	16	20	25	25	37	37
Total	94	87	101	112	141	147

Table 7 analyzes the historical growth rate for the number of resident in-center patients from King 11 to determine if the linear or nonlinear regression methodology will be used in determining need per WAC 246-310-812(4)(a)(i-ii). The linear regression methodology was selected as year-to-year increases are less than 6% in several of the past five annual increases, including 2016-2017.

Table 7						
Analysis of Year-to-Year Percentage Change in In-Center Dialysis Patients						
King 11	2012	2013	2014	2015	2016	2017
Total	94	87	101	112	141	147
% Change		-7.45%	16.09%	10.89%	25.89%	4.26%

Table 8 projects dialysis utilization for five years after the last calendar year when year-end in-center patient data by planning area from the NWRN modality reports is available prior to the letter of intent submission date, per WAC 246-310-812(4)(b). This fifth future year is deemed to be the projection year for identifying the maximum number of stations that may be approved within a planning area under the state methodology, per WAC 246-310-800(16). This methodology is based on the following:

- Performing a 5-year future regression of 5-year historical data, described in WAC 246-310-812(4), using either the linear or nonlinear regression methodology determined in the prior table to determine total projected patient volume. In this case, the linear methodology is used.
- Applying the patient to station conversion factor – either 4.8 patients per station for urban areas or 3.2 patients per station for designated rural counties – to determine total station need in the area. In this case, the 4.8 patients per station utilization factor is applied.
- Subtracting existing stations for dialysis facilities in the planning area from the total station need and rounding up to the next whole number of stations to determine net station need.

Table 8					
Projected Station Need for the Planning Area by Year					
King 11	Year 1	Year 2	Year 3	Year 4	Year 5
	2018	2019	2020	2021	2022
Projected Hemodialysis Patients	165.6	181.6	197.6	213.6	229.6
Patient:Station Converstion Factor	4.8	4.8	4.8	4.8	4.8
Total Station Need	34.5	37.8	41.2	44.5	47.8
Rounded to the next whole number	35	38	42	45	48
Existing Stations	26	26	26	26	26
Net Station Need	-9	-12	-16	-19	-22 [5]

King 11 shows need for twenty-two (22) stations in the fifth year of the projection, 2022.

4. For existing facilities, provide the facility's historical utilization for the last three full calendar years.

This question is not applicable as DaVita Auburn Valley Dialysis Center would be a new facility.

5. For existing facilities proposing to add one or two stations under WAC 246-310-818, provide the facility's historical utilization data for the most recent six months preceding the letter of intent period

This question is not applicable, as DaVita is not applying under WAC 246-310-818.

6. Provide projected utilization of the proposed facility for the first three full years of operation. For existing facilities, also provide the intervening years between historical and projected. Include all assumptions used to make these projections.

The table below provides a summary of projected utilization for the first three full years of operation through completion of the third full year of operation (2021 - 2023). In-center patient volume is based on a 5-year projection of King 11 patients using a regression of 5 years historical data per the Department's methodology and DaVita's own experience. In-center treatments are based on an assumption of 3 treatments per week per patient for 52 weeks with a 5% allowance for missed treatments.

Table 9 **DaVita Auburn Valley Dialysis Center Projected Utilization**	**Projection Year 2022**	**Projection Year 2023**	**Projection Year 2024**
Total in-center stations	22	22	22
Total in-center patients*	48	80	117
Total in-center treatments	5,030	9,435	14,553
Total home patients	0	0	0
Total home treatments	0	0	0

[5] [5] Note that patient projections use 2013 through year-end 2017 existing data. A trend line using data from this period is then projected through 2022 to project station need.

*End-of-year census

7. For existing facilities, provide patient origin zip code data for the most recent full calendar year of operation.

This question is not applicable as Auburn Valley Dialysis would be a new facility.

8. Identify any factors in the planning area that could restrict patient access to dialysis services.

DaVita is not aware of factors relating to its proposed offering of services at Auburn Valley Dialysis Center that could restrict patient access to dialysis services in the planning area. On the contrary, an addition of twenty-two (22) stations in the planning area, where the existing NKC Auburn facility was operating at 5.96 patients per station as of 12/31/2017, will enhance patient access and offer provider choice. As detailed in its response to question 7 under the Project Description, no existing services provided to dialysis patients or community members diagnosed with chronic kidney disease (CKD) will be curtailed under this project.

9. Identify how this project will be available and accessible to low-income persons, racial and ethnic minorities, women, mentally handicapped persons, and other under-served groups.

DaVita's history of providing dialysis services at numerous locations throughout Washington State shows that all persons, including the underserved groups identified in WAC 246-310-210(2), have adequate access to DaVita's facilities, as required by the regulation. We have provided as Appendix 14 copies of the applicable admission, patient financial evaluation, and patient involuntary transfer policies. Additionally, the pro forma the funds that have been budgeted to provide charity care.

10. If this project is either a partial or full relocation of an existing facility, provide a detailed discussion of the limitations of the current site consistent with WAC 246-310-210(2).

This question is not applicable to this project.

11. If this project is either a partial or full relocation of an existing facility, provide a detailed discussion of benefits associated with the relocation consistent with WAC 246-310-210(2).

This question is not applicable to this project.

12. Provide a copy of the following policies:

- Admissions policy

- Charity care or financial assistance policy
- Patient Rights and Responsibilities policy
- Non-discrimination policy
- Any other policies directly associated with patient access (example, involuntary discharge)

Copies of these policies are provided in Appendix 14. Additionally, DaVita's history of providing dialysis services at numerous locations throughout Washington State shows that all persons, including the underserved groups identified in WAC 246-310-210(2), have adequate access to DaVita's facilities, as required by the regulation.

B. Financial Feasibility (WAC 246-310-220 and 246-310-815)

1. Provide the following agreements/contracts:

- Management agreement.
- Operating agreement
- Medical director agreement
- Development agreement
- Joint Venture agreement

A signed Medical Director Agreement, valid through at least the first three full years following completion of the project, is included in Appendix 3. The Medical Director is Dr. Di Zhao (MD # 1922281617).

Neither a management agreement nor an operating agreement are applicable to this project as DaVita Inc. will be the sole owner and operator of DaVita Auburn Valley Dialysis Center. Nor is a joint venture agreement applicable, as DaVita will be the sole owner of DaVita Auburn Valley Dialysis Center.

A signed and executed development agreement is provided in Appendix 15, which is also termed the building lease.

2. Provide documentation of site control. This could include either a deed to the site or a lease agreement for the site. If a lease agreement is provided, the terms must be for at least five years following project completion.

The property on which DaVita Auburn Valley will be built is owned by Southern Financial Group, LLC. DaVita Inc., via its wholly-owned subsidiary Total Renal Care, Inc. has leased the property from Southern. A copy of the ground lease is provided in Appendix 15. This executed lease establishes that DaVita has site control.

In the interest of transparency, we also would note that DaVita ultimately will lease, not own, the building in which the dialysis center will be located. This will be accomplished by (1) after CN approval, DaVita, via Total Renal Care, assigning the ground lease to Genesis KC Development, LLC; (2) Genesis constructing a gray shell building of certain specifications that matches the requirements described in the project description and single line drawings; (3) Genesis leasing the space to DaVita via Total Renal Care; and (4) Davita, via Total Renal Care, taking possession as tenant, competing construction, and beginning to provide dialysis services. A copy of an executed lease agreement between Genesis and Total Renal Care is provided in Appendix 15 following the ground lease. DaVita's rent payments to Genesis include the payments owed to Southern under the ground lease. In other words, Genesis is expected to start making the rent payments under the Appendix 15 ground lease after it takes over that lease as DaVita's assignee, but Genesis will pass those payments on to DaVita through the Appendix 15 lease.

Therefore, the ground lease provided as Appendix 15 demonstrates that Total Renal Care has control over the site now, and the lease provided as Appendix 15 demonstrates that Total Renal Care will continue to have control over the site even after it assigns the ground lease to Genesis as planned.

3. Provide county assessor information and zoning information for the site. If zoning information for the site is unclear, provide documentation or letter from the municipal authorities showing the proposed project is allowable at the identified site.

Zoning & county assessor documentation for the proposed DaVita Auburn Valley Dialysis Center is provided in Appendix 15.

4. Complete the table below with the estimated capital expenditure associated with this project. Capital expenditure for the purposes of dialysis applications is defined under WAC 246-310-800(3). If you have other line items not listed below, include the definition of the line item. Include all assumptions used to create the capital expenditure estimate.

Table 10: Estimated Capital Expenditure Item	Cost
a. Land Purchase	$ -
b. Utilities to Lot Line	$ 2,000
c. Land Improvements	$ -
d. Building Purchase	$ -
e. Residual Value of Replaced Facility	$ -
f. Building Construction (Tenant Improvements)	$ 2,082,091
g. Fixed Equipment (not already included in the construction contract)	$ 236,322
h. Movable Equipment	$ 688,212
i. Architect and Engineering Fees	$ 174,000
j. Consulting Fees	$ -
k. Site Preparation	$ -
l. Supervision and Inspection of Site (including Permits)	$ 91,000
m. Any Costs Associated with Securing the Sources of Financing (include interim interest during construction)	
1. Land	$ -
2. Building	$ -
3. Equipment	$ -
4. Other	$ -
n. Washington Sales Tax (where applicable)	$ 92,453
Total Estimated Capital Expenditure	**$3,366,078**

* There are no Landlord hard costs associated with this project because the building will be accepted as gray shell by the Tenant, Total Renal Care, Inc., consistent with past applications. Tenant is responsible for all construction necessary to make the facility dialysis-ready. In the interest of full disclosure, the cost of the gray shell, estimated by Genesis KC Development, LLC, at $4,496,381, is built into the rent, and is thus properly accounted for in the pro forma operating statement.

Construction cost is estimated based on the non-binding contractor estimate presented in response to Question 6. Construction cost number includes sales tax. Sales tax is assumed at the Auburn, King County rate of 10.0% for all fixtures, furnishings, and equipment, and where else applicable.

5. Identify the entity responsible for the estimated capital costs identified above. If more than one entity is responsible, provide breakdown of percentages and amounts for all.

DaVita Inc, via its wholly-owned subsidiary Total Renal Care, Inc., is solely responsible for the capital costs identified above.

6. Provide a non-binding contractor's estimate for the construction costs for the project.

Please see the estimate provided in Appendix 22.

7. Provide a detailed narrative regarding how the project would or would not impact costs and charges for services. WAC 246-310-220.

The DaVita Auburn Valley Dialysis Center Detailed Projected Operating Statement (Pro Forma) covering the first three full years in operation is included in Appendix 9. As required per WAC 246-310-815(1)(b), the pro forma is based on the three nearest DaVita facilities' current payor mixes and current expenses. All major pro forma assumptions are also outlined in Appendix 9.

No existing facility is expected to lose volume or market share below Certificate of Need standards as a result of this project. The proposed facility will operate at utilization levels consistent with a 4.8 patients per station standard within three years. Finally, reimbursements for dialysis services are not subject to or affected by capital improvements and expenditures by providers; the proposed project will have no impact on increases in charges for services within the ESRD planning area, and will actually increase patient choice of provider from one provider to two in the planning area.

8. Provide documentation that the costs of the project, including any construction costs, will not result in an unreasonable impact on the costs and charges for health services in the planning area. WAC 246-310-220.

WAC 246-310-815(2) requires that applicants limit the costs of facility projects by creating a test of reasonableness in the construction of finished treatment floor area square footage. The treatment floor area must not exceed the maximum treatment floor area square footage defined in WAC 246-310-800(11). As outlined in response to Question Eleven under the Project Description, DaVita does not propose to construct treatment floor space in excess of the maximum treatment floor area square footage, and thus, under the WAC 246-310-815(2) test, this project does not have an unreasonable impact on costs and charges.

Additionally, as noted in response to question seven, reimbursements for dialysis services are not subject to or affected by capital improvements and expenditures by providers; the proposed project will have no impact on increases in charges for services within the ESRD planning area.

9. Provide the projected payer mix by revenue and by patients using the example table below. If "other" is a category, define what is included in "other."

Table 11 provides expected payor mix for the Auburn Valley Dialysis Center, projected using DaVita's comparable facilities and aligned with the pro forma operating statement.

Table 11 DaVita Auburn Dialysis Center Projected Payor Mix	Percentage by Revenue	Percentage by Patient
Medicare	30.67%	56.74%
Medicaid	1.01%	2.18%
Commercial, HMO, Other Government, and Other	68.32%	41.08%
Total	100.00%	100.00%

10. If this project proposes the addition of stations to an existing facility, provide the historical payer mix by revenue and patients for the existing facility.

This question is not applicable to this project.

11. Provide a listing of all new equipment proposed for this project. The list should include estimated costs for the equipment. If no new equipment is required, explain.

Table 12 provides a listing of all new equipment proposed for this project (including estimated sales tax).

Table 12 DaVita Auburn Valley Dialysis Center New Equipment	
Expenditure Category	**Allocated Equipment Cost**
Communication/Computer Equipment	$ 158,809
Water Treatment/Biomedical/Reuse	$ 207,102
Clinical Equipment	$ 414,143
Dialysis Machines, IV Pumps, AED, EKG, etc.	
Permanent bed	
Patient Scale, Ice Machine, Patient Lift, etc.	
Dialysis Chairs, Chart Racks, Stools, etc.	
Storage, Fixtures, Artwork, Office Equipment, etc.	$ 144,480
Sales Tax	$ 92,453
Total Equipment Costs	**$ 1,016,987**

12. Provide a description of any equipment to be replaced, including cost of the equipment, and salvage value (if any) or disposal, or use of the equipment to be replaced.

No equipment is to be replaced during this project.

13. Identify the source(s) of financing (loan, grant, gifts, etc.) and provide supporting documentation from the source.

The project will be funded from DaVita's capital expenditures budget. Capital budgeting reflects appropriate allocations of funds for projects in the Pacific Northwest. A letter from Mike Staffieri, Chief Operating Officer, committing to these funds is included as Appendix 6.

14. Provide the applicant's audited financial statements covering at least the most recent three years. WAC 246-310-220.

Audited financial statements for DaVita Inc., covering the time period from 2015-2017, are provided in Appendix 10.

C. Structure and Process (Quality) of Care (WAC 246-310-230)

1. Provide a table that shows FTEs [full time equivalents] by category for the proposed facility. If the facility is currently in operation, include at least the last three full years of operation, the current year, and the first three full years of operation following project completion. There should be no gaps in years.

Table 13 below presents the staffing for the DaVita Auburn Valley Dialysis Center. The salary and wage and benefit costs for the facility are detailed below.

Table 13

	FY22	FY23	FY24
Stations	22	22	22
Average Census			
Total	34	64	98
In-Center	34	64	98
PD	-	-	-
HHD	-	-	-

	Comp Clinics			FTEs		
	Avg Wage Rate	Override Wage Rate	Staffing Ratio (pts per shift)	FY22	FY23	FY24
Administrator	$ 42.34		80	1.00	1.00	1.00
Admin Assistant	$ 21.67		110	1.00	1.00	1.00
Social Worker	$ 30.34		120	0.28	0.53	0.82
Dietician	$ 31.84		120	0.28	0.53	0.82
RN - In-Center	$ 39.59		12	0.94	1.77	2.73
LPN	$ 25.23			-	-	-
PCT	$ 20.16		4	2.83	5.31	8.18
RN - PD	$ -		18	-	-	-
RN - HHD	$ -		14	-	-	-
Biomed	$ 23.02		40	0.55	0.55	0.55
Reuse	$ -			-	-	-
Other	$ 26.54		80	0.42	0.80	1.23

2. Provide the assumptions used to project the number and types of FTEs identified for this project.

DaVita projects FTEs based on staffing ratios for patients per shift, combined with clinical expertise. Standard ratios are noted in Table 13. Overall census estimates are based on the assumptions describing the pro forma in Appendix 9.

3. Identify the salaries, wages, and employee benefits for each FTE category.

Aggregated salary, wage, and benefit rates for each FTE category are noted in Table 13, based on actual rates from 2017 comparable facilities. Benefits are assumed at 60% of wage rates.

4. Provide the name and professional license number of the current or proposed medical director. If not already disclosed under 210(1) identify if the medical director is an employee or under contract.

The proposed Medical Director is Dr. Di Zhao (MD # 1922281617). She is under contract to provide medical director services to Auburn Valley Dialysis Center, and is not an employee of DaVita.

5. Identify key staff, if known. (nurse manager, clinical director, etc.)

DaVita Auburn Valley Dialysis Center will have a Facility Administrator (FA) and Clinical Coordinator (CC). These staff are not yet identified.

6. For existing facilities, provide names and professional license numbers for current credentialed staff.

This question is not applicable.

7. Describe your methods for staff recruitment and retention. If any barriers to staff recruitment exist in the planning area, provide a detailed description of your plan to staff this project.

DaVita anticipates no difficulty in recruiting the necessary personnel to staff DaVita Auburn Valley Dialysis Center. Based on our experience operating facilities in the western Washington area, DaVita anticipates that staff from geographically adjacent facilities will serve patients at the new DaVita Auburn Valley Dialysis Center, and some new staff may also be required. DaVita has been repeatedly recognized as a Top Employer and a Military Friendly Employer (davita.com/about/awards) and offers a competitive wage and benefit package to employees. DaVita posts openings nationally both internally and external to DaVita.

8. Provide a listing of proposed ancillary and support agreements for the facility. For existing facilities, provide a listing of the vendors.

Please see a listing of proposed ancillary and support agreements for DaVita Auburn Valley Dialysis Center in Appendix 11.

9. For existing facilities, provide a listing of ancillary and support service vendors already in place.

This question is not applicable.

10. For new facilities, provide a listing of ancillary and support services that will be established.

Please see a listing of proposed ancillary and support agreements, and services to be established, for DaVita Auburn Valley Dialysis Center in Appendix 11.

11. Provide a listing of ancillary and support services that would be provided on site and those provided through a parent corporation off site.

Ancillary services such as social services, nutrition services, financial counseling, pharmacy access, patient education, staff education, information services, material management, administration and biomedical technical services will be provided on site. Additional services are coordinated through DaVita's main office in Denver, Colorado, and support offices in Federal Way and Tacoma, Washington, and elsewhere. These ancillary and support services provided centrally include the Guest Services Program that provides assistance in locating other dialysis facilities for patients wishing to travel or relocate. In addition, DaVita offers centralized revenue cycle, management services, quality improvement services, biomedical equipment maintenance and a number of other high-value off-site programs.

12. Identify whether any of the existing ancillary or support agreements are expected to change as a result of this project.

No existing ancillary or support agreements are expected to change as a result of this project.

13. If the dialysis center is currently operating, provide a listing of healthcare facilities with which the dialysis center has working relationships.

This question is not applicable.

14. For a new facility, provide a listing of healthcare facilities with which the dialysis center would establish working relationships.

DaVita anticipates establishing working relationships with local hospitals, for patient transfer, coordinated discharge and acceptance of patients, and support of kidney transplant efforts. DaVita also anticipates continuing its relationships with area physician practices to ensure the highest quality coordinated care for patients. Finally, DaVita anticipates establishing relationships with local nursing homes to provide care for their resident ESRD patients, many of which it already collaborates with in other area dialysis facilities.

15. Clarify whether any of the existing working relationships would change as a result of this project.

No existing working relationships are expected to change as a result of this project, although area hospitals and nursing homes may expect enhanced access for their ESRD patients upon project completion.

16. Fully describe any history of the applicant concerning the actions noted in Certificate of Need rules and regulations WAC 246-310-230(5)(a). If there is such history, provide documentation that the proposed project will be operated in a manner that ensures safe and adequate care to the public to be served and in conformance with applicable federal and state requirements. This could include a corporate integrity agreement or plan of correction.

DaVita and the United States Department of Health and Human Services, Office of Inspector General entered into a Corporate Integrity Agreement ("CIA") to promote compliance with the statutes, regulations, and written directives of Medicare, Medicaid, and all other Federal health care programs and, in particular, included the appointment of an Independent Monitor to prospectively review DaVita's arrangements with nephrologists and other health care providers for compliance with the Anti-Kickback Statute (collectively, "Federal Health Care Programs and Laws"). That Independent Monitor completed the prospective review process in the fall of 2017. Each arrangement is now reviewed by the Risk Rating team to ensure that it is compliant with these Federal Health Care Programs and Laws. A full copy of the Corporate Integrity Agreement is included with this application in Appendix 20.

17. Provide documentation that the proposed project will promote continuity in the provision of health care services in the planning area, and not result in an unwarranted fragmentation of services. WAC 246-310-230

Appendix 17 provides a summary of quality and continuity of care indicators used in DaVita's quality improvement program. The DaVita Continuous Quality Improvement (CQI) program incorporates all areas of the dialysis program. The program monitors and evaluates all activities related to clinical outcomes, operations management, and process flow. Dialysis-specific statistical tools (developed by DaVita) are used for measurement, analysis, communication, and feedback. Continuing employee and patient education are integral parts of this program. Appendix 17 includes an example of DaVita Quality Index (DQI) data. Appendix 18 includes an example of DaVita's Physician, Community and Patient Services offered through DaVita's Kidney Smart Education Program. Appendix 12 includes a draft copy of a patient transfer agreement with an area partner. DaVita has been honored as one of the World's Most Admired Companies® by FORTUNE® magazine since 2006, confirming its excellence in working effectively with the communities it serves (davita.com/about/awards).

18. Provide documentation that the proposed project will have an appropriate relationship to the service area's existing health care system as required in WAC 246-310-230.

The proposed DaVita Auburn Valley Dialysis Center will have an appropriate relationship to the service area's existing health care system. DaVita Auburn Valley Dialysis will be a key component of the expanded health care system in the service area, and the project will enable enhanced patient access in the King 11 planning area with highly utilized facilities meeting the 4.5 patients per station threshold, and NKC Auburn at 5.96

patients per station in December 2017. Furthermore, DaVita has a long track record of working with area providers and collaborating with them to provide the highest quality care for patients.

19. Provide documentation to verify that the facility would be operated in compliance with applicable state and federal standards. The assessment of the conformance of a project to this criterion shall include, but not be limited to, consideration as to whether the applicant or licensee has no history, in this state or elsewhere, of a criminal conviction which is reasonably related to the applicant's competency to exercise responsibility for the ownership or operation of a health care facility, a denial or revocation of a license to operate a health care facility, a revocation of a license to practice a health profession, or a decertification as a provider of services in the Medicare or Medicaid program because of failure to comply with applicable federal conditions of participation.

The applicant has no adverse history of license revocation or decertification in Washington State. DaVita has no criminal convictions related to DaVita's competency to exercise responsibility for the ownership or operation of its facilities. As previously reported, a DaVita facility in Tennessee was decertified and closed eleven years ago (2007) and DaVita voluntarily temporarily shut down a facility in Texas ten years ago (2008). DaVita has also supplied, in Appendix 13, a list of all state regulatory agencies with which it interacts.

D. Cost Containment (WAC 246-310-240)

1. Identify all alternatives considered prior to submitting this project.

Alternative 1: Do nothing. That is, do not apply for additional stations in the King 11 planning area. King 11 is growing in ESRD population, with a three-year annualized in-center ESRD census growth rate of 13.33% and demonstrated need for twenty-two (22) stations. NKC Auburn has little additional capacity, with utilization of 5.96 patients per station when it had double the stations, and NKC Federal Way East has not become operational within its projected timeline. With strong demand for access to dialysis services but no application, patients will be forced to dialyze at less convenient times, locations, or even out of the planning area entirely. This alternative was rejected.

Alternative 2: Apply for twenty-two (22) stations in the King 11 planning area. As summarized above, King 11 shows substantial need for dialysis services. DaVita will offer high-quality dialysis services to patients in the King 11 planning area, additional provider choice, and additional, centrally located access. **This alternative was selected.**

2. Provide a comparison of the project with alternatives rejected by the applicant. Include the rationale for considering this project to be superior to the rejected

alternatives. Factors to consider can include, but are not limited to: patient access to healthcare services, capital cost, legal restrictions, staffing impacts, quality of care, and cost or operation efficiency.

Please see the exploration and analysis of alternatives in response to Question One above.

3. For existing facilities, identify your closest two facilities as required in WAC 246-310-827(3)(a).

This question is not applicable.

4. For new facilities, identify your closes three facilities as required in WAC 246-310-827(3)(b).

DaVita's three closest facilities to Auburn Valley Dialysis Center are:

- DaVita Federal Way Community Dialysis Center
- DaVita Kent Dialysis Center
- DaVita Puyallup Dialysis Center

5. Identify whether any aspects of the facility's design could lead to operational efficiency. This could include but is not limited to: LEED building, water filtration, or the methods for construction, etc. WAC 246-310-240(2) and (3).

DaVita Auburn Valley Center will meet all current energy conservation standards required. Furthermore, DaVita design standards, reflected in the single-line drawing, are planned to promote energy efficiency, create efficient workflows, clean sightlines and a safe and welcoming environment for patients. When possible, this may be reflected in locating patients away from the exterior envelope for optimal HVAC layout, providing southern exposure for daylighting and solar comfort, and minimizing process piping length.

APPENDICES

Appendix 01 Organizational Chart

Appendix 02 Master Legal Entity List; National DaVita Facilities

Appendix 03 Medical Director Agreement

Appendix 04 Patients by Zip Code

Appendix 05 Letter of Intent

Appendix 06 Operational and Financial Commitment Letter

Appendix 07 Credentialed Staff

Appendix 08 Historical & Current Financials

Appendix 09 Detailed Projected Operating Statement (Pro Forma)

Appendix 10 Audited Financial Statements; SEC 10k – 2014, 2015, 2016

Appendix 11 Ancillary and Support Agreements and Vendors

Appendix 12 Patient Transfer Agreement

Appendix 13 List of State Regulatory Agencies

Appendix 14 Accepting Patients for Treatment; Indigent Care Policy; Involuntary Transfer Procedure; Patient Rights

Appendix 15 Lease Agreement, Development Agreement, Zoning Documentation

Appendix 16 Single Line Drawing

Appendix 17 DaVita Quality Index (DQI) Data; DaVita Continuous Quality Improvement (CQI) Data

Appendix 18 DaVita's Physician, Community and Patient Services

Appendix 19 AJKD Original Investigation "Clinical Outcomes Associated with Receipt of Integrated Pharmacy Services by Hemodialysis Patients: A Quality Improvement Report"

Appendix 20 Corporate Integrity Agreement

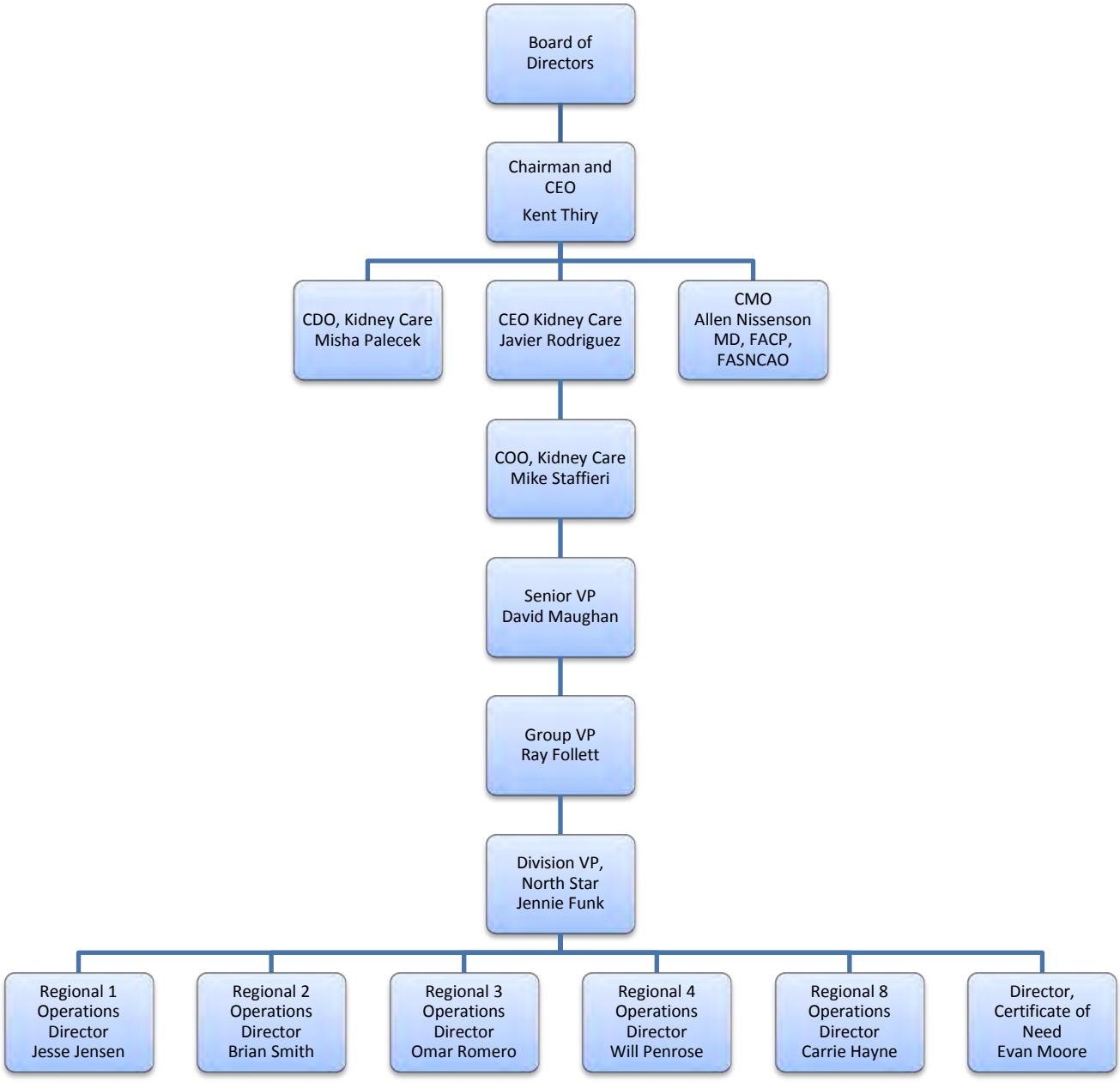
Appendix 21 DaVita Top Clinical Outcomes; Press Release April 27, 2018

Appendix 22 Nonbinding Contractor Estimate

Appendix 1

Organizational Chart

DaVita Organizational Structure



Appendix 2

Master Legal Entity List
National DaVita Facilities

	A	B	C	D	E	F	G	H	I	J	K
1	**Entity Name**	**Domestic Jurisdiction**	**Formation Date**	**Entity Type**	**CSC Indicator**	**CSC Service Status**	**Entity Status**	**Entity Status Date**	**Wholly Owned (Yes/No)**	**DVA Ownership 50% or Less (Yes/No)**	**SIC/NAICS**
2	Aberdeen Dialysis, LLC	DE	11/06/2006	LLC	CSC	ACTIVE	Active	11/06/2006	No	No	621492
3	Able Dialysis, LLC	DE	03/08/2013	LLC	CSC	ACTIVE	Active	03/08/2013	No	No	621492
4	Acadia Dialysis, LLC	DE	11/20/2012	LLC	CSC	ACTIVE	Active	11/20/2012	Yes	No	621492
5	Accountable Kidney Care, LLC	DE	01/31/2011	LLC	CSC	ACTIVE	Active	01/31/2011	Yes	No	621492
6	Ackley Dialysis, LLC	DE	10/08/2015	LLC	CSC	ACTIVE	Active	10/08/2015	Yes	No	621492
7	Acton Dialysis, LLC	DE	01/10/2013	LLC	CSC	ACTIVE	Active	01/10/2013	Yes	No	621492
8	Adair Dialysis, LLC	DE	08/20/2012	LLC	CSC	ACTIVE	Active	08/20/2012	Yes	No	621492
9	Adiron Dialysis, LLC	DE	12/02/2016	LLC	CSC	ACTIVE	Active	12/02/2016	Yes	No	621492
10	Afton Dialysis, LLC	DE	09/02/2014	LLC	CSC	ACTIVE	Active	09/02/2014	Yes	No	621492
11	Ahern Dialysis, LLC	DE	06/16/2015	LLC	CSC	ACTIVE	Active	06/16/2015	No	No	621492
12	Aikens Dialysis, LLC	DE	12/04/2013	LLC	CSC	ACTIVE	Active	12/04/2013	Yes	No	621492
13	Alamosa Dialysis, LLC	DE	09/03/2008	LLC	CSC	ACTIVE	Active	09/03/2008	Yes	No	621492
14	Alenes Dialysis, LLC	DE	10/08/2015	LLC	CSC	ACTIVE	Active	10/08/2015	No	No	621492
15	Alexandria Dialysis, LLC	DE	01/10/2012	LLC	CSC	ACTIVE	Active	01/10/2012	Yes	No	621492
16	Alomie Dialysis, LLC	DE	01/09/2014	LLC	CSC	ACTIVE	Active	01/09/2014	Yes	No	621492
17	Alterra Dialysis, LLC	DE	10/05/2016	LLC	CSC	ACTIVE	Active	10/05/2016	No	No	621492
18	Amarillo Dialysis, LLC	DE	06/19/2007	LLC	CSC	ACTIVE	Active	06/19/2007	Yes	No	621492
19	American Dialysis, LLC	DE	05/16/2008	LLC	CSC	ACTIVE	Active	05/15/2008	Yes	No	621492
20	American Fork Dialysis, LLC	DE	06/21/2007	LLC	CSC	ACTIVE	Active	06/21/2007	No	No	621492
21	American Medical Insurance, Inc.	AZ	09/25/2017	CORP	CSC	ACTIVE	Active	09/25/2017	Yes	No	
22	Amery Dialysis, LLC	DE	02/27/2008	LLC	CSC	ACTIVE	Active	02/27/2008	No	No	621492
23	Amity Dialysis, LLC	DE	08/15/2017	LLC	CSC	ACTIVE	Active	08/15/2017	No	No	621492
24	AMR - Assistencia Medica Ao Renal Ltda.	Brazil	08/01/2017	LLCL	NonCSC	N/A	Active	08/01/2017	Yes	No	
25	Anderson Kidney Dialysis, LLC	DE	12/17/2010	LLC	CSC	ACTIVE	Active	12/12/2010	Yes	No	621492
26	Andrews Dialysis, LLC	DE	07/08/2014	LLC	CSC	ACTIVE	Active	07/08/2014	Yes	No	621492
27	Aneka Produktif Sdn. Bhd.	Malaysia	04/18/2016	PCLS	NonCSC	N/A	Active	04/18/2016			
28	Animas Dialysis, LLC	DE	09/23/2008	LLC	CSC	ACTIVE	Active	09/23/2008	Yes	No	621492
29	Arcadia Gardens Dialysis, LLC	DE	11/15/2007	LLC	CSC	ACTIVE	Active	11/15/2007	No	No	621492
30	Arcadia Outpatient Surgery Center, L.P.	CA	03/09/1988	LP	NonCSC	N/A	Active	03/09/1988	No		
31	Arches Dialysis, LLC	DE	05/16/2008	LLC	CSC	ACTIVE	Active	05/16/2008	Yes	No	621492
32	Ardigm Dialysis, LLC	DE	06/26/2015	LLC	CSC	ACTIVE	Active	06/26/2015	Yes	No	621492
33	Argyle Dialysis, LLC	DE	11/01/2013	LLC	CSC	ACTIVE	Active	11/01/2013	Yes	No	621492
34	Arrowhead Dialysis, LLC	DE	03/10/2009	LLC	CSC	ACTIVE	Active	03/10/2009	Yes	No	621492
35	Artesia Dialysis, LLC	DE	02/13/2015	LLC	CSC	ACTIVE	Active	02/13/2015	No	No	621492
36	Ashdow Dialysis, LLC	DE	08/22/2017	LLC	CSC	ACTIVE	Active	08/22/2017	Yes	No	621492
37	Aspen Group	DC	09/16/2014	NFP	NonCSC	N/A	Active	09/16/2014			
38	Astro, Hobby, West Mt. Renal Care Limited Partnership	DE	12/27/1996	LP	CSC	ACTIVE	Active	12/27/2006	Yes	No	621492
39	Atchison Dialysis, LLC	DE	11/28/2016	LLC	CSC	ACTIVE	Active	11/28/2016	No	No	621492
40	Athio Dialysis, LLC	DE	12/16/2014	LLC	CSC	ACTIVE	Active	12/16/2014	No	No	621492
41	Atlantic Dialysis, LLC	DE	03/13/2013	LLC	CSC	ACTIVE	Active	03/13/2013	No	No	621492
42	Attell Dialysis, LLC	DE	12/23/2015	LLC	CSC	ACTIVE	Active	12/23/2015	No	No	621492
43	Austin Dialysis Centers, L.P.	DE	07/14/2004	LP	CSC	ACTIVE	Active	07/14/2004	No	No	621492
44	Avertrail Dialysis, LLC	DE	03/10/2017	LLC	CSC	ACTIVE	Active	03/10/2017	Yes	No	621492
45	Babler Dialysis, LLC	DE	09/26/2014	LLC	CSC	ACTIVE	Active	09/26/2014	No	No	621492
46	Bagby Dialysis, LLC	DE	04/09/2013	LLC	CSC	ACTIVE	Active	04/09/2013	Yes	No	621492
47	Bainbridge Dialysis, LLC	DE	02/16/2012	LLC	CSC	ACTIVE	Active	02/16/2012	No	No	621492
48	Baker Dialysis, LLC	DE	07/09/2014	LLC	CSC	ACTIVE	Active	07/09/2014	Yes	No	621492
49	Balch Springs Dialysis, LLC	DE	09/08/2011	LLC	CSC	ACTIVE	Active	09/08/2011	Yes	No	621492
50	Bancroft Dialysis, LLC	DE	07/18/2017	LLC	CSC	ACTIVE	Active	07/18/2017	Yes	No	621492
51	Banfort Dialysis, LLC	DE	03/31/2017	LLC	CSC	ACTIVE	Active	03/31/2017	Yes	No	621492

	A	B	C	D	E	F	G	H	I	J	K
52	Bannack Dialysis, LLC	DE	11/12/2015	LLC	CSC	ACTIVE	Active	11/12/2015	No	No	621492
53	Bannon Dialysis, LLC	DE	10/24/2013	LLC	CSC	ACTIVE	Active	10/24/2013	No	No	62149
54	Barnell Dialysis, LLC	DE	09/19/2013	LLC	CSC	ACTIVE	Active	09/19/2013	No	No	621492
55	Barrington Dialysis, LLC	DE	09/19/2012	LLC	CSC	ACTIVE	Active	09/19/2012	Yes	No	621492
56	Barrons Dialysis, LLC	DE	11/07/2017	LLC	CSC	ACTIVE	Active	11/07/2017	Yes	No	621492
57	Barton Dialysis, LLC	DE	08/02/2011	LLC	CSC	ACTIVE	Active	08/02/2011	No	No	621492
58	Basin Dialysis, LLC	DE	05/23/2012	LLC	CSC	ACTIVE	Active	05/23/2012	No	No	621492
59	Bastrop Dialysis, LLC	DE	09/19/2012	LLC	CSC	ACTIVE	Active	09/19/2012	Yes	No	621492
60	Bay Area Dialysis Partnership	FL	01/21/2003	GP	CSC	INACTIVE	Active	01/21/2003	Yes	No	621492
61	Bayfield Dialysis, LLC	DE	03/27/2018	LLC	CSC	ACTIVE	Active	03/27/2018	Yes	No	621492
62	Bayonne Renal Center, LLC	DE	11/01/2000	LLC	CSC	ACTIVE	Active	11/01/2000	Yes	No	621492
63	Bayshore Dialysis, LLC	DE	12/04/2013	LLC	CSC	ACTIVE	Active	12/05/2013	No	No	621492
64	Baytown Dialysis, LLC	DE	06/08/2007	LLC	CSC	ACTIVE	Active	06/08/2007	Yes	No	621492
65	Beachside Dialysis, LLC	DE	01/11/2012	LLC	CSC	ACTIVE	Active	01/11/2012	No	No	621492
66	Beacon Dialysis, LLC	DE	12/07/2010	LLC	CSC	ACTIVE	Active	12/07/2010	No	No	621492
67	Beals Dialysis, LLC	DE	04/03/2014	LLC	CSC	ACTIVE	Active	04/03/2014	Yes	No	621492
68	Bear Creek Dialysis Center, L.P.	DE	03/23/2006	LP	CSC	ACTIVE	Active	03/23/2006	No	No	621492
69	Beck Dialysis, LLC	DE	11/01/2012	LLC	CSC	ACTIVE	Active	11/01/2012	Yes	No	621492
70	Bedell Dialysis, LLC	DE	06/30/2015	LLC	CSC	ACTIVE	Active	06/30/2015	Yes	No	621492
71	Belfair Dialysis, LLC	DE	03/13/2013	LLC	CSC	ACTIVE	Active	03/13/2013	Yes	No	621492
72	Bellevue Dialysis, LLC	DE	07/30/2012	LLC	CSC	ACTIVE	Active	07/30/2012	No	No	621492
73	Belmont Dialysis, LLC	DE	10/05/2016	LLC	CSC	ACTIVE	Active	10/05/2016	No	No	621492
74	Bemity Dialysis, LLC	DE	02/05/2016	LLC	CSC	ACTIVE	Active	02/05/2016	Yes	No	621492
75	Bennett Dialysis, LLC	NY	04/23/2015	LLC	CSC	ACTIVE	Active	04/23/2015	Yes	No	621492
76	Beverly Dialysis, LLC	DE	11/03/2010	LLC	CSC	ACTIVE	Active	11/03/2010	Yes	No	621492
77	Beverly Hills Dialysis Partnership	CA	12/01/1994	GP	NonCSC	N/A	Active - Dissolution Pending	08/15/2016	Yes	No	621492
78	Bidwell Dialysis, LLC	DE	10/01/2012	LLC	CSC	ACTIVE	Active	10/01/2012	Yes	No	621492
79	Birch Dialysis, LLC	OH	12/29/2010	LLC	CSC	ACTIVE	Active	12/29/2010	No	No	621492
80	Biscayne Dialysis, LLC	DE	05/09/2014	LLC	CSC	ACTIVE	Active	05/09/2014	Yes	No	621492
81	Blackfoot Dialysis Partners, LLC	DE	06/09/2006	LLC	CSC	ACTIVE	Active	06/09/2006	Yes	No	621492
82	Bladon Dialysis, LLC	DE	03/29/2011	LLC	CSC	ACTIVE	Active	03/29/2011	No	No	621492
83	Blake Dialysis, LLC	DE	04/20/2011	LLC	CSC	ACTIVE	Active	04/20/2011	Yes	No	621492
84	Blanco Dialysis, LLC	DE	07/22/2011	LLC	CSC	ACTIVE	Active	07/22/2011	No	No	621492
85	Blauvelt Dialysis, LLC	DE	12/05/2016	LLC	CSC	ACTIVE	Active	12/05/2016	Yes	No	621492
86	Bliss Dialysis, LLC	DE	07/16/2012	LLC	CSC	ACTIVE	Active	07/16/2012	No	No	621492
87	Blue Dialysis, LLC	DE	09/02/2008	LLC	CSC	ACTIVE	Active	09/02/2008	Yes	No	621492
88	Bluegrass Dialysis, LLC	DE	05/16/2008	LLC	CSC	ACTIVE	Active	05/16/2008	No	No	621492
89	Bogachiel Dialysis, LLC	DE	04/23/2014	LLC	CSC	ACTIVE	Active	04/23/2014	No	No	621492
90	Bohama Dialysis, LLC	DE	10/01/2012	LLC	CSC	ACTIVE	Active	10/01/2012	No	No	621492
91	Bollinger Dialysis, LLC	DE	09/29/2014	LLC	CSC	ACTIVE	Active	09/29/2014	No	No	621492
92	Boltron Dialysis, LLC	DE	11/21/2013	LLC	CSC	ACTIVE	Active	11/21/2013	Yes	No	621492
93	Bonister Dialysis, LLC	DE	12/23/2015	LLC	CSC	ACTIVE	Active	12/23/2015	No	No	621492
94	Boonville Dialysis, LLC	DE	02/23/2017	LLC	CSC	ACTIVE	Active	02/23/2017	Yes	No	621492
95	Borrego Dialysis, LLC	DE	12/18/2012	LLC	CSC	ACTIVE	Active	12/18/2012	No	No	621492
96	Bothwell Dialysis, LLC	DE	08/20/2014	LLC	CSC	ACTIVE	Active	08/20/2014	No	No	621492
97	Botkins Dialysis, LLC	DE	11/06/2017	LLC	CSC	ACTIVE	Active	12/06/2017	Yes	No	621492
98	Bottle Dialysis, LLC	DE	05/02/2011	LLC	CSC	ACTIVE	Active	05/02/2011	No	No	621492
99	Bowan Dialysis, LLC	DE	01/11/2013	LLC	CSC	ACTIVE	Active	01/11/2013	Yes	No	621492
100	Brache Dialysis, LLC	DE	05/16/2014	LLC	CSC	ACTIVE	Active	05/16/2014	No	No	621492
101	Braddock Dialysis, LLC	DE	12/22/2016	LLC	CSC	ACTIVE	Active	12/22/2016	Yes	No	621492
102	Braden Dialysis, LLC	DE	05/30/2013	LLC	CSC	ACTIVE	Active	05/30/2013	Yes	No	621492

	A	B	C	D	E	F	G	H	I	J	K
103	Braggs Dialysis, LLC	DE	01/16/2013	LLC	CSC	ACTIVE	Active	01/16/2013	Yes	No	621492
104	Braidwood Dialysis, LLC	DE	12/05/2013	LLC	CSC	ACTIVE	Active	12/05/2013	Yes	No	621492
105	Brantley Dialysis, LLC	DE	02/04/2011	LLC	CSC	ACTIVE	Active	02/04/2011	Yes	No	621492
106	Bretton Dialysis, LLC	DE	07/11/2017	LLC	CSC	ACTIVE	Active	07/11/2017	Yes	No	621492
107	Bridge of Life, Inc.	DE	05/29/2013	NFP	CSC	ACTIVE	Active	05/29/2013			
108	Bridges Dialysis, LLC	DE	05/18/2010	LLC	CSC	ACTIVE	Active	05/18/2010	No	No	621492
109	Bright Dialysis, LLC	DE	06/18/2009	LLC	CSC	ACTIVE	Active	10/01/2015	No	No	621492
110	Brighton Dialysis Center, LLC	DE	01/12/2004	LLC	CSC	ACTIVE	Active	01/12/2004	Yes	No	621492
111	Bronson Dialysis, LLC	DE	02/08/2016	LLC	CSC	ACTIVE	Active	02/08/2016	Yes	No	621492
112	Brook Dialysis, LLC	DE	12/08/2010	LLC	CSC	ACTIVE	Active	12/08/2010	No	No	621492
113	Brooksprings Dialysis, LLC	DE	03/27/2018	LLC	CSC	ACTIVE	Active	03/27/2018	Yes	No	621492
114	Brownsville Kidney Center, Ltd.	TX	07/10/1995	LP	CSC	ACTIVE	Active	07/10/1995	No	No	621492
115	Brownwood Dialysis, LLC	DE	01/11/2012	LLC	CSC	ACTIVE	Active	01/11/2012	No	No	621492
116	Brule Dialysis, LLC	DE	11/08/2017	LLC	CSC	ACTIVE	Active	11/08/2017	Yes	No	621492
117	Bruno Dialysis, LLC	DE	09/17/2008	LLC	CSC	ACTIVE	Active	09/17/2008	No	No	621492
118	Bryce Dialysis, LLC	DE	09/09/2008	LLC	CSC	ACTIVE	Active	09/09/2008	Yes	No	621492
119	Buckhorn Dialysis, LLC	DE	11/20/2017	LLC	CSC	ACTIVE	Active	11/20/2017	No	No	621492
120	Buescher Dialysis, LLC	NY	12/12/2012	LLC	CSC	ACTIVE	Active	12/12/2012	Yes	No	621492
121	Buford Dialysis, LLC	DE	03/07/2006	LLC	CSC	ACTIVE	Active	03/07/2006	No	No	621492
122	Bulfinch Dialysis, LLC	DE	11/07/2011	LLC	CSC	ACTIVE	Active	11/07/2011	Yes	No	621492
123	Bullards Dialysis, LLC	DE	08/10/2011	LLC	CSC	ACTIVE	Active	08/01/2011	No	No	621492
124	Bullock Dialysis, LLC	DE	12/23/2015	LLC	CSC	ACTIVE	Active	12/23/2015	Yes	No	621492
125	Burman Dialysis, LLC	DE	02/28/2017	LLC	CSC	ACTIVE	Active	02/28/2017	Yes	No	621492
126	Burney Dialysis, LLC	DE	11/22/2011	LLC	CSC	ACTIVE	Active	11/22/2011	Yes	No	621492
127	Burton Dialysis, LLC	DE	06/17/2008	LLC	CSC	ACTIVE	Active	06/17/2008	Yes	No	621492
128	Butano Dialysis, LLC	DE	08/03/2011	LLC	CSC	ACTIVE	Active	08/03/2011	No	No	621492
129	Caballo Dialysis, LLC	DE	06/24/2011	LLC	CSC	ACTIVE	Active	06/24/2011	Yes	No	621492
130	Cache Dialysis, LLC	DE	07/14/2014	LLC	CSC	ACTIVE	Active	07/14/2014	Yes	No	621492
131	Caddo Dialysis, LLC	DE	08/08/2011	LLC	CSC	ACTIVE	Active	08/08/2011	Yes	No	621492
132	Caddoan Dialysis, LLC	DE	10/20/2016	LLC	CSC	ACTIVE	Active	10/20/2016	No	No	621492
133	Cadiz Dialysis, LLC	DE	11/09/2016	LLC	CSC	ACTIVE	Active	11/09/2016	No	No	621492
134	Caesar Dialysis, LLC	DE	05/14/2014	LLC	CSC	ACTIVE	Active	05/14/2014	Yes	No	621492
135	Cagles Dialysis, LLC	DE	06/17/2013	LLC	CSC	ACTIVE	Active	06/17/2013	No	No	621492
136	Cahaba Dialysis, LLC	DE	04/13/2017	LLC	CSC	ACTIVE	Active	04/13/2017	Yes	No	621492
137	Calamus Dialysis, LLC	DE	03/08/2012	LLC	CSC	ACTIVE	Active	03/08/2012	Yes	No	621492
138	Calante Dialysis, LLC	DE	07/05/2016	LLC	CSC	ACTIVE	Active	07/05/2016	No	No	621492
139	Calaveras Dialysis, LLC	DE	09/17/2012	LLC	CSC	ACTIVE	Active	09/17/2012	Yes	No	621492
140	Calico Dialysis, LLC	DE	08/25/2017	LLC	CSC	ACTIVE	Active	08/25/2017	Yes	No	621492
141	California Medical Group Insurance Company, Risk Retention Group	AZ	10/04/2004	CORP	CSC	ACTIVE	Active	10/04/2004	No	Yes	524292
142	Cama Dialysis, LLC	DE	07/09/2014	LLC	CSC	ACTIVE	Active	07/09/2014	No	No	621492
143	Camino Dialysis, LLC	DE	12/17/2010	LLC	CSC	ACTIVE	Active	12/17/2010	No	No	621492
144	Campton Dialysis, LLC	DE	03/07/2013	LLC	CSC	ACTIVE	Active	03/07/2013	No	No	621492
145	Canney Dialysis, LLC	DE	06/23/2017	LLC	CSC	ACTIVE	Active	06/23/2017	Yes	No	621492
146	Cannon Dialysis, LLC	DE	10/28/2011	LLC	CSC	ACTIVE	Active	10/28/2011	No	No	621492
147	Canoe Dialysis, LLC	DE	02/20/2015	LLC	CSC	ACTIVE	Active	02/20/2015	No	No	621492
148	Canyon Dialysis, LLC	DE	03/16/2016	LLC	CSC	ACTIVE	Active	03/16/2016	No	No	621492
149	Canyon Springs Dialysis, LLC	DE	08/22/2007	LLC	CSC	ACTIVE	Active	08/22/2007	No	No	621492
150	Canyonlands Dialysis, LLC	DE	04/30/2008	LLC	CSC	ACTIVE	Active	04/30/2008	Yes	No	621492
151	Capano Dialysis, LLC	DE	09/20/2016	LLC	CSC	ACTIVE	Active	09/20/2016	Yes	No	621492
152	Capelville Dialysis, LLC	DE	01/16/2008	LLC	CSC	ACTIVE	Active	01/16/2008	Yes	No	621492
153	Capes Dialysis, LLC	DE	10/06/2010	LLC	CSC	ACTIVE	Active	10/06/2010	No	No	621492
154	Capital Dialysis Partnership	CA	11/01/1997	GP	NonCSC	N/A	Active	12/05/2005	No	No	621492

	A	B	C	D	E	F	G	H	I	J	K
155	Captree Dialysis, LLC	DE	03/07/2017	LLC	CSC	ACTIVE	Active	03/07/2017	Yes	No	621492
156	Cardinal Dialysis, LLC	DE	12/05/2013	LLC	CSC	ACTIVE	Active	12/05/2013	Yes	No	621492
157	CardioCentrum Betriebs GmbH	Germany	08/09/2012	GMBH	NonCSC	N/A	Active	08/09/2012	Yes	No	N/A
158	Care NM ACO, LLC	DE	05/11/2016	LLC	CSC	ACTIVE	Active	05/11/2016	Yes	No	621111
159	Carlsbad Dialysis, LLC	DE	07/05/2012	LLC	CSC	ACTIVE	Active	07/05/2012	Yes	No	621492
160	Carlton Dialysis, LLC	U.S. Virgin Islands	02/10/2014	LLC	CSC	ACTIVE	Active	02/10/2014	Yes	No	621492
161	Carroll County Dialysis Facility Limited Partnership	MD	06/11/1990	LP	CSC	ACTIVE	Active	06/11/1990	No	No	621492
162	Carroll County Dialysis Facility, Inc.	MD	04/26/1990	CORP	CSC	ACTIVE	Active	04/26/1990	Yes	No	621492
163	Casas Dialysis, LLC	DE	01/26/2009	LLC	CSC	ACTIVE	Active	01/26/2009	Yes	No	621492
164	Cascades Dialysis, LLC	DE	06/11/2008	LLC	CSC	ACTIVE	Active	06/11/2008	No	No	621492
165	Cassin Dialysis, LLC	U.S. Virgin Islands	02/12/2014	LLC	CSC	ACTIVE	Active	02/12/2014	Yes	No	621492
166	Castle Dialysis, LLC	DE	06/27/2014	LLC	CSC	ACTIVE	Active	06/27/2014	Yes	No	621492
167	Castlewood Dialysis, LLC	DE	10/23/2017	LLC	CSC	ACTIVE	Active	10/23/2017	Yes	No	621492
168	Caswell Dialysis, LLC	DE	09/05/2008	LLC	CSC	ACTIVE	Active	09/05/2008	No	No	621492
169	Cataldo Dialysis, LLC	NY	02/08/2013	LLC	CSC	ACTIVE	Active	02/08/2013	Yes	No	621492
170	Catello Dialysis, LLC	DE	11/21/2013	LLC	CSC	ACTIVE	Active	11/21/2013	Yes	No	621492
171	Cathedral Dialysis, LLC	DE	12/03/2010	LLC	CSC	ACTIVE	Active	12/03/2012	Yes	No	621492
172	Caverns Dialysis, LLC	DE	10/05/2012	LLC	CSC	ACTIVE	Active	10/05/2012	Yes	No	621492
173	Cawen Dialysis, LLC	DE	04/11/2018	LLC	CSC	ACTIVE					
174	Cedar Dialysis, LLC	DE	03/03/2009	LLC	CSC	ACTIVE	Active	03/03/2009	Yes	No	621492
175	Centennial LV, LLC	DE	04/23/2007	LLC	CSC	ACTIVE	Active	04/23/2007	No	No	621492
176	Central Carolina Dialysis Centers, LLC	DE	01/26/2004	LLC	CSC	ACTIVE	Active	01/26/2004	No	No	621492
177	Central Georgia Dialysis, LLC	DE	04/28/2005	LLC	CSC	ACTIVE	Active	04/28/2005	No	No	621492
178	Central Iowa Dialysis Partners, LLC	DE	02/24/2004	LLC	CSC	ACTIVE	Active	02/24/2004	No	No	621492
179	Central Kentucky Dialysis Centers, LLC	DE	07/14/2004	LLC	CSC	ACTIVE	Active	07/14/2004	Yes	No	621492
180	Central Ohio Dialysis, LLC	DE	07/29/2005	LLC	CSC	ACTIVE	Active	07/29/2005	Yes	No	621492
181	Centrum Dializa 3 Sp. Z o.o.	Poland	09/29/2017	LLC	NonCSC	N/A	Active	09/29/2017	Yes	No	
182	Centrum Dializa II Sp. Z o.o.	Poland	12/16/2016	LLC	NonCSC	N/A	Active	12/16/2016	Yes	No	N/A
183	Cerito Dialysis Partners, LLC	DE	05/12/2010	LLC	CSC	ACTIVE	Active	02/01/2011	No	No	621492
184	Chadron Dialysis, LLC	DE	07/08/2008	LLC	CSC	ACTIVE	Active	07/08/2008	Yes	No	621492
185	Chaffee Dialysis, LLC	DE	02/20/2018	LLC	CSC	ACTIVE	Active	02/20/2018	Yes	No	621492
186	Challis Dialysis, LLC	DE	06/23/2017	LLC	CSC	ACTIVE	Active	06/23/2017	Yes	No	621492
187	Champions Dialysis, LLC	DE	01/19/2010	LLC	CSC	ACTIVE	Active	01/19/2010	Yes	No	621492
188	Channel Dialysis, LLC	DE	08/27/2008	LLC	CSC	ACTIVE	Active	08/01/2008	Yes	No	621492
189	Chantry Dialysis, LLC	DE	03/08/2017	LLC	CSC	ACTIVE	Active	03/08/2017	No	No	621492
190	Chenango Dialysis, LLC	DE	01/25/2017	LLC	CSC	ACTIVE	Active	01/25/2017	No	No	621492
191	Cheraw Dialysis, LLC	DE	10/04/2013	LLC	CSC	ACTIVE	Active	10/04/2013	No	No	621492
192	Cherry Valley Dialysis, LLC	DE	07/05/2007	LLC	CSC	ACTIVE	Active	07/05/2007	Yes	No	621492
193	Cheshire Dialysis, LLC	DE	04/11/2018	LLC	CSC	ACTIVE	Active	04/11/2018	Yes	No	641492
194	Chesterfield Dialysis, LLC	DE	11/01/2004	LLC	CSC	ACTIVE	Active	11/01/2004	Yes	No	621492
195	Chicago Heights Dialysis, LLC	DE	06/08/2004	LLC	CSC	ACTIVE	Active	06/08/2004	No	No	621492
196	Chicot Dialysis, LLC	DE	06/13/2017	LLC	CSC	ACTIVE	Active	06/13/2017	Yes	No	621492
197	Chipeta Dialysis, LLC	DE	09/02/2008	LLC	CSC	ACTIVE	Active	09/02/2008	Yes	No	621492
198	Chouteau Dialysis, LLC	DE	08/18/2014	LLC	CSC	ACTIVE	Active	08/18/2014	No	No	621492
199	Churchill Dialysis, LLC	DE	10/26/2010	LLC	CSC	ACTIVE	Active	10/26/2010	No	No	621492
200	Cimarron Dialysis, LLC	DE	08/09/2012	LLC	CSC	ACTIVE	Active	08/09/2012	No	No	621492
201	Cinco Rios Dialysis, LLC	DE	03/10/2010	LLC	CSC	ACTIVE	Active	03/10/2010	No	No	621492
202	Clark Dialysis, LLC	DE	02/22/2011	LLC	CSC	ACTIVE	Active	02/22/2011	No	No	621492
203	Clayton Dialysis, LLC	DE	02/16/2012	LLC	CSC	ACTIVE	Active	02/16/2012	No	No	621492
204	Clearee Dialysis, LLC	DE	09/14/2012	LLC	CSC	ACTIVE	Active	09/14/2012	Yes	No	621492
205	Cleburne Dialysis, LLC	DE	09/19/2012	LLC	CSC	ACTIVE	Active	09/09/2012	No	No	621492

	A	B	C	D	E	F	G	H	I	J	K
206	Clifton Dialysis, LLC	DE	09/19/2013	LLC	CSC	ACTIVE	Active	09/19/2013	Yes	No	621492
207	Clini-Rim Clinica do Rim e Hipertensao Arterial Ltda.	Brazil	12/01/2017	LLCL	NonCSC	N/A	Active	12/01/2017	Yes	No	
208	Clinica Central do Bonfim S.A.	Portugal	05/25/2006	S.A.	NonCSC	N/A	Active	05/25/2006	Yes	No	CAE:86220R3 (Primar)
209	Clinica Medica DaVita Arapongas Servicos de Nefrologia Ltda.	Brazil	03/05/1993	LLCL	NonCSC	N/A	Active	04/01/1993	No	No	
210	Clinica Medica DaVita Londrina Servicos de Nefrologia Ltda.	Brazil	08/11/1989	LLCL	NonCSC	N/A	Active	08/11/1989	No	No	
211	Clinica Medica DaVita Rolandia Servicos de Nefrologia Ltda.	Brazil	09/04/2013	LLCL	NonCSC	N/A	Active	12/31/2016	No	No	
212	Clinical Partners of Colorado Springs, LLC	CO	05/30/2013	LLC	NonCSC	N/A	Active	05/30/2013	No	Yes	
213	Clinisa - Clinica de Nefrologia de Itapecerica da Serra Ltda.	Brazil	12/01/2017	LLCL	NonCSC	N/A	Active	12/01/2017	Yes	No	
214	Clinton Township Dialysis, LLC	DE	06/28/2007	LLC	CSC	ACTIVE	Active	06/28/2007	No	No	621492
215	Cloudland Dialysis, LLC	DE	08/12/2014	LLC	CSC	ACTIVE	Active	08/12/2014	Yes	No	621492
216	Clover Dialysis, LLC	DE	01/30/2013	LLC	CSC	ACTIVE	Active	01/30/2013	No	No	621492
217	Clyfee Dialysis, LLC	DE	08/19/2014	LLC	CSC	ACTIVE	Active	08/19/2014	No	No	621492
218	Coast Dialysis, LLC	DE	08/19/2010	LLC	CSC	ACTIVE	Active	08/19/2010	No	No	621492
219	Cobbles Dialysis, LLC	DE	06/27/2013	LLC	CSC	ACTIVE	Active	07/09/2013	Yes	No	621492
220	Coe Dialysis, LLC	DE	12/30/2008	LLC	CSC	ACTIVE	Active	12/30/2008	Yes	No	621492
221	Colleton Dialysis, LLC	DE	07/19/2013	LLC	CSC	ACTIVE	Active	07/19/2013	No	No	621492
222	Collier Dialysis, LLC	DE	10/22/2010	LLC	CSC	ACTIVE	Active	10/22/2010	Yes	No	621492
223	Colorado Innovative Physician Solutions, Inc.	CO	03/10/2011	CORP	CSC	ACTIVE	Active	03/10/2011	Yes		
224	Columbus-RNA-DaVita, LLC	DE	01/25/2008	LLC	CSC	ACTIVE	Active	01/25/2008	Yes	No	621492
225	Colville Dialysis, LLC	DE	06/19/2007	LLC	CSC	ACTIVE	Active	06/19/2007	Yes	No	621492
226	Commerce Township Dialysis Center, LLC	DE	11/09/2006	LLC	CSC	ACTIVE	Active	11/09/2006	No	No	621492
227	Community Acutes Dialysis, LLC	DE	01/23/2009	LLC	CSC	ACTIVE	Active	01/23/2009	Yes	No	621492
228	Comprehensive Care Solutions, LLC	PA	06/30/2016	LLC	CSC	ACTIVE	Active	06/30/2016	No	No	TBD
229	Conchasa Dialysis, LLC	DE	10/15/2012	LLC	CSC	ACTIVE	Active	10/15/2012	Yes	No	621492
230	Conconully Dialysis, LLC	DE	04/17/2012	LLC	CSC	ACTIVE	Active	06/01/2013	No	No	621492
231	Conecuh Dialysis, LLC	DE	05/12/2017	LLC	CSC	ACTIVE	Active	05/12/2017	No	No	621492
232	Continental Dialysis Center of Springfield-Fairfax, Inc.	VA	10/18/1982	CORP	CSC	ACTIVE	Active	10/18/1992	Yes	No	621492
233	Continental Dialysis Center, Inc.	VA	08/10/1983	CORP	CSC	ACTIVE	Active	08/10/1983	Yes	No	621492
234	Cooper Dialysis, LLC	DE	02/25/2009	LLC	CSC	ACTIVE	Active	02/25/2009	No	No	621492
235	Coral Dialysis, LLC	DE	01/30/2013	LLC	CSC	ACTIVE	Active	01/30/2013	No	No	621492
236	Cordele Dialysis Center, LLC	DE	08/24/2007	LLC	CSC	ACTIVE	Active	08/24/2007	Yes	No	621492
237	Cormick Dialysis, LLC	DE	01/29/2016	LLC	CSC	ACTIVE	Active	01/29/2016	Yes	No	621492
238	Cottonwood Dialysis, LLC	DE	11/30/2009	LLC	CSC	ACTIVE	Active	11/30/2009	Yes	No	
239	Couer Dialysis, LLC	DE	10/02/2015	LLC	CSC	ACTIVE	Active	10/02/2015	No	No	621492
240	Court Dialysis, LLC	DE	10/28/2010	LLC	CSC	ACTIVE	Active	10/28/2010	No	No	621492
241	Covell Dialysis, LLC	DE	04/10/2015	LLC	CSC	ACTIVE	Active	04/10/2015	Yes	No	621492
242	Cowell Dialysis, LLC	DE	09/07/2011	LLC	CSC	ACTIVE	Active	09/07/2011	No	No	621492
243	Cowley Dialysis, LLC	NY	11/04/2016	LLC	CSC	ACTIVE	Active	11/04/2016	Yes	No	621492
244	Crawford Dialysis, LLC	DE	07/18/2014	LLC	CSC	ACTIVE	Active	07/18/2014	Yes	No	621492
245	Creek Dialysis, LLC	DE	08/27/2008	LLC	CSC	ACTIVE	Active	08/27/2008	Yes	No	621492
246	Creston Dialysis, LLC	DE	02/15/2013	LLC	CSC	ACTIVE	Active	02/15/2013	Yes	No	621492
247	Crestshore Dialysis, LLC	NY	02/08/2013	LLC	CSC	ACTIVE	Active	02/08/2013	Yes	No	621492
248	Croft Dialysis, LLC	DE	05/31/2013	LLC	CSC	ACTIVE	Active	05/31/2013	Yes	No	621492
249	Croskee Dialysis, LLC	DE	11/12/2015	LLC	CSC	ACTIVE	Active	11/12/2015	No	No	621492
250	Crossings Dialysis, LLC	DE	02/20/2015	LLC	CSC	ACTIVE	Active	02/20/2015	Yes	No	621492
251	Crowder Dialysis, LLC	DE	08/20/2014	LLC	CSC	ACTIVE	Active	08/20/2014	No	No	621492
252	Crystals Dialysis, LLC	DE	06/25/2008	LLC	CSC	ACTIVE	Active	06/25/2008	No	No	621492
253	Cuivre Dialysis, LLC	DE	08/20/2014	LLC	CSC	ACTIVE	Active	08/20/2014	No	No	621492
254	Culbert Dialysis, LLC	DE	03/01/2018	LLC	CSC	ACTIVE	Active	03/01/2018	Yes	No	621492
255	Curecanti Dialysis, LLC	DE	07/18/2012	LLC	CSC	ACTIVE	Active	07/18/2012	No	No	621492
256	Curlew Dialysis, LLC	DE	02/06/2012	LLC	CSC	ACTIVE	Active	02/06/2012	No	No	621492
257	Custers Dialysis, LLC	DE	05/11/2016	LLC	CSC	ACTIVE	Active	05/11/2016	Yes	No	621492

	A	B	C	D	E	F	G	H	I	J	K
258	Dackman Dialysis, LLC	DE	02/23/2017	LLC	CSC	ACTIVE	Active	02/23/2017	Yes	No	621492
259	Dagmar Dialysis, LLC	DE	06/20/2017	LLC	CSC	ACTIVE	Active	06/20/2017	Yes	No	621492
260	Dale Dialysis, LLC	DE	07/31/2014	LLC	CSC	ACTIVE	Active	07/31/2014	Yes	No	621492
261	Dalhart Dialysis, LLC	DE	03/23/2017	LLC	CSC	ACTIVE	Active	03/23/2017	Yes	No	621492
262	Dallas-Fort Worth Nephrology II, LLC	DE	12/29/2006	LLC	CSC	ACTIVE	Active	12/29/2006	Yes	No	621492
263	Dallas-Fort Worth Nephrology, L.P.	DE	03/07/2005	LP	CSC	ACTIVE	Active	03/07/2005	Yes	No	621492
264	Damon Dialysis, LLC	DE	06/28/2011	LLC	CSC	ACTIVE	Active	06/28/2011	No	No	621492
265	Daroga Dialysis, LLC	DE	05/10/2012	LLC	CSC	ACTIVE	Active	05/10/2012	Yes	No	621492
266	Darter Dialysis, LLC	DE	05/08/2017	LLC	CSC	ACTIVE	Active	05/08/2017	Yes	No	621492
267	Davis Dialysis, LLC	DE	02/18/2011	LLC	CSC	ACTIVE	Active	02/18/2011	No	No	612492
268	DaVita (Shandong) Kidney Disease Hospital Co., Ltd.	China	10/28/2013	LLC	NonCSC	N/A	Active	02/26/2015	No	No	
269	DaVita - Riverside II, LLC	DE	08/17/2006	LLC	CSC	ACTIVE	Active	08/17/2006	No	No	621492
270	DaVita - Riverside, LLC	DE	03/01/2002	LLC	CSC	ACTIVE	Active	03/01/2002	No	No	621492
271	DaVita - West, LLC	DE	12/17/2001	LLC	CSC	ACTIVE	Active	12/17/2001	Yes	No	621492
272	DaVita 3SBio Healthcare Management (Liaoning) Co., Ltd.	China	06/05/2012	LLC	NonCSC	N/A	Active	06/05/2012			
273	DaVita Accountable Care Solutions, LLC	DE	11/10/2015	LLC	CSC	ACTIVE	Active	11/10/2015	Yes	No	621492
274	DaVita APAC Holding B.V.	Netherlands	12/14/2016	BV	NonCSC	N/A	Active	12/14/2016	Yes	No	
275	DaVita Brasil Participacoes e Servicos de Gestao Ltda.	Brazil	08/19/2015	LLCL	NonCSC	N/A	Active	08/19/2015	Yes	No	
276	DaVita Brasil Servicos de Nefrologia Uber Ltda.	Brazil	06/27/1993	LLCL	NonCSC	N/A	Active	08/24/1993	No	No	
277	DaVita Care (India) Private Limited	India	07/21/2008	PRIVATELIMITED	NonCSC	N/A	Active	04/01/2012	No		
278	DaVita Care (Philippines), Inc.	Philippines	01/07/2011	STOCKCORP	NonCSC	N/A	Active - In Liquidation	09/01/2011	Yes		
279	DaVita Care (Saudi Arabia)	Saudi Arabia	05/30/2012	LLC	NonCSC	N/A	Active	05/30/2012	Yes	No	
280	DaVita Care (Taiwan) Private Limited	Taiwan, Province Of China	01/07/2011	LIMITEDCOMPANY	NonCSC	N/A	Active	10/24/2011			
281	DaVita Care KSA B.V.	Netherlands	02/21/2013	BV	NonCSC	N/A	Active	02/21/2013			
282	DaVita Care Pte. Ltd.	Singapore	07/02/2010	PRIVATELIMITED	NonCSC	N/A	Active	08/16/2010	No	No	
283	DaVita Children's Foundation	CA	09/22/2000	NFP	CSC	ACTIVE	Active	09/22/2000		Yes	
284	DaVita China Pte. Ltd.	Singapore	02/16/2012	PRIVATELIMITED	NonCSC	N/A	Active	03/27/2012	Yes	No	
285	DaVita CKD Dietitians, LLC	DE	03/15/2016	LLC	CSC	ACTIVE	Active	03/15/2016	Yes	No	621492
286	DaVita Clinical Research Deutschland GmbH	Germany	12/17/2010	GMBH	NonCSC	N/A	Active	12/17/2010	Yes	No	N/A
287	DaVita Clinical Trials, LLC	DE	07/18/2014	LLC	CSC	ACTIVE	Active	07/18/2014	Yes	No	541712
288	DaVita Dakota Dialysis Center, LLC	DE	05/16/2007	LLC	CSC	ACTIVE	Active	05/16/2007	No	No	621492
289	DaVita Denham Springs Kidney Care, LLC	DE	06/23/2004	LLC	CSC	ACTIVE	Active	06/23/2004	Yes	No	621492
290	DaVita Deutschland AG	Germany	01/15/2002	AG	NonCSC	N/A	Active	03/30/2012	Yes	No	N/A
291	DaVita Deutschland Beteiligungs GmbH & Co. KG	Germany	05/12/2014	GMBH	NonCSC	N/A	Active	05/12/2014	No		
292	DaVita Deutschland Verwaltungs GmbH	Germany	12/05/2014	GMBH	NonCSC	N/A	Active	12/05/2014	No	No	
293	DaVita Dialysis Contracting, LLC	DE	08/23/2012	LLC	CSC	ACTIVE	Active	08/23/2012	Yes	No	
294	DaVita DPC Holding Co., LLC	DE	09/22/2011	LLC	CSC	ACTIVE	Active	09/22/2011	Yes	No	
295	DaVita El Paso East, L.P.	DE	03/23/2006	LP	CSC	ACTIVE	Active	03/23/2006	No	No	621492
296	DaVita Everett Physicians, Inc. P.S.	WA	02/26/2016	CORP	CSC	ACTIVE	Active	02/26/2016	No	Yes	need to get from Tax
297	DaVita Germany GmbH	Germany	01/11/2011	GMBH	NonCSC	N/A	Active	10/24/2011	Yes	Yes	N/A
298	DaVita Health Plan of California, Inc.	DE	03/25/2013	CORP	CSC	ACTIVE	Active	03/25/2013	Yes	No	524292
299	DaVita Health Plan of Nevada, Inc.	NV	09/05/2013	CORP	CSC	ACTIVE	Active	09/05/2013	Yes	No	621111
300	DaVita Health Solutions, LLC	DE	07/08/2016	LLC	CSC	ACTIVE	Active	07/08/2016	Yes	No	621492
301	DaVita HealthCare Brasil Servicos Medicos Ltda.	Brazil	02/09/2017	LLCL	NonCSC	N/A	Active	02/09/2017	Yes	No	
302	DaVita HK Holdings Limited	Hong Kong	12/14/2017	CLBS	NonCSC	N/A	Active	12/14/2017	Yes	No	
303	DaVita Hospital Management Consulting (Shanghai) Co., Ltd.	China	06/29/2012	LLC	NonCSC	N/A	Active	06/29/2012	Yes	No	
304	DaVita Inc.	DE	04/04/1994	CORP	CSC	ACTIVE	Active	04/04/1994	No	No	551112
305	DaVita Institute for Patient Safety, Inc.	DE	06/25/2015	CORP	CSC	ACTIVE	Active	06/25/2015	Yes	No	
306	DaVita International Limited	United Kingdom	10/16/2017	PVLC	NonCSC	N/A	Active	10/16/2017	Yes	No	86900

	A	B	C	D	E	F	G	H	I	J	K
307	DaVita Lehbi Cayman	Cayman Islands	10/31/2011	LIMITEDCOMPANY	NonCSC	N/A	Active	04/01/2012	No	No	
308	DaVita Magan Management, Inc.	CA	08/06/1975	CORP	CSC	ACTIVE	Active	08/06/1975	Yes	No	561110
309	DaVita Medical ACO California, LLC	CA	08/15/2011	LLC	CSC	ACTIVE	Active	08/15/2011	Yes	No	621111
310	DaVita Medical ACO Florida, LLC	FL	08/01/2011	LLC	CSC	ACTIVE	Active	11/01/2012	Yes	No	621111
311	DaVita Medical ACO Nevada, LLC	NV	08/15/2011	LLC	CSC	ACTIVE	Active	08/15/2011	Yes	No	621111
312	DaVita Medical ACO New Mexico, LLC	DE	05/11/2016	LLC	CSC	ACTIVE	Active	05/11/2016	Yes	No	
313	DaVita Medical ACO, LLC	CA	08/15/2011	LLC	CSC	ACTIVE	Active	08/15/2011	Yes	No	
314	DaVita Medical ASC Colorado, LLC	CO	10/27/2014	LLC	CSC	ACTIVE	Active	10/27/2014	Yes	No	621493
315	DaVita Medical ASC-LB California, LLC	CA	08/16/1996	LLC	CSC	ACTIVE	Active	11/01/2012	Yes	No	621493
316	DaVita Medical Colorado ASC, LLC	CO	06/02/2017	LLC	CSC	ACTIVE	Active	06/02/2017	Yes	No	
317	DaVita Medical Colorado, LLC	CO	10/27/2014	LLC	CSC	ACTIVE	Active	10/27/2014	Yes	No	621111
318	DaVita Medical Endoscopy Center New Mexico, LLC	NM	11/21/2007	LLC	CSC	ACTIVE	Active	11/21/2007	Yes	No	621498
319	DaVita Medical Explorer, LLC	DE	03/20/2014	LLC	CSC	ACTIVE	Active	03/20/2014	Yes	No	621111
320	DaVita Medical Florida, Inc.	DE	09/15/1983	CORP	CSC	ACTIVE	Active	09/15/1983	Yes	No	621111
321	DaVita Medical Group ARTA Health Network California, P.C.	CA	06/15/1994	PC	CSC	ACTIVE	Active	06/15/1994		Yes	621111
322	DaVita Medical Group ARTA Western California, Inc.	CA	03/30/1995	CORP	CSC	ACTIVE	Active	03/30/1995	No	Yes	621111
323	DaVita Medical Group Associates California, Inc.	CA	04/25/2012	CORP	CSC	ACTIVE	Active	04/25/2012	No	Yes	561110
324	DaVita Medical Group California, P.C.	CA	09/19/1991	PC	CSC	ACTIVE	Active	09/19/1991	No	Yes	621111
325	DaVita Medical Group Colorado Springs, LLC	CO	10/27/2014	LLC	CSC	ACTIVE	Active	10/27/2014	Yes	No	621111
326	Davita Medical Group Florida CI, LLC	DE	07/20/2017	LLC	CSC	ACTIVE	Active	07/20/2017	Yes	No	
327	DaVita Medical Group Florida, P.A.	FL	05/26/2006	CORP	CSC	ACTIVE	Active	05/06/2006	Yes		621111
328	DaVita Medical Group Nevada (Coats), Ltd.	NV	07/05/1984	CORP	CSC	ACTIVE	Active	07/05/1984		No	621111
329	DaVita Medical Group New Mexico, LLC	DE	01/13/2005	LLC	CSC	ACTIVE	Active	01/13/2005	Yes	No	621111
330	DaVita Medical Group South Florida, LLC	FL	09/30/2011	LLC	CSC	ACTIVE	Active	09/30/2011	Yes	No	621111
331	DaVita Medical Group Talbert California, P.C.	CA	11/23/1995	PC	CSC	ACTIVE	Active	11/23/1995	No	Yes	621111
332	DaVita Medical Holding Company, New Mexico, LLC	NM	02/23/2007	LLC	CSC	ACTIVE	Active	02/23/2007	Yes	No	551112
333	Davita Medical Holdings Colorado, LLC	CO	08/01/2017	LLC	CSC	ACTIVE	Active	08/01/2017	Yes	No	561110
334	DaVita Medical Holdings Florida, Inc.	DE	06/03/2003	CORP	CSC	ACTIVE	Active	11/01/2012	Yes	No	551112
335	DaVita Medical Holdings, LLC	CA	02/16/2005	LLC	CSC	ACTIVE	Active	02/16/2005	Yes	No	551112
336	DaVita Medical IPA Nevada, LLC	NV	06/08/2006	LLC	CSC	ACTIVE	Active	11/01/2012	Yes	No	621111
337	DaVita Medical IPA Washington, PLLC	WA	08/16/2017	LLC	CSC	ACTIVE	Active	08/16/2017	Yes	No	921492
338	DaVita Medical LV, LLC	NV	11/14/2016	LLC	CSC	ACTIVE	Active		Yes	No	
339	DaVita Medical Management Services California, LLC	DE	10/05/2015	LLC	CSC	ACTIVE	Active	10/05/2015	Yes	No	621492
340	DaVita Medical Management Services Nevada, LLC	NV	06/18/2009	LLC	CSC	ACTIVE	Active	06/18/2009	Yes	No	
341	DaVita Medical Management, LLC	CA	02/23/2005	LLC	CSC	ACTIVE	Active	02/23/2005	Yes	No	621111
342	DaVita Medical Nevada, LLC	NV	05/11/2006	LLC	CSC	ACTIVE	Active	05/11/2006	Yes	No	621111
343	DaVita Medical RE, LLC	DE	01/07/2016	LLC	CSC	ACTIVE	Active	01/07/2016	Yes	No	need to get from Tax
344	DaVita Nephrology Associates Of Utah, L.L.C.	UT	11/25/2002	LLC	CSC	ACTIVE	Active	11/25/2002	Yes	No	621492
345	Davita Nurse Practitioner Organization New Jersey, LLC	NJ	01/13/2017	LLC	CSC	ACTIVE	Active	01/13/2017	No	Yes	621492
346	DaVita of New York, Inc.	NY	09/04/2007	CORP	CSC	ACTIVE	Active	09/04/2007	Yes	No	621492
347	DaVita Pharmacy Colorado, LLC	CO	10/27/2014	LLC	CSC	INACTIVE	Active	10/27/2014	Yes	No	621399
348	DaVita Renal Care India Private Limited	India	11/12/2010	PRIVATELIMITED	NonCSC	N/A	Active	11/12/2010	Yes	No	
349	DaVita Renal Pte, Ltd.	Singapore	07/29/2010	PRVTCOMP	NonCSC	N/A	Active	08/16/2010	Yes	No	
350	DaVita Rx, LLC	DE	12/21/2005	LLC	CSC	ACTIVE	Active	12/21/2005	Yes	No	621399
351	DaVita S.A.S.	Colombia	05/29/2012	SPA	NonCSC	N/A	Active	06/01/2013	No		
352	DaVita Servicos de Cirurgia Vascular Ltda.	Brazil	02/21/2011	LLCL	NonCSC	N/A	Active	06/01/2017	Yes	No	
353	DaVita Servicos de Nefrologia Botafogo Ltda.	Brazil	08/01/2017	LLCL	NonCSC	N/A	Active	08/01/2017	Yes	No	
354	DaVita Servicos de Nefrologia de Araraquara Ltda.	Brazil	02/29/1988	LLCL	NonCSC	N/A	Active	12/01/2016	No	No	
355	DaVita Servicos de Nefrologia Jardim das Imbuias Ltda.	Brazil	01/03/1994	LLCL	NonCSC	N/A	Active	01/03/1994	Yes	No	CNAE 86.40-2-03
356	DaVita Servicos de Nefrologia Joao Dias Ltda.	Brazil	02/04/1982	LLCL	NonCSC	N/A	Active	02/04/1982	Yes	No	
357	DaVita Servicos de Nefrologia Meireles Ltda.	Brazil	08/01/2017	LLCL	NonCSC	N/A	Active	08/01/2017	Yes	No	

	A	B	C	D	E	F	G	H	I	J	K
358	DaVita Servicos de Nefrologia Mondubim Ltda.	Brazil	08/01/2017	LLCL	NonCSC	N/A	Active	08/01/2017	Yes	No	
359	DaVita Servicos de Nefrologia Niteroi Ltda.	Brazil	06/14/1994	LLCL	NonCSC	N/A	Active	06/01/2017	No	No	
360	DaVita Servicos de Nefrologia Penha Ltda.	Brazil	12/31/2016	LLCL	NonCSC	N/A	Active	12/31/2016	No	No	CNAE 86.40-1-03
361	DaVita Servicos de Nefrologia Perdizes Ltda.	Brazil	10/01/2017	LLCL	NonCSC	N/A	Active - Current	10/01/2017	Yes	No	
362	DaVita Servicos de Nefrologia Recife Ltda.	Brazil	01/12/1994	LLCL	NonCSC	N/A	Active	01/12/1994	No	No	
363	DaVita Servicos de Nefrologia Santos Ltda.	Brazil	01/31/2000	LLCL	NonCSC	N/A	Active	06/01/2017	Yes	No	
364	DaVita Servicos de Nefrologia Sao Gerardo Ltda.	Brazil	08/01/2017	LLCL	NonCSC	N/A	Active	08/01/2017	Yes	No	
365	DaVita Servicos Dialise Movel Ltda.	Brazil	12/06/2017	LLCL	NonCSC	N/A	Active	12/06/2017	Yes	No	
366	DaVita Sp. z o.o.	Poland	10/19/2011	LLC	NonCSC	N/A	Active	05/14/2012			N/A
367	DaVita Surgical Associates Talbert California, LLC	CA	12/30/2008	LLC	CSC	ACTIVE	Active	12/30/2008	No	No	621498
368	DaVita Tidewater - Virginia Beach, LLC	DE	10/13/2006	LLC	CSC	ACTIVE	Active	10/13/2006	Yes	No	621492
369	DaVita Tidewater, LLC	DE	05/06/2004	LLC	CSC	ACTIVE	Active	05/06/2004	Yes	No	621492
370	DaVita VillageHealth of California, Inc.	CA	01/11/2008	CORP	CSC	ACTIVE	Active	01/11/2008	Yes	No	
371	DaVita VillageHealth of Colorado, Inc.	CO	05/22/2007	CORP	CSC	ACTIVE	Active	05/22/2007	Yes	No	N/A
372	DaVita VillageHealth of Kansas, Inc.	KS	03/23/2007	CORP	CSC	ACTIVE	Active	03/23/2007	Yes	No	
373	DaVita VillageHealth, Inc.	DE	12/15/2006	CORP	CSC	ACTIVE	Active	12/15/2006	Yes	No	
374	Dawson Dialysis, LLC	DE	09/09/2014	LLC	CSC	ACTIVE	Active	09/09/2014	No	No	621492
375	Daytone Dialysis, LLC	DE	02/05/2010	LLC	CSC	ACTIVE	Active	02/05/2010	Yes	No	621492
376	DC Healthcare International, Inc.	DE	07/07/2010	CORP	CSC	ACTIVE	Active	07/07/2010	Yes	No	
377	DE Oro Dialysis, LLC	DE	07/22/2008	LLC	CSC	ACTIVE	Active	07/22/2008	Yes	No	621492
378	Decker Dialysis, LLC	DE	11/30/2007	LLC	CSC	ACTIVE	Active	11/30/2007	Yes	No	621492
379	Decklund Dialysis, LLC	DE	02/18/2016	LLC	CSC	ACTIVE	Active	02/18/2016	No	No	621492
380	Deerbrook Dialysis Center, LLC	DE	07/19/2006	LLC	CSC	ACTIVE	Active	07/19/2006	Yes	No	621492
381	Delabar Dialysis, LLC	DE	11/12/2013	LLC	CSC	ACTIVE	Active	11/12/2013	No	No	621492
382	Demlow Dialysis, LLC	DE	02/20/2018	LLC	CSC	ACTIVE	Active	02/20/2018	Yes	No	621492
383	Deneault Dialysis, LLC	DE	03/01/2018	LLC	CSC	ACTIVE	Active	03/01/2018	Yes	No	621492
384	Deowee Dialysis, LLC	DE	07/26/2013	LLC	CSC	ACTIVE	Active	07/26/2013	No	No	621492
385	Deschutes Dialysis, LLC	DE	01/13/2012	LLC	CSC	ACTIVE	Active	01/13/2012	No	No	621492
386	Desert Rocks Dialysis, LLC	DE	07/26/2011	LLC	CSC	ACTIVE	Active	07/26/2011	No	No	621492
387	DeSoto Dialysis, LLC	DE	05/03/2011	LLC	CSC	ACTIVE	Active	05/03/2011	No	No	621492
388	Detroit Integrated Kidney Care, LLC	DE	07/17/2015	LLC	CSC	ACTIVE	Active	07/17/2015	Yes	No	621492
389	Diablo Dialysis, LLC	DE	01/09/2013	LLC	CSC	ACTIVE	Active	01/09/2013	Yes	No	621492
390	DiaCare AG	Switzerland	01/01/2016	STOCKCORP	NonCSC	N/A	Active	01/01/2016	No	No	
391	Dialysis Center Of Abilene, L.P.	DE	02/10/2005	LP	CSC	ACTIVE	Active	02/10/2005	Yes	No	621492
392	Dialysis Holdings, Inc.	DE	04/25/1989	CORP	CSC	ACTIVE	Active	04/25/1989	Yes	No	
393	Dialysis of Des Moines, LLC	DE	04/02/2003	LLC	CSC	ACTIVE	Active	04/02/2003	No	No	621492
394	Dialysis of North Atlanta, LLC	DE	05/13/2002	LLC	CSC	ACTIVE	Active	05/13/2002	Yes	No	621492
395	Dialysis of Northern Illinois, LLC	DE	05/20/2003	LLC	CSC	ACTIVE	Active	05/20/2003	No	No	621492
396	Dialysis Specialists of Dallas, Inc.	TX	11/17/1993	CORP	CSC	ACTIVE	Active	11/17/1993	Yes	No	621492
397	Dierks Dialysis, LLC	DE	09/12/2017	LLC	CSC	ACTIVE	Active	09/12/2017	Yes	No	621492
398	Dillard Dialysis, LLC	DE	08/21/2014	LLC	CSC	ACTIVE	Active	08/21/2014	Yes	No	621492
399	DNP Management Company, LLC	DE	08/13/2007	LLC	CSC	ACTIVE	Active	08/13/2007	Yes	No	
400	Dolores Dialysis, LLC	DE	09/03/2008	LLC	CSC	ACTIVE	Active	09/03/2008	No	No	621492
401	Dome Dialysis, LLC	DE	02/22/2011	LLC	CSC	ACTIVE	Active	02/22/2011	No	No	621492
402	Dorchester Dialysis, LLC	DE	05/28/2014	LLC	CSC	ACTIVE	Active	05/28/2014	No	No	621492
403	Doves Dialysis, LLC	DE	05/21/2010	LLC	CSC	ACTIVE	Active	05/21/2010	Yes	No	621492
404	Downriver Centers, Inc.	MI	09/07/1999	CORP	CSC	ACTIVE	Active	09/07/1999	Yes	No	621492
405	Downtown Houston Dialysis Center, L.P.	DE	01/23/2004	LP	CSC	ACTIVE	Active	01/23/2004	No	No	621492
406	DPC Medical Group, P.C.	WA	09/30/2011	PC	CSC	ACTIVE	Active	09/30/2011	No		
407	DPC Vail, LLC	DE	12/02/2011	LLC	CSC	ACTIVE	Active	12/02/2011	Yes	No	
408	DPS CKD, LLC	DE	10/30/2017	LLC	CSC	ACTIVE	Active	10/30/2017	Yes	No	621492
409	Dr. Ali Al Lehbi Medical Center	Saudi Arabia	07/01/2007	LLC	NonCSC	N/A	Active	04/01/2012			

	A	B	C	D	E	F	G	H	I	J	K
410	Dresher Dialysis, LLC	DE	02/21/2014	LLC	CSC	ACTIVE	Active	02/21/2014	No	No	621492
411	Drummer Dialysis, LLC	DE	05/16/2016	LLC	CSC	ACTIVE	Active	05/16/2016	No	No	621492
412	Dunes Dialysis, LLC	DE	11/12/2015	LLC	CSC	ACTIVE	Active	11/12/2015	No	No	621492
413	Dunkins Dialysis, LLC	DE	09/29/2014	LLC	CSC	ACTIVE	Active	09/29/2014	Yes	No	621492
414	Dunklinson Dialysis, LLC	DE	10/23/2017	LLC	CSC	ACTIVE	Active	10/23/2017	Yes	No	621492
415	Durango Dialysis Center, LLC	DE	08/25/2004	LLC	CSC	ACTIVE	Active	08/25/2004	No	No	621492
416	Duston Dialysis, LLC	DE	07/01/2015	LLC	CSC	ACTIVE	Active	07/01/2015	No	No	621492
417	DV Care Netherlands B.V.	Netherlands	12/06/2011	BV	NonCSC	N/A	Active	12/29/2011	Yes	No	SBI-Code: 6420
418	DV Care Netherlands C.V.	Netherlands	12/13/2013	LP	NonCSC	N/A	Active	12/23/2013	Yes	No	
419	DV Pharmaceuticals B.V.	Netherlands	04/14/2015	PRLLC	NonCSC	N/A	Active	04/14/2015	Yes	No	
420	DV Renal Care Denmark ApS	Denmark	09/18/2015	APS	NonCSC	N/A	Active	09/18/2015	Yes	No	
421	DV Renal Care Sweden AB	Sweden	08/03/2011	PRLLC	NonCSC	N/A	Active	11/03/2011	Yes	No	N/A
422	DVA (Malaysia) SDN. BHD.	Malaysia	10/27/2010	PRVTCOMP	NonCSC	N/A	Active	09/01/2011			
423	DVA Healthcare - Southwest Ohio, LLC	TN	03/18/1997	LLC	CSC	ACTIVE	Active	03/18/1997	No	No	621492
424	DVA Healthcare of Maryland, LLC	MD	12/16/2016	LLC	CSC	ACTIVE	Active	05/10/1995	Yes	No	621492
425	DVA Healthcare of Massachusetts, Inc.	MA	04/23/1993	CORP	CSC	ACTIVE	Active	04/23/1993	Yes	No	
426	DVA Healthcare of New London, LLC	TN	05/10/1999	LLC	CSC	ACTIVE	Active	05/10/1999	No	No	621492
427	DVA Healthcare of Norwich, LLC	TN	05/10/1999	LLC	CSC	ACTIVE	Active	05/10/1999	No	No	621492
428	DVA Healthcare of Pennsylvania, LLC	PA	10/06/1997	LLC	CSC	ACTIVE	Active	10/06/1997	Yes	No	621492
429	DVA Healthcare of Tuscaloosa, LLC	TN	11/15/1995	LLC	CSC	ACTIVE	Active	11/15/1995	No	No	621492
430	DVA Healthcare Procurement Services, Inc.	CA	10/10/1996	CORP	CSC	ACTIVE	Active	10/10/1996	Yes	No	
431	DVA Healthcare Renal Care, Inc.	NV	11/19/1975	CORP	CSC	ACTIVE	Active	11/19/1975	Yes	No	621492
432	DVA Holdings Pte. Ltd.	Singapore	06/02/2016	PCLS	NonCSC	N/A	Active	06/02/2016	Yes	No	
433	DVA Laboratory Services, Inc.	FL	06/27/1989	CORP	CSC	ACTIVE	Active	06/27/1989	Yes	No	
434	DVA of New York, Inc.	NY	08/15/1996	CORP	CSC	ACTIVE	Active	08/15/1996	Yes	No	
435	DVA Renal Care Portugal, Unipessoal LDA	Portugal	03/08/2012	PRLLC	NonCSC	N/A	Active	04/01/2012	Yes	No	86906; 86220;86210;
436	DVA Renal Healthcare, Inc.	TN	07/20/1987	CORP	CSC	ACTIVE	Active	07/20/1987	Yes	No	621492
437	DVA Seri Setia Sdn. Bhd.	Malaysia	04/14/2011	PRIVATELIMITED	NonCSC	N/A	Active	09/01/2011			
438	DVA/Washington University Healthcare of Greater St. Louis, LLC	DE	11/22/1999	LLC	CSC	ACTIVE	Active	11/22/1999	No	No	621492
439	Dworsher Dialysis, LLC	DE	03/14/2014	LLC	CSC	ACTIVE	Active	03/14/2014	No	No	6621493
440	Eagles Dialysis, LLC	DE	03/02/2010	LLC	CSC	ACTIVE	Active	03/02/2010	Yes	No	621492
441	East Bay - DaVita Dialysis, LLC	DE	10/13/2005	LLC	CSC	ACTIVE	Active	10/13/2005	Yes	No	621492
442	East Dearborn Dialysis, LLC	DE	11/12/2004	LLC	CSC	ACTIVE	Active	11/12/2004	Yes	No	62492
443	East End Dialysis Center, Inc.	VA	01/30/1985	CORP	CSC	ACTIVE	Active	01/30/1985	Yes	No	621492
444	East Ft. Lauderdale, LLC	DE	06/11/2003	LLC	CSC	ACTIVE	Active	06/11/2003	No	No	621492
445	East Houston Kidney Center, L.P.	DE	01/23/2004	LP	CSC	ACTIVE	Active	01/23/2004	No	No	621492
446	East Oaks Dialysis, LLC	DE	10/09/2017	LLC	CSC	ACTIVE	Active	10/09/2017	Yes	No	6214925
447	Eastmont Dialysis Partnership	CA	03/01/1997	GP	NonCSC	N/A	Active	12/07/2005	Yes	No	621492
448	Eastover Dialysis, LLC	DE	10/04/2007	LLC	CSC	ACTIVE	Active	10/04/2007	No	No	621492
449	Eavers Dialysis, LLC	DE	03/01/2016	LLC	CSC	ACTIVE	Active	03/01/2016	Yes	No	621492
450	Ebrea Dialysis, LLC	DE	10/30/2012	LLC	CSC	ACTIVE	Active	10/30/2012	No	No	621492
451	Echos Dialysis, LLC	DE	03/11/2010	LLC	CSC	ACTIVE	Active	03/11/2010	Yes	No	621492
452	Edisto Dialysis, LLC	DE	10/07/2013	LLC	CSC	ACTIVE	Active	10/07/2013	Yes	No	621492
453	Edna Dialysis, L.P.	DE	02/01/2006	LP	CSC	ACTIVE	Active	02/01/2006	Yes	No	621492
454	Egonsa Dialysis, LLC	DE	12/19/2017	LLC	CSC	ACTIVE	Active	12/19/2017	Yes	No	621492
455	Elberton Dialysis Facility, Inc.	GA	07/29/1986	CORP	CSC	ACTIVE	Active	07/29/1986	Yes	No	621492
456	Eldrist Dialysis, LLC	DE	11/01/2013	LLC	CSC	ACTIVE	Active	11/01/2013	Yes	No	621492
457	Elgin Dialysis, LLC	DE	01/03/2012	LLC	CSC	ACTIVE	Active	01/03/2012	No	No	621492
458	Elk Grove Dialysis Center, LLC	DE	01/06/2004	LLC	CSC	ACTIVE	Active	01/06/2004	No	No	621492
459	Elkhorn Dialysis, LLC	DE	11/10/2015	LLC	CSC	ACTIVE	Active	11/10/2015	No	No	621492
460	Ellacoya Dialysis, LLC	DE	07/21/2015	LLC	CSC	ACTIVE	Active	07/21/2015	Yes	No	621492
461	Ellsworth Dialysis, LLC	DE	11/28/2016	LLC	CSC	ACTIVE	Active	11/28/2016	Yes	No	621492

	A	B	C	D	E	F	G	H	I	J	K
462	Empire State DC, Inc.	NY	08/19/1996	CORP	CSC	ACTIVE	Active	08/19/1996	Yes	No	621492
463	Enchanted Dialysis, LLC	NY	12/06/2011	LLC	CSC	ACTIVE	Active	12/06/2011	No	No	621492
464	Endicott Dialysis, LLC	DE	04/11/2018	LLC	CSC	ACTIVE					
465	Estero Dialysis, LLC	DE	04/21/2009	LLC	CSC	ACTIVE	Active	04/21/2000	Yes	No	
466	Etowah Dialysis, LLC	DE	05/03/2013	LLC	CSC	ACTIVE	Active	11/15/2007	Yes	No	621492
467	Ettleton Dialysis, LLC	DE	12/12/2017	LLC	CSC	ACTIVE	Active	12/12/2017	Yes	No	621492
468	Eufaula Dialysis, LLC	DE	08/14/2012	LLC	CSC	ACTIVE	Active	08/14/2012	No	No	621492
469	EURODIAL - Centro de Nefrologia e Dialise de Leiria S.A.	Portugal	02/12/2001	PLC	NonCSC	N/A	Active	02/12/2001	Yes	No	CAE: 86210-R3
470	Everett MSO, Inc.	WA	11/20/2015	CORP	CSC	ACTIVE	Active	11/20/2015	Yes	No	621111
471	Everglades Dialysis, LLC	DE	09/12/2012	LLC	CSC	ACTIVE	Active	09/12/2012	No	No	621492
472	Fairfield Dialysis, LLC	DE	12/07/2011	LLC	CSC	ACTIVE	Active	12/07/2011	No	No	621492
473	Falcon, LLC	DE	09/14/2009	LLC	CSC	ACTIVE	Active	09/14/2009	Yes	No	518210
474	Falls Dialysis, LLC	DE	11/20/2009	LLC	CSC	ACTIVE	Active	11/20/2009	Yes	No	621492
475	Fannin Dialysis, LLC	DE	02/16/2012	LLC	CSC	ACTIVE	Active	02/16/2012	Yes	No	621492
476	Fanthorp Dialysis, LLC	DE	01/26/2012	LLC	CSC	ACTIVE	Active	01/26/2012	No	No	621492
477	Farragut Dialysis, LLC	DE	02/07/2013	LLC	CSC	ACTIVE	Active	02/07/2013	Yes	No	621492
478	Federal Way Assurance, Inc.	CO	09/18/2017	CORP	CSC	ACTIVE	Active	09/18/2017	Yes	No	
479	Felixon Dialysis, LLC	DE	10/26/2017	LLC	CSC	ACTIVE	Active	10/26/2017	Yes	No	621492
480	Fenton Dialysis, LLC	DE	03/07/2011	LLC	CSC	ACTIVE	Active	03/07/2011	No	No	621492
481	Ferne Dialysis, LLC	DE	11/19/2014	LLC	CSC	ACTIVE	Active	11/19/2014	No	No	621492
482	Ferron Dialysis, LLC	DE	06/23/2016	LLC	CSC	ACTIVE	Active	06/23/2016	No	No	621492
483	Fields Dialysis, LLC	DE	12/12/2008	LLC	CSC	ACTIVE	Active	12/12/2008	No	No	621492
484	Five Star Dialysis, LLC	DE	08/30/2007	LLC	CSC	ACTIVE	Active	08/30/2007	No	No	621492
485	Fjords Dialysis, LLC	DE	06/15/2012	LLC	CSC	ACTIVE	Active	06/15/2012	No	No	621492
486	Flagler Dialysis, LLC	DE	04/13/2012	LLC	CSC	ACTIVE	Active	04/13/2012	Yes	No	621492
487	Flamingo Park Kidney Center, Inc.	FL	05/28/1993	CORP	CSC	ACTIVE	Active	05/28/1993	Yes	No	621492
488	Flandrau Dialysis, LLC	DE	10/14/2014	LLC	CSC	ACTIVE	Active	10/14/2014	No	No	621492
489	Flor Dialysis, LLC	DE	02/01/2011	LLC	CSC	ACTIVE	Active	02/01/2011	Yes	No	
490	Forester Dialysis, LLC	DE	10/01/2008	LLC	CSC	ACTIVE	Active	10/01/2008	No	No	621492
491	Fort Dialysis, LLC	DE	06/18/2010	LLC	CSC	ACTIVE	Active	06/18/2010	Yes	No	621492
492	Foss Dialysis, LLC	DE	01/11/2013	LLC	CSC	ACTIVE	Active	01/11/2013	Yes	No	621492
493	Freehold Artificial Kidney Center, L.L.C.	NJ	07/13/1994	LLC	CSC	ACTIVE	Active	07/13/1994	Yes	No	621492
494	Freeman Dialysis, LLC	DE	03/21/2016	LLC	CSC	ACTIVE	Active	03/21/2016	Yes	No	621492
495	Freeportbay Dialysis, LLC	DE	07/11/2011	LLC	CSC	ACTIVE	Active	07/11/2011	No	No	621492
496	Fremont Dialysis, LLC	DE	03/07/2013	LLC	CSC	ACTIVE	Active	03/07/2013	No	No	621492
497	Frierton Dialysis, LLC	DE	06/23/2017	LLC	CSC	ACTIVE	Active	06/23/2017	Yes	No	621492
498	Frontenac Dialysis, LLC	DE	05/13/2015	LLC	CSC	ACTIVE	Active	05/13/2015	No	No	621492
499	Frontier Dialysis, LLC	DE	09/24/2014	LLC	CSC	ACTIVE	Active	09/24/2014	No	No	621492
500	Fullerton Dialysis Center, LLC	DE	12/28/2004	LLC	CSC	ACTIVE	Active	12/28/2004	No	No	621492
501	Gallatin Dialysis, LLC	DE	03/17/2016	LLC	CSC	ACTIVE	Active	03/17/2016	Yes	No	621492
502	Ganchis Dialysis, LLC	DE	05/11/2016	LLC	CSC	ACTIVE	Active	05/11/2016	Yes	No	621492
503	Ganois Dialysis, LLC	DE	01/03/2014	LLC	CSC	ACTIVE	Active	01/03/2013	Yes	No	621492
504	Gardenside Dialysis, LLC	DE	07/26/2010	LLC	CSC	ACTIVE	Active	07/26/2010	No	No	621492
505	Garner Dialysis, LLC	DE	02/04/2011	LLC	CSC	ACTIVE	Active	02/04/2011	No	No	621492
506	Garnet Dialysis, LLC	DE	09/13/2011	LLC	CSC	ACTIVE	Active	09/13/2011	No	No	621492
507	Garrett Dialysis, LLC	DE	01/22/2013	LLC	CSC	ACTIVE	Active	01/22/2013	No	No	621492
508	Garson Dialysis, LLC	DE	07/11/2016	LLC	CSC	ACTIVE	Active	07/11/2016	Yes	No	621492
509	Garth Dialysis, LLC	DE	01/21/2014	LLC	CSC	ACTIVE	Active	01/21/2014	Yes	No	621492
510	Gate Dialysis, LLC	DE	04/05/2013	LLC	CSC	ACTIVE	Active	04/05/2013	Yes	No	621492
511	Gaviota Dialysis, LLC	DE	02/22/2011	LLC	CSC	ACTIVE	Active	02/22/2011	No	No	621492
512	GDC International, LLC	DE	11/06/2009	LLC	CSC	ACTIVE	Active	11/06/2009	Yes	No	
513	GDC Resources, LLC	DE	11/06/2009	LLC	CSC	ACTIVE	Active	11/06/2009	Yes	No	

	A	B	C	D	E	F	G	H	I	J	K
514	Gebhard Dialysis, LLC	DE	12/18/2014	LLC	CSC	ACTIVE	Active	12/18/2014	No	No	621492
515	Gemini Dialysis, LLC	DE	04/17/2008	LLC	CSC	ACTIVE	Active	04/17/2008	Yes	No	621492
516	Genesis KC Development, LLC	DE	03/26/2014	LLC	CSC	ACTIVE	Active	03/26/2014	Yes	No	531190
517	Gertrude Dialysis, LLC	DE	02/12/2014	LLC	CSC	ACTIVE	Active	02/12/2014	No	No	621492
518	Geyser Dialysis, LLC	DE	10/30/2012	LLC	CSC	ACTIVE	Active	10/30/2012	No	No	621492
519	Gilwards Dialysis, LLC	DE	06/09/2016	LLC	CSC	ACTIVE	Active	06/09/2016	No	No	621492
520	Gioconda Dialysis, LLC	DE	06/19/2014	LLC	CSC	ACTIVE	Active	06/19/2014	Yes	No	621492
521	GiveLife Dialysis, LLC	DE	07/10/2009	LLC	CSC	ACTIVE	Active	07/10/2009	No	No	621492
522	Givhan Dialysis, LLC	DE	07/26/2013	LLC	CSC	ACTIVE	Active	07/26/2013	Yes	No	621492
523	Glacier Dialysis, LLC	DE	06/05/2012	LLC	CSC	ACTIVE	Active	06/05/2012	No	No	621492
524	Glarus Dialysis, LLC	DE	12/19/2017	LLC	CSC	ACTIVE	Active	12/19/2017	Yes	No	621492
525	Glassland Dialysis, LLC	DE	07/16/2012	LLC	CSC	ACTIVE	Active	07/16/2012	No	No	621492
526	Glosser Dialysis, LLC	DE	01/07/2015	LLC	CSC	ACTIVE	Active	01/07/2015	No	No	621492
527	Golden ASC, LLC	DE	06/03/2010	LLC	CSC	ACTIVE	Active	06/03/2010	No	No	621492
528	Golden Dialysis, LLC	DE	11/15/2012	LLC	CSC	ACTIVE	Active	11/15/2012	No	No	621492
529	Golden Sun Bear, LLC	DE	07/16/2010	LLC	CSC	ACTIVE	Active	07/16/2010	Yes	No	621492
530	Goldendale Dialysis, LLC	DE	11/08/2012	LLC	CSC	ACTIVE	Active	11/08/2012	No	No	621492
531	Goliad Dialysis, LLC	DE	02/24/2012	LLC	CSC	ACTIVE	Active	02/24/2012	No	No	621492
532	Golver Dialysis, LLC	DE	11/28/2016	LLC	CSC	ACTIVE	Active	11/28/2016	Yes	No	621492
533	Goodale Dialysis, LLC	DE	06/03/2013	LLC	CSC	ACTIVE	Active	06/03/2013	No	No	621492
534	Gordina Dialysis, LLC	DE	04/07/2014	LLC	CSC	ACTIVE	Active	04/07/2014	No	No	621492
535	Gouache Dialysis, LLC	DE	05/31/2016	LLC	CSC	ACTIVE	Active	05/31/2016	No	No	621492
536	Goza Dialysis, LLC	DE	12/18/2012	LLC	CSC	ACTIVE	Active	12/18/2012	No	No	621492
537	Grahams Dialysis, LLC	DE	05/27/2015	LLC	CSC	ACTIVE	Active	05/27/2015	Yes	No	621492
538	Grambrill Dialysis, LLC	DE	06/29/2017	LLC	CSC	ACTIVE	Active	06/29/2017	Yes	No	621492
539	Gramleer Dialysis, LLC	DE	09/15/2017	LLC	CSC	ACTIVE	Active	09/15/2017	Yes	No	621492
540	Grand Home Dialysis, LLC	DE	06/28/2007	LLC	CSC	ACTIVE	Active	06/28/2007	No	No	621492
541	Granue Dialysis, LLC	DE	07/20/2016	LLC	CSC	ACTIVE	Active	07/20/2016	No	No	621492
542	Grayland Dialysis, LLC	DE	01/04/2013	LLC	CSC	ACTIVE	Active	06/28/2007	Yes	No	621492
543	Great Dialysis, LLC	DE	01/08/2009	LLC	CSC	ACTIVE	Active	01/08/2009	Yes	No	621492
544	Greater Las Vegas Dialysis, LLC	DE	08/05/2005	LLC	CSC	ACTIVE	Active	08/05/2005	No	No	621492
545	Greater Los Angeles Dialysis Centers, LLC	DE	04/07/2005	LLC	CSC	ACTIVE	Active	04/07/2005	No	No	621492
546	Green Country Dialysis, LLC	DE	09/21/2011	LLC	CSC	ACTIVE	Active	09/21/2011	No	No	621492
547	Green Desert Dialysis, LLC	DE	02/23/2007	LLC	CSC	ACTIVE	Active	02/23/2007	No	No	621492
548	Greenleaf Dialysis, LLC	DE	07/27/2012	LLC	CSC	ACTIVE	Active	07/27/2012	No	No	621492
549	Greenspoint Dialysis, LLC	DE	12/18/2007	LLC	CSC	ACTIVE	Active	12/18/2007	Yes	No	621492
550	Greenwood Dialysis, LLC	DE	06/02/2003	LLC	CSC	ACTIVE	Active	06/02/2003	No	No	621492
551	Griffin Dialysis, LLC	DE	03/17/2009	LLC	CSC	ACTIVE	Active	03/17/2009	No	No	621492
552	Griffs Dialysis, LLC	DE	01/18/2013	LLC	CSC	ACTIVE	Active	01/18/2013	Yes	No	621492
553	Grosse Pointe Dialysis, LLC	DE	06/25/2007	LLC	CSC	ACTIVE	Active	06/25/2007	Yes	No	621492
554	Grove Dialysis, LLC	DE	09/23/2008	LLC	CSC	ACTIVE	Active	09/23/2008	Yes	No	621492
555	Gulch Dialysis, LLC	DE	02/18/2014	LLC	CSC	ACTIVE	Active	02/18/2014	Yes	No	621492
556	Gunnison Dialysis, LLC	DE	08/02/2011	LLC	CSC	ACTIVE	Active	08/02/2011	Yes	No	621492
557	Guntersville Dialysis, LLC	DE	01/27/2012	LLC	CSC	ACTIVE	Active	01/27/2012	Yes	No	621492
558	Hagerstown Dialysis, LLC	DE	06/19/2007	LLC	CSC	ACTIVE	Active	06/19/2007	No	No	621492
559	Hailstone Dialysis, LLC	DE	03/10/2017	LLC	CSC	ACTIVE	Active	03/10/2017	No	No	621492
560	Hampton Dialysis, LLC	DE	01/29/2016	LLC	CSC	ACTIVE	Active	01/29/2016	No	No	621492
561	Hanford Dialysis, LLC	DE	10/26/2007	LLC	CSC	ACTIVE	Active	10/26/2007	Yes	No	621492
562	Hardy Dialysis, LLC	DE	01/06/2014	LLC	CSC	ACTIVE	Active	01/06/2014	Yes	No	621492
563	Harmony Dialysis, LLC	DE	08/01/2013	LLC	CSC	ACTIVE	Active	08/01/2013	Yes	No	621492
564	Harriman Dialysis, LLC	DE	12/09/2013	LLC	CSC	ACTIVE	Active	12/09/2013	Yes	No	621492
565	Harris Dialysis, LLC	DE	03/21/2012	LLC	CSC	ACTIVE	Active	03/21/2012	Yes	No	621492

	A	B	C	D	E	F	G	H	I	J	K
566	Hart Dialysis, LLC	DE	11/20/2009	LLC	CSC	ACTIVE	Active	11/20/2009	No	No	621492
567	Haskell Dialysis, LLC	DE	11/28/2016	LLC	CSC	ACTIVE	Active	11/28/2016	No	No	621492
568	Havanna Dialysis, LLC	DE	03/31/2017	LLC	CSC	ACTIVE	Active	03/31/2017	No	No	621492
569	Havenwood Dialysis, LLC	DE	01/10/2018	LLC	CSC	ACTIVE	Active	01/10/2018	Yes	No	621492
570	Haverhills Dialysis, LLC	DE	04/11/2018	LLC	CSC	ACTIVE	Active	04/11/2018	Yes	No	641492
571	Hawaiian Gardens Dialysis Center, LLC	DE	05/22/2007	LLC	CSC	ACTIVE	Active	05/22/2007	Yes	No	621492
572	Hawn Dialysis, LLC	DE	12/18/2014	LLC	CSC	ACTIVE	Active	12/18/2014	No	No	621492
573	Hays Dialysis, LLC	DE	03/23/2017	LLC	CSC	ACTIVE	Active	03/23/2017	No	No	621492
574	Hazelton Dialysis, LLC	DE	03/11/2013	LLC	CSC	ACTIVE	Active	03/11/2013	No	No	621496
575	HCP/ARTA Medical Group, P.C.	CA	08/27/2012	PC	CSC	ACTIVE	Active	08/27/2012	No	Yes	551112
576	Headlands Dialysis, LLC	DE	02/18/2014	LLC	CSC	ACTIVE	Active	02/18/2014	No	No	621492
577	HealthCare Partners Affiliates Medical Group	CA	09/01/1996	GP	NonCSC	N/A	Active	09/01/1996	No		621111
578	HealthCare Partners Institute for Applied Research and Education	CA	05/28/1996	NFP	CSC	ACTIVE	Active	05/28/1996			541712
579	Heavener Dialysis, LLC	DE	11/20/2012	LLC	CSC	ACTIVE	Active	11/20/2012	Yes	No	621492
580	Heckscher Dialysis, LLC	DE	01/31/2017	LLC	CSC	ACTIVE	Active	01/31/2017	No	No	621492
581	Heideck Dialysis, LLC	DE	11/01/2013	LLC	CSC	ACTIVE	Active	11/01/2013	Yes	No	621492
582	Helmer Dialysis, LLC	DE	06/10/2015	LLC	CSC	ACTIVE	Active	06/10/2015	No	No	621492
583	Hendy Dialysis, LLC	DE	06/25/2008	LLC	CSC	ACTIVE	Active	06/25/2008	Yes	No	621492
584	Hennepin Dialysis, LLC	DE	11/12/2014	LLC	CSC	ACTIVE	Active	11/12/2014	Yes	No	621492
585	Heron Dialysis, LLC	DE	02/26/2010	LLC	CSC	ACTIVE	Active	02/26/2010	Yes	No	621492
586	Hewett Dialysis, LLC	DE	04/29/2016	LLC	CSC	ACTIVE	Active	04/29/2016	No	No	621492
587	Heyburn Dialysis, LLC	DE	02/11/2013	LLC	CSC	ACTIVE	Active	02/11/2013	No	No	621492
588	Hialeah Kidney Dialysis, LLC	DE	07/30/2007	LLC	CSC	ACTIVE	Active	07/30/2007	Yes	No	621492
589	Higbee Dialysis, LLC	DE	07/31/2012	LLC	CSC	ACTIVE	Active	07/31/2012	No	No	621492
590	Higden Dialysis, LLC	DE	09/26/2017	LLC	CSC	ACTIVE	Active	09/26/2017	Yes	No	621492
591	Hightower Dialysis, LLC	DE	03/22/2016	LLC	CSC	ACTIVE	Active	03/22/2016	No	No	621492
592	Hilgards Dialysis, LLC	DE	05/12/2016	LLC	CSC	ACTIVE	Active	05/12/2016	Yes	No	621492
593	Hills Dialysis, LLC	DE	02/04/2010	LLC	CSC	ACTIVE	Active	02/04/2010	Yes	No	621492
594	Historic Dialysis, LLC	DE	12/19/2008	LLC	CSC	ACTIVE	Active	12/19/2008	Yes	No	621492
595	Hochatown Dialysis, LLC	DE	08/27/2012	LLC	CSC	ACTIVE	Active	08/27/2012	Yes	No	621492
596	Holiday Dialysis, LLC	DE	01/06/2012	LLC	CSC	ACTIVE	Active	01/06/2012	Yes	No	621492
597	Holten Dialysis, LLC	DE	12/17/2014	LLC	CSC	ACTIVE	Active	12/17/2014	No	No	621492
598	Home Kidney Care, LLC	DE	12/31/2008	LLC	CSC	ACTIVE	Active	12/31/2008	Yes	No	621492
599	Honey Dialysis, LLC	DE	07/28/2009	LLC	CSC	ACTIVE	Active	07/28/2009	Yes	No	621492
600	Honeyman Dialysis, LLC	DE	05/04/2011	LLC	CSC	ACTIVE	Active	05/04/2011	No	No	621492
601	Hooper Dialysis, LLC	DE	03/23/2016	LLC	CSC	ACTIVE	Active	03/23/2016	No	No	621492
602	Hosller Dialysis, LLC	DE	05/31/2016	LLC	CSC	ACTIVE	Active	05/31/2016	Yes	No	621492
603	Houston Acute Dialysis, L.P.	DE	07/14/2004	LP	CSC	ACTIVE	Active	07/14/2004	Yes	No	621492
604	Houston Kidney Center/Total Renal Care Integrated Service Network Limited Partnership	DE	07/29/1996	LP	CSC	ACTIVE	Active	07/29/1996	Yes	No	621492
605	HubP-Genesis Joint Venture LLC	DE	11/07/2016	LLC	CSC	ACTIVE	Active	11/07/2016	No	Yes	
606	Hugo Dialysis, LLC	DE	02/18/2014	LLC	CSC	ACTIVE	Active	02/18/2014	No	No	621492
607	Humboldt Dialysis, LLC	DE	09/20/2011	LLC	CSC	ACTIVE	Active	09/20/2011	No	No	621492
608	Hummer Dialysis, LLC	DE	06/27/2014	LLC	CSC	ACTIVE	Active	06/27/2014	No	No	621492
609	Hunter Dialysis, LLC	DE	12/17/2012	LLC	CSC	ACTIVE	Active	12/17/2012	No	No	621492
610	Huntington Artificial Kidney Center, Ltd.	NY	11/09/1978	CORP	CSC	ACTIVE	Active	11/09/1978	Yes	No	621492
611	Huntington Park Dialysis, LLC	DE	07/16/2007	LLC	CSC	ACTIVE	Active	07/16/2007	Yes	No	621492
612	Hunts Dialysis, LLC	DE	05/22/2009	LLC	CSC	ACTIVE	Active	05/22/2009	Yes	No	621492
613	Hutchinson Dialysis, L.L.C.	KS	09/16/1992	LLC	CSC	ACTIVE	Active	09/16/1992	Yes	No	621492
614	Hyattsville Dialysis, LLC	DE	10/25/2007	LLC	CSC	ACTIVE	Active	10/25/2007	No	No	621492
615	Hyde Dialysis, LLC	DE	03/06/2013	LLC	CSC	ACTIVE	Active	03/06/2013	No	No	621492
616	Icelandic Dialysis, LLC	DE	08/04/2017	LLC	CSC	ACTIVE	Active	08/04/2017	Yes	No	621492

	A	B	C	D	E	F	G	H	I	J	K
617	IDC - International Dialysis Centers SGPS, Unipessoal, Lda.	Portugal	03/31/2009	PRVTCOMP	NonCSC	N/A	Active	03/31/2009	Yes	No	CAE: 64202-R3
618	IDC -International Dialysis Centers, Lda	Portugal	03/29/2009	PVLC	NonCSC	N/A	Active	03/29/2009	Yes	No	CAE: 86906-R3
619	Indian River Dialysis Center, LLC	DE	10/13/2006	LLC	CSC	ACTIVE	Active	10/13/2006	No	No	621492
620	Infomasi Ekuiti Sdn. Bhd.	Malaysia	10/01/2015	PCLS	NonCSC	N/A	Active	10/01/2015		No	
621	Ionia Dialysis, LLC	DE	05/05/2006	LLC	CSC	ACTIVE	Active	05/05/2006	No	No	621492
622	Iowa Health-Des Moines DaVita Dialysis Partnership, LLC	DE	08/17/2004	LLC	CSC	ACTIVE	Active	08/17/2004	Yes	No	621492
623	Iroquois Dialysis, LLC	DE	08/06/2014	LLC	CSC	ACTIVE	Active	08/06/2014	No	No	621492
624	ISD Bartlett, LLC	DE	07/08/2010	LLC	CSC	ACTIVE	Active	07/08/2010	No	No	621492
625	ISD Bends Dialysis, LLC	DE	03/17/2010	LLC	CSC	ACTIVE	Active	03/17/2010	Yes	No	621492
626	ISD Brandon, LLC	DE	04/10/1996	LLC	CSC	ACTIVE	Active	04/10/1996	No	No	621492
627	ISD Buffalo Grove, LLC	DE	11/22/2002	LLC	CSC	ACTIVE	Active	11/22/2002	Yes	No	621492
628	ISD Canton, LLC	DE	10/24/2005	LLC	CSC	ACTIVE	Active	10/24/2005	Yes	No	621492
629	ISD Corpus Christi, LLC	DE	05/18/2007	LLC	CSC	ACTIVE	Active	05/18/2007	Yes	No	621492
630	ISD I Holding Company, Inc.	DE	12/29/2009	CORP	CSC	ACTIVE	Active	12/29/2009	Yes	No	
631	ISD II Holding Company, Inc.	DE	12/29/2009	CORP	CSC	ACTIVE	Active	12/29/2009	Yes	No	
632	ISD Kansas City, LLC	DE	09/26/2007	LLC	CSC	ACTIVE	Active	09/26/2007	Yes	No	621492
633	ISD Kendallville, LLC	DE	02/06/2007	LLC	CSC	ACTIVE	Active	02/26/2007	Yes	No	621492
634	ISD Las Vegas, LLC	DE	03/21/2007	LLC	CSC	ACTIVE	Active	03/21/2007	No	No	621492
635	ISD Lees Summit, LLC	DE	06/04/2007	LLC	CSC	ACTIVE	Active	06/04/2007	No	No	621492
636	ISD Pharmacy, LLC	DE	01/15/2008	LLC	CSC	ACTIVE	Active	01/15/2008	Yes	No	
637	ISD Plainfield, LLC	DE	02/06/2007	LLC	CSC	ACTIVE	Active	02/06/2007	No	No	621492
638	ISD Renal, Inc.	DE	03/03/2005	CORP	CSC	ACTIVE	Active	03/03/2005	Yes	No	621492
639	ISD Schaumburg, LLC	DE	06/10/2003	LLC	CSC	ACTIVE	Active	06/10/2003	Yes	No	621492
640	ISD Spring Valley, LLC	DE	11/10/2010	LLC	CSC	ACTIVE	Active	11/10/2010	No	No	621492
641	ISD Summit Renal Care, LLC	OH	07/27/1998	LLC	CSC	ACTIVE	Active	07/27/1998	No	No	621492
642	Itasca Dialysis, LLC	DE	03/04/2016	LLC	CSC	ACTIVE	Active	03/04/2016	Yes	No	621492
643	J.E.T. New Orleans East Dialysis, LLC	DE	06/28/2007	LLC	CSC	ACTIVE	Active	06/28/2007	Yes	No	621492
644	Jabine Dialysis, LLC	DE	07/11/2017	LLC	CSC	ACTIVE	Active	07/11/2017	Yes	No	621492
645	Jacinto Dialysis, LLC	DE	08/02/2012	LLC	CSC	ACTIVE	Active	08/02/2012	No	No	621492
646	Jedburg Dialysis, LLC	DE	01/18/2008	LLC	CSC	ACTIVE	Active	01/18/2008	Yes	No	621492
647	Jenness Dialysis, LLC	DE	07/17/2015	LLC	CSC	ACTIVE	Active	07/17/2015	Yes	No	621492
648	Jericho Dialysis, LLC	DE	07/21/2015	LLC	CSC	ACTIVE	Active	07/21/2015	No	No	621492
649	Joliet Dialysis, LLC	DE	09/06/2007	LLC	CSC	ACTIVE	Active	09/06/2007	Yes	No	621492
650	Joshua Dialysis, LLC	DE	06/06/2012	LLC	CSC	ACTIVE	Active	06/06/2012	No	No	621492
651	Jubilee Dialysis, LLC	DE	06/03/2014	LLC	CSC	ACTIVE	Active	06/03/2014	No	No	621492
652	Junctions ASC, LLC	DE	06/03/2010	LLC	CSC	ACTIVE	Active	06/03/2010	Yes	No	
653	Junta Dialysis, LLC	DE	03/10/2017	LLC	CSC	ACTIVE	Active	03/10/2017	Yes	No	621492
654	Kadden Dialysis, LLC	DE	01/21/2015	LLC	CSC	ACTIVE	Active	01/21/2015	No	No	621492
655	Kadron Dialysis, LLC	DE	09/25/2017	LLC	CSC	ACTIVE	Active	09/25/2017	Yes	No	621492
656	Kalpine Dialysis, LLC	DE	05/29/2015	LLC	CSC	ACTIVE	Active	05/29/2015	Yes	No	621492
657	Kamaka Dialysis, LLC	DE	03/24/2016	LLC	CSC	ACTIVE	Active	03/24/2016	No	No	621492
658	Kamakee Dialysis, LLC	DE	01/07/2015	LLC	CSC	ACTIVE	Active	01/07/2015	No	No	621492
659	Kamiah Dialysis, LLC	DE	10/03/2013	LLC	CSC	ACTIVE	Active	10/03/2013	Yes	No	621492
660	Kandunce Dialysis, LLC	DE	10/13/2014	LLC	CSC	ACTIVE	Active	10/13/2014	Yes	No	621492
661	Kanika Dialysis, LLC	DE	03/28/2016	LLC	CSC	ACTIVE	Active	03/28/2016	Yes	No	621492
662	Kartman Dialysis, LLC	DE	11/27/2017	LLC	CSC	ACTIVE	Active	11/27/2017	Yes	No	621492
663	Kasaskia Dialysis, LLC	DE	05/24/2016	LLC	CSC	ACTIVE	Active	05/24/2016	Yes	No	621492
664	Kavett Dialysis, LLC	DE	10/15/2012	LLC	CSC	ACTIVE	Active	10/15/2012	No	No	621492
665	Kearn Dialysis, LLC	DE	01/25/2010	LLC	CSC	ACTIVE	Active	01/25/2010	No	No	621492
666	Keller Dialysis, LLC	DE	01/25/2010	LLC	CSC	ACTIVE	Active	01/25/2010	Yes	No	621492
667	Kenai Dialysis, LLC	DE	06/12/2012	LLC	CSC	ACTIVE	Active	06/12/2012	No	No	621492
668	Kerricher Dialysis, LLC	DE	02/18/2014	LLC	CSC	ACTIVE	Active	02/18/2014	No	No	621492

	A	B	C	D	E	F	G	H	I	J	K
669	Kershaw Dialysis, LLC	DE	06/28/2017	LLC	CSC	ACTIVE	Active	06/28/2017	Yes	No	621492
670	Keystone Dialysis, LLC	DE	01/28/2013	LLC	CSC	ACTIVE	Active	01/28/2013	No	No	621492
671	Kidney Care Services, LLC	DE	03/24/2003	LLC	CSC	ACTIVE	Active	03/24/2003	Yes	No	621492
672	Kidney Center South LLC	DE	07/08/2014	LLC	CSC	ACTIVE	Active	07/08/2014	No	No	621492
673	Kidney Centers of Michigan, L.L.C.	DE	07/03/2003	LLC	CSC	ACTIVE	Active	07/03/2003	Yes	No	621492
674	Kidney Home Center, LLC	DE	06/10/2008	LLC	CSC	ACTIVE	Active	06/10/2008	No	No	62492
675	Kidney Life, LLC	NJ	10/25/2007	LLC	CSC	ACTIVE	Active	10/25/2007	Yes	No	621492
676	Kimball Dialysis, LLC	DE	02/01/2011	LLC	CSC	ACTIVE	Active	02/01/2011	No	No	621492
677	Kings Dialysis, LLC	DE	12/15/2008	LLC	CSC	ACTIVE	Active	12/15/2008	Yes	No	621492
678	Kingston Dialysis, LLC	DE	07/15/2015	LLC	CSC	ACTIVE	Active	07/15/2015	Yes	No	621492
679	Kinkaid Dialysis, LLC	DE	07/21/2014	LLC	CSC	ACTIVE	Active	07/21/2014	Yes	No	621492
680	Kinnick Dialysis, LLC	DE	01/10/2018	LLC	CSC	ACTIVE	Active	01/10/2018	Yes	No	621492
681	Kinswa Dialysis, LLC	DE	05/10/2012	LLC	CSC	ACTIVE	Active	05/10/2012	No	No	621492
682	Kinter Dialysis, LLC	DE	04/25/2017	LLC	CSC	ACTIVE	Active	04/25/2017	Yes	No	621492
683	Kiowa Dialysis, LLC	DE	11/09/2016	LLC	CSC	ACTIVE	Active	11/09/2016	Yes	No	621492
684	Klinger Dialysis, LLC	DE	07/25/2017	LLC	CSC	ACTIVE	Active	07/25/2017	Yes	No	621492
685	Knickerbocker Dialysis, Inc.	NY	01/26/2001	CORP	CSC	ACTIVE	Active	01/26/2001	Yes	No	621492
686	Knobbs Dialysis, LLC	DE	10/20/2014	LLC	CSC	ACTIVE	Active	10/20/2014	No	No	621492
687	Knotts Dialysis, LLC	DE	05/16/2014	LLC	CSC	ACTIVE	Active	05/16/2014	No	No	621942
688	Kobuk Dialysis, LLC	DE	06/20/2012	LLC	CSC	ACTIVE	Active	06/20/2012	Yes	No	621492
689	Labette Dialysis, LLC	DE	10/20/2016	LLC	CSC	ACTIVE	Active	10/20/2016	No	No	621492
690	Lakeshore Dialysis, LLC	DE	02/13/2013	LLC	CSC	ACTIVE	Active	02/13/2013	No	No	621492
691	Lakeside Dialysis, LLC	DE	03/13/2008	LLC	CSC	ACTIVE	Active	03/13/2008	Yes	No	621492
692	Landing Dialysis, LLC	DE	02/18/2011	LLC	CSC	ACTIVE	Active	02/18/2011	No	No	621492
693	Landor Dialysis, LLC	DE	10/05/2016	LLC	CSC	ACTIVE	Active	10/05/2016	No	No	621492
694	Landsford Dialysis, LLC	DE	08/13/2013	LLC	CSC	ACTIVE	Active	08/13/2013	Yes	No	621492
695	Lanier Dialysis, LLC	DE	05/29/2013	LLC	CSC	ACTIVE	Active	06/18/2013	Yes	No	621492
696	Lapham Dialysis, LLC	DE	05/13/2013	LLC	CSC	ACTIVE	Active	06/17/2013	No	No	621492
697	LaPine Ventures, LLC	DE	08/27/2010	LLC	CSC	ACTIVE	Active	08/27/2010	Yes		62492
698	Las Olas De Sequoia, LLC	DE	09/30/2011	LLC	CSC	ACTIVE	Active	09/30/2011	No	No	
699	Las Vegas Pediatric Dialysis, LLC	DE	10/15/2007	LLC	CSC	ACTIVE	Active	10/15/2007	No	No	621492
700	Lasalle Dialysis, LLC	DE	09/03/2013	LLC	CSC	ACTIVE	Active	09/03/2013	Yes	No	621492
701	Lassen Dialysis, LLC	DE	06/27/2012	LLC	CSC	ACTIVE	Active	06/27/2012	Yes	No	621492
702	Lathrop Dialysis, LLC	DE	09/08/2011	LLC	CSC	ACTIVE	Active	09/08/2011	No	No	621492
703	Latrobe Dialysis, LLC	DE	11/07/2011	LLC	CSC	ACTIVE	Active	11/07/2011	No	No	621492
704	Latsch Dialysis, LLC	NY	09/12/2014	LLC	CSC	ACTIVE	Active	09/12/2014	Yes		62149
705	Lawrenceburg Dialysis, LLC	DE	10/02/2003	LLC	CSC	ACTIVE	Active	10/02/2003	No	No	621492
706	Leasburg Dialysis, LLC	DE	04/19/2011	LLC	CSC	ACTIVE	Active	04/19/2011	No	No	621492
707	Leaton Dialysis, LLC	DE	08/10/2011	LLC	CSC	ACTIVE	Active	08/10/2011	Yes	No	621492
708	Leawood Dialysis, LLC	DE	11/18/2016	LLC	CSC	ACTIVE	Active	11/18/2016	No	No	621492
709	Lees Dialysis, LLC	DE	08/11/2014	LLC	CSC	ACTIVE	Active	08/11/2014	No	No	621492
710	Legare Development LLC	DE	02/15/2017	LLC	CSC	ACTIVE	Active	02/15/2017	Yes	No	621492
711	Lehbi Investment Limited	United Arab Emirates	10/26/2011	LLC	NonCSC	N/A	Active	10/18/2011	No		
712	Leo Dialysis, LLC	DE	04/17/2008	LLC	CSC	ACTIVE	Active	04/17/2008	Yes	No	621492
713	Leoti Dialysis, LLC	DE	12/01/2016	LLC	CSC	ACTIVE	Active	12/01/2016	Yes	No	621492
714	Lexington Dialysis, LLC	DE	02/26/2008	LLC	CSC	ACTIVE	Active	02/26/2008	Yes	No	621492
715	Liberty RC, Inc.	NY	10/20/1997	CORP	CSC	ACTIVE	Active	10/20/1997	Yes	No	621492
716	Lifeline Midwest Associates Of Allen Park LLC	DE	04/08/2015	LLC	CSC	ACTIVE	Active	04/08/2015	Yes	No	621492
717	Lifeline Pensacola, LLC	DE	11/15/2012	LLC	CSC	ACTIVE	Active	11/15/2012	No	No	
718	Lifeline Peripheral Arterial Disease Associates Of Allen Park, LLC	DE	10/02/2014	LLC	CSC	ACTIVE	Active	10/02/2014	Yes	No	
719	Lifeline Sequoia Peach, LLC	DE	09/28/2011	LLC	CSC	ACTIVE	Active	09/28/2011	Yes	No	

	A	B	C	D	E	F	G	H	I	J	K
720	Lifeline Vascular Access Network, LLC	DE	05/16/2007	LLC	CSC	INACTIVE	Active	05/16/2007	Yes	No	
721	Lifeline Vascular Associates Of Allen Park, LLC	DE	01/18/2013	LLC	CSC	ACTIVE	Active	01/18/2013	No	No	
722	Lifeline Vascular Center Of South Orlando, LLC	DE	07/25/2012	LLC	CSC	ACTIVE	Active	07/25/2012	Yes	No	
723	Lifeline Vascular Center-Albany, LLC	DE	10/01/2012	LLC	CSC	ACTIVE	Active	10/01/2012	No	No	
724	Lifeline Vascular Center-Niceville, LLC	DE	12/21/2012	LLC	CSC	ACTIVE	Active	12/21/2012	Yes	No	
725	Lifeline Vascular Center-Orlando, LLC	DE	04/26/2012	LLC	CSC	ACTIVE	Active	04/26/2012	Yes	No	
726	Lifeline Vascular Management Of Houston, LLC	DE	05/20/2013	LLC	CSC	ACTIVE	Active	06/18/2013	Yes		
727	Lighthouse Dialysis, LLC	DE	04/19/2010	LLC	CSC	ACTIVE	Active	04/19/2010	No	No	621492
728	Limon Dialysis, LLC	DE	08/27/2008	LLC	CSC	ACTIVE	Active	08/27/2008	No	No	621492
729	Lincoln Park Dialysis Services, Inc.	IL	04/26/1982	CORP	CSC	ACTIVE	Active	04/26/1982	Yes	No	621492
730	Lincolnton Dialysis, LLC	DE	04/08/2013	LLC	CSC	ACTIVE	Active	04/08/2013	No	No	621492
731	Little Rock Dialysis Centers, LLC	DE	03/12/2007	LLC	CSC	ACTIVE	Active	03/12/2007	Yes	No	621492
732	Livingston Dialysis, LLC	DE	08/02/2011	LLC	CSC	ACTIVE	Active	08/02/2011	No	No	621492
733	Llano Dialysis, LLC	DE	03/27/2009	LLC	CSC	ACTIVE	Active	03/27/2009	No	No	621492
734	Lockhart Dialysis, LLC	DE	08/02/2011	LLC	CSC	ACTIVE	Active	08/02/2011	No	No	621492
735	Lockport Dialysis, LLC	DE	09/06/2007	LLC	CSC	ACTIVE	Active	09/06/2007	Yes	No	621492
736	Locuston Dialysis, LLC	DE	10/30/2017	LLC	CSC	ACTIVE	Active	10/30/2017	Yes	No	621492
737	Lofield Dialysis, LLC	DE	04/29/2016	LLC	CSC	ACTIVE	Active	04/29/2016	No	No	621492
738	Logoley Dialysis, LLC	DE	06/26/2017	LLC	CSC	ACTIVE	Active	06/26/2017	No	No	621492
739	Lone Dialysis, LLC	DE	09/03/2008	LLC	CSC	ACTIVE	Active	09/03/2008	Yes	No	621492
740	Long Beach Dialysis Center, LLC	DE	10/27/2005	LLC	CSC	ACTIVE	Active	10/27/2005	No	No	621492
741	Longworth Dialysis, LLC	DE	10/28/2011	LLC	CSC	ACTIVE	Active	10/28/2011	No	No	621492
742	Lord Baltimore Dialysis, LLC	DE	02/16/2007	LLC	CSC	ACTIVE	Active	02/16/2007	No	No	621492
743	Lory Dialysis, LLC	DE	04/14/2011	LLC	CSC	ACTIVE	Active	04/14/2011	No	No	621492
744	Los Angeles Dialysis Center	CA	05/04/1998	GP	NonCSC	N/A	Active	12/09/2005	Yes	No	621492
745	Los Arcos Dialysis, LLC	DE	05/22/2009	LLC	CSC	ACTIVE	Active	05/22/2009	Yes	No	621492
746	Loup Dialysis, LLC	DE	08/24/2009	LLC	CSC	ACTIVE	Active	08/24/2009	No	No	621492
747	Lourdes Dialysis, LLC	DE	03/07/2013	LLC	CSC	ACTIVE	Active	03/07/2013	Yes	No	621492
748	Lowden Dialysis, LLC	DE	07/08/2013	LLC	CSC	ACTIVE	Active	07/08/2013	Yes	No	621492
749	Lufield Dialysis, LLC	DE	01/06/2015	LLC	CSC	ACTIVE	Active	01/06/2015	No	No	621492
750	Lufkin Dialysis, LLC	DE	08/02/2005	LLC	CSC	ACTIVE	Active	08/02/2005	Yes	No	621492
751	Lurleen Dialysis, LLC	DE	02/01/2011	LLC	CSC	ACTIVE	Active	02/01/2011	No	No	621492
752	Lyndale Dialysis, LLC	DE	12/18/2014	LLC	CSC	ACTIVE	Active	12/18/2014	No	No	621492
753	Lyndon Dialysis, LLC	DE	03/17/2009	LLC	CSC	ACTIVE	Active	03/17/2009	Yes	No	62942
754	Lynwick Dialysis, LLC	DE	03/16/2016	LLC	CSC	ACTIVE	Active	03/16/2016	No	No	621492
755	Macab Dialysis LLC	DE	07/13/2016	LLC	CSC	ACTIVE	Active	07/13/2016	Yes	No	621492
756	Machesney Bay Dialysis, LLC	DE	01/27/2016	LLC	CSC	ACTIVE	Active	01/27/2016	No	No	621492
757	Mackinaw Dialysis, LLC	CA	01/02/2014	LLC	CSC	ACTIVE	Active	01/02/2014	Yes	No	621492
758	Madigan Dialysis, LLC	DE	07/17/2014	LLC	CSC	ACTIVE	Active	07/17/2014	No	No	621492
759	Madison Dialysis, LLC	DE	12/04/2013	LLC	CSC	ACTIVE	Active	12/04/2013	No	No	621492
760	Magney Dialysis, LLC	DE	09/12/2014	LLC	CSC	ACTIVE	Active	09/12/2014	No	No	621492
761	Magnolia Dialysis, LLC	DE	05/03/2013	LLC	CSC	ACTIVE	Active	05/03/2013	No	No	621492
762	Magoffin Dialysis, LLC	DE	09/07/2012	LLC	CSC	ACTIVE	Active	09/07/2012	No	No	621492
763	Mahoney Dialysis, LLC	DE	12/10/2012	LLC	CSC	ACTIVE	Active	12/10/2012	No	No	621492
764	Makonee Dialysis, LLC	DE	01/11/2016	LLC	CSC	ACTIVE	Active	01/11/2016	No	No	621492
765	Mammoth Dialysis, LLC	DE	10/13/2011	LLC	CSC	ACTIVE	Active	10/13/2011	No	No	621492
766	Manchester Dialysis, LLC	DE	09/08/2011	LLC	CSC	ACTIVE	Active	09/08/2011	No	No	621492
767	Manito Dialysis, LLC	DE	11/12/2013	LLC	CSC	ACTIVE	Active	11/12/2013	Yes	No	621492
768	Manzano Dialysis, LLC	DE	03/04/2010	LLC	CSC	ACTIVE	Active	03/04/2010	No	No	621492
769	Maple Grove Dialysis, LLC	DE	01/11/2008	LLC	CSC	ACTIVE	Active	01/11/2008	Yes	No	621492
770	Maples Dialysis, LLC	DE	06/19/2009	LLC	CSC	ACTIVE	Active	06/19/2009	Yes	No	621492
771	Margette Dialysis, LLC	DE	06/12/2015	LLC	CSC	ACTIVE	Active	06/12/2015	Yes	No	621492

	A	B	C	D	E	F	G	H	I	J	K
772	Marlton Dialysis Center, LLC	DE	10/03/2005	LLC	CSC	ACTIVE	Active	10/03/2005	Yes	No	621492
773	Marseille Dialysis, LLC	DE	11/25/2013	LLC	CSC	ACTIVE	Active	11/25/2013	Yes	No	621492
774	Marsher Dialysis, LLC	DE	04/02/2018	LLC	CSC	ACTIVE	Active	04/02/2018	Yes	No	641492
775	Martin Dialysis, LLC	DE	01/07/2013	LLC	CSC	ACTIVE	Active	01/07/2013	Yes	No	621492
776	Marysville Dialysis Center, LLC	DE	08/09/2002	LLC	CSC	ACTIVE	Active	08/09/2002	Yes	No	621492
777	Mashero Dialysis, LLC	DE	05/19/2015	LLC	CSC	ACTIVE	Active	05/19/2015	No	No	621492
778	Mason-Dixon Dialysis Facilities, Inc.	MD	05/11/1992	CORP	CSC	ACTIVE	Active	05/11/1992	Yes	No	621492
779	Mastodon Dialysis, LLC	DE	10/26/2017	LLC	CSC	ACTIVE	Active	10/26/2017	Yes	No	621492
780	Matheson Dialysis, LLC	DE	07/11/2016	LLC	CSC	ACTIVE	Active	07/11/2016	No	No	621492
781	Mautino Dialysis, LLC	DE	04/23/2014	LLC	CSC	ACTIVE	Active	04/23/2014	No	No	621492
782	Mayfield Dialysis, LLC	DE	12/26/2007	LLC	CSC	ACTIVE	Active	12/26/2007	Yes	No	621492
783	Mazonia Dialysis, LLC	DE	11/05/2013	LLC	CSC	ACTIVE	Active	11/05/2013	No	No	621492
784	Mazsum Dialysis, LLC	DE	07/26/2017	LLC	CSC	ACTIVE	Active	07/26/2017	Yes	No	621492
785	MD Investments, L.L.C.	VA	04/23/1997	LLC	NonCSC	N/A	Active	04/19/2016	No	No	
786	Meadows Dialysis, LLC	DE	02/20/2014	LLC	CSC	ACTIVE	Active	02/20/2014	No	No	621492
787	Medlock Bridge Dialysis, LLC	DE	08/22/2007	LLC	CSC	ACTIVE	Active	08/22/2007	Yes	No	621492
788	Meesa Dialysis, LLC	DE	04/30/2014	LLC	CSC	ACTIVE	Active	04/30/2014	No	No	621492
789	Mellen Dialysis, LLC	DE	12/06/2017	LLC	CSC	ACTIVE	Active	12/06/2017	Yes	No	621492
790	Memorial Dialysis Center, L.P.	DE	02/10/2005	LP	CSC	ACTIVE	Active	02/10/2005	No	No	621492
791	Mena Dialysis Center, LLC	DE	08/29/2006	LLC	CSC	ACTIVE	Active	08/29/2006	Yes	No	621492
792	Mendocino Dialysis, LLC	DE	05/02/2011	LLC	CSC	ACTIVE	Active	05/02/2011	Yes	No	621492
793	Meramec Dialysis, LLC	DE	12/04/2014	LLC	CSC	ACTIVE	Active	12/04/2014	Yes	No	621492
794	Meridian Dialysis, LLC	DE	02/05/2009	LLC	CSC	ACTIVE	Active	02/05/2009	Yes	No	621492
795	Mermet Dialysis, LLC	DE	04/11/2014	LLC	CSC	ACTIVE	Active	04/11/2014	No	No	621492
796	Merrik Dialysis, LLC	DE	01/25/2018	LLC	CSC	ACTIVE	Active	01/25/2018	Yes	No	621492
797	Mesilla Dialysis, LLC	DE	03/04/2010	LLC	CSC	ACTIVE	Active	03/04/2010	No	No	621492
798	MHS-XIV, LLC	DE	06/23/1998	LLC	CSC	ACTIVE	Active	06/23/1998	No	Yes	621492
799	MHS-XV, LLC	DE	06/23/1998	LLC	CSC	ACTIVE	Active	06/23/1998	No	Yes	621492
800	Mid-City New Orleans Dialysis Center, LLC	DE	09/01/2004	LLC	CSC	ACTIVE	Active	09/01/2004	Yes	No	621492
801	Middlesex Dialysis Center, LLC	DE	01/12/1999	LLC	CSC	ACTIVE	Active	01/12/1999	Yes	No	621492
802	Millonee Dialysis, LLC	DE	07/30/2015	LLC	CSC	ACTIVE	Active	07/30/2015	No	No	621492
803	Millsite Dialysis, LLC	DE	06/15/2016	LLC	CSC	ACTIVE	Active	06/15/2016	Yes	No	621492
804	Milltown Dialysis, LLC	DE	10/28/2015	LLC	CSC	ACTIVE	Active	10/28/2015	No	No	621492
805	Milo Dialysis, LLC	DE	05/03/2011	LLC	CSC	ACTIVE	Active	05/03/2011	No	No	621492
806	Minam Dialysis, LLC	DE	04/14/2011	LLC	CSC	ACTIVE	Active	04/14/2011	No	No	621492
807	Minneopa Dialysis, LLC	DE	04/29/2016	LLC	CSC	ACTIVE	Active	04/29/2016	Yes	No	621492
808	Miramar Dialysis Center, LLC	DE	05/16/2007	LLC	CSC	ACTIVE	Active	05/16/2007	Yes	No	621492
809	Mocca Dialysis, LLC	DE	02/06/2014	LLC	CSC	ACTIVE	Active	02/06/2014	No	No	621492
810	Modesto Dialysis, LLC	DE	06/28/2007	LLC	CSC	ACTIVE	Active	06/28/2007	Yes	No	621492
811	Mohansic Dialysis, LLC	DE	02/21/2017	LLC	CSC	ACTIVE	Active	02/21/2017	Yes	No	621492
812	Molera Dialysis, LLC	DE	07/16/2012	LLC	CSC	ACTIVE	Active	07/16/2012	Yes	No	621492
813	Monahans Dialysis, LLC	DE	01/03/2012	LLC	CSC	ACTIVE	Active	01/03/2012	Yes	No	621492
814	Moncrief Dialysis Center/Total Renal Care Limited Partnership	DE	08/20/1997	LP	CSC	ACTIVE	Active	08/20/1997	Yes	No	621492
815	Monett Dialysis, LLC	DE	11/06/2014	LLC	CSC	ACTIVE	Active	11/06/2014	No	No	621492
816	Montauk Dialysis, LLC	DE	11/25/2014	LLC	CSC	ACTIVE	Active	11/25/2014	No	No	621492
817	Monte Perla Dialysis, LLC	DE	01/23/2009	LLC	CSC	ACTIVE	Active	01/23/2009	Yes	No	621492
818	Montville Dialysis, LLC	DE	10/16/2014	LLC	CSC	ACTIVE	Active	10/16/2014	Yes	No	621492
819	Moraine Dialysis, LLC	DE	12/17/2014	LLC	CSC	ACTIVE	Active	12/17/2014	No	No	621492
820	Morrison Dialysis, LLC	DE	10/05/2016	LLC	CSC	ACTIVE	Active	10/05/2016	No	No	621492
821	Morro Dialysis, LLC	DE	09/23/2008	LLC	CSC	ACTIVE	Active	09/23/2008	No	No	621492
822	Mosaic Management Services, Inc.	CA	02/14/2006	CORP	CSC	ACTIVE	Active	02/14/2006	No	Yes	541690
823	Motte Dialysis, LLC	DE	11/06/2017	LLC	CSC	ACTIVE	Active	11/06/2017	Yes	No	621492

	A	B	C	D	E	F	G	H	I	J	K
824	Mounds Dialysis, LLC	DE	06/02/2014	LLC	CSC	ACTIVE	Active	06/02/2014	No	No	621492
825	Mountain Park Dialysis Center, LLC	DE	03/12/2007	LLC	CSC	ACTIVE	Active	03/12/2007	Yes	No	621492
826	Mountain View Medical Group, LLC	CO	07/07/2016	LLC	CSC	ACTIVE	Active	07/07/2016	Yes	No	
827	Mountain West Dialysis Services, LLC	DE	05/22/2008	LLC	CSC	ACTIVE	Active	05/22/2008	No	No	621492
828	Mulgee Dialysis, LLC	DE	01/11/2013	LLC	CSC	ACTIVE	Active	01/11/2013	No	No	621492
829	Musgrove Dialysis, LLC	DE	06/13/2013	LLC	CSC	ACTIVE	Active	06/20/2013	Yes	No	621492
830	Muskogee Dialysis, LLC	DE	06/14/2004	LLC	CSC	ACTIVE	Active	06/14/2004	Yes	No	621492
831	MVZ DaVita Alzey GmbH	Germany	12/20/2013	GMBH	NonCSC	N/A	Active	01/30/2014	Yes		
832	MVZ DaVita Ambulantes Kardiologisches Zentrum Peine GmbH	Germany	01/05/2017	GMBH	NonCSC	N/A	Active	01/05/2017	Yes	No	N/A
833	MVZ DaVita Aurich GmbH	Germany	09/01/2016	GMBH	NonCSC	N/A	Active	09/01/2016	Yes	No	
834	MVZ DaVita Bad Duben GmbH	Germany	07/19/2016	GMBH	NonCSC	N/A	Active	12/31/2016	Yes	No	
835	MVZ DaVita Cardio Centrum Dusseldorf GmbH	Germany	02/28/2017	GMBH	NonCSC	N/A	Active	02/28/2017	Yes	No	N/A
836	MVZ DaVita Dialyse 10 GmbH	Germany	12/18/2016	GMBH	NonCSC	N/A	Active	12/18/2016	Yes	No	N/A
837	MVZ DaVita Dormagen GmbH	Germany	07/01/2016	GMBH	NonCSC	N/A	Active	07/01/2016	Yes		
838	MVZ DaVita Dresden GmbH	Germany	03/16/2006	GMBH	NonCSC	N/A	Active	04/01/2012	Yes		N/A
839	MVZ DaVita Duisburg GmbH	Germany	08/01/2016	GMBH	NonCSC	N/A	Active	08/01/2016	Yes	No	
840	MVZ DaVita Elsterland GmbH	Germany	07/01/2016	GMBH	NonCSC	N/A	Active	07/01/2016	Yes	No	
841	MVZ DaVita Emden GmbH	Germany	12/20/2013	GMBH	NonCSC	N/A	Active	12/20/2013	Yes	No	
842	MVZ DaVita Geilenkirchen GmbH	Germany	11/18/2015	GMBH	NonCSC	N/A	Active	11/18/2015	Yes	No	N/A
843	MVZ DaVita Gera GmbH	Germany	01/22/2014	GMBH	NonCSC	N/A	Active	01/22/2014	Yes	No	
844	MVZ DaVita Iserlohn GmbH	Germany	06/20/2016	GMBH	NonCSC	N/A	Active	12/31/2016	Yes	No	
845	MVZ DaVita Monchengladbach GmbH	Germany	10/01/2016	GMBH	NonCSC	N/A	Active	10/01/2016	Yes		
846	MVZ DaVita Neuss GmbH	Germany	12/01/2015	GMBH	NonCSC	N/A	Active	12/01/2015	Yes		
847	MVZ DaVita Niederrhein GmbH	Germany	10/01/2016	GMBH	NonCSC	N/A	Active	10/01/2016	Yes		
848	MVZ DaVita Nierenzentrum Berlin-Britz GmbH	Germany	10/01/2016	GMBH	NonCSC	N/A	Active	10/01/2016	Yes		
849	MVZ DaVita Prenzlau-Pasewalk GmbH	Germany	01/01/2017	GMBH	NonCSC	N/A	Active	01/04/2017	Yes	No	N/A
850	MVZ DaVita Rhein-Ahr GmbH	Germany	01/05/2017	GMBH	NonCSC	N/A	Active	01/05/2017	Yes	No	N/A
851	MVZ DaVita Rhein-Ruhr GmbH	Germany	07/16/2013	GMBH	NonCSC	N/A	Active	07/16/2013	Yes	No	N/A
852	MVZ DaVita Salzgitter-Seesen GmbH	Germany	01/26/2005	GMBH	NonCSC	N/A	Active	03/31/2012	Yes	No	
853	MVZ DaVita Schwalm-Eder GmbH	Germany	01/09/2017	GMBH	NonCSC	N/A	Active	01/09/2017	Yes	No	
854	MVZ DaVita Sud-Niedersachsen GmbH	Germany	08/12/2015	PVLC	NonCSC	N/A	Active	08/12/2015	Yes		
855	MVZ DaVita Viersen GmbH	Germany	07/13/2016	GMBH	NonCSC	N/A	Active	07/21/2016	Yes	No	
856	Myrtle Dialysis, LLC	DE	02/05/2015	LLC	CSC	ACTIVE	Active	02/05/2015	No	No	621492
857	Nadell Dialysis, LLC	DE	09/28/2012	LLC	CSC	ACTIVE	Active	06/24/2013	No	No	621492
858	Nansen Dialysis, LLC	DE	08/26/2015	LLC	CSC	ACTIVE	Active	08/26/2015	No	No	621492
859	National Trail Dialysis, LLC	DE	05/04/2011	LLC	CSC	ACTIVE	Active	05/04/2011	No	No	621492
860	Natomas Dialysis, LLC	DE	06/12/2006	LLC	CSC	ACTIVE	Active	06/12/2006	No	No	621492
861	Nauvue Dialysis, LLC	DE	05/11/2016	LLC	CSC	ACTIVE	Active	05/11/2016	Yes	No	621492
862	Navarro Dialysis, LLC	DE	02/17/2014	LLC	CSC	ACTIVE	Active	02/17/2014	No	No	621492
863	Naville Dialysis, LLC	DE	11/26/2013	LLC	CSC	ACTIVE	Active	11/26/2013	Yes	No	621492
864	Neff Dialysis, LLC	DE	02/01/2012	LLC	CSC	ACTIVE	Active	02/01/2012	No	No	621492
865	Nefros Unidade de Nefrologia e Hipertensao Sociedade Simples Ltda.	Brazil	03/01/2018	LLCL	NonCSC	N/A	Active	03/01/2018	Yes	No	
866	Nehalem Dialysis, LLC	DE	05/11/2016	LLC	CSC	ACTIVE	Active	05/11/2016	Yes	No	621492
867	Nehall Dialysis, LLC	DE	05/24/2016	LLC	CSC	ACTIVE	Active	05/24/2016	No	No	621492
868	Nelworth Dialysis, LLC	DE	06/09/2016	LLC	CSC	ACTIVE	Active	06/09/2016	Yes	No	621492
869	Neoporte Dialysis, LLC	DE	03/04/2016	LLC	CSC	ACTIVE	Active	03/04/2016	No	No	621492
870	Nephrology Medical Associates of Georgia, LLC	GA	09/28/2001	LLC	CSC	ACTIVE	Active	09/28/2001	Yes	No	621399
871	Nephrology Practice Solutions, LLC	DE	06/24/2014	LLC	CSC	ACTIVE	Active	06/24/2014	Yes	No	
872	Neptune Artificial Kidney Center, L.L.C.	NJ	07/13/1994	LLC	CSC	ACTIVE	Active	07/13/1994	Yes	No	621492
873	New Bay Dialysis, LLC	DE	12/12/2008	LLC	CSC	ACTIVE	Active	12/12/2008	No	No	621492
874	New Castle Dialysis, LLC	DE	12/09/2008	LLC	CSC	ACTIVE	Active	12/09/2008	Yes	No	621492
875	New Hope Dialysis, LLC	DE	08/15/2005	LLC	CSC	ACTIVE	Active	08/15/2005	Yes	No	621492

	A	B	C	D	E	F	G	H	I	J	K
876	New Springs Dialysis, LLC	DE	12/12/2008	LLC	CSC	ACTIVE	Active	12/12/2008	No	No	621492
877	Newhall Dialysis, LLC	DE	09/09/2016	LLC	CSC	ACTIVE	Active	09/09/2016	No	No	621492
878	Nicona Dialysis, LLC	DE	01/18/2018	LLC	CSC	ACTIVE	Active	01/18/2018	Yes	No	621492
879	Nisene Dialysis, LLC	DE	09/22/2011	LLC	CSC	ACTIVE	Active	09/22/2011	Yes	No	621492
880	NM Partners ACO, LLC	DE	05/11/2016	LLC	CSC	ACTIVE	Active	05/11/2016	Yes	No	
881	Nolia Dialysis, LLC	DE	02/12/2014	LLC	CSC	ACTIVE	Active	02/12/2014	No	No	621492
882	Norbert Dialysis, LLC	DE	04/11/2014	LLC	CSC	ACTIVE	Active	04/11/2014	No	No	621492
883	Norte Dialysis, LLC	DE	12/21/2012	LLC	CSC	ACTIVE	Active	12/21/2012	No	No	621492
884	North Atlanta Dialysis Center, LLC	DE	10/09/2003	LLC	CSC	ACTIVE	Active	10/09/2003	Yes	No	621492
885	North Austin Dialysis, LLC	DE	10/03/2006	LLC	CSC	ACTIVE	Active	10/03/2006	No	No	621492
886	North Colorado Springs Dialysis, LLC	DE	02/26/2008	LLC	CSC	ACTIVE	Active	02/26/2008	Yes	No	621492
887	North Ogden Dialysis, LLC	DE	11/07/2007	LLC	CSC	ACTIVE	Active	11/07/2007	Yes	No	621492
888	North Puget Sound Center For Sleep Disorders, LLC	WA	04/09/2004	LLC	CSC	ACTIVE	Active	04/09/2004	No	Yes	
889	North Puget Sound Oncology Equipment Leasing Company, LLC	WA	03/24/2005	LLC	NonCSC	N/A	Active	03/24/2005	No	No	
890	Northeast Ohio Home Dialysis, LLC	DE	03/07/2008	LLC	CSC	ACTIVE	Active	03/07/2008	Yes	No	621492
891	Northridge Medical Group, Inc.	CA	05/18/1999	PC	CSC	ACTIVE	Active	05/18/1999	No	Yes	621111
892	Northshore Dialysis, LLC	DE	10/30/2012	LLC	CSC	ACTIVE	Active	10/30/2012	Yes	No	621492
893	Northwest Arkansas Kidney Centers, LLC	DE	10/29/2007	LLC	CSC	ACTIVE	Active	10/29/2007	Yes	No	621492
894	Northwest Tucson Dialysis, LLC	DE	08/15/2007	LLC	CSC	ACTIVE	Active	08/15/2007	No	No	621492
895	Noster Dialysis, LLC	DE	10/28/2014	LLC	CSC	ACTIVE	Active	10/28/2014	No	No	621492
896	NPS Physicians (TN), PLLC	TN	11/16/2015	PLLC	CSC	ACTIVE	Active	11/16/2015	Yes	No	
897	Nuevo Dialysis, LLC	DE	07/22/2008	LLC	CSC	ACTIVE	Active	07/22/2008	Yes	No	621492
898	NUSB Global (M) Sdn. BhD.	Malaysia	09/03/2015	PRIVATELIMITED	NonCSC	N/A	Active	09/03/2015	Yes	No	
899	Oakdale Dialysis, LLC	DE	10/30/2012	LLC	CSC	ACTIVE	Active	10/30/2012	Yes	No	621492
900	Oakes Dialysis, LLC	DE	11/14/2007	LLC	CSC	ACTIVE	Active	11/14/2007	Yes	No	621492
901	Oasis Dialysis, LLC	DE	03/10/2010	LLC	CSC	ACTIVE	Active	03/10/2010	No	No	621492
902	Odiorne Dialysis, LLC	DE	09/10/2015	LLC	CSC	ACTIVE	Active	09/10/2015	No	No	621492
903	Ogano Dialysis, LLC	DE	08/14/2017	LLC	CSC	ACTIVE	Active	08/14/2017	Yes	No	621492
904	Ohio River Dialysis, LLC	DE	08/01/2006	LLC	CSC	ACTIVE	Active	08/01/2006	No	No	621492
905	Okanogan Dialysis, LLC	DE	04/09/2012	LLC	CSC	ACTIVE	Active	04/09/2012	No	No	621492
906	Olive Dialysis, LLC	DE	10/17/2011	LLC	CSC	ACTIVE	Active	10/17/2011	No	No	621492
907	Olympic Dialysis, LLC	DE	07/22/2008	LLC	CSC	ACTIVE	Active	07/22/2008	Yes	No	621492
908	Ontario Dialysis Center, LLC	DE	09/13/2004	LLC	CSC	ACTIVE	Active	09/13/2004	Yes	No	621492
909	Open Access Lifeline, LLC	DE	06/08/2007	LLC	CSC	ACTIVE	Active	06/08/2007	Yes	No	
910	Open Access Sonography, Inc.	FL	05/10/1994	CORP	CSC	ACTIVE	Active	05/10/1994	Yes	No	
911	Orange Dialysis, LLC	CA	09/05/2001	LLC	CSC	ACTIVE	Active	09/05/2001	Yes	No	621492
912	Ordust Dialysis, LLC	DE	11/25/2013	LLC	CSC	ACTIVE	Active	11/25/2013	Yes	No	621492
913	Oriello Dialysis, LLC	NY	02/08/2013	LLC	CSC	ACTIVE	Active	02/28/2013	Yes	No	621492
914	Orion Dialysis, LLC	DE	10/20/2016	LLC	CSC	ACTIVE	Active	10/20/2016	No	No	621492
915	Osage Dialysis, LLC	DE	08/13/2013	LLC	CSC	ACTIVE	Active	08/13/2013	No	No	621492
916	Ouabache Dialysis, LLC	DE	10/29/2013	LLC	CSC	ACTIVE	Active	10/29/2013	Yes	No	621492
917	Owasso Dialysis, LLC	DE	07/06/2007	LLC	CSC	ACTIVE	Active	07/06/2007	No	No	621492
918	Owens Dialysis, LLC	DE	03/30/2016	LLC	CSC	ACTIVE	Active	03/30/2016	Yes	No	621492
919	Owyhee Dialysis, LLC	DE	04/28/2016	LLC	CSC	ACTIVE	Active	04/28/2016	No	No	621492
920	Ozark Dialysis, LLC	DE	10/23/2014	LLC	CSC	ACTIVE	Active	10/23/2014	No	No	621492
921	Pablo Dialysis, LLC	DE	04/05/2016	LLC	CSC	ACTIVE	Active	04/05/2016	No	No	621492
922	Pacheco Dialysis, LLC	DE	07/30/2012	LLC	CSC	ACTIVE	Active	07/13/2012	Yes	No	621492
923	Pacific Coast Dialysis Center	CA	03/31/1985	GP	NonCSC	N/A	Active	12/13/2005	Yes	No	621492
924	Pacific Dialysis, LLC	DE	10/29/2007	LLC	CSC	ACTIVE	Active	10/29/2007	Yes	No	621492
925	Pacific Kidney & Hypertension, LLC	OR	11/12/2013	LLC	CSC	ACTIVE	Active	11/12/2013			
926	Paladina Health Group of Texas	TX	11/15/2012	NFP	CSC	ACTIVE	Active	11/15/2012		Yes	
927	Paladina Health Medical Group, PC	CO	05/16/2013	CORP	CSC	ACTIVE	Active	05/16/2013			

	A	B	C	D	E	F	G	H	I	J	K
928	Paladina Health, LLC	DE	09/23/2011	LLC	CSC	ACTIVE	Active	09/23/2011	Yes	No	
929	Paladina Medical Group of New Jersey, P.C.	NJ	04/20/2017	CORP	CSC	ACTIVE	Active	04/20/2017	No	No	621492
930	Palisades Dialysis, LLC	DE	01/06/2012	LLC	CSC	ACTIVE	Active	01/06/2012	No	No	621492
931	Palmas Dialysis, LLC	DE	07/26/2010	LLC	CSC	ACTIVE	Active	07/26/2010	Yes	No	621492
932	Palmetto Dialysis, LLC	DE	02/09/2012	LLC	CSC	ACTIVE	Active	02/09/2012	No	No	621492
933	Palo Dialysis, LLC	DE	03/10/2009	LLC	CSC	ACTIVE	Active	03/10/2009	Yes	No	621492
934	Palomar Dialysis, LLC	DE	08/27/2008	LLC	CSC	ACTIVE	Active	08/27/2008	No	No	621492
935	Panola Dialysis, LLC	DE	05/21/2013	LLC	CSC	ACTIVE	Active	05/21/2013	Yes	No	621492
936	Panther Dialysis, LLC	DE	08/07/2014	LLC	CSC	ACTIVE	Active	08/07/2014	No	No	621492
937	Papello Dialysis, LLC	DE	06/11/2015	LLC	CSC	ACTIVE	Active	06/11/2015	Yes	No	621492
938	Parker Dialysis, LLC	DE	02/09/2009	LLC	CSC	ACTIVE	Active	02/09/2009	No	No	621492
939	Parkside Dialysis, LLC	DE	12/06/2012	LLC	CSC	ACTIVE	Active	12/06/2012	No	No	621492
940	Patch Dialysis, LLC	DE	08/08/2011	LLC	CSC	ACTIVE	Active	08/08/2011	Yes	No	621492
941	Patient Pathways, LLC	DE	07/24/2009	LLC	CSC	ACTIVE	Active	07/24/2009	Yes	No	621490
942	Patoka Dialysis, LLC	DE	08/05/2013	LLC	CSC	ACTIVE	Active	08/05/2013	No	No	621492
943	Pattison Dialysis, LLC	DE	01/05/2018	LLC	CSC	ACTIVE	Active	01/05/2018	Yes	No	621492
944	Pavalak Dialysis, LLC	DE	06/29/2017	LLC	CSC	ACTIVE	Active	06/29/2017	Yes	No	621492
945	Pawlier Dialysis, LLC	DE	09/29/2015	LLC	CSC	ACTIVE	Active	09/29/2015	No	No	621492
946	PD La Dialysis, LLC	DE	06/08/2011	LLC	CSC	ACTIVE	Active	06/08/2011	Yes		621492
947	PDI Holdings, Inc.	DE	05/14/2001	CORP	CSC	ACTIVE	Active	05/14/2001	Yes	No	621492
948	Peaks Dialysis, LLC	DE	06/25/2008	LLC	CSC	ACTIVE	Active	06/25/2008	No	No	621492
949	Pearl Dialysis, LLC	DE	11/12/2008	LLC	CSC	ACTIVE	Active	11/12/2008	No	No	621492
950	Pedernales Dialysis, LLC	DE	11/01/2013	LLC	CSC	ACTIVE	Active	11/01/2013	No	No	621492
951	Pekin Dialysis, LLC	DE	05/30/2012	LLC	CSC	ACTIVE	Active	05/30/2012	No	No	621492
952	Pembina Dialysis, LLC	DE	08/09/2017	LLC	CSC	ACTIVE	Active	08/28/2017	Yes	No	621492
953	Pendster Dialysis, LLC	DE	03/20/2014	LLC	CSC	ACTIVE	Active	03/20/2014	No	No	621492
954	Peninsula Dialysis Center, Inc.	VA	07/18/1994	CORP	CSC	ACTIVE	Active	07/18/1994	Yes	No	621492
955	Percha Dialysis, LLC	DE	03/02/2012	LLC	CSC	ACTIVE	Active	03/02/2012	Yes	No	621492
956	Pering Dialysis, LLC	DE	07/23/2012	LLC	CSC	ACTIVE	Active	07/23/2012	Yes	No	621492
957	Perry County Dialysis, LLC	DE	01/07/2008	LLC	CSC	ACTIVE	Active	01/07/2008	Yes	No	621492
958	Perryton Dialysis, LLC	DE	03/10/2017	LLC	CSC	ACTIVE	Active	03/10/2017	Yes	No	621492
959	Pershing Dialysis, LLC	DE	12/18/2014	LLC	CSC	ACTIVE	Active	12/18/2014	Yes	No	621492
960	Petra Dialysis, LLC	DE	04/28/2016	LLC	CSC	ACTIVE	Active	04/28/2016	Yes	No	621492
961	Pfeiffer Dialysis, LLC	DE	05/02/2011	LLC	CSC	ACTIVE	Active	05/02/2011	No	No	621492
962	Pharis Dialysis, LLC	DE	01/27/2016	LLC	CSC	ACTIVE	Active	01/27/2016	No	No	621492
963	Philadelphia Comprehensive Care Program, LLC	DE	01/17/2018	LLC	CSC	ACTIVE	Active	01/17/2018	Yes	No	621492
964	Philadelphia-Camden Integrated Kidney Care, LLC	DE	07/15/2015	LLC	CSC	ACTIVE	Active	07/15/2015	Yes	No	621492
965	Phoenix-Tucson Integrated Kidney Care, LLC	DE	07/15/2015	LLC	CSC	ACTIVE	Active	07/15/2015	Yes	No	621492
966	Physician Associates of the Greater San Gabriel Valley, a Medical Group, Inc.	CA	05/17/1999	PC	CSC	ACTIVE	Active	05/17/1999	Yes	No	621111
967	Physicians Choice Dialysis Of Alabama, LLC	DE	04/25/2003	LLC	CSC	ACTIVE	Active	04/25/2003	Yes	No	621492
968	Physicians Choice Dialysis, LLC	DE	04/25/2003	LLC	CSC	ACTIVE	Active	04/25/2003	Yes	No	621492
969	Physicians Dialysis Acquisitions, Inc.	DE	01/25/2001	CORP	CSC	ACTIVE	Active	01/25/2001	Yes	No	621492
970	Physicians Dialysis of Houston, LLP	TX	12/17/2002	LLP	NonCSC	N/A	Active	11/17/2005	No	No	621492
971	Physicians Dialysis of Lancaster, LLC	PA	08/26/2002	LLC	CSC	ACTIVE	Active	08/26/2002	No	No	621492
972	Physicians Dialysis of Newark, LLC	NJ	11/28/2001	LLC	CSC	ACTIVE	Active	11/28/2001	Yes	No	621492
973	Physicians Dialysis Ventures, LLC	DE	01/25/2001	LLC	CSC	ACTIVE	Active	01/25/2001	Yes	No	621492
974	Physicians Management, LLC	DE	04/25/2003	LLC	CSC	ACTIVE	Active	04/25/2003	Yes	No	
975	Pible Dialysis, LLC	DE	03/14/2012	LLC	CSC	ACTIVE	Active	03/14/2012	No	No	621492
976	Pike Dialysis, LLC	DE	11/12/2008	LLC	CSC	ACTIVE	Active	11/12/2008	Yes	No	621492
977	Pine Dialysis, LLC	DE	07/30/2012	LLC	CSC	ACTIVE	Active	07/30/2012	No	No	621492
978	Pinewoods Dialysis, LLC	DE	07/22/2014	LLC	CSC	ACTIVE	Active	07/22/2014	No	No	621492
979	Pirogue Dialysis, LLC	DE	03/01/2016	LLC	CSC	ACTIVE	Active	03/01/2016	Yes	No	621492

	A	B	C	D	E	F	G	H	I	J	K
980	Pittsburgh Dialysis Partners, LLC	DE	04/30/2007	LLC	CSC	ACTIVE	Active	04/30/2007	No	Yes	621492
981	Piute Dialysis, LLC	DE	08/18/2016	LLC	CSC	ACTIVE	Active	08/18/2016	No	No	621492
982	Placid Dialysis, LLC	DE	11/10/2015	LLC	CSC	ACTIVE	Active	11/10/2015	No	No	621492
983	Plaine Dialysis, LLC	DE	08/31/2010	LLC	CSC	ACTIVE	Active	08/31/2010	No	No	621492
984	Plateau Dialysis, LLC	DE	04/17/2012	LLC	CSC	ACTIVE	Active	04/17/2012	Yes	No	621492
985	Platte Dialysis, LLC	DE	07/28/2009	LLC	CSC	ACTIVE	Active	07/28/2009	No	No	621492
986	Plover Dialysis, LLC	DE	03/16/2018	LLC	CSC	ACTIVE	Active	03/16/2018	Yes	No	621492
987	Plumas Dialysis, LLC	DE	09/17/2008	LLC	CSC	ACTIVE	Active	09/17/2008	Yes	No	621492
988	Pluribus Dialise - Alcobaca, S.A.	Portugal	08/01/2017	S.A.	NonCSC	N/A	Active	08/01/2017	Yes	No	
989	Pluribus Dialise - Benfica, S.A.	Portugal	08/01/2017	S.A.	NonCSC	N/A	Active	08/01/2017	Yes	No	
990	Pluribus Dialise - Cascais, S.A.	Portugal	08/01/2017	S.A.	NonCSC	N/A	Active	08/01/2017	Yes	No	
991	Pluribus Dialise - Sacavem, S.A.	Portugal	08/01/2017	S.A.	NonCSC	N/A	Active	08/01/2017	Yes	No	
992	Pluribus Dialise, S.A.	Portugal	08/01/2017	S.A.	NonCSC	N/A	Active	08/01/2017	Yes	No	
993	Pobello Dialysis, LLC	DE	11/08/2012	LLC	CSC	ACTIVE	Active	11/08/2012	No	No	621492
994	Poinsett Dialysis, LLC	DE	01/28/2014	LLC	CSC	ACTIVE	Active	01/28/2014	No	No	621492
995	Pointe Dialysis, LLC	DE	08/19/2010	LLC	CSC	ACTIVE	Active	08/19/2010	No	No	621492
996	Pokagon Dialysis, LLC	DE	06/25/2013	LLC	CSC	ACTIVE	Active	06/25/2013	No	No	621492
997	Pomme Dialysis, LLC	DE	05/31/2017	LLC	CSC	ACTIVE	Active	05/31/2017	Yes	No	621492
998	Pommer Dialysis, LLC	DE	04/10/2015	LLC	CSC	ACTIVE	Active	04/10/2015	Yes	No	621492
999	Ponca Dialysis, LLC	DE	09/28/2012	LLC	CSC	ACTIVE	Active	09/28/2012	No	No	621492
1000	Ponderosa Dialysis, LLC	DE	02/12/2013	LLC	CSC	ACTIVE	Active	02/12/2013	Yes	No	621492
1001	Pooler Dialysis, LLC	DE	05/16/2007	LLC	CSC	ACTIVE	Active	05/16/2007	Yes	No	621492
1002	Portola Dialysis, LLC	DE	02/14/2011	LLC	CSC	ACTIVE	Active	08/14/2011	No	No	621492
1003	Powerton Dialysis, LLC	DE	11/04/2013	LLC	CSC	ACTIVE	Active	11/04/2013	Yes	No	621492
1004	Prairie Dialysis, LLC	DE	08/06/2014	LLC	CSC	ACTIVE	Active	08/06/2014	Yes	No	621492
1005	Priday Dialysis, LLC	DE	05/22/2012	LLC	CSC	ACTIVE	Active	05/22/2012	No	No	621492
1006	Primrose Dialysis, LLC	DE	10/28/2014	LLC	CSC	ACTIVE	Active	10/28/2014	No	No	621492
1007	Princeton Dialysis, LLC	DE	01/24/2008	LLC	CSC	ACTIVE	Active	01/24/2008	Yes	No	621492
1008	Prineville Dialysis, LLC	DE	04/03/2012	LLC	CSC	ACTIVE	Active	04/03/2012	No	No	621492
1009	Prings Dialysis, LLC	DE	01/25/2013	LLC	CSC	ACTIVE	Active	01/25/2013	Yes	No	621492
1010	Pruneau Dialysis, LLC	DE	02/26/2014	LLC	CSC	ACTIVE	Active	02/26/2014	No	No	621492
1011	Purtis Dialysis, LLC	DE	02/16/2012	LLC	CSC	ACTIVE	Active	02/16/2012	Yes	No	621492
1012	Pyramid Dialysis, LLC	DE	01/14/2015	LLC	CSC	ACTIVE	Active	01/14/2015	No	No	621492
1013	Quality Dialysis Care Sdn. Bhd.	Malaysia	03/19/2013	PRVTCOMP	NonCSC	N/A	Active - Current	03/19/2013	Yes	No	
1014	Quincy Dialysis, LLC	DE	11/15/2007	LLC	CSC	ACTIVE	Active	11/15/2007	Yes	No	621492
1015	Quinn Dialysis, LLC	DE	09/12/2011	LLC	CSC	ACTIVE	Active	09/12/2011	Yes	No	621492
1016	Rainer Dialysis, LLC	DE	07/02/2012	LLC	CSC	ACTIVE	Active	07/02/2012	Yes	No	621492
1017	Ralfton Dialysis, LLC	DE	06/04/2014	LLC	CSC	ACTIVE	Active	06/04/2014	Yes	No	621492
1018	Ramsey Dialysis, LLC	DE	10/14/2014	LLC	CSC	ACTIVE	Active	10/14/2014	Yes	No	621492
1019	Rancho Dialysis, LLC	DE	12/18/2008	LLC	CSC	ACTIVE	Active	12/18/2008	No	No	621492
1020	Randolph Dialysis, LLC	DE	02/19/2015	LLC	CSC	ACTIVE	Active	02/19/2015	No	No	621492
1021	Ravalli Dialysis, LLC	DE	06/15/2016	LLC	CSC	ACTIVE	Active	06/15/2016	No	No	621492
1022	Ravine Dialysis, LLC	DE	08/08/2014	LLC	CSC	ACTIVE	Active	08/08/2014	No	No	621492
1023	Rayburn Dialysis, LLC	DE	10/27/2011	LLC	CSC	ACTIVE	Active	10/27/2011	No	No	621492
1024	Red Willow Dialysis, LLC	DE	08/26/2009	LLC	CSC	ACTIVE	Active	08/26/2009	Yes	No	621492
1025	Redcliff Dialysis, LLC	DE	06/13/2013	LLC	CSC	ACTIVE	Active	06/13/2013	No	No	621492
1026	Redwood Dialysis, LLC	DE	05/16/2008	LLC	CSC	ACTIVE	Active	05/16/2008	Yes	No	621492
1027	Reef Dialysis, LLC	DE	07/06/2012	LLC	CSC	ACTIVE	Active	07/06/2012	Yes	No	621492
1028	Refuge Dialysis, LLC	DE	01/26/2009	LLC	CSC	ACTIVE	Active	01/26/2009	Yes	No	621492
1029	Renaissance Dialysis, LLC	DE	02/26/2008	LLC	CSC	ACTIVE	Active	02/26/2008	Yes	No	621492
1030	Renal Center of Beaumont, LLC	DE	11/18/2011	LLC	CSC	ACTIVE	Active	11/18/2011	Yes	No	621492
1031	Renal Center of Brick, LLC	DE	12/19/2000	LLC	CSC	ACTIVE	Active	12/19/2000	Yes	No	621492

	A	B	C	D	E	F	G	H	I	J	K
1032	Renal Center of Carrollton, L.P.L.L.L.P.	DE	08/12/2003	LP	CSC	ACTIVE	Active	08/12/2003	Yes	No	621492
1033	Renal Center of Englewood, LLC	DE	04/05/2010	LLC	CSC	ACTIVE	Active	04/05/2010	Yes	No	621492
1034	Renal Center of Flower Mound, LLC	DE	05/06/2014	LLC	CSC	ACTIVE	Active	05/06/2014	Yes	No	621492
1035	Renal Center of Fort Dodge, LLC	DE	07/21/2011	LLC	CSC	ACTIVE	Active	07/21/2011	Yes	No	621492
1036	Renal Center of Frisco, LLC	DE	03/17/2008	LLC	CSC	ACTIVE	Active	03/17/2008	Yes	No	621492
1037	Renal Center of Hamilton, LLC	DE	10/27/2010	LLC	CSC	ACTIVE	Active	10/27/2010	Yes	No	621492
1038	Renal Center of Keller, LLC	DE	06/07/2013	LLC	CSC	ACTIVE	Active	06/07/2013	Yes	No	621492
1039	Renal Center of Keyser, LLC	DE	03/03/2009	LLC	CSC	ACTIVE	Active	03/03/2009	Yes	No	621492
1040	Renal Center of Lewisville, LLC	DE	01/23/2007	LLC	CSC	ACTIVE	Active	01/23/2007	Yes	No	621492
1041	Renal Center of Monroe, LLC	DE	12/09/2014	LLC	CSC	ACTIVE	Active	12/09/2014	Yes	No	621492
1042	Renal Center of Moorefield, LLC	DE	03/12/2003	LLC	CSC	ACTIVE	Active	03/12/2003	Yes	No	621492
1043	Renal Center of Morristown, LLC	DE	10/18/2012	LLC	CSC	ACTIVE	Active	10/18/2012	Yes	No	621492
1044	Renal Center of Mountain Home, LLC	DE	11/27/2001	LLC	CSC	ACTIVE	Active	11/27/2001	Yes	No	621492
1045	Renal Center of Nederland, LLC	DE	11/18/2011	LLC	CSC	ACTIVE	Active	11/18/2011	Yes	No	621492
1046	Renal Center of Newton, LLC	DE	03/12/2002	LLC	CSC	ACTIVE	Active	03/12/2002	Yes	No	621492
1047	Renal Center of North Dallas, LLC	DE	08/04/2010	LLC	CSC	ACTIVE	Active	08/04/2010	Yes	No	621492
1048	Renal Center of North Denton, L.L.L.P.	DE	06/22/2006	LLLP	CSC	ACTIVE	Active	06/22/2006	Yes	No	621492
1049	Renal Center of Orange, LLC	DE	11/18/2011	LLC	CSC	ACTIVE	Active	11/18/2011	Yes	No	621492
1050	Renal Center of Passaic, LLC	DE	09/29/1998	LLC	CSC	ACTIVE	Active	09/29/1998	Yes	No	621492
1051	Renal Center of Philadelphia, LLC	DE	07/28/1998	LLC	CSC	ACTIVE	Active	07/28/1998	Yes	No	621492
1052	Renal Center of Plano, LLC	DE	09/21/2009	LLC	CSC	ACTIVE	Active	09/21/2009	Yes	No	621492
1053	Renal Center of Port Arthur, LLC	DE	11/18/2011	LLC	CSC	ACTIVE	Active	11/18/2011	Yes	No	621492
1054	Renal Center of Sewell, LLC	DE	12/19/2000	LLC	CSC	ACTIVE	Active	12/19/2000	Yes	No	621492
1055	Renal Center of Somerville, LLC	DE	03/26/2003	LLC	CSC	ACTIVE	Active	03/26/2003	Yes	No	621492
1056	Renal Center of Storm Lake, LLC	DE	05/14/1998	LLC	CSC	ACTIVE	Active	05/14/1998	Yes	No	621492
1057	Renal Center of Succasunna, LLC	DE	10/18/2012	LLC	CSC	ACTIVE	Active	10/18/2012	Yes	No	621492
1058	Renal Center of the Hills, LLC	DE	08/13/2008	LLC	CSC	ACTIVE	Active	05/01/2017	Yes	No	621492
1059	Renal Center of Trenton, LLC	DE	03/12/2002	LLC	CSC	ACTIVE	Active	03/12/2002	Yes	No	621492
1060	Renal Center of Tyler, L.P.L.L.L.P.	DE	03/26/2003	LLLP	CSC	ACTIVE	Active	03/26/2003	Yes	No	621492
1061	Renal Center of Waterton, L.L.L.P.	DE	06/22/2006	LLLP	CSC	ACTIVE	Active	06/22/2006	Yes	No	621492
1062	Renal Center of West Beaumont, LLC	DE	11/18/2011	LLC	CSC	ACTIVE	Active	11/18/2011	Yes	No	621492
1063	Renal Center of Westwood, LLC	DE	01/01/2006	LLC	CSC	ACTIVE	Active	01/01/2006	Yes	No	621492
1064	Renal Clinic Of Houston, LLC	DE	12/04/2007	LLC	CSC	ACTIVE	Active	12/04/2007	No	No	621492
1065	Renal Life Link, Inc.	DE	08/18/2004	CORP	CSC	ACTIVE	Active	08/18/2004	Yes	No	621492
1066	Renal Treatment Centers - California, Inc.	DE	10/06/1993	CORP	CSC	ACTIVE	Active	10/06/1993	Yes	No	621492
1067	Renal Treatment Centers - Hawaii, Inc.	DE	12/15/1995	CORP	CSC	ACTIVE	Active	12/15/1995	Yes	No	621492
1068	Renal Treatment Centers - Illinois, Inc.	DE	02/07/1995	CORP	CSC	ACTIVE	Active	02/07/1995	Yes	No	621492
1069	Renal Treatment Centers - Mid-Atlantic, Inc.	DE	12/12/1988	CORP	CSC	ACTIVE	Active	12/12/1988	Yes	No	621492
1070	Renal Treatment Centers - Northeast, Inc.	DE	01/04/1993	CORP	CSC	ACTIVE	Active	01/04/1993	Yes	No	621492
1071	Renal Treatment Centers - Southeast, LP	DE	12/09/1994	LP	CSC	ACTIVE	Active	12/09/1994	Yes	No	621492
1072	Renal Treatment Centers - West, Inc.	DE	04/27/1994	CORP	CSC	ACTIVE	Active	04/27/1994	Yes	No	621492
1073	Renal Treatment Centers, Inc.	DE	08/11/1988	CORP	CSC	ACTIVE	Active	08/11/1988	Yes	No	621492
1074	Renal Ventures Management, LLC	DE	11/25/1997	LLC	CSC	ACTIVE	Active	11/25/1997	Yes	No	621492
1075	RenalServ LLC	DE	05/06/2005	LLC	CSC	ACTIVE	Active	05/06/2005	Yes	No	621492
1076	Rend Dialysis, LLC	DE	06/10/2014	LLC	CSC	ACTIVE	Active	06/10/2014	No	No	621492
1077	Reno Avenue Dialysis, LLC	DE	01/31/2008	LLC	CSC	ACTIVE	Active	01/31/2008	Yes	No	621492
1078	Renwick Dialysis, LLC	DE	08/09/2017	LLC	CSC	ACTIVE	Active	08/09/2017	Yes	No	621492
1079	Rhodes Dialysis, LLC	DE	09/28/2015	LLC	CSC	ACTIVE	Active	09/28/2015	No	No	621492
1080	Richfield Dialysis, LLC	DE	09/12/2005	LLC	CSC	ACTIVE	Active	09/12/2005	Yes	No	621492
1081	Rickwood Dialysis, LLC	DE	09/28/2010	LLC	CSC	ACTIVE	Active	09/28/2010	Yes	No	621492
1082	Riddle Dialysis, LLC	DE	01/24/2007	LLC	CSC	ACTIVE	Active	01/24/2007	No	No	621492
1083	Ridgeland Dialysis, LLC	DE	01/24/2008	LLC	CSC	ACTIVE	Active	01/24/2008	Yes	No	621492

	A	B	C	D	E	F	G	H	I	J	K
1084	Ridgely Dialysis, LLC	DE	12/19/2014	LLC	CSC	ACTIVE	Active	12/19/2014	Yes	No	621492
1085	Rio Dialysis, LLC	DE	02/18/2011	LLC	CSC	ACTIVE	Active	12/18/2011	No	No	621492
1086	Ripley Dialysis, LLC	DE	11/27/2007	LLC	CSC	ACTIVE	Active	11/27/2007	Yes	No	621492
1087	Rita Ranch Dialysis, LLC	DE	01/31/2008	LLC	CSC	ACTIVE	Active	01/31/2008	Yes	No	621492
1088	River Valley Dialysis, LLC	DE	08/01/2006	LLC	CSC	ACTIVE	Active	08/01/2006	No	No	621492
1089	Riverside County Home PD Program, LLC	DE	04/29/2003	LLC	CSC	ACTIVE	Active	04/29/2003	Yes	No	621492
1090	RMS Lifeline Inc.	DE	10/22/1998	CORP	CSC	ACTIVE	Active	10/22/1998	Yes	No	
1091	RNA - DaVita Dialysis, LLC	DE	02/09/2007	LLC	CSC	ACTIVE	Active	02/09/2007	No	No	621492
1092	Roaring Dialysis, LLC	DE	09/11/2008	LLC	CSC	ACTIVE	Active	09/11/2008	Yes	No	621492
1093	Robertsville Dialysis, LLC	DE	05/17/2016	LLC	CSC	ACTIVE	Active	05/17/2016	No	No	621492
1094	Robinson Dialysis, LLC	DE	03/04/2008	LLC	CSC	ACTIVE	Active	03/04/2008	Yes	No	621492
1095	Robler Dialysis, LLC	NY	12/17/2015	LLC	CSC	ACTIVE	Active	12/17/2015	Yes	No	621492
1096	Rochester Dialysis Center, LLC	DE	11/17/2004	LLC	CSC	ACTIVE	Active	11/17/2004	No	No	621492
1097	Rockhound Dialysis, LLC	DE	09/06/2011	LLC	CSC	ACTIVE	Active	09/06/2011	Yes	No	621492
1098	Rockwood Dialysis, LLC	DE	03/10/2017	LLC	CSC	ACTIVE	Active	03/10/2017	Yes	No	621492
1099	Rocky Mountain Dialysis Services, LLC	DE	01/04/2002	LLC	CSC	ACTIVE	Active	01/04/2002	Yes	No	621492
1100	Roland Dialysis, LLC	DE	03/31/2017	LLC	CSC	ACTIVE	Active	03/31/2017	No	No	621492
1101	Rolf Park Dialysis, LLC	DE	11/18/2015	LLC	CSC	ACTIVE	Active	11/18/2015	Yes	No	621492
1102	Rollins Dialysis, LLC	DE	09/11/2015	LLC	CSC	ACTIVE	Active	09/11/2015	No	No	621492
1103	Ronan Dialysis, LLC	DE	10/14/2015	LLC	CSC	ACTIVE	Active	10/14/2015	No	No	
1104	Roose Dialysis, LLC	DE	12/31/2008	LLC	CSC	ACTIVE	Active	12/31/2008	No	No	621492
1105	Rophets Dialysis, LLC	DE	05/11/2016	LLC	CSC	ACTIVE	Active	05/11/2016	Yes	No	621492
1106	Ross Clark Circle Dialysis, LLC	DE	01/04/2008	LLC	CSC	ACTIVE	Active	01/04/2008	Yes	No	621492
1107	Roushe Dialysis, LLC	DE	06/18/2013	LLC	CSC	ACTIVE	Active	07/01/2013	No	No	621492
1108	Routt Dialysis, LLC	DE	10/10/2008	LLC	CSC	ACTIVE	Active	10/10/2010	No	Yes	621492
1109	Royale Dialysis, LLC	DE	05/16/2008	LLC	CSC	ACTIVE	Active	05/16/2008	No	No	621492
1110	RTC - Texas Acquisition, Inc.	TX	01/14/1997	CORP	CSC	ACTIVE	Active	01/14/1997	Yes	No	
1111	RTC Holdings, Inc.	DE	12/27/1991	CORP	CSC	ACTIVE	Active	12/27/1991	Yes	No	
1112	RTC TN, Inc.	DE	10/29/1996	CORP	CSC	ACTIVE	Active	10/29/1996	Yes	No	
1113	Runstone Dialysis, LLC	DE	12/30/2015	LLC	CSC	ACTIVE	Active	12/30/2015	Yes	No	621492
1114	Rusk Dialysis, LLC	DE	10/13/2011	LLC	CSC	ACTIVE	Active	10/13/2010	No	No	621492
1115	Russell Dialysis, LLC	DE	10/28/2011	LLC	CSC	ACTIVE	Active	10/28/2011	No	No	621492
1116	RV Academy, LLC	DE	10/04/2010	LLC	CSC	ACTIVE	Active	10/04/2010	Yes	No	621492
1117	RVM Holdings, LLC	DE	10/06/2008	LLC	CSC	ACTIVE	Active	07/27/2016	Yes	No	621492
1118	RVM Texas Renal Care, LLC	DE	11/18/2011	LLC	CSC	ACTIVE	Active	11/18/2011	Yes	No	621492
1119	Rye Dialysis, LLC	DE	01/03/2012	LLC	CSC	ACTIVE	Active	01/03/2012	Yes	No	621492
1120	Saddleback Dialysis, LLC	DE	08/05/2010	LLC	CSC	ACTIVE	Active	08/05/2010	No	No	621492
1121	SafeHarbor Dialysis, LLC	DE	01/13/2009	LLC	CSC	ACTIVE	Active	01/13/2009	No	No	621492
1122	Saggett Dialysis, LLC	DE	02/01/2016	LLC	CSC	ACTIVE	Active	02/01/2016	Yes	No	621492
1123	Saguaro Dialysis, LLC	DE	12/15/2008	LLC	CSC	ACTIVE	Active	12/15/2008	Yes	No	621492
1124	Sahara Dialysis, LLC	DE	07/30/2012	LLC	CSC	ACTIVE	Active	07/30/2011	No	No	621492
1125	SAKDC-DaVita Dialysis Partners, L.P.	DE	05/16/2005	LP	CSC	ACTIVE	Active	05/16/2005	No	No	621492
1126	Salisbury Dialysis, LLC	DE	10/04/2007	LLC	CSC	ACTIVE	Active	10/04/2007	Yes	No	621492
1127	San Gabriel Valley Partnership	CA	06/01/1996	GP	NonCSC	N/A	Active	12/14/2005	Yes	No	621492
1128	San Marcos Dialysis, LLC	DE	07/05/2007	LLC	CSC	ACTIVE	Active	07/05/2007	No	No	621492
1129	Sandlin Dialysis, LLC	DE	02/03/2012	LLC	CSC	ACTIVE	Active	02/03/2012	No	No	621492
1130	Sands Dialysis, LLC	DE	12/22/2009	LLC	CSC	ACTIVE	Active	12/22/2009	No	No	621492
1131	Sandusky Dialysis, LLC	DE	02/16/2007	LLC	CSC	ACTIVE	Active	02/16/2007	No	No	621492
1132	Santa Fe Springs Dialysis, LLC	DE	04/16/2007	LLC	CSC	ACTIVE	Active	04/16/2007		No	621492
1133	Santee Dialysis, LLC	DE	12/04/2013	LLC	CSC	ACTIVE	Active	12/04/2013	Yes	No	621492
1134	Santiam Dialysis, LLC	DE	03/15/2012	LLC	CSC	ACTIVE	Active	03/15/2012	No	No	621492
1135	Santo Dialysis, LLC	DE	12/07/2011	LLC	CSC	ACTIVE	Active	12/07/2011	Yes	No	621492

	A	B	C	D	E	F	G	H	I	J	K
1136	Sapelo Dialysis, LLC	DE	05/17/2013	LLC	CSC	ACTIVE	Active	06/17/2013	No	No	621492
1137	Sapinero Dialysis, LLC	DE	08/05/2011	LLC	CSC	ACTIVE	Active	08/05/2011	Yes	No	621492
1138	Sappington Dialysis, LLC	DE	09/26/2017	LLC	CSC	ACTIVE	Active	09/26/2017	Yes	No	621492
1139	Saunders Dialysis, LLC	DE	01/05/2018	LLC	CSC	ACTIVE	Active	01/05/2018	Yes	No	621492
1140	Schuler Dialysis, LLC	DE	03/16/2018	LLC	CSC	ACTIVE	Active	03/16/2018	Yes	No	621492
1141	Scoggins Dialysis, LLC	DE	06/30/2015	LLC	CSC	ACTIVE	Active	06/30/2015	Yes	No	621492
1142	SE Ohio Regional Dialysis, LLC	DE	03/07/2008	LLC	CSC	ACTIVE	Active	03/07/2008	Yes	No	621492
1143	Seabay Dialysis, LLC	DE	07/19/2013	LLC	CSC	ACTIVE	Active	07/19/2013	No	No	621492
1144	Seasons Dialysis, LLC	DE	07/21/2010	LLC	CSC	ACTIVE	Active	07/21/2010	Yes	No	621492
1145	Secour Dialysis, LLC	DE	04/25/2017	LLC	CSC	ACTIVE	Active	04/25/2017	No	No	621492
1146	Seminole Dialysis, LLC	DE	11/16/2012	LLC	CSC	ACTIVE	Active	11/16/2012	Yes	No	621492
1147	Seneca Dialysis, LLC	DE	03/09/2005	LLC	CSC	ACTIVE	Active	03/09/2005	No	No	621492
1148	Sensiba Dialysis, LLC	DE	03/01/2018	LLC	CSC	ACTIVE	Active	03/01/2018	Yes	No	621492
1149	Seward Dialysis, LLC	DE	12/01/2016	LLC	CSC	ACTIVE	Active	12/01/2016	Yes	No	621492
1150	Shade Dialysis, LLC	DE	08/18/2014	LLC	CSC	ACTIVE	Active	08/18/2014	No	No	621492
1151	Shadow Dialysis, LLC	DE	07/25/2008	LLC	CSC	ACTIVE	Active	07/25/2008	Yes	No	621492
1152	Shawano Dialysis, LLC	DE	02/20/2018	LLC	CSC	ACTIVE	Active	02/20/2018	Yes	No	621492
1153	Shayano Dialysis, LLC	DE	12/03/2008	LLC	CSC	ACTIVE	Active	12/03/2008	No	No	621492
1154	Shelby Dialysis, LLC	DE	12/04/2013	LLC	CSC	ACTIVE	Active	12/04/2013	No	No	621492
1155	Shelling Dialysis, LLC	DE	09/09/2014	LLC	CSC	ACTIVE	Active	09/09/2014	No	No	621492
1156	Sherman Dialysis, LLC	DE	08/25/2009	LLC	CSC	ACTIVE	Active	07/25/2009	No	No	621492
1157	Shetek Dialysis, LLC	DE	11/12/2014	LLC	CSC	ACTIVE	Active	11/12/2014	No	No	621492
1158	Shika Dialysis, LLC	DE	06/09/2016	LLC	CSC	ACTIVE	Active	06/09/2016	No	No	621492
1159	Shining Star Dialysis, Inc.	NJ	02/22/2001	CORP	CSC	ACTIVE	Active	02/22/2001	Yes	No	621492
1160	Shoals Dialysis, LLC	DE	05/20/2013	LLC	CSC	ACTIVE	Active	05/20/2013	No	No	621492
1161	Shone Dialysis, LLC	DE	03/07/2014	LLC	CSC	ACTIVE	Active	03/07/2014	No	No	621492
1162	Shoshone Dialysis, LLC	DE	01/14/2015	LLC	CSC	ACTIVE	Active	01/14/2015	Yes	No	621492
1163	Siena Dialysis Center, LLC	DE	02/09/2006	LLC	CSC	ACTIVE	Active	02/09/2006	No	No	621492
1164	Sierra Rose Dialysis Center, LLC	DE	05/28/2002	LLC	CSC	ACTIVE	Active	05/28/2002	Yes	No	621492
1165	Silverwood Dialysis, LLC	DE	07/12/2013	LLC	CSC	ACTIVE	Active	07/12/2013	No	No	621492
1166	Simcoe Dialysis, LLC	DE	04/13/2012	LLC	CSC	ACTIVE	Active	04/13/2012	Yes	No	621492
1167	Simeon Dialysis, LLC	DE	05/11/2011	LLC	CSC	ACTIVE	Active	05/11/2011	No	No	621492
1168	Sinewa Dialysis, LLC	DE	09/10/2013	LLC	CSC	ACTIVE	Active	09/10/2013	No	No	621492
1169	Skagit Dialysis, LLC	DE	05/22/2012	LLC	CSC	ACTIVE	Active	05/22/2012	No	No	621492
1170	Sloans Dialysis, LLC	DE	02/19/2016	LLC	CSC	ACTIVE	Active	02/19/2016	Yes	No	621492
1171	Sloss Dialysis, LLC	DE	03/31/2017	LLC	CSC	ACTIVE	Active	03/31/2017	No	No	621492
1172	Smithgall Dialysis, LLC	DE	08/11/2014	LLC	CSC	ACTIVE	Active	08/11/2014	Yes	No	621492
1173	Snowdale Dialysis, LLC	DE	11/20/2012	LLC	CSC	ACTIVE	Active	11/20/2012	Yes	No	621492
1174	Soledad Dialysis Center, LLC	DE	05/28/2002	LLC	CSC	ACTIVE	Active	05/28/2002	Yes	No	621492
1175	Solidago Dialysis, LLC	DE	08/02/2016	LLC	CSC	ACTIVE	Active	08/02/2016	No	No	621492
1176	Somerville Dialysis Center, LLC	DE	07/16/2007	LLC	CSC	ACTIVE	Active	07/16/2007	No	No	621492
1177	South Central Florida Dialysis Partners, LLC	DE	04/16/2007	LLC	CSC	ACTIVE	Active	04/16/2007	No	No	621492
1178	South Florida Integrated Kidney Care, LLC	DE	07/15/2015	LLC	CSC	ACTIVE	Active	07/15/2015	Yes	Yes	621492
1179	South Fork Dialysis, LLC	DE	03/13/2012	LLC	CSC	ACTIVE	Active	03/13/2012	No	No	621492
1180	South Lincoln Dialysis, LLC	DE	05/12/2006	LLC	CSC	ACTIVE	Active	05/12/2006	Yes	No	621492
1181	South Shore Dialysis Center, L.P.	DE	02/17/2005	LP	CSC	ACTIVE	Active	02/17/2005	No	No	621492
1182	Southcrest Dialysis, LLC	DE	08/21/2002	LLC	CSC	ACTIVE	Active	08/21/2002	No	No	621492
1183	Southeast Florida Dialysis, LLC	DE	07/14/2004	LLC	CSC	ACTIVE	Active	07/14/2004	Yes	No	621492
1184	Southeast Nephrology Center, LLC	DE	05/22/2008	LLC	CSC	ACTIVE	Active	05/22/2008	Yes	No	621492
1185	Southeastern Indiana Dialysis, LLC	DE	01/18/2008	LLC	CSC	ACTIVE	Active	01/18/2008	Yes	No	621492
1186	Southern Colorado Joint Ventures, LLC	DE	11/18/2005	LLC	CSC	ACTIVE	Active	11/18/2005	No	No	621492
1187	Southern Hills Dialysis Center, LLC	DE	10/16/2003	LLC	CSC	ACTIVE	Active	10/16/2003	No	No	621492

	A	B	C	D	E	F	G	H	I	J	K
1188	Southlake Dialysis, LLC	DE	09/20/2012	LLC	CSC	ACTIVE	Active	09/20/2012	No	No	621492
1189	Southwest Atlanta Dialysis Centers, LLC	DE	10/09/2003	LLC	CSC	ACTIVE	Active	10/09/2003	Yes	No	621492
1190	Southwest Indiana Dialysis, LLC	DE	12/18/2007	LLC	CSC	ACTIVE	Active	12/18/2007	Yes	No	621492
1191	Southwest Kidney-DaVita Dialysis Partners II, LLC	DE	08/10/2011	LLC	CSC	ACTIVE	Active	08/10/2011	No	No	621492
1192	Southwest Kidney-DaVita Dialysis Partners, LLC	DE	11/13/2007	LLC	CSC	ACTIVE	Active	11/13/2007	No	Yes	621492
1193	Southwest Rocky Mountain Dialysis, LLC	DE	08/17/2011	LLC	CSC	ACTIVE	Active	08/17/2011	No	No	621492
1194	Southwestern Tennessee Dialysis, LLC	DE	09/25/2007	LLC	CSC	ACTIVE	Active	09/25/2007	Yes	No	621492
1195	Southwood Park Dialysis, LLC	DE	11/17/2015	LLC	CSC	ACTIVE	Active	11/17/2015	Yes	Yes	621492
1196	Sparda Dialysis, LLC	DE	09/05/2017	LLC	CSC	ACTIVE	Active	09/08/2017	Yes	No	621492
1197	Sparks Dialysis, LLC	DE	01/07/2010	LLC	CSC	ACTIVE	Active	01/07/2010	Yes	No	621492
1198	Spokane Dialysis, LLC	DE	05/11/1999	LLC	CSC	ACTIVE	Active	05/11/1999	Yes	No	621492
1199	Sprague Dialysis, LLC	DE	12/01/2015	LLC	CSC	ACTIVE	Active	12/01/2015	No	No	621492
1200	Sprewell Dialysis, LLC	DE	05/08/2013	LLC	CSC	ACTIVE	Active	05/08/2013	No	No	621492
1201	Springpond Dialysis, LLC	DE	03/01/2018	LLC	CSC	ACTIVE	Active	03/01/2018	Yes	No	621492
1202	Springs Dialysis, LLC	DE	07/10/2012	LLC	CSC	ACTIVE	Active	07/10/2012	No	No	621492
1203	St. Clair Dialysis, LLC	DE	11/01/2004	LLC	CSC	ACTIVE	Active	11/01/2004	Yes	No	621492
1204	St. Luke's Dialysis, LLC	DE	12/07/2006	LLC	CSC	ACTIVE	Active	12/07/2006	Yes	No	621492
1205	Star Dialysis, LLC	DE	05/14/2009	LLC	CSC	ACTIVE	Active	05/14/2009	No	No	621492
1206	Starks Dialysis, LLC	DE	08/17/2015	LLC	CSC	ACTIVE	Active	08/17/2015	Yes	No	621492
1207	Steam Dialysis, LLC	DE	10/07/2008	LLC	CSC	ACTIVE	Active	10/07/2008	Yes	No	621492
1208	Stearns Dialysis, LLC	DE	01/31/2013	LLC	CSC	ACTIVE	Active	01/31/2013	No	No	621492
1209	Steele Dialysis, LLC	DE	04/02/2013	LLC	CSC	ACTIVE	Active	04/02/2013	No	No	621492
1210	Stevenson Dialysis, LLC	DE	11/03/2010	LLC	CSC	ACTIVE	Active	11/03/2010	No	No	621492
1211	Stewart Dialysis, LLC	DE	02/18/2011	LLC	CSC	ACTIVE	Active	02/18/2011	Yes	No	621492
1212	Stiller Dialysis, LLC	DE	05/11/2016	LLC	CSC	ACTIVE	Active	05/11/2016	Yes	No	621492
1213	Stines Dialysis, LLC	DE	11/07/2012	LLC	CSC	ACTIVE	Active	11/07/2012	No	No	621492
1214	Stockton Dialysis, LLC	DE	11/12/2014	LLC	CSC	ACTIVE	Active	11/12/2014	No	No	621492
1215	Storrie Dialysis, LLC	DE	03/04/2010	LLC	CSC	ACTIVE	Active	03/04/2010	No	No	621492
1216	Strongsville Dialysis, LLC	DE	04/07/2005	LLC	CSC	ACTIVE	Active	04/07/2005	No	No	621492
1217	Strower Dialysis, LLC	DE	01/10/2018	LLC	CSC	ACTIVE	Active	01/10/2018	Yes	No	621492
1218	Sugarite Dialysis, LLC	DE	04/19/2011	LLC	CSC	ACTIVE	Active	04/19/2011	No	No	621492
1219	Sugarloaf Dialysis, LLC	DE	03/07/2006	LLC	CSC	ACTIVE	Active	03/07/2006	No	No	621492
1220	Sula Dialysis, LLC	DE	04/28/2016	LLC	CSC	ACTIVE	Active	04/28/2016	No	No	621492
1221	Summer Dialysis, LLC	DE	03/15/2010	LLC	CSC	ACTIVE	Active	03/15/2010	Yes	No	621492
1222	Summit Dialysis Center, L.P.	DE	06/23/2004	LP	CSC	ACTIVE	Active	06/23/2004	No	No	621492
1223	Sun City Dialysis Center, L.L.C.	DE	06/24/2003	LLC	CSC	ACTIVE	Active	06/24/2003	No	No	621492
1224	Sun City West Dialysis Center, LLC	DE	05/25/2007	LLC	CSC	ACTIVE	Active	05/25/2006	No	No	621492
1225	Sun Desert Dialysis, LLC	DE	08/11/2011	LLC	CSC	ACTIVE	Active	08/11/2011	No	Yes	621492
1226	Sunapee Dialysis, LLC	DE	07/24/2015	LLC	CSC	ACTIVE	Active	07/24/2015	Yes	No	621492
1227	Sunrays Dialysis, LLC	DE	07/20/2009	LLC	CSC	ACTIVE	Active	07/20/2009	Yes	No	621492
1228	Sunset Dialysis, LLC	DE	10/26/2007	LLC	CSC	ACTIVE	Active	10/26/2007	No	No	621492
1229	Swanson Dialysis, LLC	DE	01/25/2010	LLC	CSC	ACTIVE	Active	01/25/2010	Yes	No	621492
1230	Sylvania Dialysis Center, LLC	DE	09/05/2007	LLC	CSC	ACTIVE	Active	09/05/2007	Yes	No	621492
1231	Talimena Dialysis, LLC	DE	10/23/2012	LLC	CSC	ACTIVE	Active	10/23/2012	Yes	No	621492
1232	Talladega Dialysis, LLC	DE	02/19/2008	LLC	CSC	ACTIVE	Active	02/19/2008	Yes	No	621492
1233	Tandigm Health, LLC	DE	04/01/2014	LLC	NonCSC	N/A	Active	04/01/2014	No	Yes	524290
1234	Tannor Dialysis, LLC	DE	05/29/2013	LLC	CSC	ACTIVE	Active	05/29/2013	Yes	No	621492
1235	Targhee Dialysis, LLC	DE	06/29/2017	LLC	CSC	ACTIVE	Active	06/29/2017	Yes	No	621492
1236	Tarley Dialysis, LLC	DE	08/24/2015	LLC	CSC	ACTIVE	Active	08/24/2015	No	No	621492
1237	Taum Dialysis, LLC	DE	11/06/2014	LLC	CSC	ACTIVE	Active	11/06/2014	Yes	No	621492
1238	Taylor Dialysis, LLC	DE	11/14/2007	LLC	CSC	ACTIVE	Active	11/14/2007	No	No	621492
1239	Tel-Huron Dialysis, LLC	DE	06/15/2007	LLC	CSC	ACTIVE	Active	06/15/2007	Yes	No	621492

	A	B	C	D	E	F	G	H	I	J	K
1240	Tenack Dialysis, LLC	DE	12/04/2014	LLC	CSC	ACTIVE	Active	12/04/2014	Yes	No	621492
1241	Tennessee Valley Dialysis Center, LLC	DE	08/29/2006	LLC	CSC	ACTIVE	Active	08/29/2006	No	No	621492
1242	Terre Dialysis, LLC	DE	02/20/2015	LLC	CSC	ACTIVE	Active	02/20/2015	Yes	No	621492
1243	Teton Dialysis, LLC	DE	06/05/2012	LLC	CSC	ACTIVE	Active	06/05/2012	Yes	No	621492
1244	Tetona Dialysis, LLC	DE	11/10/2015	LLC	CSC	ACTIVE	Active	11/10/2015	Yes	No	621492
1245	Texas Renal Ventures, L.P.L.L.L.P.	DE	01/21/2000	LP	CSC	ACTIVE	Active	01/21/2000	Yes	No	621492
1246	Texoma Dialysis, LLC	DE	12/30/2014	LLC	CSC	ACTIVE	Active	12/30/2014	Yes	No	621492
1247	The DaVita Collection, Inc.	CA	10/18/2006	CORP	CSC	ACTIVE	Active	10/18/2006	Yes	No	
1248	The Everett Clinic, PLLC	WA	02/09/1925	CORP	CSC	ACTIVE	Active	02/09/2016	No	No	
1249	The Magan Medical Group	CA	08/06/1975	GP	NonCSC	N/A	Active	08/06/1975	No	Yes	621111
1250	The Woodlands Dialysis Center, LP	DE	07/18/2005	LP	CSC	ACTIVE	Active	07/18/2005	No	No	621492
1251	Tolowa Dialysis, LLC	DE	02/05/2009	LLC	CSC	ACTIVE	Active	02/05/2009	No	No	621492
1252	Toltec Dialysis, LLC	DE	06/13/2017	LLC	CSC	ACTIVE	Active	06/13/2017	Yes	No	621492
1253	Tonka Bay Dialysis, LLC	DE	08/22/2014	LLC	CSC	ACTIVE	Active	08/22/2014	Yes	No	621492
1254	Topanga Dialysis, LLC	DE	07/22/2008	LLC	CSC	ACTIVE	Active	07/22/2008	No	No	621492
1255	Tortugas Dialysis, LLC	DE	05/16/2008	LLC	CSC	ACTIVE	Active	05/16/2008	Yes	No	621492
1256	Total Acute Kidney Care, Inc.	FL	09/27/1988	CORP	CSC	ACTIVE	Active	09/27/1988	Yes	No	621492
1257	Total Renal Care of North Carolina, LLC	DE	09/23/1997	LLC	CSC	ACTIVE	Active	09/23/1997	No	No	621492
1258	Total Renal Care of Utah, L.L.C.	DE	09/04/1997	LLC	CSC	ACTIVE	Active	09/04/1997	Yes	No	621492
1259	Total Renal Care Texas Limited Partnership	DE	06/18/1997	LP	CSC	ACTIVE	Active	06/18/1997	Yes	No	621492
1260	Total Renal Care, Inc.	CA	05/07/1979	CORP	CSC	ACTIVE	Active	05/07/1979	No	No	621492
1261	Total Renal Care/Crystal River Dialysis, L.C.	FL	03/04/1997	LLC	CSC	ACTIVE	Active	03/04/1997	No	Yes	621492
1262	Total Renal Care/Eaton Canyon Dialysis Center Partnership	CA	06/01/1996	GP	NonCSC	N/A	Active	12/15/2005	Yes	No	621492
1263	Total Renal Care/Peralta Renal Center Partnership	CA	07/31/1996	GP	NonCSC	N/A	Active - Dissolution Pending	08/15/2016	Yes	No	621492
1264	Total Renal Care/Piedmont Dialysis Partnership	CA	07/01/1996	GP	NonCSC	N/A	Active - Dissolution Pending	08/15/2016	Yes	No	621492
1265	Total Renal Laboratories, Inc.	FL	10/25/1993	CORP	CSC	ACTIVE	Active	10/25/1993	Yes	No	
1266	Total Renal Research, Inc.	DE	04/29/1997	CORP	CSC	ACTIVE	Active	04/29/1997	Yes	No	
1267	Toulouse Dialysis, LLC	DE	05/08/2017	LLC	CSC	ACTIVE	Active	05/08/2017	No	No	621492
1268	Tovell Dialysis, LLC	DE	07/14/2017	LLC	CSC	ACTIVE	Active	07/14/2017	Yes	No	621492
1269	Townsend Dialysis, LLC	DE	07/12/2012	LLC	CSC	ACTIVE	Active	07/12/2012	No	No	621492
1270	Trailstone Dialysis, LLC	DE	03/11/2015	LLC	CSC	ACTIVE	Active	03/11/2015	Yes	No	621492
1271	Trailway Dialysis, LLC	DE	12/29/2009	LLC	CSC	ACTIVE	Active	12/29/2009	Yes	No	621492
1272	Transmountain Dialysis, L.P.	DE	08/19/2004	LP	CSC	ACTIVE	Active	08/19/2004	No	No	621492
1273	TRC - Four Corners Dialysis Clinics, L.L.C.	NM	08/05/1998	LLC	CSC	ACTIVE	Active	08/05/1998	No	Yes	621492
1274	TRC - Indiana, LLC	IN	05/06/1999	LLC	CSC	ACTIVE	Active	05/06/1999	Yes	No	621492
1275	TRC - Petersburg, LLC	DE	11/26/1997	LLC	CSC	ACTIVE	Active	11/26/1997	Yes	No	621492
1276	TRC El Paso Limited Partnership	DE	01/01/1997	LP	CSC	ACTIVE	Active	01/01/1997	No	No	621492
1277	TRC of New York, Inc.	NY	08/01/1997	CORP	CSC	ACTIVE	Active	08/01/1997	Yes	No	
1278	TRC West, Inc.	DE	07/26/1996	CORP	CSC	ACTIVE	Active	07/26/1996	Yes	No	621492
1279	TRC-Dyker Heights, L.P.	NY	12/28/2005	LP	CSC	ACTIVE	Active	06/10/2013	Yes	No	621492
1280	TRC-Georgetown Regional Dialysis, LLC	DC	06/22/1998	LLC	CSC	ACTIVE	Active	06/22/1998	No	No	621492
1281	Tree City Dialysis, LLC	DE	06/15/2007	LLC	CSC	ACTIVE	Active	06/15/2007	Yes	No	621492
1282	Trego Dialysis, LLC	DE	12/01/2016	LLC	CSC	ACTIVE	Active	12/01/2016	Yes	No	621492
1283	Tri-City Dialysis Center, Inc.	VA	07/20/1992	CORP	CSC	ACTIVE	Active	07/20/1992	Yes	No	621492
1284	Tross Dialysis, LLC	DE	04/03/2013	LLC	CSC	ACTIVE	Active	04/03/2013	No	No	621492
1285	True North DC Holding, LLC	NY	07/22/2016	LLC	CSC	ACTIVE	Active	07/22/2016	Yes	No	621492
1286	True North Dialysis Center, LLC	NY	12/10/2013	LLC	CSC	ACTIVE	Active	12/10/2013	No	No	621492
1287	True North II DC, LLC	NY	07/22/2016	LLC	CSC	ACTIVE	Active	07/22/2016	Yes	No	621492
1288	True North IV DC, LLC	NY	01/30/2017	LLC	CSC	ACTIVE	Active	01/30/2017	Yes	No	621492
1289	True North V DC, LLC	NY	01/30/2017	LLC	CSC	ACTIVE	Active	01/30/2017	No	No	621492

	A	B	C	D	E	F	G	H	I	J	K
1290	Truman Dialysis, LLC	DE	02/12/2016	LLC	CSC	ACTIVE	Active	02/12/2016	Yes	No	621492
1291	Trusten Dialysis, LLC	DE	06/13/2017	LLC	CSC	ACTIVE	Active	06/13/2017	No	No	621492
1292	Tugaloo Dialysis, LLC	DE	05/15/2013	LLC	CSC	ACTIVE	Active	05/15/2003	Yes	No	621492
1293	Tugman Dialysis, LLC	DE	04/13/2011	LLC	CSC	ACTIVE	Active	04/13/2011	No	No	621492
1294	Tulsa Dialysis, LLC	DE	01/04/2002	LLC	CSC	ACTIVE	Active	01/04/2002	No	No	621492
1295	Tumalo Dialysis, LLC	DE	03/29/2011	LLC	CSC	ACTIVE	Active	03/25/2011	No	No	621492
1296	Tunnel Dialysis, LLC	DE	11/06/2014	LLC	CSC	ACTIVE	Active	11/06/2014	No	No	621492
1297	Turlock Dialysis Center, LLC	DE	06/15/2007	LLC	CSC	ACTIVE	Active	06/15/2007	Yes	No	621492
1298	Tustin Dialysis Center, LLC	DE	05/28/2002	LLC	CSC	ACTIVE	Active	05/28/2002	No	No	621492
1299	Twain Dialysis, LLC	DE	02/05/2016	LLC	CSC	ACTIVE	Active	02/05/2016	No	No	621492
1300	Twinstar Dialysis, LLC	DE	01/21/2015	LLC	CSC	ACTIVE	Active	01/21/2015	Yes	No	621492
1301	Tyler Dialysis, LLC	DE	12/02/2011	LLC	CSC	ACTIVE	Active	12/02/2011	No	No	621492
1302	Ukiah Dialysis, LLC	DE	02/12/2013	LLC	CSC	ACTIVE	Active	11/07/2012	No	No	621492
1303	Unicoi Dialysis, LLC	DE	07/11/2013	LLC	CSC	ACTIVE	Active	07/11/2013	No	No	621492
1304	Union City Dialysis, LLC	DE	12/18/2007	LLC	CSC	ACTIVE	Active	12/18/2007	Yes	No	621492
1305	University Dialysis Center, LLC	DE	04/07/2006	LLC	CSC	ACTIVE	Active	04/07/2005	Yes	No	621492
1306	Upper Valley Dialysis, L.P.	DE	09/15/2005	LP	CSC	ACTIVE	Active	08/15/2005	No	No	621492
1307	Urbana Dialysis, LLC	DE	11/27/2007	LLC	CSC	ACTIVE	Active	11/27/2007	Yes	No	621492
1308	USC-DaVita Dialysis Center, LLC	CA	06/30/2005	LLC	CSC	ACTIVE	Active	06/30/2005	No	No	621492
1309	UT Southwestern DVA Healthcare, L.L.P.	TX	06/14/2000	LLP	NonCSC	N/A	Active	12/02/2005	No	No	621492
1310	Valley Springs Dialysis, LLC	DE	09/20/2007	LLC	CSC	ACTIVE	Active	09/20/2007	No	No	621492
1311	Vancile Dialysis, LLC	DE	11/08/2017	LLC	CSC	ACTIVE	Active	11/08/2017	Yes	No	621492
1312	Vancleer Dialysis, LLC	DE	11/01/2017	LLC	CSC	ACTIVE	Active	11/01/2017	Yes	No	621492
1313	Verde Dialysis, LLC	DE	05/16/2008	LLC	CSC	ACTIVE	Active	05/16/2008	No	No	621492
1314	Versailles Dialysis, LLC	DE	09/10/2013	LLC	CSC	ACTIVE	Active	09/10/2013	Yes	No	62149
1315	Victory Dialysis, LLC	DE	07/26/2010	LLC	CSC	ACTIVE	Active	07/26/2010	No	No	621492
1316	Viento Dialysis, LLC	DE	05/21/2010	LLC	CSC	ACTIVE	Active	05/21/2010	Yes	No	621492
1317	Vilander Dialysis, LLC	DE	11/27/2017	LLC	CSC	ACTIVE	Active	11/27/2017	Yes	No	621492
1318	VillageHealth DM, LLC	DE	08/05/2003	LLC	CSC	ACTIVE	Active	08/05/2003	Yes	No	621490
1319	Villanueva Dialysis, LLC	DE	02/26/2010	LLC	CSC	ACTIVE	Active	02/26/2010	Yes	No	621492
1320	Vogel Dialysis, LLC	DE	07/12/2013	LLC	CSC	ACTIVE	Active	07/12/2013	No	No	621492
1321	Volo Dialysis, LLC	DE	04/21/2014	LLC	CSC	ACTIVE	Active	04/21/2014	No	No	621492
1322	Vosse Dialysis, LLC	DE	04/02/2018	LLC	CSC	ACTIVE	Active	04/02/2018	Yes	No	621492
1323	Voyage Dialysis, LLC	DE	01/12/2009	LLC	CSC	ACTIVE	Active	01/12/2009	Yes	No	621492
1324	Waddell Dialysis, LLC	DE	09/11/2015	LLC	CSC	ACTIVE	Active	09/11/2015	No	No	621492
1325	Wadeson Dialysis, LLC	DE	02/12/2018	LLC	CSC	ACTIVE	Active	02/12/2018	Yes	No	621492
1326	Wakonda Dialysis, LLC	DE	04/29/2016	LLC	CSC	ACTIVE	Active	04/29/2016	No	No	621492
1327	Wakoni Dialysis, LLC	DE	11/01/2012	LLC	CSC	ACTIVE	Active	11/01/2012	Yes	No	621492
1328	Walcott Dialysis, LLC	DE	03/05/2013	LLC	CSC	ACTIVE	Active	03/05/2013	Yes	No	621492
1329	Waldorf Dialysis, LLC	DE	11/14/2007	LLC	CSC	ACTIVE	Active	11/14/2007	Yes	No	621492
1330	Walker Dialysis, LLC	DE	02/05/2010	LLC	CSC	ACTIVE	Active	02/05/2010	No	No	621492
1331	Wallips Dialysis LLC	DE	03/18/2013	LLC	CSC	ACTIVE	Active	03/18/2013	Yes	No	621492
1332	Wallis Dialysis, LLC	DE	09/24/2015	LLC	CSC	ACTIVE	Active	09/24/2015	Yes	No	621492
1333	Wallowa Dialysis, LLC	DE	04/04/2012	LLC	CSC	ACTIVE	Active	04/04/2012	No	No	621492
1334	Walton Dialysis, LLC	DE	02/15/2013	LLC	CSC	ACTIVE	Active	02/15/2013	No	No	621492
1335	Washburne Dialysis, LLC	DE	07/03/2012	LLC	CSC	ACTIVE	Active	07/03/2012	No	No	621492
1336	Washington Plaza Dialysis, LLC	CA	07/05/2013	LLC	CSC	ACTIVE	Active	07/05/2013	Yes	No	621492
1337	Watkins Dialysis, LLC	DE	06/04/2015	LLC	CSC	ACTIVE	Active	06/04/2015	Yes	No	621492
1338	Watson Dialysis, LLC	DE	08/12/2014	LLC	CSC	ACTIVE	Active	08/12/2014	No	No	621492
1339	Wauseon Dialysis, LLC	DE	01/22/2008	LLC	CSC	ACTIVE	Active	01/22/2008	Yes	No	621492
1340	Waycross Dialysis, LLC	DE	10/30/2007	LLC	CSC	ACTIVE	Active	10/30/2007	Yes	No	621492
1341	Wayside Dialysis, LLC	DE	06/25/2015	LLC	CSC	ACTIVE	Active	06/25/2015	No	No	621492

	A	B	C	D	E	F	G	H	I	J	K
1342	Weldon Dialysis, LLC	CA	12/03/2013	LLC	CSC	ACTIVE	Active	12/03/2013	No	No	621492
1343	Wesley Chapel Dialysis, LLC	DE	01/18/2008	LLC	CSC	ACTIVE	Active	01/18/2008	No	No	621492
1344	West Broomfield Dialysis, LLC	DE	09/05/2007	LLC	CSC	ACTIVE	Active	09/05/2007	Yes	No	621492
1345	West Elk Grove Dialysis, LLC	DE	08/03/2007	LLC	CSC	ACTIVE	Active	08/03/2007	No	No	621492
1346	West Monroe Dialysis, LLC	DE	05/22/2007	LLC	CSC	ACTIVE	Active	05/22/2007	Yes	No	621492
1347	West Pensacola Dialysis, LLC	DE	09/12/2007	LLC	CSC	ACTIVE	Active	09/12/2007	Yes	No	621492
1348	West Sacramento Dialysis, LLC	DE	01/24/2007	LLC	CSC	ACTIVE	Active	01/24/2007	Yes	No	621492
1349	West Texas Dialysis, LLC	DE	12/21/2006	LLC	CSC	ACTIVE	Active	12/21/2006	Yes	No	621492
1350	Western Nevada Dialysis, LLC	DE	10/15/2007	LLC	CSC	ACTIVE	Active	10/15/2007	Yes	No	621492
1351	Weston Dialysis Center, LLC	DE	09/06/2002	LLC	CSC	ACTIVE	Active	09/06/2002	No	No	621492
1352	Westview Dialysis, LLC	DE	08/01/2006	LLC	CSC	ACTIVE	Active	08/01/2006	Yes	No	621492
1353	Whitney Dialysis, LLC	DE	09/24/2010	LLC	CSC	ACTIVE	Active	09/24/2010	No	No	621492
1354	Wilder Dialysis, LLC	DE	05/06/2009	LLC	CSC	ACTIVE	Active	05/06/2009	No	No	621492
1355	Williston Dialysis, LLC	DE	12/02/2015	LLC	CSC	ACTIVE	Active	12/02/2015	No	No	621492
1356	Willowbrook Dialysis Center, L.P.	DE	04/07/2005	LP	CSC	ACTIVE	Active	04/07/2009	No	No	621492
1357	Winchester Dialysis, LLC	DE	02/13/2013	LLC	CSC	ACTIVE	Active	02/13/2013	Yes	No	621492
1358	Windcreek Dialysis, LLC	DE	02/02/2012	LLC	CSC	ACTIVE	Active	02/02/2012	No	No	621492
1359	Winds Dialysis, LLC	DE	08/25/2009	LLC	CSC	ACTIVE	Active	08/25/2009	No	No	621492
1360	Winster Dialysis, LLC	DE	08/22/2012	LLC	CSC	ACTIVE	Active	08/22/2012	Yes	No	621492
1361	Wisner Dialysis, LLC	DE	07/03/2017	LLC	CSC	ACTIVE	Active	07/03/2017	Yes	No	621492
1362	Wissota Dialysis, LLC	DE	12/06/2017	LLC	CSC	ACTIVE	Active	12/06/2017	Yes	No	621492
1363	Wood Dialysis, LLC	DE	12/18/2008	LLC	CSC	ACTIVE	Active	12/18/2008	No	No	621492
1364	Woodford Dialysis, LLC	DE	02/19/2015	LLC	CSC	ACTIVE	Active	02/19/2015	No	No	621492
1365	Wooten Dialysis, LLC	DE	08/15/2011	LLC	CSC	ACTIVE	Active	08/15/2011	No	No	621492
1366	Wyandotte Central Dialysis, LLC	DE	12/13/2006	LLC	CSC	ACTIVE	Active	12/13/2006	No	No	621492
1367	Wyler Dialysis, LLC	DE	02/05/2009	LLC	CSC	ACTIVE	Active	02/05/2009	No	No	621492
1368	Yards Dialysis, LLC	DE	04/26/2016	LLC	CSC	ACTIVE	Active	04/26/2016	No	No	621492
1369	Yargol Dialysis, LLC	DE	05/29/2013	LLC	CSC	ACTIVE	Active	05/29/2013	No	No	621492
1370	Ybor City Dialysis, LLC	DE	06/15/2007	LLC	CSC	ACTIVE	Active	06/15/2007	No	No	621492
1371	Yucaipa Dialysis, LLC	DE	06/15/2007	LLC	CSC	ACTIVE	Active	06/07/2007	No	No	621492
1372	Zara Dialysis, LLC	DE	01/11/2013	LLC	CSC	ACTIVE	Active	01/11/2013	No	No	621492
1373	Zephyrhills Dialysis Center, LLC	DE	05/16/2008	LLC	CSC	ACTIVE	Active	05/06/2008	No	No	621492
1374	Zillmar Dialysis, LLC	DE	12/12/2017	LLC	CSC	ACTIVE	Active	12/12/2017	Yes	No	621492
1375	Zomane Dialysis, LLC	DE	04/02/2018	LLC	CSC	ACTIVE	Active	04/02/2018	Yes	No	621492
1376	(Historical Record Of) Irvine Dialysis Center, LLC	DE	05/08/2002	LLC	CSC	INACTIVE	Inactive		No		
1377	(Historical Record) Arizona Integrated Physicians, Inc.	DE	11/20/2009	CORP	CSC	INACTIVE	Inactive - Merged/Inactive/Sold	06/01/2016	Yes		621111
1378	(Historical Record) Bends Dialysis, LLC	DE	03/17/2010	LLC	CSC	INACTIVE	Inactive		No		
1379	(Historical Record) DNH Medical Management, Inc.	CA	06/13/1978	CORP	CSC	INACTIVE	Inactive - Merged/Inactive/Sold	11/01/2015	Yes	No	541600
1380	(Historical Record) HCPAZ Preferred Care Network, LLC	AZ	04/18/2014	LLC	CSC	INACTIVE	Inactive - Merged/Inactive/Sold	06/01/2016	Yes	No	621111
1381	(Historical Record) Healthcare Partners Arizona Medical Group, LLC	AZ	07/29/2014	LLC	CSC	INACTIVE	Inactive - Merged/Inactive/Sold	06/01/2016	Yes	No	621111
1382	(Historical Record) HealthCare Partners Arizona, LLC	AZ	01/15/2013	LLC	CSC	INACTIVE	Inactive - Merged/Inactive/Sold	06/01/2016	Yes	No	621111
1383	(Historical Record) HomeChoice Partners, Inc.	DE	10/18/1996	CORP	CSC	INACTIVE	Inactive	10/18/1996	No	No	N/A
1384	(Historical) Clough Dialysis, LLC	DE	06/30/2015	LLC	CSC	INACTIVE	Inactive - Merged/Inactive/Sold	05/01/2017	Yes	No	621492
1385	(Historical) ISD Trenton, LLC	DE	09/12/2007	LLC	CSC	INACTIVE	Inactive - Merged/Inactive/Sold	05/01/2017	No	No	621492

	A	B	C	D	E	F	G	H	I	J	K
1386	(Historical) Mission Dialysis Services, LLC	DE	03/03/2009	LLC	CSC	INACTIVE	Inactive - Merged/Inactive/Sold	05/01/2017	Yes	No	621492
1387	Airport Artificial Kidney Center, Ltd. L.P.	CA	10/03/1994	LP	CSC	INACTIVE	Inactive - Administratively Dissolved				
1388	American Access Care of New Jersey, L.L.C.	NJ	03/14/2001	LLC	NonCSC	N/A	Inactive	12/02/2005			
1389	American Access Care of Pennsylvania, L.L.C.	NJ	07/30/2002	LLC	NonCSC	N/A	Inactive	12/02/2005			
1390	American Access Care of SP, L.L.C.	NJ	05/14/2003	LLC	NonCSC	N/A	Inactive	12/02/2005			
1391	American Outpatient Services Corporation	DE	12/16/1985	CORP	CSC	INACTIVE	Inactive				
1392	An Ren	Taiwan, Province Of China	04/30/2013	CORP	NonCSC	N/A	Inactive - Void	06/14/2017			
1393	An Shu	Taiwan, Province Of China	04/30/2013	CORP	NonCSC	N/A	Inactive - Void	06/14/2017			
1394	Anadarko Dialysis of Oklahoma, LLC	DE	03/10/2006	LLC	CSC	INACTIVE	Inactive				
1395	BONFIMED - Clinica de Diagnostico do Bonfim, Unipessoal LDA.	Portugal	03/26/2012	PRVTCOMP	NonCSC	N/A	Inactive - Merged/Inactive/Sold	08/14/2013	Yes		
1396	Bridge Of Life DaVita Medical Missions	CA	12/11/2007	CORP	CSC	INACTIVE	Inactive				
1397	Bronx RC Development, LLC	NY	05/03/2006	LLC	CSC	INACTIVE	Inactive		No		
1398	Dallas Nephrology, L.P.	TX	04/21/2005	LP	NonCSC	N/A	Inactive	06/04/2007			
1399	DaVita Care (Dubai), LLC	DE	08/13/2012	LLC	CSC	INACTIVE	Inactive - Dissolved	09/21/2016		No	
1400	DaVita Care (Korea) Limited	Korea, Republic Of	11/26/2010	LIMITEDCOMPANY	NonCSC	N/A	Inactive - Dissolved	04/06/2012	Yes		
1401	DaVita Care (Thailand) Ltd.	Thailand	12/21/2010	LIMITEDCOMPANY	NonCSC	N/A	Inactive - Dissolved	05/25/2011			
1402	DaVita Care (UK) Ltd.	United Kingdom	05/05/2011	PRIVATELIMITED	NonCSC	N/A	Inactive - Dissolved	12/30/2014	Yes		
1403	DaVita HealthCare Partners Plan, LLC	DE	02/06/2013	LLC	CSC	INACTIVE	Inactive	03/25/2013	Yes	No	
1404	DaVita Hospice Nevada, LLC	DE	08/26/2011	LLC	CSC	INACTIVE	Inactive - Dissolved	10/18/2017	Yes		621111
1405	DaVita International, LLC	DE	05/10/2012	LLC	CSC	INACTIVE	Inactive - Dissolved	06/08/2017		No	
1406	DaVita Kidney Dialysis (Subang) SDN. BHD.	Malaysia	04/14/2011	PRVTCOMP	NonCSC	N/A	Inactive - Dissolved	05/26/2011			
1407	DaVita Kidney Dialysis (TYP) Pte. Ltd.	Singapore	03/16/2011	PCLS	NonCSC	N/A	Inactive - Dissolved	06/07/2013	No	Yes	
1408	Davita Name Change, Inc.	DE	10/17/2012	CORP	CSC	INACTIVE	Inactive - Merged	11/01/2012		No	
1409	DaVita Nephrology Medical Associates of California, Inc.	CA	04/23/2002	CORP	CSC	INACTIVE	Inactive		No	No	
1410	DaVita Nephrology Medical Associates of Illinois, P.C.	IL	10/18/2002	CORP	CSC	INACTIVE	Inactive		No	No	
1411	DaVita Nephrology Medical Associates of Pennsylvania, P.C.	PA	08/31/2006	PC	CSC	INACTIVE			No	No	
1412	DaVita Nephrology Medical Associates of Washington, P.C.	WA	02/23/2004	PC	CSC	INACTIVE	Inactive - Dissolved	12/03/2014	No	No	621492
1413	DaVita Nephrology Partners- Midwest, Co.	OH	08/29/2006	PC	CSC	INACTIVE			No	No	
1414	DaVita Patient Safety Organization, LLC	DE	08/21/2014	LLC	CSC	INACTIVE	Inactive - Dissolved	07/13/2015	Yes	No	
1415	DaVita VillageHealth Insurance Of Alabama, Inc.	AL	02/05/2007	CORP	CSC	INACTIVE	Inactive - Dissolved	03/26/2014	Yes	No	
1416	DaVita VillageHealth of Georgia, Inc.	GA	06/15/2007	CORP	CSC	INACTIVE	Inactive - Dissolved	05/02/2012	Yes	No	
1417	DaVita VillageHealth of Michigan, Inc.	MI	12/18/2006	CORP	CSC	INACTIVE	Inactive - Dissolved	06/04/2009			
1418	DaVita VillageHealth of Ohio, Inc.	OH	05/01/2007	CORP	CSC	INACTIVE	Inactive - Dissolved	03/01/2017	Yes	No	
1419	DaVita VillageHealth of Virginia, Inc.	VA	12/19/2006	CORP	CSC	INACTIVE	Inactive - Dissolved	10/04/2011	Yes	No	
1420	Dializa Grojec Sp. z.o.o.	Poland	06/21/2011	LLC	NonCSC	N/A	Inactive - Merged	02/28/2014	Yes		
1421	Dialysis Holdings Laboratory Services, Inc.	NV	02/09/1996	CORP	CSC	INACTIVE	Inactive - Merged	12/05/2002			
1422	Dialysis Treatment Centers of Macon, LLC	GA	08/15/1997	LLC	CSC	INACTIVE				No	
1423	DVA Acquisition Company	DE	01/27/2011	CORP	CSC	INACTIVE			Yes	No	
1424	DVA Dialysis Services SDN. BHD.	Malaysia	04/14/2011	PRVTCOMP	NonCSC	N/A	Inactive - Dissolved	09/16/2014			

	A	B	C	D	E	F	G	H	I	J	K
1425	DVA Healthcare Nephrology Partners, Inc.	NV	11/25/1996	CORP	CSC	INACTIVE				No	
1426	DVA Nephrology Partners, Inc.	TN	01/24/1996	CORP	CSC	INACTIVE					
1427	DVA Nephrology Services, Inc.	DE	11/23/1993	CORP	CSC	INACTIVE					
1428	DVA RENAL (MALAYSIA) SDN. BHD.	Malaysia	12/15/2010	PRVTCOMP	NonCSC	N/A	Inactive - Dissolved	05/26/2013			
1429	DVA Supply Corp.	TN	10/07/1986	CORP	CSC	INACTIVE	Inactive		No		
1430	East Orange Artificial Kidney Center, Ltd	NJ	07/13/1994	CORP	CSC	INACTIVE					
1431	Elitemed sp. z o.o.	Poland	03/18/2011	SPZOO	NonCSC	N/A	Inactive - Merged	02/28/2014	Yes		
1432	Everett Clinic Merger Sub, PLLC	WA	02/26/2016	CORP	CSC	INACTIVE					
1433	Everett Management Acquisition, Inc.	WA	11/20/2015	HC	NonCSC	N/A	Inactive - Merged	03/01/2016	Yes	No	621492
1434	Express Clinics Private Limited	India	08/03/2011	LBS	NonCSC	N/A	Inactive - Merged/Inactive/Sold	11/24/2017	No	Yes	
1435	FullWell, LLC	DE	06/19/2015	LLC	NonCSC	N/A	Inactive - Merged/Inactive/Sold	12/31/2016	No	Yes	
1436	Gambro Healthcare - Ohio Valley Holdings, LLC	TN	03/18/1997	LLC	CSC	INACTIVE					
1437	Gambro Healthcare - Stamford, LLC	TN	06/23/1997	LLC	CSC	INACTIVE					
1438	Gambro Healthcare Acute Care Services Of South Florida, Inc	FL	03/10/1994	CORP	CSC	INACTIVE					
1439	Gambro Healthcare Ads Of Santa Monica, Inc.	CA	04/15/1996	CORP	CSC	INACTIVE					
1440	Gambro Healthcare Airport Dialysis Center, Inc	CA	07/08/1992	CORP	CSC	INACTIVE					
1441	Gambro Healthcare Dialysis Clinic Of Fayette County, LLC	TN	03/02/1998	LLC	CSC	INACTIVE					
1442	Gambro Healthcare Dialysis Clinic Of Fayette County, LLC	GA	12/28/1999	CORP	CSC	INACTIVE					
1443	Gambro Healthcare Nephrology Partners, Inc	GA	12/28/1999	CORP	CSC	INACTIVE					
1444	Gambro Healthcare Of Alabama, Inc.	DE	04/03/1992	CORP	CSC	INACTIVE					
1445	Gambro Healthcare Of Arizona Inc.	DE	04/03/1992	CORP	CSC	INACTIVE					
1446	Gambro Healthcare Of Benicia, LLC	CA	02/27/1998	LLC	CSC	INACTIVE					
1447	Gambro Healthcare Of California, Inc.	CA	04/23/1993	CORP	CSC	INACTIVE					
1448	Gambro Healthcare Of Central Florida, LLP	FL	12/30/1997	LLC	CSC	INACTIVE					
1449	Gambro Healthcare Of Colorado, Inc.	CO	04/25/1995	CORP	CSC	INACTIVE					
1450	Gambro Healthcare Of Connecticut, Inc.	CT	04/26/1993	CORP	CSC	INACTIVE					
1451	Gambro Healthcare Of East Olympic Boulevard, Inc	CA	10/20/1994	CORP	CSC	INACTIVE					
1452	Gambro Healthcare Of East Orange, Inc	NJ	06/07/1993	CORP	CSC	INACTIVE					
1453	Gambro Healthcare Of East Orlando, LLP	FL	07/21/1998	LLC	CSC	INACTIVE					
1454	Gambro Healthcare Of Eastern Ohio, LLC	TN	05/21/1998	LLC	CSC	INACTIVE					
1455	Gambro Healthcare Of Florida, Inc	FL	03/18/1988	CORP	CSC	INACTIVE					
1456	Gambro Healthcare Of Frederick, LLC	TN	06/24/1998	LLC	CSC	INACTIVE					
1457	Gambro Healthcare Of Freehold Inc	NJ	06/07/1993	CORP	CSC	INACTIVE					
1458	Gambro Healthcare Of Garden Grove, Inc	CA	05/10/1982	CORP	CSC	INACTIVE					
1459	Gambro Healthcare Of Garden Grove, Inc	CA	05/10/1982	CORP	CSC	INACTIVE					
1460	Gambro Healthcare Of Illinois Inc	IL	10/31/1997	CORP	CSC	INACTIVE					
1461	Gambro Healthcare Of Kentucky Inc	DE	07/19/1990	CORP	CSC	INACTIVE					
1462	Gambro Healthcare Of Las Vegas, LLC	TN	06/24/1998	LLC	CSC	INACTIVE					
1463	Gambro Healthcare Of Laurens County, Inc.	GA	12/10/1985	CORP	CSC	INACTIVE					
1464	Gambro Healthcare Of Michigan Inc	MI	05/05/1998	CORP	CSC	INACTIVE					
1465	Gambro Healthcare Of Mid-Ohio, LLC	TN	07/22/1998	LLC	CSC	INACTIVE					
1466	Gambro Healthcare Of Missouri Inc	DE	04/11/1990	CORP	CSC	INACTIVE					
1467	Gambro Healthcare Of Neptune Inc	NJ	06/07/1993	CORP	CSC	INACTIVE					
1468	Gambro Healthcare Of Nevada, Inc	NV	05/04/1998	CORP	CSC	INACTIVE					
1469	Gambro Healthcare Of New Jersey, Inc	NJ	04/22/1993	CORP	CSC	INACTIVE					
1470	Gambro Healthcare Of North Carolina, Inc.	NC	07/30/1987	CORP	CSC	INACTIVE					
1471	Gambro Healthcare Of Ohio, Inc	OH	01/28/1998	CORP	CSC	INACTIVE					
1472	Gambro Healthcare Of Oklahoma, Inc	DE	12/14/1989	CORP	CSC	INACTIVE					
1473	Gambro Healthcare Of Peachtree, Inc.	CO		CORP	CSC	INACTIVE					
1474	Gambro Healthcare Of Plantation, Inc	FL	08/26/1976	CORP	CSC	INACTIVE					

	A	B	C	D	E	F	G	H	I	J	K
1475	Gambro Healthcare Of Rhode Island, Inc	DE	09/22/1992	CORP	CSC	INACTIVE					
1476	Gambro Healthcare Of Santa Monica, LLC	TN	04/11/1996	LLC	CSC	INACTIVE					
1477	Gambro Healthcare Of Southwest Orlando, LLP	FL	11/02/1998	LLC	CSC	INACTIVE					
1478	Gambro Healthcare Of Temple Terrace LLP	FL	11/15/1999	LLC	CSC	INACTIVE					
1479	Gambro Healthcare Of Tennessee Inc	TN	01/07/1986	CORP	CSC	INACTIVE					
1480	Gambro Healthcare Of Texas, Inc	TX	07/11/1989	CORP	CSC	INACTIVE					
1481	Gambro Healthcare Of The District, Inc.	DC	02/10/1995	CORP	CSC	INACTIVE					
1482	Gambro Healthcare Of Union City, Inc.	NJ	06/07/1993	CORP	CSC	INACTIVE					
1483	Gambro Healthcare Of Virginia, Inc.	DE	06/07/1990	CORP	CSC	INACTIVE					
1484	Gambro Healthcare Of Washington Pennsylvania, L.L.C.	TN	02/05/1999	LLC	CSC	INACTIVE					
1485	Gambro Healthcare Of Westminster, Inc.	CA	01/11/1995	CORP	CSC	INACTIVE					
1486	Gambro Healthcare Of Wisconsin, Inc	DE	12/05/1994	CORP	CSC	INACTIVE					
1487	Gambro Healthcare, Inc.	CO	12/14/1995	CORP	CSC	INACTIVE					
1488	Garey Dialysis Center Partnership	CA	05/01/1986	GP	NonCSC	N/A	Inactive	12/07/2005			
1489	Guam Renal Care Partnership	Guam	01/01/1996	GP	NonCSC	N/A	Inactive	12/07/2005	Yes		
1490	HCP Blocker Corporation	DE	02/25/2005	CORP	CSC	INACTIVE	Inactive	10/31/2012			
1491	HCP Florida Holdings LLC	DE	05/07/2007	LLC	CSC	INACTIVE			Yes	No	
1492	HCPAZ Merger Sub, Inc.	DE	06/26/2013	CORP	CSC	INACTIVE					
1493	Healthcare Partners PacifiCA Medical Group, LLC	DE	10/14/2015	LLC	CSC	INACTIVE	Inactive - Dissolved	09/22/2016	Yes	Yes	621111
1494	Hemacare Dialysis Center Limited Partnership No. 1	MI	06/22/1994	LP	CSC	INACTIVE					
1495	Hemacare Dialysis Center Limited Partnership No. 2	MI	06/22/1994	LP	CSC	INACTIVE					
1496	Hong Ren	Taiwan, Province Of China	04/30/2013	CORP	NonCSC	N/A	Inactive - Void	06/14/2017			
1497	Kidney Care Rx, Inc.	DE	05/28/1992	CORP	CSC	INACTIVE			Yes	No	
1498	La Grange Dialysis, LLC	DE	01/18/2006	LLC	CSC	INACTIVE			No		
1499	Lietor Sp. Z.o.o.	Poland	10/17/2011	LLC	NonCSC	N/A	Inactive - Merged	02/28/2014			
1500	Lifeline Vascular Birmingham, Inc.	DE	03/15/2011	CORP	CSC	INACTIVE	Inactive - Dissolved	04/12/2013	Yes	No	
1501	Louisville Dialysis Centers, LLC	DE	11/17/2004	LLC	CSC	INACTIVE			No		
1502	Manzanita At Home, LLC	DE	12/12/2007	LLC	CSC	INACTIVE					
1503	Mesa Dialysis, LLC	DE	07/22/2008	LLC	CSC	INACTIVE			Yes	No	
1504	Middle Tennessee Dialysis Centers, LLC	TN	09/02/1997	LLC	CSC	INACTIVE					
1505	Munera Sp. Z.o.o.	Poland	10/17/2011	LLC	NonCSC	N/A	Inactive - Merged	02/28/2014	Yes		
1506	Nephrology Medical Associates of California, Inc.	CA	10/28/1998	CORP	CSC	INACTIVE			No	No	
1507	New Orleans East Dialysis Center, LLC	DE	07/07/2005	LLC	CSC	INACTIVE			Yes		
1508	Northridge Medical Services Group, Incorporated	CA	11/13/2006	CORP	CSC	INACTIVE	Inactive - Dissolved	11/09/2006	No	Yes	621111
1509	NTKC Management, L.L.C.	TX	07/18/2007	LLC	NonCSC	N/A	Inactive - Merged/Inactive/Sold	01/14/2010	No	No	
1510	Oklahoma City Dialysis Services, LLC	DE	05/12/2006	LLC	CSC	INACTIVE					
1511	Pacific Dialysis Partnership	Guam	01/31/1996	GP	NonCSC	N/A	Inactive - Withdrawn	02/05/2018	Yes	No	621492
1512	PDI Supply, Inc.	DE	07/02/2001	CORP	CSC	INACTIVE					
1513	Physicians Dialysis, Inc.	DE	10/27/2000	CORP	CSC	ACTIVE	Inactive - Merged	02/01/2015	Yes	No	621492
1514	Renal Care of Seat Pleasant, LLC	MD	07/25/2003	LLC	NonCSC	N/A	Inactive - Managed Entity Only - Not Owned	07/25/2003			
1515	Resource Advisors Corporation	NV	11/27/2007	CORP	CSC	INACTIVE	Inactive	01/31/2013	Yes	No	
1516	RTC ACQ Co.	DE	12/30/2014	CORP	CSC	INACTIVE	Inactive - Administratively Dissolved	02/03/2015	Yes	No	
1517	Seismic Acquisition LLC	CA	05/02/2012	LLC	CSC	INACTIVE					
1518	Sentinel Assurance Risk Retention Group, Inc.	HI	03/10/2004	CORP	NonCSC	N/A	Inactive - Dissolved	03/10/2004			
1519	Sumner Regional Dialysis Center LLC	DE	04/15/1998	LLC	CSC	INACTIVE					

	A	B	C	D	E	F	G	H	I	J	K
1520	Talbert Health Plan	CA	12/15/2006	CORP	CSC	INACTIVE	Inactive - Dissolved	11/09/2017	No	No	524140
1521	Tandigm Care Solutions, LLC	PA	04/19/2016	PLLC	CSC	INACTIVE	Inactive - Merged/Inactive/Sold	04/19/2016	No	Yes	TBD
1522	TCMC Dialysis Center, LLC	DE	11/13/1997	LLC	CSC	INACTIVE					
1523	THP Services, Inc.	CA	12/15/2006	CORP	CSC	INACTIVE	Inactive - Dissolved	11/13/2017	No	Yes	561490
1524	Total Nephrology Care Network Medical Associates, a Prof. Corp.	CA	09/18/1995	PC	NonCSC	N/A	Inactive	02/17/2009	No		
1525	Total Nephrology Care Network Medical Associates, P.C.	IL	09/25/1997	PC	CSC	INACTIVE	Inactive			No	
1526	Total Renal Care of Colorado, Inc.	CO	03/31/1971	CORP	CSC	INACTIVE			No		
1527	Total Renal Support Services of North Carolina, LLC	DE	02/04/1998	LLC	CSC	INACTIVE			No	No	
1528	Total Renal Support Services, Inc.	DE	04/26/2007	CORP	CSC	INACTIVE					
1529	TRC Spin Healthcare, LLC	DE	06/02/2011	LLC	CSC	INACTIVE	Inactive				
1530	VRC Of Merced, LLC	CA	05/01/1996	LLC	CSC	INACTIVE					
1531	Westminster Artificial Kidney Center, A California Limited Partnership	CA	01/18/1995	LP	CSC	INACTIVE					
1532	Westside Dialysis, LLC	CA	02/20/1998	LLC	CSC	INACTIVE					
1533	Xiang You	Taiwan, Province Of China	04/30/2013	CORP	NonCSC	N/A	Inactive - Void	06/14/2017			

Facility Name (Common)	Street1	Street2	City	State	Zip	Phone	Fax	Services Provided	Num of Certified Stations	Medicare Cert Number	Active (Y/N)
PHENIX CITY DIALYSIS CENTER	4391 RIVERCHASE DR		PHENIX CITY	AL	36867-7519	3342980294	3342983538	In-Center Hemo, In-Center Hemo Self Care, PD Services	21	01-2523	Y
PDI-MONTGOMERY	1001 FOREST AVE		MONTGOMERY	AL	36106-1181	3342699416	3342690024	In-Center Hemo, In-Center Hemo Self Care, PD Services	19	01-2505	Y
PDI-EAST MONTGOMERY	6890 WINTON BLOUNT BLVD		MONTGOMERY	AL	36117-3516	3342600671	3342609496	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care	13	01-2557	Y
PDI-PRATTVILLE	1815 GLYNWOOD DR		PRATTVILLE	AL	36066-5584	3343610010	3343610035	In-Center Hemo, In-Center Hemo Self Care	16	01-2535	Y
PDI-ELMORE COUNTY	125 HOSPITAL DR		WETUMPKA	AL	36092-1626	3345142037	3345149568	In-Center Hemo, In-Center Hemo Self Care	10	01-2553	Y
ATMORE DIALYSIS CENTER	807 E CRAIG ST		ATMORE	AL	36502-3017	2513685593	2514461950	In-Center Hemo,	10	01-2600	Y
SOUTH BALDWIN DIALYSIS CENTER	150 W PEACHTREE AVE		FOLEY	AL	36535-2244	2519434155	2519701005	In-Center Hemo,	13	01-2565	Y
TALLADEGA DIALYSIS	726 BATTLE ST E	STE A	TALLADEGA	AL	35160-2583	2563622332	2563622356	In-Center Hemo, In-Center Hemo Self Care, PD Services	13	01-2622	Y
CENTER POINT DIALYSIS	2337 1ST ST NE		CENTER POINT	AL	35215-3619	2055201108	2058530933	In-Center Hemo, In-Center Hemo Self Care	16	01-2623	Y
OPELIKA DIALYSIS CENTER	2340 PEPPERELL PKWY		OPELIKA	AL	36801-6240	3347456883	3347452177	In-Center Hemo, In-Center Hemo Self Care, PD Services	10	01-2628	Y
HOME DIALYSIS OPTIONS OF BALDWIN COUNTY PD	27880 N MAIN ST	STE A	DAPHNE	AL	36526-7080	2516261086	2516264056	PD Services,	4	01-2627	Y
RAINBOW CITY DIALYSIS	2800 RAINBOW DR		RAINBOW CITY	AL	35906-5811	2564133245	2564133289	In-Center Hemo, In-Center Hemo Self Care, PD Services	16	01-2542	Y
GADSDEN DIALYSIS	409 S 1ST ST		GADSDEN	AL	35901-5358	2565472511	2565478521	In-Center Hemo, In-Center Hemo Self Care, Acute Hemo 1:1	24	01-2501	Y
DOTHAN DIALYSIS	216 GRACELAND DR		DOTHAN	AL	36305-7346	3347934077	3347932404	In-Center Hemo, In-Center Hemo Self Care, PD Services,	27	01-2506	Y
BIRMINGHAM EAST DIALYSIS	1105 E PARK DR		BIRMINGHAM	AL	35235-2560	2058336003	2058365157	In-Center Hemo, In-Center Hemo Self Care	20	01-2508	Y
TUSCALOOSA DIALYSIS	805 OLD MILL ST		TUSCALOOSA	AL	35401-7132	2057526363	2057526566	In-Center Hemo, In-Center Hemo Self Care	19	01-2545	Y
DEMOPOLIS DIALYSIS	511 S CEDAR AVE		DEMOPOLIS	AL	36732-2235	3342899700	3342897038	In-Center Hemo, In-Center Hemo Self Care, PD Services	15	01-2543	Y
SHEFFIELD DIALYSIS	1120 S JACKSON HWY	ST 107	SHEFFIELD	AL	35660-5777	2563818004	2563818199	In-Center Hemo, In-Center Hemo Self Care, PD Services	12	01-2551	Y
OZARK DIALYSIS	195 BUNTING DR		OZARK	AL	36360-1101	3347741410	3347742690	In-Center Hemo,	13	01-2544	Y
FLORENCE DIALYSIS	422 E DR HICKS BLVD	STE B	FLORENCE	AL	35630-5763	2567645050	2567673728	In-Center Hemo, In-Center Hemo Self Care, PD Services	18	01-2529	Y
GREENE COUNTY DIALYSIS	544 US HIGHWAY 43		EUTAW	AL	35462-4017	2053724000	2053724055	In-Center Hemo, In-Center Hemo Self Care	12	01-2550	Y
FAYETTE DIALYSIS	2450 TEMPLE AVE N		FAYETTE	AL	35555-1160	2059328500	2059328332	In-Center Hemo, In-Center Hemo Self Care	10	01-2548	Y
TUSCALOOSA UNIVERSITY DIALYSIS	220 15TH ST		TUSCALOOSA	AL	35401-3523	2053456004	2053455071	In-Center Hemo, In-Center Hemo Self Care, PD Services	24	01-2502	Y
BOAZ DIALYSIS	16 CENTRAL HENDERSON RD		BOAZ	AL	35957-5922	2568405931	2568401951	In-Center Hemo, In-Center Hemo Self Care	12	01-2594	Y
BIRMINGHAM CENTRAL DIALYSIS	728 RICHARD ARRINGTON JR BLVD S		BIRMINGHAM	AL	35233-2106	2052506760	2052979190	In-Center Hemo, In-Center Hemo Self Care, PD Services	32	01-2592	Y
BIRMINGHAM NORTH DIALYSIS	1917 32ND AVE N		BIRMINGHAM	AL	35207-3333	2052979052	2052979058	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care	24	01-2589	Y
BESSEMER DIALYSIS	901 W LAKE MALL		BESSEMER	AL	35020-5393	2054241848	2054243408	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care	16	01-2583	Y
ENSLEY DIALYSIS	2630 AVENUE E		BIRMINGHAM	AL	35218-2163	2057861371	2057865175	In-Center Hemo, In-Center Hemo Self Care	24	01-2585	Y
SYLACAUGA DIALYSIS	331 JAMES PAYTON BLVD		SYLACAUGA	AL	35150-8064	2562494994	2562492786	In-Center Hemo, In-Center Hemo Self Care, Acute Hemo 1:1, PD Services	18	01-2588	Y
RUSSELLVILLE DIALYSIS	14897 HIGHWAY 43		RUSSELLVILLE	AL	35653-1954	2563327044	2563328959	In-Center Hemo, In-Center Hemo Self Care	10	01-2602	Y
EUFAULA DIALYSIS	220 S ORANGE AVE		EUFAULA	AL	36027-1612	3346880806	3346889893	In-Center Hemo,	12	01-2609	Y
NORTHPORT DIALYSIS	2401 HOSPITAL DR		NORTHPORT	AL	35476-3392	2053398882	2053398807	In-Center Hemo, In-Center Hemo Self Care	14	01-2570	Y
PICKENS COUNTY DIALYSIS	289 WILLIAM E HILL DR	STE A	CARROLLTON	AL	35447-3247	2053671194	2053671248	In-Center Hemo	14	01-2640	Y
ATHENS DIALYSIS	15953 ATHENS LIMESTONE DR		ATHENS	AL	35613-2214	2562334730	2562334755	In-Center Hemo, In-Center Hemo Self Care	20	01-2517	Y
MAGIC CITY DIALYSIS PD	300 22ND ST S		BIRMINGHAM	AL	35233-2209	2059860592	2053216682	PD Services		01-2645	N
WIREGRASS KIDNEY CENTER	1450 ROSS CLARK CIR	STE 200	DOTHAN	AL	36301-4770	3347928907	3347928912	In-Center Hemo,	20	01-2630	Y
RENAISSANCE DIALYSIS	1840 DARBY DR		FLORENCE	AL	35630-2623	2567642313	2567642793	In-Center Hemo, In-Center Hemo Self Care, PD Services	10	01-2629	Y
MUSCLE SHOALS DIALYSIS	712 STATE ST		MUSCLE SHOALS	AL	35661-2940	2563867028	2563867074	In-Center Hemo	10	01-2632	Y
GULF SHORES DIALYSIS CENTER	3947 GULF SHORES PKWY	UNIT 150	GULF SHORES	AL	36542-2859	2519672205	2519672210	In-Center Hemo, PD Services,	9	01-2631	Y
ENTERPRISE DIALYSIS	6002 BOLL WEEVIL CIR		ENTERPRISE	AL	36330-9420	3343080262	3343081373	In-Center Hemo, PD Services,	16	01-2642	Y
LIMESTONE COUNTY DIALYSIS	16236 LUCAS FERRY RD		ATHENS	AL	35611-3931	2562333965	2562333184	In-Center Hemo, PD Services	10	01-2650	Y
JEWEL DIALYSIS	514 W TOWN PLZ		BESSEMER	AL	35020-5346	2054814386	2054811612	In-Center Hemo	10	01-2644	Y
CROWN DIALYSIS	3007 27TH ST N		BIRMINGHAM	AL	35207-4549	2052970143	2052442769	In-Center Hemo	14	01-2647	Y
MAGIC CITY DIALYSIS	300 22ND ST SO		BIRMINGHAM	AL	35233-2209	2059860592	2053216682	In-Center Hemo, Nocturnal Hemo	18	01-2645	Y
STEEL CITY DIALYSIS	1809 AVE H		BIRMINGHAM	AL	35218-1542	2057852972	2057863317	In-Center Hemo	10	01-2646	Y
LEEDS DIALYSIS	1650 MAXEY DR		LEEDS	AL	35094-7512	2056995383	2056999676	In-Center Hemo	10	01-2652	Y
ANDALUSIA DIALYSIS	757 S THREE NOTCH ST		ANDALUSIA	AL	36420-4403	3342221628	3342222658	In-Center Hemo, Home Hemo, PD Services	10	01-2655	Y
SPRINGVILLE DIALYSIS	40 PURPLE HEART BLVD		SPRINGVILLE	AL	35146-4008	2054676811	2054677018	In-Center Hemo	10	01-2658	Y
ANNISTON DIALYSIS	1612 NOBLE ST		ANNISTON	AL	36201-3839	2562373794	2562386855	In-Center Hemo	10	01-2666	Y
PERRY COUNTY DIALYSIS	611 E LAFAYETTE ST		MARION	AL	36756-2325	3346838519	3346834777	In-Center Hemo	10	01-2663	Y
DAVITA HOKES BLUFF DIALYSIS	300 MEDICAL CENTER DR	STE 100	GADSDEN	AL	35903-1139	2564924970	2564925543	In-Center Hemo	9	01-2661	Y
HENRY COUNTY DIALYSIS	671 OZARK RD		ABBEVILLE	AL	36310-2629	3345850131	3345850843	In-Center Hemo	10	01-2668	Y
MONARCH DIALYSIS	2958 DORCHESTER DR		MONTGOMERY	AL	36116-3193	3342804980	3342801809	In-Center Hemo	22	01-2669	Y

HOME OPTIONS OF DOTHAN (PD)	1763 E MAIN ST		DOTHAN	AL	36301-3045	3346730246	3346730328	PD Services	3	01-2673	Y
BREWTON DIALYSIS	1023 DOUGLAS AVE	STE 300	BREWTON	AL	36426-1586	2518678509	2518677325	In-Center Hemo, PD Services	10	01-2665	Y
LIMESTONE COUNTY AT HOME	16236 LUCAS FERRY RD		ATHENS	AL	35611-3931	2562333965	2562333184	Home Hemo		01-2650	Y
TALLADEGA AT HOME	726 BATTLE ST E	STE A	TALLADEGA	AL	35160-2583	2563622332	2563622356	Home Hemo		01-2622	Y
MAGIC CITY AT HOME	300 22ND ST SO		BIRMINGHAM	AL	35233-2209	2059860592	2053216682	Home Hemo		01-2645	Y
RENAISSANCE AT HOME	1840 DARBY DR		FLORENCE	AL	35630-2623	2567642313	2567642793	Home Hemo		01-2629	Y
GULF SHORES AT HOME	3947 GULF SHORES PKWY	UNIT 150	GULF SHORES	AL	36542-2735	2519672205	2519672210	Home Hemo		01-2631	Y
OPELIKA AT HOME	2340 PEPPERELL PKWY	PEPPERELL CORNERS SHOPPING CENTER	OPELIKA	AL	36801-6240	3347456883	3347452177	Home Hemo		01-2628	Y
PDI-MONTGOMERY AT HOME	1001 FOREST AVE		MONTGOMERY	AL	36106-1181	3342699416	3342690024	Home Hemo		01-2505	Y
SOUTH BALDWIN AT HOME	150 W PEACHTREE AVE		FOLEY	AL	36535-2244	2519672205	2519701005	Home Hemo		01-2565	N
HOME DIALYSIS OPTIONS OF BALDWIN COUNTY AT HOME	27880 N MAIN ST	STE A	DAPHNE	AL	36526-7080	2516261086	2516264056	Home Hemo	0	01-2627	Y
TUSCALOOSA AT HOME	805 OLD MILL ST		TUSCALOOSA	AL	35401-7132	2057526363	2057526566	Home Hemo		01-2545	N
RAINBOW CITY AT HOME	2800 RAINBOW DR		RAINBOW CITY	AL	35906-5811	2564133245	2564133289	Home Hemo		01-2542	Y
ATHENS AT HOME	15953 ATHENS LIMESTONE DR	STE 15	ATHENS	AL	35613-2214	2562334730	2562334755	Home Hemo		01-2517	Y
SYLACAUGA AT HOME	331 JAMES PAYTON BLVD		SYLACAUGA	AL	35150-8064	2562494994	2562492786	Home Hemo		01-2588	Y
DOTHAN AT HOME	216 GRACELAND DR		DOTHAN	AL	36305-7346	3346730246	3347932404	Home Hemo	0	01-2506	Y
RED MOUNTAIN HT AT HOME	300B 22ND ST S		BIRMINGHAM	AL	35233-2209	2052506757	2054580146	Home Hemo	0	01-2670	Y
WALKER COUNTY DIALYSIS	260 6TH AVE NW		JASPER	AL	35504-7419	2053846919	2052216415	In-Center Hemo, PD Services	13	01-2533	Y
HOME OPTIONS OF DOTHAN AT HOME	1763 EAST MAIN ST		DOTHAN	AL	36301-3045	3346730246	3346730328	Home Hemo	0	01-2673	Y
MODEL CITY HT AT HOME	1724 LEIGHTON AVE		ANNISTON	AL	36207-3833	2562365864	2567411782	Home Hemo	1	01-2685	Y
WALKER COUNTY AT HOME	260 6TH AVE NW		JASPER	AL	35504-7419	2053846919	2052216415	Home Hemo			Y
ADOC-ST CLAIR	1000 SAINT CLAIR RD		SPRINGVILLE	AL	35146-5582	2054679024	2056999676	In-Center Hemo			Y
GREYSTONE DIALYSIS	5406 HIGHWAY 280	STE D107	BIRMINGHAM	AL	35242-6592	2059812045	2054085116	In-Center Hemo	10	01-2676	Y
BARBOUR COUNTY DIALYSIS	1218 S EUFAULA AVE		EUFAULA	AL	36027-2713	3346877583	3346875389	In-Center Hemo	8	01-2697	Y
RED MOUNTAIN HOME TRAINING (PD-HHD)	300B 22ND STREET S		BIRMINGHAM	AL	35233-2209	2052506757	2054580146	PD Services	10	01-2670	Y
WHITE BLUFF DIALYSIS	505 US HIGHWAY 80 W	STE F	DEMOPOLIS	AL	36732-4147	3342871254	3342871166	In-Center Hemo	10	01-2679	Y
MODEL CITY HOME TRAINING (PD)	1724 LEIGHTON AVE		ANNISTON	AL	36207-3833	2562365864	2567411782	PD Services	3	01-2685	Y
COLONEL DIALYSIS	1830 LEE AVE SW	STE B-D	CULLMAN	AL	35055-5268	2567369276	2567378966	In-Center Hemo	10	01-2694	Y
SPRINGS DIALYSIS	218 MAIN ST	STE 114 & 118	TRUSSVILLE	AL	35173-1470	2056550871	2056551964	In-Center Hemo, PD Services	16	01-2693	Y
JACKSONVILLE CENTRAL DIALYSIS CENTER	400 T P WHITE DR		JACKSONVILLE	AR	72076-3287	5012411300	5019851344	In-Center Hemo, In-Center Hemo Self Care, PD Services	12	04-2553	Y
NORTH LITTLE ROCK DIALYSIS CENTER	4505 E MCCAIN BLVD		NORTH LITTLE ROCK	AR	72117-2902	5019452323	5019551162	In-Center Hemo, In-Center Hemo Self Care	12	04-2548	Y
FAYETTEVILLE DIALYSIS	509 E MILLSAP RD	STE 111	FAYETTEVILLE	AR	72703-4862	4794436688	4795279917	In-Center Hemo, In-Center Hemo Self Care, PD Services	9	04-2539	Y
BENTONVILLE DIALYSIS	1104 SE 30TH ST		BENTONVILLE	AR	72712-4290	4796576220	4796576229	In-Center Hemo, In-Center Hemo Self Care, PD Services	21	04-2540	Y
SILOAM SPRINGS DIALYSIS	500 S MOUNT OLIVE ST	STE 107	SILOAM SPRINGS	AR	72761-3602	4795240104	4795240769	In-Center Hemo, In-Center Hemo Self Care, PD Services	8	04-2549	Y
SPRINGDALE DIALYSIS	2070 MCKENZIE RD	STE B	SPRINGDALE	AR	72762-0870	4799271957	4797510523	In-Center Hemo, In-Center Hemo Self Care, Acute Hemo 1:1, Acute PD	17	04-2568	Y
MENA DIALYSIS CENTER	1200 CRESTWOOD CIR		MENA	AR	71953-5516	4793948085	4793942164	In-Center Hemo	16	04-2582	Y
CENTRAL LITTLE ROCK DIALYSIS	6 FREEWAY DR	STE 100	LITTLE ROCK	AR	72204-2486	5016646754	5012969942	In-Center Hemo, In-Center Hemo Self Care, Acute Hemo 1:1, Acute PD, PD Services, Nocturnal Hemo	20	04-2571	Y
OUACHITA DIALYSIS	1900 MALVERN AVE	STE 102	HOT SPRINGS	AR	71901-7776	5016240196	5013212415	In-Center Hemo	25	04-2507	Y
HOT SPRINGS DIALYSIS	115 WRIGHTS ST	STE A	HOT SPRINGS	AR	71913-6240	5016240153	5016240629	In-Center Hemo, PD Services	28	04-2531	Y
SOUTH ARKANSAS DIALYSIS	620 W GROVE ST		EL DORADO	AR	71730-4462	8708628788	8708625756	In-Center Hemo, PD Services	38	04-2536	Y
OUACHITA VALLEY DIALYSIS	1114 WASHINGTON ST NW		CAMDEN	AR	71701-3827	8708371330	8708371423	In-Center Hemo, PD Services	25	04-2525	Y
DEGRAY DIALYSIS	312 PROFESSIONAL PARK DR	STE H	ARKADELPHIA	AR	71923-5355	8702463021	8702453766	In-Center Hemo	17	04-2512	Y
RIVER VALLEY DIALYSIS	3121 W 2ND CT		RUSSELLVILLE	AR	72801-4504	4799684687	4799682260	In-Center Hemo, PD Services	20	04-2508	Y
ASHLEY DIALYSIS	1019 FRED LAGRONE DR		CROSSETT	AR	71635-4546	8703051225	8703051240	In-Center Hemo	25	04-2560	Y
MALVERN DIALYSIS	1590 TANNER ST		ROCKPORT	AR	72104-2023	5013323000	5013325858	In-Center Hemo	26	04-2570	Y
BRADLEY COUNTY DIALYSIS	204 BRAGG ST		WARREN	AR	71671-2500	8702267180	8702262488	In-Center Hemo	16	04-2576	Y
FORREST CITY DIALYSIS	1501 N WASHINGTON ST		FORREST CITY	AR	72335-2152	8704944022	8704944769	In-Center Hemo, PD Services	12	04-2585	Y
ROGERS DIALYSIS	101 N 37TH ST		ROGERS	AR	72756-0301	4798996868	4798996885	In-Center Hemo, PD Services	16	04-2586	Y
POCAHONTAS DIALYSIS	404 CAMP RD		POCAHONTAS	AR	72455-1487	8702480138	8702480623	In-Center Hemo, PD Services	8	04-2595	Y

SOUTH LITTLE ROCK DIALYSIS	6115 BASELINE RD	STE 100	LITTLE ROCK	AR	72209-4725	5015700543	5015700738	In-Center Hemo, PD Services	13	04-2590	Y
INDEPENDENCE COUNTY DIALYSIS	1700 HARRISON ST	STE F	BATESVILLE	AR	72501-7315	8703070828	8707935466	In-Center Hemo	12	04-2557	Y
JACKSON COUNTY DIALYSIS	1912 MCLAIN ST	PRATT SQUARE	NEWPORT	AR	72112-3659	8705232607	8705232824	In-Center Hemo	9	04-2554	Y
SEARCY DIALYSIS	3208 LANGLEY DR		SEARCY	AR	72143-6020	5012684400	5012688279	In-Center Hemo, PD Services	16	04-2514	Y
SPRINGHILL DIALYSIS	3401 SPRINGHILL DR	STE 190	NORTH LITTLE ROCK	AR	72117-2925	5019453669	5019453949	In-Center Hemo	17	04-2513	Y
PULASKI COUNTY DIALYSIS	202 JOHN HARDEN DR		JACKSONVILLE	AR	72076-3775	5019821004	5019821068	In-Center Hemo	9	04-2535	Y
LITTLE ROCK MIDTOWN DIALYSIS	2 LILE CT	STE 102A	LITTLE ROCK	AR	72205-6241	5012213123	5012213167	In-Center Hemo	24	04-2547	Y
SALINE COUNTY DIALYSIS	1200 N MAIN ST	STE 2	BENTON	AR	72015-3341	5017761816	5017761872	In-Center Hemo	12	04-2558	Y
CONWAY DIALYSIS	2445 CHRISTINA LN		CONWAY	AR	72034-6798	5013282186	5013282110	In-Center Hemo, PD Services, Nocturnal Hemo	20	04-2517	Y
SPRINGHILL HOME TRAINING	3401 SPRINGHILL DR	STE 330	NORTH LITTLE ROCK	AR	72117-2945	5016040350	5016040353	PD Services		04-2513	Y
SOUTHWEST ARKANSAS DIALYSIS	225 N DUDNEY RD		MAGNOLIA	AR	71753-3110	8702341322	8702341366	In-Center Hemo	9	04-2545	Y
HEMPSTEAD COUNTY DIALYSIS	1803 S LAUREL ST		HOPE	AR	71801-8219	8707774040	8707773567	In-Center Hemo	10	04-2563	Y
MILLER COUNTY DIALYSIS	816 EAST ST		TEXARKANA	AR	71854-6808	8707722756	8707722764	In-Center Hemo	20	04-2578	Y
HOT SPRINGS AT HOME	115 WRIGHTS ST	STE A	HOT SPRINGS	AR	71913-6240	5016240153	5013216173	Home Hemo	0	04-2531	Y
SOUTH ARKANSAS AT HOME	620 W GROVE ST	STE 101	EL DORADO	AR	71730-4409	8708628788	8708625756	Home Hemo	0	04-2536	Y
FORREST CITY AT HOME	1501 NORTH WASHINGTON ST		FORREST CITY	AR	72335-2152	8704944022	8704944769	Home Hemo		04-2585	Y
JACKSONVILLE CENTRAL AT HOME	400 T P WHITE DR		JACKSONVILLE	AR	72076-3287	5012411300	5019851344	Home Hemo		04-2553	Y
CENTRAL LITTLE ROCK AT HOME	6 FREEWAY DR	STE 100	LITTLE ROCK	AR	72204-2486	5016646754	5012969942	Home Hemo		04-2571	Y
RENAL CARE MARION AT HOME	1120 HWY 77	STE 2	MARION	AR	72364-9046	8707354006	8707354062	Home Hemo		04-2573	Y
RENAL CARE OF MARION	1120 STATE HIGHWAY 77	STE 2	MARION	AR	72364-9046	8707354087	8707354062	In-Center Hemo, PD Services	24	04-2573	Y
OSCEOLA DIALYSIS	1332 W KEISER AVE		OSCEOLA	AR	72370-2919	8705634901	8705634959	In-Center Hemo	12	04-2534	Y
BENTONVILLE AT HOME	1104 SE 30TH ST		BENTONVILLE	AR	72712-4290	4796576220	4796576229	Home Hemo	0	04-2540	Y
SOUTH LITTLE ROCK AT HOME	6115 BASELINE RD	STE 100	LITTLE ROCK	AR	72209-4725	5015700543	5015700738	Home Hemo		04-2590	Y
RENAL CENTER OF MOUNTAIN HOME	200 E 8TH ST	STE 101	MOUNTAIN HOME	AR	72653-4402	8705086500	8705086550	In-Center Hemo, PD Services	13	04-2567	Y
HOPI DIALYSIS CENTER	PO BOX 964	HWY 264	POLACCA	AZ	86042-0964	9287375490	9287375497	In-Center Hemo, PD Services	11	03-2592	Y
TUBA CITY DIALYSIS	500 EDGEWATER DR	PO BOX 2910	TUBA CITY	AZ	86045-2905	9282834525	9282834801	In-Center Hemo, PD Services	26	03-2506	Y
CAMELBACK DIALYSIS CENTER (PD)	7321 E OSBORN DR		SCOTTSDALE	AZ	85251-6418	4809700924	4804219345	PD Services	8	03-2504	N
DESERT MOUNTAIN DIALYSIS CENTER	9220 E MOUNTAIN VIEW RD	STE 105	SCOTTSDALE	AZ	85258-5134	4803912241	4804518331	In-Center Hemo, In-Center Hemo Self Care	24	03-2525	Y
CHINLE DIALYSIS	US HWY 191	PO BOX 879	CHINLE	AZ	86503-0879	9286745426	9286745461	In-Center Hemo	26	03-2518	Y
KAYENTA DIALYSIS	HIGHWAY 163 BOX 217		KAYENTA	AZ	86033-9997	9286978193	9286978195	In-Center Hemo	18	03-2559	Y
PAPAGO DIALYSIS CENTER	5115 E THOMAS RD	STE 115	PHOENIX	AZ	85018-7914	6029561831	6029560334	In-Center Hemo	13	03-2553	Y
ESTRELLA DIALYSIS CENTER	8410 W THOMAS RD	STE 100 BLDG 1	PHOENIX	AZ	85037-3356	6232470808	6232479757	In-Center Hemo, In-Center Hemo Self Care	24	03-2612	Y
GILBERT DIALYSIS CENTER	5222 E BASELINE RD	STE 104	GILBERT	AZ	85234-2963	4808326996	4808327337	In-Center Hemo, In-Center Hemo Self Care	24	03-2605	Y
TEMPE DIALYSIS CENTER	2149 E WARNER RD	STE 110	TEMPE	AZ	85284-3496	4807303531	4804915964	In-Center Hemo, In-Center Hemo Self Care	24	03-2609	Y
PHOENIX DIALYSIS CENTER	337 E CORONADO RD	STE 101	PHOENIX	AZ	85004-1582	6022539006	6022539465	In-Center Hemo, In-Center Hemo Self Care	24	03-2611	Y
ARROWHEAD LAKES DIALYSIS CENTER	20325 N 51ST AVE	BLDG 11, STE 186	GLENDALE	AZ	85308-4625	6235336521	6235336579	In-Center Hemo, In-Center Hemo Self Care	24	03-2604	Y
MOUNTAIN VISTA DIALYSIS CENTER OF ARIZONA	10238 E HAMPTON AVE	STE 108	MESA	AZ	85209-3317	4803578009	4803570372	In-Center Hemo, In-Center Hemo Self Care	24	03-2619	Y
PALM BROOK DIALYSIS CENTER	14664 N DEL WEBB BLVD		SUN CITY	AZ	85351-2137	6235836550	6239772514	In-Center Hemo, In-Center Hemo Self Care	20	03-2601	Y
WESTBROOK DIALYSIS	13907 W CAMINO DEL SOL	STE 103	SUN CITY WEST	AZ	85375-4405	6232147088	6232140109	In-Center Hemo, In-Center Hemo Self Care	16	03-2621	Y
NORTHWEST TUCSON DIALYSIS	2945 W INA RD	STE 105	TUCSON	AZ	85741-2366	5207970049	5202298957	In-Center Hemo, In-Center Hemo Self Care	20	03-2618	Y
RIM COUNTRY DIALYSIS	809 W LONGHORN RD		PAYSON	AZ	85541-4280	9284747000	9284749983	In-Center Hemo, In-Center Hemo Self Care, PD Services	6	03-2615	Y
TUCSON CENTRAL DIALYSIS	2901 E GRANT RD		TUCSON	AZ	85716-2717	5203253408	5203253469	In-Center Hemo, In-Center Hemo Self Care, PD Services	12	03-2627	Y
GRAND HOME DIALYSIS	14674 W MOUNTAIN VIEW BLVD	STE 204	SURPRISE	AZ	85374-2708	6235466120	6235462693	PD Services	4	03-2620	Y
YUMA DIALYSIS	2130 W 24TH ST		YUMA	AZ	85364-6122	9287832365	9287836870	In-Center Hemo, In-Center Hemo Self Care, PD Services	32	03-2502	Y
NOGALES DIALYSIS	1605 N INDUSTRIAL PARK DR	STE H	NOGALES	AZ	85621-4577	5202815779	5202815873	In-Center Hemo, In-Center Hemo Self Care	16	03-2543	Y
SELLS DIALYSIS	HWY 86 MILEPOST 113	PO BOX 3030	SELLS	AZ	85634-3030	5203831701	5203833667	In-Center Hemo, In-Center Hemo Self Care	28	03-2513	Y
SIERRA VISTA DIALYSIS	629 N HIGHWAY 90 BYP	STE 6	SIERRA VISTA	AZ	85635-2257	5204597791	5204597129	In-Center Hemo, In-Center Hemo Self Care, Acute Hemo 1:1, PD Services	20	03-2520	Y
SOUTH YUMA DIALYSIS	7179 E 31ST PLACE		YUMA	AZ	85365-8392	9283170517	9287269155	In-Center Hemo, In-Center Hemo Self Care, Acute Hemo 1:1, Acute PD	20	03-2556	Y
TUCSON SOUTH DIALYSIS	3662 S 16TH AVE		TUCSON	AZ	85713-6001	5208829665	5208829206	In-Center Hemo, In-Center Hemo Self Care	30	03-2557	Y

PASCUA YAQUI TRIBE DIALYSIS	7490 S CAMINO DE OESTE		TUCSON	AZ	85746-9308	5208796161	5205783655	In-Center Hemo, In-Center Hemo Self Care	13	03-2573	Y
TUCSON SOUTH CENTRAL DIALYSIS	2024 E IRVINGTON RD	STE 7	TUCSON	AZ	85714-1825	5205730200	5205730210	In-Center Hemo	30	03-2589	Y
TUCSON WEST DIALYSIS	1780 W ANKLAM RD		TUCSON	AZ	85745-2632	5206242220	5206206365	In-Center Hemo, In-Center Hemo Self Care, PD Services	34	03-2500	Y
TUCSON EAST DIALYSIS	6420 E BROADWAY BLVD	STE C300	TUCSON	AZ	85710-3534	5207902775	5207903174	In-Center Hemo, In-Center Hemo Self Care, PD Services	24	03-2501	Y
POWER ROAD DIALYSIS PD	301 SOUTH POWER RD	STE 104	MESA	AZ	85206-5243	4809245104	4809246073	PD Services		03-2638	Y
CENTRAL MESA DIALYSIS CENTER	1134 E UNIVERSITY DR	STE 101	MESA	AZ	85203-8048	4804643851	4806681460	In-Center Hemo, In-Center Hemo Self Care	24	03-2624	Y
MARYVALE DIALYSIS CENTER	4845 W MCDOWELL RD	STE 10A, 20A, 30A	PHOENIX	AZ	85035-4076	6022788349	6022722674	In-Center Hemo	24	03-2634	Y
RITA RANCH DIALYSIS (AKA TUCSON EAST II)	7355 S HOUGHTON RD	STE 101	TUCSON	AZ	85747-9380	5206634035	5206633826	In-Center Hemo	12	03-2632	Y
RAVEN DIALYSIS CENTER	3540 E BASELINE RD	STE 110	PHOENIX	AZ	85042-9628	6024312110	6024312153	In-Center Hemo, In-Center Hemo Self Care	24	03-2625	Y
BROOKWOOD DIALYSIS CENTER	8910 N 43RD AVE	STE 107	GLENDALE	AZ	85302-5340	6239372735	6239372758	In-Center Hemo, In-Center Hemo Self Care	24	03-2630	Y
OCOTILLO DIALYSIS	975 W CHANDLER HEIGHTS RD	UNIT 101	CHANDLER	AZ	85248-5724	4808024405	4808025390	In-Center Hemo	12	03-2631	Y
POWER ROAD DIALYSIS	301 S POWER RD	STE 104	MESA	AZ	85206-5243	4806411193	4808073388	In-Center Hemo	12	03-2638	Y
WICKENBURG DIALYSIS	811 N TEGNER	STE 101, 103, 105, 107	WICKENBURG	AZ	85390-5409	9286846898	9286846107	In-Center Hemo, PD Services	9	03-2637	Y
SWEETWATER RIDGE DIALYSIS	7362 W THUNDERBIRD RD	STE 104	PEORIA	AZ	85381-5028	6234860327	6238785264	In-Center Hemo	20	03-2640	Y
EDGE RIVER DIALYSIS	1197 S REDONDO CENTER DR		YUMA	AZ	85365-2036	9283294340	9287835018	In-Center Hemo, PD Services	13	03-2644	Y
DESERT DIALYSIS	13000 N 103RD AVE	STE 66	SUN CITY	AZ	85351-3060	6235833131	6235835414	In-Center Hemo	20	03-2572	Y
TEMPE DIALYSIS CENTER PD	2149 EAST WARNER RD	STE 109	TEMPE	AZ	85284-3496	4807303531	4807304092	PD Services		03-2609	Y
ARROWHEAD LAKES DIALYSIS CENTER (PD)	20325 N 51ST AVE	BLDG 11, STE 184	GLENDALE	AZ	85308-4625	6235333836	6235334033	PD Services		03-2604	Y
CAMELBACK AT HOME	7321 E OSBORN DR		SCOTTSDALE	AZ	85251-6418	4809700924	4804219345	Home Hemo	0	03-2504	N
TUCSON EAST AT HOME	6420 E BROADWAY BLVD	STE C300	TUCSON	AZ	85710-3512	5207902775	5207903174	Home Hemo		03-2501	Y
TEMPE AT HOME	2149 E WARNER RD	STE 109	TEMPE	AZ	85284-3496	4807303531	4807304092	Home Hemo		03-2609	Y
ARROWHEAD LAKES AT HOME	20325 N 51ST AVE	BLDG 11, STE 184	GLENDALE	AZ	85308-4625	6235333836	6235334033	Home Hemo		03-2604	Y
GRAND HOME AT HOME	14674 W MOUNTAIN VIEW BLVD	STE 204	SURPRISE	AZ	85374-2708	6235466120	6235462693	Home Hemo		03-2620	Y
COTTONWOOD DIALYSIS	1699 E COTTONWOOD ST	STE A200	COTTONWOOD	AZ	86326-4604	9286349295	9286349683	In-Center Hemo	13	03-2562	Y
PRESCOTT DIALYSIS	980 WILLOW CREEK RD	STE 101	PRESCOTT	AZ	86301-1619	9287769459	9287768061	In-Center Hemo	12	03-2523	Y
SIERRA VISTA AT HOME	629 N HWY 90 BYP	STE 6	SIERRA VISTA	AZ	85635-2257	5204597791	5204597129	Home Hemo	0		Y
ESTRELLA DIALYSIS CENTER (PD)	8410 W THOMAS RD	BLDG 1, STE 100	PHOENIX	AZ	85037-3356	6232471749	6232471873	PD Services	1	03-2612	Y
SCOTTSDALE DIALYSIS	5705 N SCOTTSDALE RD	STE 120	SCOTTSDALE	AZ	85250-5910	4809413860	4809414191	In-Center Hemo	12	03-2641	Y
PHOENIX HOME DIALYSIS-PD ONLY	5115 E THOMAS RD	STE 100	PHOENIX	AZ	85018-7914	6028400072	6029561405	PD Services		03-2642	Y
FOUNTAIN HILLS DIALYSIS	13430 N SAGUARO BLVD	BLDG 3	FOUNTAIN HILLS	AZ	85268-3728	4808165973	4808165767	In-Center Hemo, PD Services	12	03-2645	Y
SWAN DIALYSIS	1635 N SWAN RD		TUCSON	AZ	85712-4046	5203271125	5203272963	In-Center Hemo	12	03-2651	Y
HAYWARD DIALYSIS CENTER	21615 HESPERIAN BLVD	STE F	HAYWARD	CA	94541-7026	5107809094	5107800635	In-Center Hemo, In-Center Hemo Self Care	31	05-2685	Y
PLEASANTON DIALYSIS CENTER	5720 STONERIDGE MALL RD	STE 160	PLEASANTON	CA	94588-2882	9257370120	9257370155	In-Center Hemo, In-Center Hemo Self Care, PD Services	22	05-2568	Y
UNION CITY DIALYSIS CENTER	32930 ALVARADO NILES RD	STE 300	UNION CITY	CA	94587-8101	5104896996	5104893747	In-Center Hemo, In-Center Hemo Self Care, PD Services	38	05-2571	Y
EAST BAY PERITONEAL DIALYSIS CENTER	13939 E 14TH ST	STE 110	SAN LEANDRO	CA	94578-2613	5106141380	5106140393	PD Services	4	05-2675	Y
SOUTH HAYWARD DIALYSIS	254 JACKSON ST		HAYWARD	CA	94544-1907	5105831255	5105830631	In-Center Hemo, In-Center Hemo Self Care	24	05-2845	Y
KENNETH HAHN PLAZA DIALYSIS CENTER	11854 S WILMINGTON AVE		LOS ANGELES	CA	90059-3016	3235675077	3235671490	In-Center Hemo	20	05-2858	Y
LODI DIALYSIS CENTER	1610 W KETTLEMAN LN	STE D	LODI	CA	95242-4210	2093349888	2093330888	In-Center Hemo, In-Center Hemo Self Care	21	05-2753	Y
FLORIN DIALYSIS CENTER	7000 STOCKTON BLVD		SACRAMENTO	CA	95823-2312	9164243990	9164243799	In-Center Hemo	31	05-2857	Y
NORTH HIGHLANDS DIALYSIS CTR	4612 ROSEVILLE RD	STE 100	NORTH HIGHLANDS	CA	95660-5175	9163341368	9163341543	In-Center Hemo	27	05-2826	Y
ALHAMBRA DIALYSIS CENTER	1315 ALHAMBRA BLVD	STE 100	SACRAMENTO	CA	95816-5245	9164578252	9164573649	In-Center Hemo	20	05-2707	Y
ANTELOPE DIALYSIS CENTER	6406 TUPELO DR	STE A	CITRUS HEIGHTS	CA	95621-1780	9167211800	9167214376	In-Center Hemo, In-Center Hemo Self Care	31	05-2663	Y
CHICO DIALYSIS CENTER	530 COHASSET RD		CHICO	CA	95926-2212	5308958966	5308950419	In-Center Hemo, PD Services	21	05-2553	Y
MANZANITA HOME TRAINING CENTER	4005 MANZANITA AVE	STE 18	CARMICHAEL	CA	95608-1779	9169711419	9169711439	PD Services		05-2604	Y
MANZANITA DIALYSIS CENTER	4005 MANZANITA AVE	STE 17	CARMICHAEL	CA	95608-1779	9164833241	9164836347	In-Center Hemo	21	05-2604	Y
CAMERON PARK DIALYSIS	3311 COACH LN	STE C	CAMERON PARK	CA	95682-7247	5306775114	5306775190	In-Center Hemo, In-Center Hemo Self Care	24	05-2691	Y
SOUTH SACRAMENTO DIALYSIS CENTER	7000 FRANKLIN BLVD	STE 880	SACRAMENTO	CA	95823-1838	9164272561	9164272025	In-Center Hemo	18	05-2569	Y
REDDING DIALYSIS CENTER	1876 PARK MARINA DR		REDDING	CA	96001-0913	5302467474	5302460179	In-Center Hemo, In-Center Hemo Self Care, PD Services	28	05-2528	Y
YUBA CITY DIALYSIS CENTER	1525 PLUMAS CT	STE A	YUBA CITY	CA	95991-2971	5306713652	5306714903	In-Center Hemo, In-Center Hemo Self Care	24	05-2563	Y

UNIVERSITY DIALYSIS CENTER	333 UNIVERSITY AVE	STE 100	SACRAMENTO	CA	95825-6533	9169200877	9169201931	In-Center Hemo, Nocturnal Hemo	21	55-2549	Y
ORANGEVALE DIALYSIS CTR	9267 GREENBACK LN	STE A2	ORANGEVALE	CA	95662-4864	9169885666	9169885636	In-Center Hemo, In-Center Hemo Self Care	20	05-2850	Y
EATON CANYON DIALYSIS	2551 E WASHINGTON BLVD		PASADENA	CA	91107-1446	6267988896	6263988279	In-Center Hemo, In-Center Hemo Self Care, PD Services, Nocturnal Hemo	31	05-2613	Y
PARAMOUNT DIALYSIS CENTER	15625 LAKEWOOD BLVD		PARAMOUNT	CA	90723-4633	5627902478	5622720038	In-Center Hemo, In-Center Hemo Self Care	37	05-2652	Y
DOCTORS DIALYSIS OF EAST LOS ANGELES	950 S EASTERN AVE		LOS ANGELES	CA	90022-4801	3232622229	3232629418	In-Center Hemo	32	05-2725	Y
DOCTORS DIALYSIS CENTER OF MONTEBELLO	1721 W WHITTIER BLVD		MONTEBELLO	CA	90640-4004	3237221116	3237225501	In-Center Hemo	28	05-2785	Y
CRESCENT HEIGHTS DIALYSIS CENTER	8151 BEVERLY BLVD		LOS ANGELES	CA	90048-4514	3236556226	3236556512	In-Center Hemo, Nocturnal Hemo, PD Services	20	05-2852	Y
OAKLAND PERITONEAL DIALYSIS CENTER	5352 CLAREMONT AVE		OAKLAND	CA	94618-1035	5105970398	5105970385	PD Services	2	05-2822	Y
ANTIOCH DIALYSIS CENTER	3100 DELTA FAIR BLVD		ANTIOCH	CA	94509-4001	9257535000	9257535055	In-Center Hemo, In-Center Hemo Self Care, PD Services	20	05-2841	Y
SALINAS VALLEY DIALYSIS CENTER	955 BLANCO CIR	STE C	SALINAS	CA	93901-4452	8317586222	8317588345	In-Center Hemo, In-Center Hemo Self Care, PD Services	34	05-2602	Y
LOS ANGELES DIALYSIS CENTER	3901 S WESTERN AVE		LOS ANGELES	CA	90062-1112	3232940670	3232940499	In-Center Hemo, PD Services	28	05-2695	Y
MONTEREY PARK DIALYSIS CENTER	2560 CORPORATE PL	STE 100-101 BLDG D	MONTEREY PARK	CA	91754-7612	3237808787	3237800246	In-Center Hemo, PD Services	28	05-2700	Y
DELTA SIERRA DIALYSIS CENTER	555 W BENJAMIN HOLT DR	STE 200	STOCKTON	CA	95207-3839	2094732294	2094732214	In-Center Hemo, In-Center Hemo Self Care, PD Services	12	05-2784	Y
CENTURY CITY DIALYSIS	10630 SANTA MONICA BLVD		LOS ANGELES	CA	90025-4837	3109542700	3104744565	In-Center Hemo, In-Center Hemo Self Care, PD Services	30	05-2865	Y
SOLEDAD DIALYSIS CENTER	901 LOS COCHES DR		SOLEDAD	CA	93960-2995	8316784310	8316784324	In-Center Hemo, In-Center Hemo Self Care, PD Services	18	05-2892	Y
MONTCLAIR DIALYSIS CENTER	9142 MONTE VISTA AVE		MONTCLAIR	CA	91763-1723	9096266505	9096245736	In-Center Hemo, PD Services, In-Center Hemo Self Care	28	05-2804	Y
PREMIER DIALYSIS CENTER	7612 ATLANTIC AVE		CUDAHY	CA	90201-5020	3235625511	3235623347	In-Center Hemo, In-Center Hemo Self Care, PD Services	36	05-2761	Y
UNITED DIALYSIS CENTER	3111 LONG BEACH BLVD		LONG BEACH	CA	90807-5015	5624265155	5624265007	In-Center Hemo, In-Center Hemo Self Care	27	05-2671	Y
WASHINGTON PLAZA DIALYSIS CENTER	516 E WASHINGTON BLVD	# 522	LOS ANGELES	CA	90015-3723	2137492433	2137490518	In-Center Hemo	25	05-2856	Y
LAKE ELSINORE DIALYSIS	32291 MISSION TRL	BLDG S	LAKE ELSINORE	CA	92530-4524	9516745050	9516745570	In-Center Hemo, In-Center Hemo Self Care	18	05-2895	Y
GARFIELD HEMODIALYSIS CENTER	118 HILLIARD AVE		MONTEREY PARK	CA	91754-1118	6262885796	6262883870	In-Center Hemo, In-Center Hemo Self Care, PD Services	24	05-2564	Y
KIDNEY DIALYSIS CARE UNIT	3600 E MARTIN LUTHER KING JR BLVD		LYNWOOD	CA	90262-2607	3108865156	3106086947	In-Center Hemo	40	05-2502	Y
LAKEWOOD DIALYSIS CENTER	4611 SILVA ST		LAKEWOOD	CA	90712-2512	5626337441	5626304609	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care	30	05-2539	Y
VALLEY DIALYSIS	6840 SEPULVEDA BLVD	STE 101	VAN NUYS	CA	91405-4401	8187791450	8187791466	In-Center Hemo, PD Services	32	05-2554	Y
DOWNEY DIALYSIS CENTER	8630 FLORENCE AVE	STE 100	DOWNEY	CA	90240-4017	5629236741	5629232471	In-Center Hemo, In-Center Hemo Self Care	19	05-2574	Y
COVINA DIALYSIS CENTER	1547 W GARVEY AVE N		WEST COVINA	CA	91790-2139	6269609405	6269602695	In-Center Hemo	17	05-2580	Y
WILSHIRE DIALYSIS CENTER	1212 WILSHIRE BLVD		LOS ANGELES	CA	90017-1902	2134825181	2134824470	In-Center Hemo, Nocturnal Hemo, PD Services	22	05-2631	Y
Beverly Hills Dialysis Center	50 N LA CIENEGA BLVD	STE 300	BEVERLY HILLS	CA	90211-2284	3102891612	3102891547	In-Center Hemo	30	05-2599	Y
WALNUT CREEK DIALYSIS CENTER	404 N WIGET LN		WALNUT CREEK	CA	94598-2408	9259370203	9259469482	In-Center Hemo, Nocturnal Hemo, PD Services	24	05-2689	Y
NORWALK DIALYSIS CENTER	12375 E IMPERIAL HWY	STE D3	NORWALK	CA	90650-3129	5629297430	5628631864	In-Center Hemo	17	05-2718	Y
GREATER EL MONTE DIALYSIS CENTER	1938 TYLER AVE	STE J168	SOUTH EL MONTE	CA	91733-3623	6263506692	6263506986	In-Center Hemo, In-Center Hemo Self Care	14	05-2717	Y
TRC/USC KIDNEY CENTER	2310 ALCAZAR ST		LOS ANGELES	CA	90033-5327	3234419966	3234419960	In-Center Hemo, In-Center Hemo Self Care, PD Services	59	05-2794	Y
UNIVERSITY PARK DIALYSIS CENTER	3986 S FIGUEROA ST		LOS ANGELES	CA	90037-1222	2137498297	2137490472	In-Center Hemo	20	05-2713	Y
AIRPORT SUNRISE DIALYSIS	11300 HAWTHORNE BLVD		INGLEWOOD	CA	90304-2715	3106800601	3106809166	In-Center Hemo, In-Center Hemo Self Care, PD Services	58	05-2746	Y
HOLLYWOOD DIALYSIS CENTER	5108 W SUNSET BLVD		LOS ANGELES	CA	90027-5708	3239134010	3239134022	In-Center Hemo, PD Services	22	05-2801	Y
TRC/HARBOR-UCLA MFI TOTAL RENAL DIALYSIS CENTER	21602 S VERMONT AVE		TORRANCE	CA	90502-1940	3105330413	3102126248	In-Center Hemo, PD Services	30	05-2802	Y
NAPA DIALYSIS CENTER	3900 BEL AIRE PLZ	STE C	NAPA	CA	94558-2823	7072538938	7072532851	In-Center Hemo, In-Center Hemo Self Care, PD Services	20	05-2615	Y
LAKEPORT DIALYSIS CENTER	804 11TH ST	STE 2	LAKEPORT	CA	95453-4102	7072637132	7072638926	In-Center Hemo, In-Center Hemo Self Care, PD Services	12	05-2601	Y
FAIRFIELD DIALYSIS CENTER	4660 CENTRAL WAY		FAIRFIELD	CA	94534-1803	7078637369	7078637384	In-Center Hemo, In-Center Hemo Self Care, PD Services	32	05-2618	Y
VACAVILLE DIALYSIS CENTER	941 MERCHANT ST		VACAVILLE	CA	95688-5315	7074478191	7074478196	In-Center Hemo, In-Center Hemo Self Care	21	05-2709	Y
SANTA ANA DIALYSIS CENTER	1820 E DEERE AVE		SANTA ANA	CA	92705-5721	9492511221	9492511455	In-Center Hemo	26	05-2716	Y
BREA DIALYSIS CENTER	595 TAMARACK AVE	STE A	BREA	CA	92821-3125	7149900110	7149900946	In-Center Hemo	21	05-2621	Y
CORONA DIALYSIS CENTER	2057 COMPTON AVE	STE 101	CORONA	CA	92881-7287	9517355845	9517353941	In-Center Hemo, In-Center Hemo Self Care	24	05-2661	Y
HEMET DIALYSIS CENTER	3050 W FLORIDA AVE		HEMET	CA	92545-3619	9519259723	9519259789	In-Center Hemo, In-Center Hemo Self Care	39	05-2620	Y
VALLEY VIEW DIALYSIS CENTER	26900 CACTUS AVE		MORENO VALLEY	CA	92555-3912	9512472844	9512478631	In-Center Hemo, In-Center Hemo Self Care	34	05-2807	Y
RIVERSIDE DIALYSIS CENTER	4361 LATHAM ST	STE 100	RIVERSIDE	CA	92501-1767	9516822700	9516823024	In-Center Hemo	32	05-2532	Y
MOUNTAIN VISTA DIALYSIS CENTER	4041 UNIVERSITY PKWY		SAN BERNARDINO	CA	92407-1823	9098870173	9098872892	In-Center Hemo, PD Services	28	05-2743	Y
TEMECULA DIALYSIS CENTER	40945 COUNTY CENTER DR	STE G	TEMECULA	CA	92591-6006	9512969744	9512969749	In-Center Hemo, In-Center Hemo Self Care	18	05-2735	Y
MAINPLACE DIALYSIS CENTER	972 W TOWN AND COUNTRY RD		ORANGE	CA	92868-4714	7148360155	7148360711	In-Center Hemo, Nocturnal Hemo, PD Services	21	05-2503	Y

ROSEMEAD SPRINGS DIALYSIS CENTER	3212 ROSEMEAD BLVD		EL MONTE	CA	91731-2807	6262803019	6262802856	In-Center Hemo	16	55-2511	Y
IMPERIAL CARE DIALYSIS CENTER	4345 E IMPERIAL HWY		LYNWOOD	CA	90262-2318	3109000333	3109000334	In-Center Hemo	31	05-2844	Y
DIAMOND VALLEY DIALYSIS	1030 E FLORIDA AVE		HEMET	CA	92543-4511	9517664581	9517664585	In-Center Hemo	12	05-2768	Y
MURRIETA DIALYSIS	27602 CLINTON KEITH RD	BLDG F	MURRIETA	CA	92562-8513	9516797914	9516797693	In-Center Hemo, In-Center Hemo Self Care	24	05-2730	Y
ASH TREE DIALYSIS	2666 N GROVE INDUSTRIAL DR	STE 106	FRESNO	CA	93727-1552	5592511919	5592511333	In-Center Hemo, In-Center Hemo Self Care, PD Services	36	55-2563	Y
ASH TREE PD	2666 N GROVE INDUSTRIAL DR		FRESNO	CA	93727-1552	5592521077	5594564305	PD Services		55-2563	Y
WASCO PRISON DIALYSIS	701 SCOFIELD AVE		WASCO	CA	93280-7515	6617587668		In-Center Hemo	6		Y
SOUTH VALLEY DIALYSIS	17815 VENTURA BLVD	STE 100	ENCINO	CA	91316-3600	8187574520	8187571043	In-Center Hemo, In-Center Hemo Self Care	25	05-2744	Y
CARABELLO DIALYSIS CENTER	757 E WASHINGTON BLVD		LOS ANGELES	CA	90021-3016	2137452860	2137452868	In-Center Hemo, PD Services	24	55-2649	Y
RIVERSIDE PD CENTRAL	3660 PARK SIERRA DR	STE 108	RIVERSIDE	CA	92505-3071	9516873900	9516877998	PD Services	11	55-2627	Y
TURLOCK DIALYSIS CENTER	50 W SYRACUSE AVE		TURLOCK	CA	95380-3143	2096567299	2096561715	In-Center Hemo, In-Center Hemo Self Care	16	55-2528	Y
BAKERSFIELD DIALYSIS CENTER	5143 OFFICE PARK DR		BAKERSFIELD	CA	93309-0660	6613254741	6613257631	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care, PD Services	76	05-2673	Y
ANTELOPE VALLEY DIALYSIS	1759 W AVENUE J	STE 102	LANCASTER	CA	93534-2703	6619426400	6617293985	In-Center Hemo, PD Services	30	05-2521	Y
INDIAN WELLS VALLEY DIALYSIS	212 S RICHMOND RD		RIDGECREST	CA	93555-4434	7603717506	7603717806	In-Center Hemo, In-Center Hemo Self Care	12	05-2789	Y
PALMDALE REGIONAL	1643 E PALMDALE BLVD		PALMDALE	CA	93550-4847	6615400925	6615400930	In-Center Hemo	24	05-2869	Y
NORTH HIGHLANDS DIALYSIS CENTER PD	4612 ROSEVILLE RD	STE 100	NORTH HIGHLANDS	CA	95660-5175	9163311567	9163341570	PD Services		05-2826	Y
STOCKTON KIDNEY CENTER	1523 E MARCH LN	STE 200	STOCKTON	CA	95210-5607	2094723300	2094720900	In-Center Hemo	20	55-2592	Y
WHITTIER DIALYSIS	10055 WHITTWOOD DR		WHITTIER	CA	90603-2313	5629471808	5629471186	In-Center Hemo, Nocturnal Hemo, PD Services	18	55-2509	Y
NORCO DIALYSIS	1901 TOWN AND COUNTRY DR	STE 100	NORCO	CA	92860-3611	9517380185	9517388490	In-Center Hemo, In-Center Hemo Self Care	20	55-2571	Y
MAGNOLIA WEST DIALYSIS	11161 MAGNOLIA AVE		RIVERSIDE	CA	92505-3605	9513518090	9513518099	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care	30	55-2553	Y
TOKAY DIALYSIS CENTER	312 S FAIRMONT AVE	STE A	LODI	CA	95240-3840	2093695418	2093695963	In-Center Hemo, In-Center Hemo Self Care	12	55-2504	Y
CREEKSIDE DIALYSIS CENTER	141 PARKER ST		VACAVILLE	CA	95688-3921	7074531325	7074531329	In-Center Hemo, In-Center Hemo Self Care	12	55-2510	Y
TUSTIN DIALYSIS	2090 N TUSTIN AVE	STE 100	SANTA ANA	CA	92705-7869	7148352450	7148355715	In-Center Hemo, In-Center Hemo Self Care, PD Services, Nocturnal Hemo	24	05-2897	Y
ELK GROVE DIALYSIS	9281 OFFICE PARK CIR	STE 105	ELK GROVE	CA	95758-8069	9166910480	9166910488	In-Center Hemo, In-Center Hemo Self Care	21	55-2529	Y
MARYSVILLE DIALYSIS CENTER	1015 8TH ST		MARYSVILLE	CA	95901-5271	5307419801	5307419805	In-Center Hemo, In-Center Hemo Self Care, PD Services	15	55-2533	Y
SOUTH CHICO DIALYSIS CENTER	2345 FOREST AVE		CHICO	CA	95928-7641	5308942180	5308942647	In-Center Hemo, In-Center Hemo Self Care	18	55-2530	Y
CONCORD DIALYSIS CENTER	2300 STANWELL DR	STE C	CONCORD	CA	94520-4841	9256777492	9256777497	In-Center Hemo, In-Center Hemo Self Care	21	55-2535	Y
MAR VISTA DIALYSIS CENTER	2020 SANTA MONICA BLVD	STE 100	SANTA MONICA	CA	90404-2139	3104534900	3104534966	In-Center Hemo, PD Services	20	55-2580	Y
LAGUNA HILLS DIALYSIS	25332 CABOT RD		LAGUNA HILLS	CA	92653-5506	9493801925	9493801746	In-Center Hemo	20	55-2718	Y
CITRUS VALLEY DIALYSIS	894 HARDT STREET		SAN BERNARDINO	CA	92408-2854	9093886608	9093886639	In-Center Hemo, In-Center Hemo Self Care	20	55-2541	Y
YUCAIPA DIALYSIS CENTER	33487 YUCAIPA BLVD		YUCAIPA	CA	92399-2064	9097976200	9097976446	In-Center Hemo, In-Center Hemo Self Care	12	55-2578	Y
CROSSROADS DIALYSIS	3214 YORBA LINDA BLVD		FULLERTON	CA	92831-1707	7145776940	7145770530	In-Center Hemo, PD Services, Nocturnal Hemo	24	55-2544	Y
CLEARLAKE DIALYSIS	14400 OLYMPIC DR		CLEARLAKE	CA	95422-8809	7079949785	7079949790	In-Center Hemo, In-Center Hemo Self Care	12	55-2586	Y
CARQUINEZ DIALYSIS	125 CORPORATE PL	STE C	VALLEJO	CA	94590-6968	7075563637	7075563642	In-Center Hemo, In-Center Hemo Self Care	21	55-2572	Y
ONTARIO DIALYSIS	1950 S GROVE AVE	STE 101-105	ONTARIO	CA	91761-5693	9099305566	9099305690	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care	20	55-2548	Y
RED BLUFF DIALYSIS CENTER	2455 SISTER MARY COLUMBA DR		RED BLUFF	CA	96080-4364	5305270052	5305270059	In-Center Hemo, In-Center Hemo Self Care	15	55-2557	Y
BIXBY KNOLLS DIALYSIS	3744 LONG BEACH BLVD		LONG BEACH	CA	90807-3310	5624241403	5624244310	In-Center Hemo	24	55-2614	Y
BELLFLOWER DIALYSIS CENTER	15736 WOODRUFF AVE		BELLFLOWER	CA	90706-4018	5628043099	5628041544	In-Center Hemo, Nocturnal Hemo	20	55-2588	Y
LONG BEACH HARBOR DIALYSIS	1075 E PACIFIC COAST HWY		LONG BEACH	CA	90806-5089	5625991511	5625991922	In-Center Hemo	12	55-2579	Y
SILVER LAKE DIALYSIS	2723 W TEMPLE ST		LOS ANGELES	CA	90026-4723	2134803039	2134803287	In-Center Hemo	30	55-2659	Y
FOSTER CITY DIALYSIS	1261 E HILLSDALE BLVD	STE 2	FOSTER CITY	CA	94404-1236	6506389301	6506389306	In-Center Hemo	16	55-2620	Y
NATOMAS DIALYSIS	30 GOLDEN LAND CT	BLDG G	SACRAMENTO	CA	95834-2423	9162856452	9162859715	In-Center Hemo, In-Center Hemo Self Care	24	55-2569	Y
SANGER SEQUOIA DIALYSIS	2517 JENSEN AVE	BLDG B	SANGER	CA	93657-2251	5598763852	5598763930	In-Center Hemo	16	55-2650	Y
WEST SACRAMENTO DIALYSIS CENTER	3450 INDUSTRIAL BLVD	STE 100	WEST SACRAMENTO	CA	95691-5053	9163714947	9163718845	In-Center Hemo, In-Center Hemo Self Care, PD Services	21	55-2591	Y
ABORN DIALYSIS	3162 S WHITE RD	STE 100	SAN JOSE	CA	95148-4019	4082230620	4082230625	In-Center Hemo	18	55-2643	Y
REDWOOD CITY DIALYSIS	1000 MARSHALL ST		REDWOOD CITY	CA	94063-2027	6503650129	6503650232	In-Center Hemo, PD Services	24	55-2665	Y
DOWNEY LANDING DIALYSIS CENTER	11611 BELLFLOWER BLVD		DOWNEY	CA	90241-5408	5628620001	5628620040	In-Center Hemo, In-Center Hemo Self Care	31	55-2624	Y
CERES DIALYSIS CENTER	1768 MITCHELL RD	STE 308	CERES	CA	95307-2156	2095389853	2095389858	In-Center Hemo, In-Center Hemo Self Care, PD Services	16	55-2581	Y
ALMOND WOOD DIALYSIS	501 E ALMOND AVE		MADERA	CA	93637-5661	5596649252	5596649255	In-Center Hemo, In-Center Hemo Self Care	22	55-2564	Y
SANTA FE SPRINGS DIALYSIS	11147 WASHINGTON BLVD		WHITTIER	CA	90606-3007	5626950827	5626951132	In-Center Hemo, In-Center Hemo Self Care	16	55-2597	Y
SAN MARCOS DIALYSIS CENTER	2135 MONTIEL RD	BLDG B	SAN MARCOS	CA	92069-3511	7609750170	7609750177	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care, PD Services	20	55-2618	Y

SUNSET DIALYSIS CENTER	3071 GOLD CANAL DR		RANCHO CORDOVA	CA	95670-6129	9166388429	9166388039	In-Center Hemo, In-Center Hemo Self Care	24	55-2612	Y
GARDEN GROVE HARBOR DIALYSIS	13054 N HARBOR BLVD		GARDEN GROVE	CA	92843-1744	7145393395	7145393467	In-Center Hemo, PD Services	25	55-2781	Y
WESTLAKE DALY CITY DIALYSIS CENTER	2201 JUNIPERO SERRA BLVD	STE 175	DALY CITY	CA	94014-1908	6507559480	6507559485	In-Center Hemo	24	55-2642	Y
EXETER DIALYSIS	1116 W VISALIA RD	STE 106	EXETER	CA	93221-1482	5595921025	5595924103	In-Center Hemo, In-Center Hemo Self Care	24	55-2594	Y
CORNERHOUSE DIALYSIS CENTER	2005 NAGLEE AVE		SAN JOSE	CA	95128-4801	4089980183	4082953790	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care	16	55-2608	Y
HESPERIA DIALYSIS CENTER	14135 MAIN ST	STE 501	HESPERIA	CA	92345-8097	7609477405	7609497925	In-Center Hemo, PD Services	22	55-2626	Y
CANYON SPRINGS DIALYSIS	22555 ALESSANDRO BLVD		MORENO VALLEY	CA	92553-8533	9516536400	9518673270	In-Center Hemo	32	55-2622	Y
NORTHGATE DIALYSIS CENTER	650 LAS GALLINAS AVE		SAN RAFAEL	CA	94903-3620	4154440376	4154914014	In-Center Hemo, In-Center Hemo Self Care, PD Services	12	55-2607	Y
TOKAY HOME DIALYSIS CENTER PD	777 S HAM LN	STE L	LODI	CA	95242-3593	2093338909	2093338914	PD Services	0	55-2576	Y
HUNTINGTON PARK DIALYSIS	5942 RUGBY AVE		HUNTINGTON PARK	CA	90255-2803	3235857605	3235857635	In-Center Hemo	21	55-2667	Y
VISALIA VINEYARD DIALYSIS	1140 S BEN MADDOX WAY		VISALIA	CA	93292-3643	5596351938	5596255713	In-Center Hemo, PD Services	24	55-2806	Y
RICHMOND DIALYSIS	4200 MACDONALD AVE	STE A	RICHMOND	CA	94805-2315	5102368861	5102362563	In-Center Hemo	24	55-2688	Y
LIVERMORE DIALYSIS	3201 DOOLAN RD	STE 175	LIVERMORE	CA	94551-9610	9252459780	9252459785	In-Center Hemo	24	55-2638	Y
WEST ELK GROVE DIALYSIS	2208 KAUSEN DR	STE 100	ELK GROVE	CA	95758-7174	9166835992	9166836025	In-Center Hemo, In-Center Hemo Self Care	22	55-2604	Y
LOS ALAMITOS DIALYSIS	4141 KATELLA AVE		LOS ALAMITOS	CA	90720-3406	7149520175	7149520180	In-Center Hemo, PD Services	24	55-2691	Y
JOY OF DIXON DIALYSIS CENTER	1640 N LINCOLN ST		DIXON	CA	95620-9268	7076938301	7076938306	In-Center Hemo, In-Center Hemo Self Care, Nocturnal Hemo	12	55-2603	Y
FRESNO AT HOME CENTER PD	568 E HERNDON AVE	STE 301	FRESNO	CA	93720-2989	5594480127	5594480132	PD Services	0	55-2645	Y
YOSEMITE STREET DIALYSIS CENTER	1650 W YOSEMITE AVE		MANTECA	CA	95337-5193	2098245552	2098251786	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care	21	55-2606	Y
DELTA VIEW DIALYSIS	1150 E LELAND RD		PITTSBURG	CA	94565-5319	9254270867	9254270873	In-Center Hemo	20	55-2664	Y
SOUTH CERRITOS DIALYSIS	12191 226TH ST		HAWAIIAN GARDENS	CA	90716-1510	5624214016	5624214652	In-Center Hemo	16	55-2686	Y
HIGHLAND RANCH DIALYSIS	7223 CHURCH ST STE A14		HIGHLAND	CA	92346-6837	9098629670	9098629675	In-Center Hemo	21	55-2663	Y
SAN JOSE AT HOME (PD)	4400 STEVENS CREEK BLVD	STE 50	SAN JOSE	CA	95129-1104	4089852011	4089852016	PD Services	0	55-2602	Y
GOLDEN GATE DIALYSIS	2700 GEARY BLVD	STE A	SAN FRANCISCO	CA	94118-3406	4153451869	4156731206	In-Center Hemo	24	55-2811	Y
FREMONT AT HOME PD	39355 CALIFORNIA ST	STE 101	FREMONT	CA	94538-1447	5104941348	5107972587	PD Services	0	55-2699	Y
ANAHEIM WEST DIALYSIS	1821 W LINCOLN AVE		ANAHEIM	CA	92801-6731	7147656510	7147656515	In-Center Hemo, PD Services	20	55-2676	Y
FREMONT DIALYSIS	2599 STEVENSON BLVD		FREMONT	CA	94538-2315	5107964385	5107131249	In-Center Hemo	24	55-2698	Y
BERMUDA DUNES DIALYSIS	78030 WILDCAT DR	STE 101	PALM DESERT	CA	92211-1116	7603455115	7603603110	In-Center Hemo	21	55-2707	Y
EAST LA PLAZA DIALYSIS	1700 E CESAR E CHAVEZ AVE	STE L 100	LOS ANGELES	CA	90033-2472	3232610484	3232615348	In-Center Hemo, In-Center Hemo Self Care, PD Services	33	05-2622	Y
IMPERIAL DIALYSIS	2738 W IMPERIAL HWY		INGLEWOOD	CA	90303-3111	3237795399	3237795651	In-Center Hemo, In-Center Hemo Self Care, PD Services	30	05-2670	Y
NORTH HOLLYWOOD DIALYSIS	12126 VICTORY BLVD		NORTH HOLLYWOOD	CA	91606-3205	8189805070	8189809956	In-Center Hemo, PD Services	28	05-2781	Y
SAN JUAN CAPISTRANO SOUTH DIALYSIS	31736 RANCHO VIEJO RD	STE B	SAN JUAN CAPISTRANO	CA	92675-2783	9492401454	9492400735	In-Center Hemo, PD Services	18	05-2648	Y
MISSION VIEJO DIALYSIS	27640 MARGUERITE PKWY		MISSION VIEJO	CA	92692-3604	9493472433	9493475958	In-Center Hemo, PD Services	20	05-2597	Y
HI-DESERT DIALYSIS	56845 29 PALMS HWY		YUCCA VALLEY	CA	92284-2940	7603658706	7602280154	In-Center Hemo, In-Center Hemo Self Care, PD Services	25	05-2776	Y
BANNING DIALYSIS	6090 W RAMSEY ST		BANNING	CA	92220-3052	9518454494	9518454845	In-Center Hemo, In-Center Hemo Self Care, PD Services	18	55-2520	Y
ALAMEDA COUNTY DIALYSIS	10700 MACARTHUR BLVD	BLDG 7	OAKLAND	CA	94605-5260	5105685849	5103821632	In-Center Hemo, In-Center Hemo Self Care	24	05-2787	Y
INGLEWOOD DIALYSIS	125 E ARBOR VITAE ST		INGLEWOOD	CA	90301-3839	3106776114	3106779456	In-Center Hemo, In-Center Hemo Self Care, PD Services	40	05-2538	Y
POMONA DIALYSIS	2111 N GAREY AVE		POMONA	CA	91767-2328	9095969997	9095967687	In-Center Hemo, In-Center Hemo Self Care, PD Services	32	05-2591	Y
VICTOR VALLEY DIALYSIS	16049 KAMANA RD		APPLE VALLEY	CA	92307-1331	7602428311	7602425419	In-Center Hemo, In-Center Hemo Self Care, PD Services	22	05-2561	Y
BERKELEY DIALYSIS	2655 SHATTUCK AVE		BERKELEY	CA	94704-3237	5104868706	5108491008	In-Center Hemo, In-Center Hemo Self Care	25	05-2587	Y
ESCONDIDO DIALYSIS	203 E 2ND AVE		ESCONDIDO	CA	92025-4212	7607434401	7607437059	In-Center Hemo, In-Center Hemo Self Care	22	05-2525	Y
FULLERTON DIALYSIS	238 ORANGEFAIR MALL		FULLERTON	CA	92832-3037	7144473045	7144473645	In-Center Hemo	25	05-2505	Y
HUNTINGTON BEACH DIALYSIS	16892 BOLSA CHICA ST	STE 100	HUNTINGTON BEACH	CA	92649-3571	7148462102	7148468053	In-Center Hemo	10	05-2641	Y
PALM SPRINGS DIALYSIS	1061 N INDIAN CANYON DR		PALM SPRINGS	CA	92262-4854	7603250909	7603201723	In-Center Hemo, In-Center Hemo Self Care, PD Services	20	05-2541	Y
BENICIA DIALYSIS	560 1ST ST	STE D103	BENICIA	CA	94510-3293	7077451488	7077458089	In-Center Hemo, In-Center Hemo Self Care, PD Services	14	05-2810	Y
ATWATER DIALYSIS	1201 COMMERCE AVE		ATWATER	CA	95301-5224	2093587681	2093587568	In-Center Hemo, In-Center Hemo Self Care	16	05-2706	Y
MERCED DIALYSIS	3393 G ST	STE A	MERCED	CA	95340-1308	2097230013	2097232725	In-Center Hemo, In-Center Hemo Self Care, PD Services	32	05-2584	Y
SAN DIEGO SOUTH DIALYSIS	995 GATEWAY CENTER WAY	STE 101	SAN DIEGO	CA	92102-4550	6192621960	6192622420	In-Center Hemo, Nocturnal Hemo	17	05-2799	Y
SANTA MONICA DIALYSIS	1260 15TH ST	STE 102	SANTA MONICA	CA	90404-1136	3103934744	3103935308	In-Center Hemo, In-Center Hemo Self Care	22	05-2665	Y
TULARE DIALYSIS	545 E TULARE AVE		TULARE	CA	93274-4220	5596888991	5596880326	In-Center Hemo, In-Center Hemo Self Care	16	05-2666	Y
VISALIA DIALYSIS	5429 W CYPRESS AVE		VISALIA	CA	93277-8341	5597389279	5597334785	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care, PD Services	24	05-2696	Y
SAN YSIDRO DIALYSIS	1445 30TH ST	STE A-B	SAN DIEGO	CA	92154-3496	6195753901	6195755538	In-Center Hemo, In-Center Hemo Self Care, PD Services	41	05-2866	Y

SAN DIEGO EAST DIALYSIS	292 EUCLID AVE	STE 100	SAN DIEGO	CA	92114-3629	6192627225	6192627470	In-Center Hemo, PD Services	25	05-2883	Y
ENCINITAS DIALYSIS	332 SANTA FE DR	STE 100	ENCINITAS	CA	92024-5143	7606322323	7606322311	In-Center Hemo, In-Center Hemo Self Care, PD Services	15	05-2756	Y
CHINO DIALYSIS	4445 RIVERSIDE DR		CHINO	CA	91710-3961	9094640347	9094640936	In-Center Hemo	24	05-2739	Y
GLENDALE DIALYSIS	1000 E PALMER AVE		GLENDALE	CA	91205-3532	8182416382	8182418153	In-Center Hemo, In-Center Hemo Self Care, Acute Hemo 1:1, PD Services	22	05-2632	Y
WESTMINSTER SOUTH DIALYSIS	14014 MAGNOLIA ST		WESTMINSTER	CA	92683-4736	7148948712	7148948734	In-Center Hemo, PD Services	24	05-2773	Y
COLLEGE DIALYSIS	6535 UNIVERSITY AVE		SAN DIEGO	CA	92115-5810	6192878796	6192874862	In-Center Hemo, PD Services	20	55-2513	Y
TOWER DIALYSIS	8635 W 3RD ST	STE 560W	LOS ANGELES	CA	90048-6110	3108551742	3102891032	In-Center Hemo, PD Services	25	05-2643	Y
CARMEL MOUNTAIN DIALYSIS	9850 CARMEL MOUNTAIN RD		SAN DIEGO	CA	92129-2892	8585381083	8585386734	In-Center Hemo, Nocturnal Hemo, PD Services	16	55-2515	Y
FRESNO PALM BLUFFS DIALYSIS	770 W PINEDALE AVE		FRESNO	CA	93711-5744	5594388512	5594388696	In-Center Hemo, Nocturnal Hemo	25	55-2505	Y
COSTA MESA DIALYSIS	1590 SCENIC AVE		COSTA MESA	CA	92626-1400	7145409401	7145409420	In-Center Hemo, PD Services, Nocturnal Hemo	24	55-2518	Y
WHITE LANE DIALYSIS	7701 WHITE LN	STE D	BAKERSFIELD	CA	93309-0201	6613967158	6613967286	In-Center Hemo, In-Center Hemo Self Care, PD Services	20	55-2521	Y
STOCKTON HOME TRAINING DIALYSIS	5608 N PERSHING AVE		STOCKTON	CA	95207-4906	2099549563	2099549938	PD Services	0	55-2523	Y
HANFORD AT HOME DIALYSIS	900 N DOUTY ST		HANFORD	CA	93230-3918	5595879014	5595879285	PD Services		55-2644	Y
MANTECA DIALYSIS	1620 W YOSEMITE AVE		MANTECA	CA	95337-5190	2098253905	2098246870	In-Center Hemo, In-Center Hemo Self Care, PD Services	12	05-2723	Y
DALY CITY DIALYSIS	1498 SOUTHGATE AVE	STE 101	DALY CITY	CA	94015-4015	6507554751	6507550356	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care	34	05-2546	Y
VALLEJO DIALYSIS	830 REDWOOD ST		VALLEJO	CA	94590-2942	7076422016	7076422023	In-Center Hemo	24	05-2567	Y
FRESNO DIALYSIS	4753 W SHAW AVE	STE 101	FRESNO	CA	93722-6209	5592778738	5592773465	In-Center Hemo, In-Center Hemo Self Care, Acute Hemo 1:1	24	05-2608	Y
OAKLAND DIALYSIS	5354 CLAREMONT AVE		OAKLAND	CA	94618-1035	5105970104	5105970249	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care	40	05-2729	Y
BAKERSFIELD BRIMHALL DIALYSIS	8501 BRIMHALL RD	STE 500	BAKERSFIELD	CA	93312-2258	6613876603	6613876780	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care, PD Services	20	05-2635	Y
NORTHEAST DIALYSIS	3761 MALL VIEW RD		BAKERSFIELD	CA	93306-3048	6618729836	6618729933	In-Center Hemo, In-Center Hemo Self Care	12	05-2839	Y
SAN FRANCISCO DIALYSIS	1499 WEBSTER ST		SAN FRANCISCO	CA	94115-3705	4159289003	4159289018	In-Center Hemo	30	05-2719	Y
HANFORD DIALYSIS	402 W 8TH ST		HANFORD	CA	93230-4536	5595825462	5595822329	In-Center Hemo, In-Center Hemo Self Care	20	05-2628	Y
SAN PABLO DIALYSIS	14020 SAN PABLO AVE		SAN PABLO	CA	94806-3604	5102340835	5102343854	In-Center Hemo, In-Center Hemo Self Care	22	05-2560	Y
CHINATOWN DIALYSIS	636 CLAY ST		SAN FRANCISCO	CA	94111-2502	4152918992	4152918985	In-Center Hemo, In-Center Hemo Self Care, Acute Hemo 1:1	22	05-2769	Y
EL CERRITO DIALYSIS	10690 SAN PABLO AVE		EL CERRITO	CA	94530-2620	5105289590	5105289803	In-Center Hemo, In-Center Hemo Self Care, PD Services	20	05-2786	Y
TRACY DIALYSIS	425 W BEVERLY PL	STE A	TRACY	CA	95376-3086	2098390398	2098390799	In-Center Hemo, In-Center Hemo Self Care, PD Services	12	05-2814	Y
AUBURN DIALYSIS	3126 PROFESSIONAL DR	STE 100	AUBURN	CA	95603-2411	5308868221	5308868608	In-Center Hemo, In-Center Hemo Self Care, PD Services	16	05-2614	Y
GRASS VALLEY DIALYSIS	360 CROWN POINT CIRCLE	STE 210	GRASS VALLEY	CA	95945-2543	5304770734	5304770178	In-Center Hemo, In-Center Hemo Self Care, PD Services	18	05-2805	Y
UPLAND DIALYSIS	600 N 13TH AVE		UPLAND	CA	91786-4957	9099463802	9099460515	In-Center Hemo, In-Center Hemo Self Care, PD Services	24	05-2552	Y
FONTANA DIALYSIS	17590 FOOTHILL BLVD		FONTANA	CA	92335-8416	9093569664	9093569687	In-Center Hemo, In-Center Hemo Self Care	28	05-2682	Y
LOS BANOS DIALYSIS	60 G ST	BLDG 5 STE D	LOS BANOS	CA	93635-3658	2098262787	2098266325	In-Center Hemo, In-Center Hemo Self Care, PD Services	24	05-2738	Y
BURBANK DIALYSIS	1211 N SAN FERNANDO BLVD		BURBANK	CA	91504-4234	8188425576	8188424250	In-Center Hemo, In-Center Hemo Self Care	24	05-2637	Y
DELANO DIALYSIS	405 DOVER PKWY		DELANO	CA	93215-3714	6617251370	6617251323	In-Center Hemo, In-Center Hemo Self Care, Nocturnal Hemo	32	05-2674	Y
SELMA DIALYSIS	2711 CINEMA WAY	STE 111	SELMA	CA	93662-2662	5598912750	5598912755	In-Center Hemo, In-Center Hemo Self Care, PD Services	30	05-2770	Y
LOS ANGELES DOWNTOWN DIALYSIS	2021 S FLOWER ST		LOS ANGELES	CA	90007-1342	2137454222	2137491753	In-Center Hemo	28	05-2828	Y
ANAHEIM DIALYSIS	1341 W LA PALMA AVE		ANAHEIM	CA	92801-2804	7142541484	7142541914	In-Center Hemo, PD Services	35	05-2734	Y
SADDLEBACK DIALYSIS	23141 PLAZA POINTE DR		LAGUNA HILLS	CA	92653-1425	9495889211	9495889299	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care	25	05-2808	Y
MERCED EAST DIALYSIS	464 E YOSEMITE AVE	STE B	MERCED	CA	95340-8489	2092051126	2092051130	In-Center Hemo, PD Services	12	55-2647	Y
WEST GLENDALE DIALYSIS	1427 S GLENDALE AVE		GLENDALE	CA	91205-3313	8182410016	8182410038	In-Center Hemo	18	05-2859	Y
CENTURY CITY DIALYSIS-PEDIATRICS	10630 SANTA MONICA BLVD		LOS ANGELES	CA	90025-4837	3109542700 OPTION 2	3104747918	In-Center Hemo, PD Services		05-2865	Y
GATEWAY PLAZA DIALYSIS	1580 W ROSECRANS AVE		COMPTON	CA	90220-1001	3106313085	3106313670	In-Center Hemo	16	55-2661	Y
PASADENA FOOTHILLS DIALYSIS	3722 E COLORADO BLVD		PASADENA	CA	91107-3872	6264324331	6264324336	In-Center Hemo, PD Services	20	55-2660	Y
POMONA VALLEY DIALYSIS	2703 S TOWNE AVE		POMONA	CA	91766-6206	9095904930	9095918425	In-Center Hemo	32	55-2774	Y
HAWTHORNE DIALYSIS	14204 PRAIRIE AVE		HAWTHORNE	CA	90250-7908	3103491174	3103491903	In-Center Hemo	25	55-2744	Y
ARTESIA HOME TRAINING	16506 LAKEWOOD BLVD	STE 100	BELLFLOWER	CA	90706-5165	5629204084	5629204136	PD Services		55-2694	Y
GARFIELD HOME PROGRAM PD	228 N GARFIELD AVE	STE 301	MONTEREY PARK	CA	91754-1709	6262886379	6262886383	PD Services		55-2666	Y
WESTBOROUGH DIALYSIS CENTER	925 EL CAMINO REAL		SOUTH SAN FRANCISCO	CA	94080-3203	6506245433	6506245439	In-Center Hemo	5	55-2619	Y
BAKERSFIELD OAK ST DIALYSIS	422 OAK ST		BAKERSFIELD	CA	93304-1744	6616310227	6616310501	In-Center Hemo, PD Services	24	55-2769	Y
LEMOORE DIALYSIS	1345 W BUSH ST		LEMOORE	CA	93245-3303	5599243175	5599242485	In-Center Hemo	16	55-2679	Y
CATHEDRAL CITY DIALYSIS	30885 DATE PALM DR		CATHEDRAL CITY	CA	92234-2958	7602023491	7602027015	In-Center Hemo, PD Services	21	55-2700	Y
SAN LEANDRO DIALYSIS	15555 E 14TH ST	STE 520	SAN LEANDRO	CA	94578-1949	5103176510	5103176515	In-Center Hemo, Nocturnal Hemo	24	55-2633	Y
ROSEVILLE DIALYSIS	1836 SIERRA GARDENS DR	STE 150	ROSEVILLE	CA	95661-2943	9167720306	9167720189	In-Center Hemo	24	55-2771	Y
CALVINE DIALYSIS	8243 E STOCKTON BLVD	STE 100	SACRAMENTO	CA	95828-8204	9166826655	9166826554	In-Center Hemo	24	55-2683	Y
ARVIN DIALYSIS	902 BEAR MOUNTAIN BLVD		ARVIN	CA	93203-1317	6618543699	6618545118	In-Center Hemo	16	55-2753	Y

HAYWARD MISSION HILLS DIALYSIS	1661 INDUSTRIAL PKWY W		HAYWARD	CA	94544-7046	5102665743	5102591270	In-Center Hemo	24	55-2672	Y
SUN CITY MENIFEE DIALYSIS	1702 ILLINOIS AVE		PERRIS	CA	92571-9371	9519281369	9519282150	In-Center Hemo	24	55-2715	Y
MOJAVE SAGE DIALYSIS	17207 JASMINE ST		VICTORVILLE	CA	92395-7786	7602418167	7608435685	In-Center Hemo, PD Services	24	55-2708	Y
NORTH SACRAMENTO DIALYSIS	251 LATHROP WAY	STE A	SACRAMENTO	CA	95815-4223	9169224721	9169222189	In-Center Hemo	24	55-2705	Y
FIRESTONE BLVD DIALYSIS	11913 FIRESTONE BLVD		NORWALK	CA	90650-2904	5628632127	5628633052	In-Center Hemo, Nocturnal Hemo	24	55-2727	Y
NORTH MADERA DIALYSIS	720 N I ST		MADERA	CA	93637-3079	5596648780	5596648971	In-Center Hemo, PD Services	20	55-2729	Y
SEQUOIA DIALYSIS	440 N 11TH AVE		HANFORD	CA	93230-4404	5595870105	5595870293	In-Center Hemo	20	55-2721	Y
SANTA CLARA DIALYSIS	777 LAWRENCE EXPRESSWAY	STE 18	SANTA CLARA	CA	95051-5118	4082431130	4082431139	In-Center Hemo	24	55-2737	Y
LAUREL MEADOWS DIALYSIS	3 ROSSI CIR	STE A	SALINAS	CA	93907-2356	8314245726	8314242565	In-Center Hemo	24	55-2713	Y
LAUREL MEADOWS HOME TRAINING	3 ROSSI CIR	STE B	SALINAS	CA	93907-2356	8317574360	8317548955	PD Services		55-2724	Y
BOYLE HEIGHTS DIALYSIS	1936 E 1ST ST		LOS ANGELES	CA	90033-3413	3232682729	3232682848	In-Center Hemo, PD Services	28	55-2742	Y
SILICON VALLEY DIALYSIS	725 RIDDER PARK DR	STE 10	SAN JOSE	CA	95131-2431	4083920390	4083920405	In-Center Hemo	32	55-2711	Y
MOORPARK DIALYSIS	883 PATRIOT DR	STE C	MOORPARK	CA	93021-3352	8055171442	8055171604	In-Center Hemo, PD Services	20	55-2728	Y
EL CAMINO DIALYSIS	412 W EL CAMINO REAL		MOUNTAIN VIEW	CA	94040-2610	6509621903	6509620102	In-Center Hemo	24		Y
COALINGA DIALYSIS	1147 PHELPS AVE		COALINGA	CA	93210-9662	5599340690	5599340644	In-Center Hemo	12	55-2726	Y
SILICON VALLEY HOME TRAINING	725 RIDDER PARK DR	STE 50	SAN JOSE	CA	95131-2431	4083920239	4083920328	PD Services		55-2712	Y
COLTON RANCH DIALYSIS	1405 W VALLEY BLVD	STE 100	COLTON	CA	92324-1910	9097837948	9097830125	In-Center Hemo, Home Hemo, PD Services	32	55-2791	Y
SOUTH SAN FRANCISCO AT HOME (PD)	74 CAMARITAS AVE		SOUTH SAN FRANCISCO	CA	94080-3133	6505898562	6505898494	PD Services		55-2716	Y
JURUPA VALLEY DIALYSIS	8080 LIMONITE AVE		JURUPA VALLEY	CA	92509-6107	9513619405	9517270027	In-Center Hemo	25	55-2817	Y
PORT CITY DIALYSIS	1810 S FRESNO AVE		STOCKTON	CA	95206-1861	2099460738	2099460827	In-Center Hemo	24	55-2808	Y
SOUTH GATE DIALYSIS	9848 ATLANTIC AVE		SOUTH GATE	CA	90280-5219	3235691035	3235691790	In-Center Hemo, PD Services	25	55-2821	Y
DINUBA DIALYSIS	510 E NORTH WAY		DINUBA	CA	93618-1653	5595959462	5595959471	In-Center Hemo, PD Services	20	55-2740	Y
STEVENS CREEK DIALYSIS	275 DI SALVO AVE		SAN JOSE	CA	95128-1628	4082970103	4082972265	In-Center Hemo, Nocturnal Hemo	24	55-2738	Y
LOS GATOS DIALYSIS	14251 WINCHESTER BLVD	STE 100	LOS GATOS	CA	95032-1811	4083706756	4083706787	In-Center Hemo, PD Services	18	55-2743	Y
ARCHWAY DIALYSIS OF MODESTO	3001 HEALTH CARE WAY	BLDG E, STE 102	MODESTO	CA	95356-8503	2095431720	2095431596	In-Center Hemo	20	55-2760	Y
HERNDON DIALYSIS	560 E HERNDON AVE	STE 101	FRESNO	CA	93720-2907	5594325278	5594351422	In-Center Hemo	48	55-2702	Y
SAN FRANCISCO HOME TRAINING (PD)	1493 WEBSTER ST		SAN FRANCISCO	CA	94115-3705	4153463382	4153463528	PD Services		55-2736	Y
RANCHO CUCAMONGA HOME TRAINING	8219 ROCHESTER AVE		RANCHO CUCAMONGA	CA	91730-0722	9094665489	9094772098	PD Services		55-2757	Y
ARCHWAY MODESTO HOME TRAINING (PD)	3001 HEALTH CARE WAY	BLDG E, STE 101	MODESTO	CA	95356-8503	2095431721	2095431750	PD Services	4	55-2765	Y
CHANNEL ISLANDS DIALYSIS	3541 W 5TH ST	STE A	OXNARD	CA	93030-6403	8059845140	8059845647	In-Center Hemo, PD Services	16	55-2764	Y
NEWPORT IRVINE DIALYSIS	4300 VON KARMAN AVE		NEWPORT BEACH	CA	92660-2004	9498631382	9498631407	In-Center Hemo, PD Services	17	55-2789	Y
SAN LEANDRO MARINA DIALYSIS	2551 MERCED ST		SAN LEANDRO	CA	94577-4207	5103521207	5103521294	In-Center Hemo	24	55-2749	Y
BASTANCHURY DIALYSIS	1950 SUNNYCREST DR	STE 1300	FULLERTON	CA	92835-3638	7145780015	7145785907	In-Center Hemo, PD Services	25	55-2759	Y
BLUFF RD DIALYSIS	100 WASHINGTON BLVD		MONTEBELLO	CA	90640-6211	3237282984	3237266747	In-Center Hemo, PD Services	24	55-2773	Y
TULLY DIALYSIS	1290 TULLY RD	STE 80	SAN JOSE	CA	95122-3069	4089938959	4089756223	In-Center Hemo	32	55-2723	Y
SAN RAFAEL DIALYSIS	1415 3RD ST		SAN RAFAEL	CA	94901-2826	4154534437	4154534616	In-Center Hemo, PD Services	24	55-2794	Y
BEVERLYWOOD DIALYSIS	2080 CENTURY PARK E	STE 210	LOS ANGELES	CA	90067-2001	3107720224	3107720120	In-Center Hemo, PD Services	13	55-2800	Y
FAIRFIELD DOWNTOWN DIALYSIS	1800 N TEXAS ST		FAIRFIELD	CA	94533-4441	7073999984	7073999925	In-Center Hemo	24	55-2763	Y
BROADWAY DIALYSIS	2624 STOCKTON BLVD		SACRAMENTO	CA	95817-2210	9164570113	9164570116	In-Center Hemo	34	55-2802	Y
CALVINE HOME TRAINING	8231 E STOCKTON BLVD	STE A	SACRAMENTO	CA	95828-8202	9166894254	9166899563	PD Services	6	55-2747	Y
WALNUT CREEK WEST DIALYSIS	1221 ROSSMOOR PKWY		WALNUT CREEK	CA	94595-2539	9252959830	9252950256	In-Center Hemo	21	55-2772	Y
TULLY ROAD HOME TRAINING (PD)	1290 TULLY RD	STE 60	SAN JOSE	CA	95122-3069	4082750105	4082750115	PD Services	4	55-2731	Y
MENIFEE HOME DIALYSIS	29878 HAUN RD	STE 100	MENIFEE	CA	92586-6531	9516792396	9513019725	PD Services		55-2780	Y
AVALON DIALYSIS	5807 AVALON BLVD		LOS ANGELES	CA	90011-5303	3232332452	3232332549	In-Center Hemo	24	55-2793	Y
UPLAND COLONIES DIALYSIS	587 N MOUNTAIN AVE		UPLAND	CA	91786-5016	9099314515	9099815086	In-Center Hemo	25	55-2813	Y
SAN BERNARDINO HOME TRAINING	966 E HOSPITALITY LN		SAN BERNARDINO	CA	92408-2818	9097968421	9094787547	PD Services		55-2776	Y
GLENDORA FOOTHILLS DIALYSIS	750 W ROUTE 66	STE Q	GLENDORA	CA	91740-4164	6263352063	6269141480	In-Center Hemo	24	55-2785	Y
ONTARIO MILLS DIALYSIS	2403 S VINEYARD AVE	STE D	ONTARIO	CA	91761-6471	9099233850	9099238569	In-Center Hemo	25	55-2815	Y
ARCADIA OAKS DIALYSIS	721 W HUNTINGTON DR		ARCADIA	CA	91007-6734	6262949682	6264457455	In-Center Hemo	20	55-2787	Y
EL SOBRANTE DIALYSIS	3380 SAN PABLO DAM RD	STE C-D	SAN PABLO	CA	94803-7218	5102629230	5102629203	In-Center Hemo	20	55-2779	Y

SAN QUENTIN PRISON PROGRAM	1 MAIN ST	ATTN MEDICAL WAREHOUSE/DIALYSIS	SAN QUENTIN	CA	94964-1000	4154541460x3765	4157213551	In-Center Hemo			Y
NORTH GLENDALE DIALYSIS	1505 WILSON TER STE 190		GLENDALE	CA	91206-4015	8186378348	8186378354	In-Center Hemo, PD Services	36	55-2589	Y
CAMARILLO DIALYSIS	2438 N PONDEROSA DR	STE C101	CAMARILLO	CA	93010-2465	8057640171	8053880360	In-Center Hemo, PD Services	18	55-2551	Y
THOUSAND OAKS DIALYSIS	375 ROLLING OAKS DR	STE 100	THOUSAND OAKS	CA	91361-1024	8055571036	8055571173	In-Center Hemo, PD Services	15	05-2873	Y
SIMI VALLEY DIALYSIS	970 ENCHANTED WAY		SIMI VALLEY	CA	93065-0953	8055849621	8055849703	In-Center Hemo, PD Services	24	05-2638	Y
SANTA PAULA DIALYSIS	253 MARCH ST		SANTA PAULA	CA	93060-2511	8055253977	8055254746	In-Center Hemo	10	05-2800	Y
CSATF-19 PRISON DIALYSIS PROGRAM	900 QUEBEC AVE		CORCORAN	CA	93212-9715	5599927100 EXT 6642 / EXT 6645	5599927525	In-Center Hemo	0		N
PACIFIC DIALYSIS	2351 CLAY ST	FL 4	SAN FRANCISCO	CA	94115-1931	4154402852	4154478305	In-Center Hemo	30	55-2668	Y
DAVIES DIALYSIS	45 CASTRO ST	SOUTH TOWER 2ND FL	SAN FRANCISCO	CA	94114-1032	4152527030	4152527659	In-Center Hemo	16	55-2669	Y
VENTURA DIALYSIS	2705 LOMA VISTA RD	STE 101	VENTURA	CA	93003-1596	8056437549	8056436891	In-Center Hemo, PD Services	20	55-2575	Y
VISALIA AT HOME PD	1120 N CHINOWTH ST		VISALIA	CA	93291-7896	5596229844	5596220778	PD Services	0	05-2771	Y
OXNARD DIALYSIS	1900 OUTLET CENTER DR		OXNARD	CA	93036-0677	8052783815	8059818596	In-Center Hemo, PD Services	20	55-2684	Y
SAN LUIS OBISPO DIALYSIS	1043 MARSH ST		SAN LUIS OBISPO	CA	93401-3629	8055431013	8055435645	In-Center Hemo, Acute Hemo 1:1, PD Services	20	05-2811	Y
TEMPLETON DIALYSIS	1310 LAS TABLAS RD	STE 101	TEMPLETON	CA	93465-9746	8054343473	8054343246	In-Center Hemo, PD Services	16	55-2567	Y
PISMO BEACH DIALYSIS	320 JAMES WAY	STE 110	PISMO BEACH	CA	93449-2875	8055560577	8055560510	In-Center Hemo	14	55-2556	Y
SILVERADO DIALYSIS	1100 TRANCAS ST	STE 266 AND 267	NAPA	CA	94558-2921	7072246533	7072246535	In-Center Hemo, PD Services	10	05-2565	Y
BURLINGAME DIALYSIS	1720 EL CAMINO REAL	STE 12	BURLINGAME	CA	94010-3225	6506977601	6506977926	In-Center Hemo, PD Services	13	55-2681	Y
MILLS DIALYSIS	100 S SAN MATEO DR		SAN MATEO	CA	94401-3805	6505484985	6506964639	In-Center Hemo, PD Services	19	55-2682	Y
CARSON DIALYSIS	1309 E CARSON ST		CARSON	CA	90745-1631	3105131427	3105131581	In-Center Hemo	16	05-2803	Y
MORENO VALLEY DIALYSIS	22620 GOLDENCREST DR	STE 101	MORENO VALLEY	CA	92553-9032	9516563804	9516567508	In-Center Hemo	24	55-2599	Y
CERRITOS DIALYSIS	19222 PIONEER BLVD	STE 101	CERRITOS	CA	90703-6601	5629249990	5629249955	In-Center Hemo	21	05-2896	Y
ANAHEIM HILLS DIALYSIS	4201 E LA PALMA AVE		ANAHEIM	CA	92807-1815	7149962900	7149962969	In-Center Hemo	21	55-2545	Y
LA PALMA DIALYSIS	5451 LA PALMA AVE	STE 35	LA PALMA	CA	90623-1731	7145235970	7145234404	In-Center Hemo, PD Services	12	05-2627	Y
FOUNTAIN VALLEY DIALYSIS	17150 EUCLID ST	STE 111	FOUNTAIN VALLEY	CA	92708-4092	7149661595	7149661555	In-Center Hemo	21	55-2630	Y
NEPHRON DIALYSIS	5820 DOWNEY AVE		LONG BEACH	CA	90805-4517	5626630788	5626630794	In-Center Hemo	21	05-2788	Y
SFS DIALYSIS	10012 NORWALK BLVD	STE 190	SANTA FE SPRINGS	CA	90670-3345	5629038281	5629038289	In-Center Hemo	24	05-2724	Y
IOWA STREET DIALYSIS	8333 IOWA ST	STE 100	DOWNEY	CA	90241-4994	5629235901	5629236000	In-Center Hemo	21	55-2639	Y
LAUREL MEADOWS HT AT HOME	3 ROSSI CIRCLE	STE B	SALINAS	CA	93907-2356	8317574360	8317548955	Home Hemo		55-2724	Y
SILICON VALLEY HT AT HOME	725 RIDDER PRK DR	STE 50	SAN JOSE	CA	95131-2431	4083920239	4083920328	Home Hemo		55-2712	Y
SAN FRANCISCO HT AT HOME	1493 WEBSTER ST		SAN FRANCISCO	CA	94115-3705	4153463382	4153463528	Home Hemo		55-2736	Y
WEST GLENDALE AT HOME	1427 S GLENDALE AVE		GLENDALE	CA	91205-3313	8182410016	8182410038	Home Hemo	0	05-2859	Y
MOORPARK AT HOME	883 PATRIOT DR	STE C	MOORPARK	CA	93021-3352	8055171442	8055171871	Home Hemo		55-2728	Y
LAGUNA HILLS AT HOME	25332 CABOT RD		LAGUNA HILLS	CA	92653-5506	9493801925	9493801746	Home Hemo		55-2718	Y
SOUTH SAN FRANCISCO AT HOME	74 CAMARITAS AVE		SOUTH SAN FRANCISCO	CA	94080-3133	6505898562	6505898494	Home Hemo		55-2716	Y
OAKLAND PERITONEAL AT HOME	5352 CLAREMONT AVE		OAKLAND	CA	94618-1035	5105970398	5105970385	Home Hemo		05-2822	Y
FREMONT AT HOME HHD	39355 CALIFORNIA AVE	STE 101	FREMONT	CA	94538-1447	5104941348	5107972587	Home Hemo	0	55-2699	Y
ARTESIA HOME AT HOME	16506 LAKEWOOD BLVD	STE 100	BELLFLOWER	CA	90706-5165	5629204084	5629204136	Home Hemo		55-2694	Y
CATHEDRAL CITY AT HOME	30-885 DATE PALM DR		CATHEDRAL CITY	CA	92234-2958	7602023491	7602027015	Home Hemo		55-2700	Y
REDWOOD CITY AT HOME	1000 MARSHALL ST		REDWOOD CITY	CA	94063-2027	6503650129	6503650232	Home Hemo		55-2665	Y
THOUSAND OAKS AT HOME	375 ROLLING OAKS DR	STE 100	THOUSAND OAKS	CA	91361-1024	8055571036	8055571173	Home Hemo		05-2873	Y
SIMI VALLEY AT HOME	970 ENCHANTED WAY		SIMI VALLEY	CA	93065-0953	8055849621	8055879703	Home Hemo		05-2638	Y
FRESNO AT HOME CENTER CENTER	568 E HERNDON AVE	STE 301	FRESNO	CA	93720-2989	5594480127	5594480132	Home Hemo		55-2645	Y
NORTHGATE AT HOME	650 LAS GALLINAS AVE		SAN RAFAEL	CA	94903-3620	4154440376		Home Hemo	0	55-2607	Y
MAINPLACE AT HOME	972 W TOWN AND COUNTRY RD		ORANGE	CA	92868-4714	7148360155	7148360711	Home Hemo		05-2503	Y
MANZANITA AT HOME	4005 MANZANITA AVE	STE 18	CARMICHAEL	CA	95608-1779	9169711419	9169711439	Home Hemo		05-2604	Y
CENTURY CITY AT HOME	10630 SANTA MONICA BLVD		LOS ANGELES	CA	90025-4837	3109542700	3104744565	Home Hemo		05-2865	Y
REDDING AT HOME	1876 PARK MARINA DR		REDDING	CA	96001-0913	5302467474	5302460179	Home Hemo		05-2528	Y
WALNUT CREEK AT HOME	400 N WIGET LN		WALNUT CREEK	CA	94598-2408	9259799732	9259799738	Home Hemo	0	55-2611	Y
DALY CITY AT HOME	1498 SOUTHGATE AVE	STE 101	DALY CITY	CA	94015-4015	6507554751	6507557530	Home Hemo		05-2546	N

TOKAY AT HOME	777 S HAM LN	STE L	LODI	CA	95242-3593	2093338909	2093338914	Home Hemo	0	55-2576	Y
MAGNOLIA WEST AT HOME	3660 PARK SIERRA DR	STE 103	RIVERSIDE	CA	92505-3071	9513734004	9513734005	Home Hemo	0	55-2617	Y
CITRUS VALLEY AT HOME	894 HARDT ST		SAN BERNARDINO	CA	92408-2854	9093886608	9093886639	Home Hemo		55-2541	Y
CRESCENT HEIGHTS AT HOME	8151 BEVERLY BLVD		LOS ANGELES	CA	90048-4514	3236556226	3236556512	Home Hemo		05-2852	N
UNION CITY CENTER AT HOME (CA)	32930 ALVARADO NILES RD	STE 300	UNION CITY	CA	94587-8101	5104896996	5104893747	Home Hemo	0	05-2571	Y
CHICO AT HOME	530 COHASSET RD		CHICO	CA	95926-2212	5308921509	5308921580	Home Hemo	0	05-2553	Y
MONTCLAIR AT HOME	9142 MONTE VISTA AVE		MONTCLAIR	CA	91763-1723	9096266505	9096245736	Home Hemo	0	05-2804	Y
PREMIER AT HOME	7612 ATLANTIC AVE		CUDAHY	CA	90201-5020	3235625511	3235623347	Home Hemo		05-2761	N
TRC/HARBOR - UCLA AT HOME	21602 S VERMONT AVE		TORRANCE	CA	90502-1940	3105330413	3105331709	Home Hemo	0	05-2802	N
WEST SACRAMENTO AT HOME	3450 INDUSTRIAL BLVD	STE 100	WEST SACRAMENTO	CA	95691-5003	9163713318	9163718332	Home Hemo	0	55-2591	Y
SOUTH VALLEY AT HOME	17815 VENTURA BLVD	STE 100	ENCINO	CA	91316-3600	8187574520	8187571043	Home Hemo		05-2744	Y
FAIRFIELD AT HOME	4660 CENTRAL WAY		FAIRFIELD	CA	94534-1803	7078637369	7078637384	Home Hemo		05-2618	Y
BIXBY KNOLLS AT HOME	3744 LONG BEACH BLVD		LONG BEACH	CA	90807-3310	5624241403	5624275408	Home Hemo			N
SAN JOSE AT HOME	4400 STEVENS CREEK BLVD	STE 50	SAN JOSE	CA	95129-1104	4089852011	4089852016	Home Hemo	0	55-2602	Y
WHITE LANE AT HOME	7701 WHITE LN	STE D	BAKERSFIELD	CA	93309-0201	6618344561	6618345412	Home Hemo	0	55-2521	Y
HANFORD AT HOME	900 N DOUTY ST		HANFORD	CA	93230-3918	5595879014	5595879285	Home Hemo	0	55-2644	Y
ANAHEIM AT HOME	1107 W LA PALMA AVE		ANAHEIM	CA	92801-2804	7145022400	7145022414	Home Hemo		05-2734	N
MERCED AT HOME	3393 G ST	STE B	MERCED	CA	95340-1308	2097230013	2097232725	Home Hemo		05-2584	Y
GRASS VALLEY AT HOME	360 CROWN POINT CIR	STE 210	GRASS VALLEY	CA	95945-2543	5304770734	5304770178	Home Hemo		05-2805	Y
POMONA AT HOME	2111 N GAREY AVE		POMONA	CA	91767-2328	9095969997	9095967687	Home Hemo	0	05-2591	Y
LOS BANOS AT HOME	60 G ST	BLDG 5 STE D	LOS BANOS	CA	93635-3658	2098262787	2098266325	Home Hemo		05-2738	Y
LOS GATOS AT HOME	14251 WINCHESTER BVD	STE 100	LOS GATOS	CA	95032-1811	4083706756	4083706787	Home Hemo		55-2743	Y
AIRPORT SUNRISE AT HOME	11300 HAWTHORNE BLVD		INGLEWOOD	CA	90304-2715	3106800601	3106809166	Home Hemo			Y
RANCHO CUCAMONGA HT AT HOME	8219 ROCHESTER AVE		RANCHO CUCAMONGA	CA	91730-0722	9094665489	9094772098	Home Hemo		55-2757	Y
SAN MARCOS AT HOME	2135 MONTIEL RD	BLDG B	SAN MARCOS	CA	92069-3511	7609750170	7609750177	Home Hemo		55-2618	Y
TULLY ROAD HT AT HOME	1290 TULLY RD	STE 60	SAN JOSE	CA	95122-3069	4082750105	4082750115	Home Hemo		55-2731	Y
ARCHWAY MODESTO HT AT HOME	3001 HEALTH CARE WAY	BLDG E, STE 101	MODESTO	CA	95356-8503	2095431721	2095431750	Home Hemo		55-2765	Y
CALVINE HT AT HOME	8231 STOCKTON BLVD	STE A	SACRAMENTO	CA	95828-8202	9166894254	9166899563	Home Hemo		55-2747	Y
MENIFEE HOME AT HOME	29878 HAUN RD	STE 100	MENIFEE	CA	92586-6531	9516792396	9513019725	Home Hemo		55-2780	Y
SAN BERNARDINO HT AT HOME	966 E HOSPITALITY LN		SAN BERNARDINO	CA	92408-2818	9097968421	9094787547	Home Hemo		55-2776	Y
GARDEN GROVE HARBOR AT HOME	13054 N HARBOR BLVD		GARDEN GROVE	CA	92843-1744	7145393395	7145393467	Home Hemo		55-2781	Y
VISALIA VINEYARD AT HOME	1140 S BEN MADDOX WAY		VISALIA	CA	93292-3643	5596351938	5596255713	Home Hemo		55-2806	Y
FRESNO NORTH HT AT HOME	6655 N MILBURN AVE		FRESNO	CA	93722-2162	5594510768	5594471542	Home Hemo		55-2782	Y
BEVERLYWOOD AT HOME	2080 CENTURY PARK E	STE 210	LOS ANGELES	CA	90067-2001	3107720224	3107720120	Home Hemo			Y
RIVERLAKES HT AT HOME	3933 COFFEE RD	STE A	BAKERSFIELD	CA	93308-5024	6615882326	6615880037	Home Hemo	0	55-2795	Y
DAVITA HUNTINGTON AT HOME	390 S FAIR OAKS AVE	STE 120	PASADENA	CA	91105-2540	6265781593	6265642891	Home Hemo		55-2822	Y
CASA DEL RIO HT AT HOME	8331 BRIMHALL RD	STE 902, BLDG 900	BAKERSFIELD	CA	93312-2249	6613876405	6613876442	Home Hemo		55-2823	Y
ROLLING HILLS AT HOME	25210 CRENSHAW BLVD	STE 110	TORRANCE	CA	90505-6134	3106301180	3106301312	Home Hemo			Y
STOCKTON PRISON (CHCF) CONTRACT	7707 S AUSTIN RD	DIALYSIS UNIT	STOCKTON	CA	95215-8312	2094677295	2094675429	In-Center Hemo			Y
CIRCLE CITY DIALYSIS	1180 W 6TH ST	STE 101	CORONA	CA	92882-3135	9518089068	9518089861	In-Center Hemo	33	55-2826	Y
EL DORADO DIALYSIS	2977 REDONDO AVE		LONG BEACH	CA	90806-2445	5629883418	5629815698	In-Center Hemo, PD Services	25	55-2801	Y
FRESNO NORTH HOME TRAINING (PD)	6655 N MILBURN AVE		FRESNO	CA	93722-2162	5594510768	5594471542	PD Services	6	55-2782	Y
SEVEN OAKS DIALYSIS	4651 CORPORATE COURT		BAKERSFIELD	CA	93311-8822	6616645887	6616640145	In-Center Hemo	24	55-2796	Y
CASA ST HOME TRAINING (PD ONLY)	35 CASA ST	STE 110	SAN LUIS OBISPO	CA	93405-1887	8057850321	8057850328	PD Services	0	55-2792	Y
CASA DEL RIO HOME TRAINING (PD-HHD)-CA	8331 BRIMHALL RD	STE 902, BLDG 900	BAKERSFIELD	CA	93312-2249	6613876405	6613876442	PD Services		55-2823	Y
WESTLAKE VILLAGE DIALYSIS	30730 RUSSELL RANCH RD	STE A	WESTLAKE VILLAGE	CA	91362-6354	8187077834	8187077874	In-Center Hemo	21		Y
SERRANO DIALYSIS	1800 MEDICAL CENTER DR	STE 150	SAN BERNARDINO	CA	92411-1218	9098872717	9098873794	In-Center Hemo	25		Y
ANAHEIM SPRINGS DIALYSIS	1324 S EUCLID ST		ANAHEIM	CA	92802-2002	7147741518	7147741549	In-Center Hemo	25	55-2766	Y
TUSTIN RANCH DIALYSIS	721 WEST 1ST ST		TUSTIN	CA	92780-2903	7145440079	7145440071	In-Center Hemo, PD Services	25	55-2807	Y
RIVERLAKES HOME TRAINING (PD)	3933 COFFEE RD	STE A	BAKERSFIELD	CA	93308-5024	6615882326	6615880037	PD Services	0	55-2795	Y
DAVITA HUNTINGTON DIALYSIS	390 S FAIR OAKS AVE	STE 120	PASADENA	CA	91105-2540	6265642818	6265642889	In-Center Hemo, PD Services	25	55-2822	Y

ROLLING HILLS DIALYSIS	25210 CRENSHAW BLVD	STE 110	TORRANCE	CA	90505-6134	3105301180	3105301312	In-Center Hemo, PD Services	25		Y
DEER PARK DIALYSIS	4401 MACK RD		SACRAMENTO	CA	95823-4545	9167383575	9164292368	In-Center Hemo	24	55-2814	Y
PACHECO DIALYSIS	1245 W PACHECO BLVD		LOS BANOS	CA	93635-8619	2098273934	2098273973	In-Center Hemo	24	55-2804	Y
GOLDEN STATE DIALYSIS	4200 N GOLDEN STATE BLVD		TURLOCK	CA	95382-8840	2096340014	2096340048	In-Center Hemo, PD Services	24	55-2812	Y
HIDDEN VALLEY DIALYSIS	1951 CITRACADO PKWY		ESCONDIDO	CA	92029-4158	7607460464	7607460392	In-Center Hemo, PD Services	37		Y
MARINA DIALYSIS	930 2ND AVE		MARINA	CA	93933-6009	8313847831	8313847786	In-Center Hemo, PD Services	24		Y
CENTRAL COAST KIDNEY CENTER	2263 S DEPOT ST		SANTA MARIA	CA	93455-1216	8053498600	8059285145	In-Center Hemo, PD Services	42	05-2871	Y
WEST HILLS DIALYSIS	7230 MEDICAL CENTER DR	STE 101	WEST HILLS	CA	91307-1907	8187041033	8187041568	In-Center Hemo, PD Services	12	05-2588	Y
MARINA AT HOME	930 2ND AVE		MARINA	CA	93933-6009	8313847831	8313874486	Home Hemo			Y
SAN RAFAEL AT HOME	1415 3RD ST		SAN RAFAEL	CA	94901-2826	4154534437	4154534616	Home Hemo			Y
EAST AURORA DIALYSIS	482 S CHAMBERS RD		AURORA	CO	80017-2092	3036961137	3036961140	In-Center Hemo, In-Center Hemo Self Care	28	06-2540	Y
LAKEWOOD CROSSING DIALYSIS	1057 S WADSWORTH BLVD	STE 100	LAKEWOOD	CO	80226-4361	7209626199	7209626196	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care	22	06-2535	Y
LOWRY DIALYSIS CENTER	7465 E 1ST AVE	STE A	DENVER	CO	80230-6877	3033670946	3033670951	In-Center Hemo, In-Center Hemo Self Care	24	06-2529	Y
ENGLEWOOD DIALYSIS CENTER	3247 S LINCOLN ST		ENGLEWOOD	CO	80113-2505	3037610600	3037617666	In-Center Hemo, In-Center Hemo Self Care	19	06-2531	Y
LONGMONT DIALYSIS CENTER	1715 IRON HORSE DR	STE 170	LONGMONT	CO	80501-9617	3034854084	3034854081	In-Center Hemo, In-Center Hemo Self Care, PD Services	18	06-2534	Y
COMMERCE CITY DIALYSIS	6320 HOLLY ST		COMMERCE CITY	CO	80022-3325	3038534300	3038534333	In-Center Hemo, In-Center Hemo Self Care	18	06-2533	Y
LAKEWOOD DIALYSIS CENTER	1750 PIERCE ST	STE C	LAKEWOOD	CO	80214-1434	3032386111	3034620946	In-Center Hemo, In-Center Hemo Self Care	18	06-2502	Y
THORNTON DIALYSIS CENTER	8800 FOX DR		THORNTON	CO	80260-6880	3034307020	3034879572	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care	24	06-2511	Y
BOULDER DIALYSIS CENTER	2880 FOLSOM ST	STE 110	BOULDER	CO	80304-3769	3034405600	3034404165	In-Center Hemo, In-Center Hemo Self Care	14	06-2517	Y
ARVADA DIALYSIS CENTER	9950 W 80TH AVE	STE 25	ARVADA	CO	80005-3914	3034569556	3034568836	In-Center Hemo, In-Center Hemo Self Care	16	06-2521	Y
PIKES PEAK DIALYSIS CENTER	2002 LELARAY ST	STE 130	COLORADO SPRINGS	CO	80909-2804	7194714615	7194710621	In-Center Hemo, In-Center Hemo Self Care, PD Services	43	06-2507	Y
PRINTERS PLACE DIALYSIS CENTER	2802 INTERNATIONAL CIR		COLORADO SPRINGS	CO	80910-3127	7196300602	7195205291	In-Center Hemo	16	06-2524	Y
CORTEZ DIALYSIS CENTER	610 E MAIN ST	STE C	CORTEZ	CO	81321-3308	9705654302	9705654374	In-Center Hemo, PD Services	18	06-2528	Y
DENVER DIALYSIS CENTER	2900 DOWNING ST	STE C	DENVER	CO	80205-4699	3032920303	3032921266	In-Center Hemo, In-Center Hemo Self Care	16	06-2546	Y
AURORA DIALYSIS CENTER	1411 S POTOMAC ST	AMC II STE 100	AURORA	CO	80012-4536	3033681911	3033681857	In-Center Hemo, In-Center Hemo Self Care	27	06-2514	Y
WESTMINSTER DIALYSIS CENTER	9053 HARLAN ST	STE 90	WESTMINSTER	CO	80031-2908	3034272400	3034272504	In-Center Hemo, In-Center Hemo Self Care	22	06-2516	Y
LITTLETON DIALYSIS CENTER	209 W COUNTY LINE RD		LITTLETON	CO	80129-1901	3037307540	3037307628	In-Center Hemo, In-Center Hemo Self Care	17	06-2519	Y
SOUTH DENVER DIALYSIS CENTER	850 E HARVARD AVE	STE 60	DENVER	CO	80210-5030	3037440559	3037440922	In-Center Hemo, In-Center Hemo Self Care	17	06-2518	Y
MILE HIGH HOME DIALYSIS	1750 PIERCE ST	STE A	LAKEWOOD	CO	80214-1434	3032320939	3032746096	PD Services	3	06-2541	Y
ALAMOSA DIALYSIS	612 DEL SOL DR		ALAMOSA	CO	81101-8548	7195892022	7195896233	In-Center Hemo, In-Center Hemo Self Care, PD Services	12	06-2550	Y
GRAND JUNCTION DIALYSIS CENTER	710 WELLINGTON AVE	STE 20	GRAND JUNCTION	CO	81501-6100	9702638573	9702454398	In-Center Hemo, PD Services	18	06-2553	Y
LOWRY DIALYSIS CENTER PD	7465 E 1ST AVE	STE A	DENVER	CO	80230-6877	3033675604	3033671452	PD Services		06-2529	Y
LONETREE DIALYSIS CENTER	9777 PYRAMID CT	STE 140	ENGLEWOOD	CO	80112-6017	3036620466	3036620575	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care	12	06-2543	Y
BELCARO DIALYSIS CENTER	755 S COLORADO BLVD		DENVER	CO	80246-8005	3037772844	3037772850	In-Center Hemo, In-Center Hemo Self Care	14	06-2544	Y
SOUTH WEST DENVER DIALYSIS	8601 W CROSS DR	UNIT C-2	DENVER	CO	80123-2200	3039332367	3039332566	In-Center Hemo, PD Services	9	06-2572	Y
BRIGHTON DIALYSIS	4700 E BROMLEY LN	STE 103	BRIGHTON	CO	80601-7821	3036592511	3036592595	In-Center Hemo, In-Center Hemo Self Care	12	06-2542	Y
DURANGO DIALYSIS CENTER	72 SUTTLE STREET	STE D	DURANGO	CO	81303-6829	9703858608	9703858626	In-Center Hemo, In-Center Hemo Self Care, PD Services	8	06-2547	Y
PARKER DIALYSIS CENTER	10371 S PARKGLENN WAY	STE 180	PARKER	CO	80138-3871	3038400541	3038409051	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care, PD Services	14	06-2562	Y
NORTH METRO DIALYSIS CENTER	12365 HURON ST	STE 500	WESTMINSTER	CO	80234-3498	3034519093	3034510561	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care, PD Services	18	06-2559	Y
NORTH COLORADO SPRINGS DIALYSIS	6071 E WOODMEN RD	STE 100	COLORADO SPRINGS	CO	80923-2610	7196381223	7195977052	In-Center Hemo, PD Services	15	06-2561	Y
MESA COUNTY DIALYSIS	561 25 RD	STE D	GRAND JUNCTION	CO	81505-1360	9702489120	9702489125	In-Center Hemo, PD Services	15	06-2567	Y
BLACK CANYON DIALYSIS	3421 S RIO GRANDE AVE	UNIT D1	MONTROSE	CO	81401-4840	9702407925	9702406197	In-Center Hemo, PD Services	13	06-2569	Y
RED HAWK DIALYSIS	4348 WOODLANDS BLVD	STE 131	CASTLE ROCK	CO	80104-2800	3036632875	3036632913	In-Center Hemo, PD Services	8	06-2574	Y
SABLE DIALYSIS	509 N SABLE BLVD		AURORA	CO	80011-0801	3033669458	3033649206	In-Center Hemo, Nocturnal Hemo, PD Services	30	06-2576	Y
WEST LAKEWOOD DIALYSIS	11700 WEST 2ND PL	STE 325	LAKEWOOD	CO	80228-1710	3039874672	3039874687	In-Center Hemo, PD Services	14	06-2582	Y
LOVELAND CENTRAL DIALYSIS	1453 DENVER AVE		LOVELAND	CO	80538-5226	9706634607	9706639076	In-Center Hemo, PD Services	12	06-2579	Y
CASA DEL MUNDO OFFICE	2000 16TH ST		DENVER	CO	80202-5117	8003817063		Support, PD Services	0		Y
NORTHEASTERN COLORADO DIALYSIS	603 HOLLY DR		STERLING	CO	80751-4539	9705215368	9705213120	In-Center Hemo, PD Services	12	06-2577	Y
MESA COUNTY AT HOME	561 25 RD	STE D	GRAND JUNCTION	CO	81505-1360	9702489120	9702489125	Home Hemo		06-2567	Y
PARKER AT HOME	10371 S PARK GLENN WAY	STE 180	PARKER	CO	80138-3871	3038400541	3038409051	Home Hemo	0	06-2562	Y
NORTH COLORADO SPRINGS AT HOME	6071 E WOODMEN RD	STE 100	COLORADO SPRINGS	CO	80923-2610	7196381223	7195977052	Home Hemo		06-2561	Y

NORTH METRO AT HOME	12365 HURON ST	STE 500	WESTMINSTER	CO	80234-3498	3034519093	3034510561	Home Hemo, Staff Assisted Home Hemo		06-2559	Y
LAKEWOOD AT HOME	1750 PIERCE ST	STE A	LAKEWOOD	CO	80214-1434	3032320939	3032746096	Home Hemo	0	06-2502	Y
LOWRY AT HOME	7465 E 1ST AVE	STE A	DENVER	CO	80230-6877	3033675604	3033670951	Home Hemo		06-2529	Y
PIKES PEAK AT HOME	2002 LELARAY ST	STE 130	COLORADO SPRINGS	CO	80909-2804	7194714616	7195205422	Home Hemo		06-2507	Y
GREELEY DIALYSIS	2812 W 10TH ST		GREELEY	CO	80634-5425	9703529072	9703529366	In-Center Hemo, PD Services	14	06-2586	Y
FORT COLLINS DIALYSIS	1601 PROSPECT PKWY	STE 180	FORT COLLINS	CO	80525-1076	9704930753	9704077230	In-Center Hemo, PD Services	13	06-2588	Y
PLATTE VALLEY DIALYSIS	1321 S 4TH AVE	STE 100	BRIGHTON	CO	80601-6809	3036548202	3036548506	In-Center Hemo, PD Services	12	06-2591	Y
PDI-ROCKY HILL	30 WATERCHASE DR		ROCKY HILL	CT	06067-2110	8605636000	8602573895	In-Center Hemo, PD Services	23	07-2518	Y
PDI-MIDDLESEX DIALYSIS CENTER	100 MAIN ST	STE A	MIDDLETOWN	CT	06457-3477	8603465600	8603465700	In-Center Hemo, PD Services	22	07-2524	Y
VERNON DIALYSIS CENTER	460 HARTFORD TPKE STE C		VERNON ROCKVILLE	CT	06066-4847	8608961537	8608961689	In-Center Hemo, Acute PD, PD Services	22	07-2529	Y
WINDHAM DIALYSIS CENTER	375 TUCKIE RD	STE C	NORTH WINDHAM	CT	06256-1345	8604561677	8604508403	In-Center Hemo	9	07-2530	Y
WATERBURY DIALYSIS CENTER	150 MATTATUCK HEIGHTS RD		WATERBURY	CT	06705-3893	2034190488	2034650197	In-Center Hemo, Nocturnal Hemo	16	07-2533	Y
BRIDGEPORT DIALYSIS	900 MADISON AVE	STE 221	BRIDGEPORT	CT	06606-5534	2033350191	2033820322	In-Center Hemo, PD Services	50	07-2501	Y
GREATER WATERBURY DIALYSIS	209 HIGHLAND AVE		WATERBURY	CT	06708-3026	2035747933	2035744136	In-Center Hemo, PD Services	30	07-2511	Y
SHELTON DIALYSIS	750 BRIDGEPORT AVE		SHELTON	CT	06484-4734	2039259520	2039259536	In-Center Hemo	22	07-2510	Y
HARTFORD DIALYSIS	675 TOWER AVE	RENAL UNIT 2ND FL	HARTFORD	CT	06112-1260	8602420735	8602422239	In-Center Hemo, PD Services	27	07-2516	Y
NEW HAVEN DIALYSIS	15 CENTER ST	STE 201	NEW HAVEN	CT	06510-3003	2038597770	2034951454	In-Center Hemo, PD Services	30	07-2507	Y
NEW LONDON DIALYSIS	5 SHAWS COVE	STE 100	NEW LONDON	CT	06320-4974	8607011357	8604440802	In-Center Hemo, PD Services	23	07-2515	Y
STAMFORD DIALYSIS	30 COMMERCE RD		STAMFORD	CT	06902-4550	2033589969	2033599252	In-Center Hemo, PD Services	34	07-2504	Y
NORWICH DIALYSIS	113 SALEM TPKE	ATTN DAVITA DIALYSIS	NORWICH	CT	06360-6484	8608871632	8608879095	In-Center Hemo, In-Center Hemo Self Care, PD Services	16	07-2520	Y
BRANFORD DIALYSIS	249 W MAIN ST		BRANFORD	CT	06405-4048	2034818531	2034818557	In-Center Hemo	13	07-2517	Y
MILFORD DIALYSIS	470 BRIDGEPORT AVE	STE S	MILFORD	CT	06460-4167	2033019040	2033019947	In-Center Hemo	22	07-2514	Y
SOUTH NORWALK DIALYSIS	31 STEVENS ST		NORWALK	CT	06850-3805	2038386017	2038386494	In-Center Hemo, In-Center Hemo Self Care, PD Services	22	07-2521	Y
TORRINGTON DIALYSIS	780 LITCHFIELD ST	STE 100	TORRINGTON	CT	06790-6268	8604960661	8604960504	In-Center Hemo, PD Services	19	07-2523	Y
BLOOMFIELD DIALYSIS	29 GRIFFIN RD S		BLOOMFIELD	CT	06002-1351	8602435389	8602438150	In-Center Hemo, PD Services	16	07-2528	Y
BLACK ROCK DIALYSIS	427 STILLSON RD		FAIRFIELD	CT	06824-3153	2033829566	2033689289	In-Center Hemo	16	07-2535	Y
WILLARD AVENUE DIALYSIS	445E WILLARD AVE		NEWINGTON	CT	06111-2318	8606671700	8606671708	In-Center Hemo, PD Services	19	07-2541	Y
HAMDEN DIALYSIS	3000 DIXWELL AVE	STE 100	HAMDEN	CT	06518-3522	2032815361	2032815376	In-Center Hemo, PD Services	19	07-2543	Y
FARMINGTON DIALYSIS	11 SOUTH RD	STE 110	FARMINGTON	CT	06032-2483	8606780587	8606780613	In-Center Hemo, PD Services	13	07-2545	Y
PALOMBA DRIVE DIALYSIS	51 PALOMBA DR		ENFIELD	CT	06082-3801	8607490476	8607490649	In-Center Hemo, PD Services	10	07-2547	Y
HOUSATONIC DIALYSIS	164 MOUNT PLEASANT RD		NEWTOWN	CT	06470-1408	2032700081	2032700065	In-Center Hemo, PD Services	10	07-2548	Y
DANBURY DIALYSIS	111 OSBORNE ST	STE 211	DANBURY	CT	06810-6031	2037941938	2037960015	In-Center Hemo, PD Services	19	07-2544	Y
STAMFORD AT HOME	30 COMMERCE RD		STAMFORD	CT	06902-4506	2033589969	2033599252	Home Hemo		07-2504	Y
BRIDGEPORT AT HOME	900 MADISON AVE	STE 221	BRIDGEPORT	CT	06606-5534	2033350191	2033820322	Home Hemo	0	07-2501	Y
NEW HAVEN AT HOME	15 CENTER ST	STE 201	NEW HAVEN	CT	06510-3003	2038597770	2034951454	Home Hemo		07-2507	Y
PDI-ROCKY HILL AT HOME	30 WATERCHASE DR		ROCKY HILL	CT	06067-2110	8605639391	8602574789	Home Hemo		07-2518	Y
WATERBURY AT HOME	150 MATTATUCK HEIGHTS RD		WATERBURY	CT	06705-3893	2037591205	2037591236	Home Hemo		07-2533	Y
BLOOMFIELD AT HOME	29 GRIFFIN RD S		BLOOMFIELD	CT	06002-1351	8602435389	8602438150	Home Hemo		07-2528	Y
NEW LONDON AT HOME	5 SHAWS COVE	STE 100	NEW LONDON	CT	06320-4974	8607011357	8604440802	Home Hemo		07-2515	Y
PALOMBA DRIVE AT HOME	51 PALOMBA DR		ENFIELD	CT	06082-3801	8607490476	8607490649	Home Hemo		07-2547	N
HOUSATONIC AT HOME	164 MOUNT PLEASANT RD		NEWTOWN	CT	06470-1408	2032700081	2032700065	Home Hemo		07-2548	Y
NORWALK RIVER DIALYSIS	112 MAIN ST		NORWALK	CT	06851-4617	2032290420	2032290688	In-Center Hemo, Home Hemo, PD Services			Y
CHILDREN'S NATIONAL MEDICAL CENTER	111 MICHIGAN AVE NW		WASHINGTON	DC	20010-2916	2024765148	2024763580	In-Center Hemo, Acute Hemo 1:1, PD Services	6	09-3300	Y
UNION PLAZA DIALYSIS CENTER	810 1ST ST NE	STE 100	WASHINGTON	DC	20002-4227	2028423127	2028423160	In-Center Hemo	15	09-2520	Y
GRANT PARK DIALYSIS	5000 NANNIE HELEN BURROUGHS AVE NE		WASHINGTON	DC	20019-5506	2023997700	2023993708	In-Center Hemo	12	09-2522	Y
LEE STREET DIALYSIS	5155 LEE ST NE		WASHINGTON	DC	20019-4051	2023981047	2023983468	In-Center Hemo	20	09-2510	Y
WASHINGTON NURSING FACILITY	2425 25TH ST SE		WASHINGTON	DC	20020-3409	2026780013	2026780083	In-Center Hemo	9	09-2524	Y
K STREET DIALYSIS	2131 K ST NW		WASHINGTON	DC	20037-1898	2022238453	2022239789	In-Center Hemo, Nocturnal Hemo, PD Services	25	09-2518	Y
GWU SOUTHEAST DIALYSIS	3857A PENNSYLVANIA AVE SE		WASHINGTON	DC	20020-1309	2025819440	2025819446	In-Center Hemo	25	09-2517	Y
BRENTWOOD DIALYSIS	1231 BRENTWOOD RD NE		WASHINGTON	DC	20018-1019	2026363711	2026363769	In-Center Hemo, Home Hemo, PD Services	24	09-2519	Y
EIGHTH STREET DIALYSIS	920 BLADENSBURG RD NE		WASHINGTON	DC	20002-3930	2023990812	2023968767	In-Center Hemo, PD Services	24	09-2513	Y

GEORGETOWN HOME TRAINING	2233 WISCONSIN AVE NW	STE 215	WASHINGTON	DC	20007-4119	2023371431	2023371625	Home Hemo, PD Services	4	09-2516	Y
INTERNATIONAL DIALYSIS	1730 HAMLIN ST NE		WASHINGTON	DC	20018-1838	2025255415	2025255418	In-Center Hemo, PD Services	15	09-2525	Y
GEORGETOWN HOME AT HOME	2233 WISCONSIN AVE NW	STE 215	WASHINGTON	DC	20007-4119	2023371431	2023371625	Home Hemo		09-2516	Y
CELEBRATION DIALYSIS	1154 CELEBRATION BLVD		KISSIMMEE	FL	34747-4605	4075661780	4075661756	In-Center Hemo, Nocturnal Hemo	20	10-2751	Y
GULF BREEZE DIALYSIS CENTER	1519 MAIN ST		DUNEDIN	FL	34698-4650	7277384425	7277363353	In-Center Hemo, In-Center Hemo Self Care, PD Services	20	10-2693	Y
LIGHTHOUSE POINT DIALYSIS	200 SW NATURA AVE		DEERFIELD BEACH	FL	33441-3026	9544260152	9544260441	In-Center Hemo	16	10-2670	Y
POMPANO BEACH ARTIFICIAL KIDNEY CENTER	600 SW 3RD ST	STE 1100	POMPANO BEACH	FL	33060-6932	9549425115	9549420946	In-Center Hemo, PD Services	28	10-2615	Y
TAMARAC ARTIFICIAL KIDNEY CENTER	7140 W MCNAB RD		TAMARAC	FL	33321-5306	9547205336	9547203626	In-Center Hemo	12	10-2632	Y
HUNTERS CREEK DIALYSIS	14050 TOWN LOOP BLVD	STE 104A	ORLANDO	FL	32837-6190	4078589458	4078580761	In-Center Hemo	15	10-2740	Y
ARCADIA DIALYSIS CENTER	1341 E OAK ST		ARCADIA	FL	34266-8902	8634918550	8634918553	In-Center Hemo	16	10-2757	Y
BAY BREEZE DIALYSIS	11550 ULMERTON RD		LARGO	FL	33778-1501	7275844047	7275844790	In-Center Hemo, PD Services,	20	10-2742	Y
CENTER FOR KIDNEY DISEASE AT NORTH SHORE	1190 NW 95TH ST	STE 208	MIAMI	FL	33150-2065	3056912144	3056910362	In-Center Hemo,	22	10-2583	Y
CENTER FOR KIDNEY DISEASE AT VENTURE	1680 NE 164TH ST		NORTH MIAMI BEACH	FL	33162-4017	3057877345	3057875805	In-Center Hemo, In-Center Hemo Self Care,	16	10-2630	Y
FLAMINGO PARK KIDNEY CENTER	901 E 10TH AVE	BAY 17	HIALEAH	FL	33010-3762	3058845677	3058842466	In-Center Hemo, In-Center Hemo Self Care	21	10-2664	Y
INTERAMERICAN DIALYSIS CENTER	7815 CORAL WAY	STE 115	MIAMI	FL	33155-6541	3052614823	3052647263	In-Center Hemo, PD Services	24	10-2532	Y
CORAL GABLES KIDNEY CENTER	3280 PONCE DE LEON BLVD		CORAL GABLES	FL	33134-7252	3054489888	3054454984	In-Center Hemo	20	10-2578	Y
MIAMI LAKES ARTIFICIAL KIDNEY CENTER	14600 NW 60TH AVE		MIAMI LAKES	FL	33014-2811	7866390496	3055564924	In-Center Hemo	18	10-2648	Y
SOUTH BROWARD ARTIFICIAL KIDNEY CENTER	4401 HOLLYWOOD BLVD		HOLLYWOOD	FL	33021-6609	9549622211	9549643546	In-Center Hemo	30	10-2504	Y
PINE ISLAND KIDNEY CENTER	1871 N PINE ISLAND RD		PLANTATION	FL	33322-5208	9549168958	9549168960	In-Center Hemo	15	10-2708	Y
PORT CHARLOTTE ARTIFICIAL KIDNEY CENTER	4300 KINGS HWY	STE 406	PORT CHARLOTTE	FL	33980-2990	9416252822	9416259877	In-Center Hemo	21	10-2549	Y
GULF COAST DIALYSIS	3300 TAMIAMI TRL	STE 101A	PORT CHARLOTTE	FL	33952-8054	9416259985	9416291522	PD Services	0	10-2628	Y
COMPLETE DIALYSIS CARE	7467 W SAMPLE RD		CORAL SPRINGS	FL	33065-4754	9547530248	9547553692	In-Center Hemo, PD Services	24	10-2645	Y
NORTH PALM BEACH DIALYSIS CENTER	2841 PGA BLVD		PALM BEACH GARDENS	FL	33410-2910	5616305081	5616301535	In-Center Hemo, PD Services	20	10-2634	Y
OCALA REGIONAL KIDNEY CENTER-EAST	2870 SE 1ST AVE		OCALA	FL	34471-0406	3523519140	3527323825	In-Center Hemo, In-Center Hemo Self Care	31	10-2678	Y
OCALA REGIONAL KIDNEY CENTER-WEST	8585 SW HIGHWAY 200	STE 19	OCALA	FL	34481-9644	3528545011	3528546299	In-Center Hemo	28	10-2683	Y
OCALA REGIONAL KIDNEY CENTER-SOUTH	13940 N US HWY 441	BLDG 400	LADY LAKE	FL	32159-8908	3527511240	3527511250	In-Center Hemo	25	10-2731	Y
OCALA REGIONAL KIDNEY CENTER-NORTH	2620 W HWY 316		CITRA	FL	32113-3555	3525914680	3525914679	In-Center Hemo, Nocturnal Hemo, PD Services,	25	10-2793	Y
BRIGHT DIALYSIS	2000 HARTMAN RD		FORT PIERCE	FL	34947-4412	7724671117	7725959340	In-Center Hemo, PD Services,	22	10-2754	Y
BOCA RATON ARTIFICIAL KIDNEY CENTER	998 NW 9TH CT		BOCA RATON	FL	33486-2214	5613923940	5613955663	In-Center Hemo, PD Services,	12	10-2520	Y
CRYSTAL RIVER DIALYSIS	7435 W GULF TO LAKE HWY		CRYSTAL RIVER	FL	34429-7834	3525648400	3525640147	In-Center Hemo, Acute Hemo 1:1, PD Services,	16	10-2720	Y
DIALYSIS ASSOCIATES OF THE PALM BEACHES	2611 POINSETTIA AVE		WEST PALM BEACH	FL	33407-5919	5618330759	5618351056	In-Center Hemo,	20	10-2510	Y
BAYONET POINT-HUDSON KIDNEY CENTER	14144 NEPHRON LN		HUDSON	FL	34667-6504	7278635459	7278620723	In-Center Hemo, In-Center Hemo Self Care, Nocturnal Hemo,	16	10-2563	Y
NEW PORT RICHEY KIDNEY CENTER	7421 RIDGE RD		PORT RICHEY	FL	34668-6935	7278468401	7278440100	In-Center Hemo, In-Center Hemo Self Care, PD Services,	28	10-2590	Y
HERNANDO KIDNEY CENTER	2985 LANDOVER BLVD		SPRING HILL	FL	34608-7258	3526833630	3526838892	In-Center Hemo, Home Hemo, PD Services,	34	10-2602	Y
VENICE DIALYSIS CENTER	816 PINEBROOK RD		VENICE	FL	34285-7103	9414869057	9414849624	In-Center Hemo, In-Center Hemo Self Care, PD Services,	23	10-2675	Y
PANAMA CITY DIALYSIS CENTER	615 HIGHWAY 231		PANAMA CITY	FL	32405-4704	8507851233	8509138048	In-Center Hemo, Acute PD, PD Services,	37	10-2514	Y
MARIANNA DIALYSIS CENTER	2930 OPTIMIST DR		MARIANNA	FL	32448-7703	8504825328	8504825329	In-Center Hemo, PD Services,	21	10-2666	Y
LEESBURG DIALYSIS CENTER	8425 US HWY 441	STE 104	LEESBURG	FL	34788-4038	3524350082	3524350380	In-Center Hemo, PD Services,	24	10-2551	Y
MT DORA DIALYSIS	2735 W OLD US HIGHWAY 441		MOUNT DORA	FL	32757-3526	3523837022	3523836251	In-Center Hemo, PD Services,	24	10-2635	Y
COASTAL KIDNEY CENTER	510 N MACARTHUR AVE		PANAMA CITY	FL	32401-3636	8509140824	8509149962	In-Center Hemo,	28	10-2813	Y
AMELIA ISLAND DIALYSIS	1525 LIME ST	STE 120	FERNANDINA BEACH	FL	32034-3015	9044911998	9044910006	In-Center Hemo	12	10-2743	N
CHIPLEY DIALYSIS	877 3RD ST	STE 2	CHIPLEY	FL	32428-1855	8506387783	8506388550	In-Center Hemo,	20	10-2771	Y
NORTH OKALOOSA DIALYSIS	320 REDSTONE AVE W		CRESTVIEW	FL	32536-6433	8506835700	8506835704	In-Center Hemo,	15	10-2759	Y

WEST FLORIDA DIALYSIS	8333 N DAVIS HWY	1ST FLOOR ATTN DIALYSIS ROOM	PENSACOLA	FL	32514-6050	8504748424	8509692879	In-Center Hemo,	27	10-2518	Y
SANTA ROSA DIALYSIS	5819 HIGHWAY 90		MILTON	FL	32583-1763	8506238299	8506239616	In-Center Hemo,	12	10-2726	Y
FLORIDA RENAL CENTER	5300 W FLAGLER ST		CORAL GABLES	FL	33134-1148	3054435702	3054435176	In-Center Hemo,	20	10-2840	Y
ST CLOUD DIALYSIS	4750 OLD CANOE CREEK RD		SAINT CLOUD	FL	34769-1430	4074980018	4074980881	In-Center Hemo,	23	10-2832	Y
LAKE GRIFFIN EAST DIALYSIS	401 E NORTH BLVD		LEESBURG	FL	34748-5262	3523150062	3523150089	In-Center Hemo,	16	10-2822	Y
HIALEAH ARTIFICIAL KIDNEY CENTER	8524 NW 103RD ST		HIALEAH	FL	33016-4870	3058270576	3058270871	In-Center Hemo,	16	10-2834	Y
PINNACLE DIALYSIS OF BOCA RATON	2900 N MILITARY TRL	STE 195	BOCA RATON	FL	33431-6308	5612416667	5619898550	In-Center Hemo, Acute Hemo 1:1, PD Services,	27	10-2658	Y
APOPKA DIALYSIS	640 EXECUTIVE PARK CT		APOPKA	FL	32703-6075	4073898980	4073898984	In-Center Hemo,	24	10-2829	Y
CASSELBERRY DIALYSIS	4970 S US HWY 17/92		CASSELBERRY	FL	32707-3888	3212077135	3212070254	In-Center Hemo,	20	10-2857	Y
CENTRAL ORLANDO DIALYSIS	2548 N ORANGE BLOSSOM TRL	STE 400	ORLANDO	FL	32804-4863	4072465081	4072465192	In-Center Hemo,	24	10-2837	Y
SANFORD DIALYSIS	1701 W 1ST ST		SANFORD	FL	32771-1605	4072689425	4072689899	In-Center Hemo,	24	10-2827	Y
WINTER PARK HEMO DIALYSIS	4100 METRIC DR	STE 300	WINTER PARK	FL	32792-6832	4076817600	4076817690	In-Center Hemo, In-Center Hemo Self Care,	24	10-2858	Y
WINTER PARK HOME PD DIALYSIS	4100 METRIC DR	STE 200	WINTER PARK	FL	32792-6832	4076818730	4076818739	PD Services,	2	10-2823	Y
EAST FT LAUDERDALE DIALYSIS CENTER	1301 S ANDREWS AVE	STE 101	FT LAUDERDALE	FL	33316-1823	9547611273	9544670384	In-Center Hemo, PD Services,	18	10-2805	Y
WESTON DIALYSIS CENTER	2685 EXECUTIVE PARK DR	STE 1	WESTON	FL	33331-3651	9543891290	9543848207	In-Center Hemo, PD Services,	15	10-2807	Y
AVENTURA KIDNEY CENTER	22 SW 11TH ST	FLOOR 2	HALLANDALE BEACH	FL	33009-7038	9544580887	9544580948	In-Center Hemo,	12	10-2875	Y
EMBASSY LAKES ARTIFICIAL KIDNEY CENTER	11011 SHERIDAN ST	STE 308	HOLLYWOOD	FL	33026-1505	9544309166	9544309329	In-Center Hemo, PD Services,	16	10-2817	Y
DAVENPORT DIALYSIS	45597 HIGHWAY 27	RIDGEVIEW PLAZA	DAVENPORT	FL	33897-4519	8634197408	8634209165	In-Center Hemo,	12	10-2819	Y
LAUREL MANOR DIALYSIS CENTER AT THE VILLAGES	1950 LAUREL MANOR DR	STE 190	LADY LAKE	FL	32162-5603	3522590250	3522590335	In-Center Hemo, PD Services,	16	10-2838	Y
OCALA REGIONAL KIDNEY CENTERS HOME DIALYSIS DIVISION PD	2860 SE 1ST AVE		OCALA	FL	34471-0406	2292265931	2292265940	PD Services,	0	10-2825	Y
REGENCY DIALYSIS CENTER	9535 REGENCY SQUARE BLVD N		JACKSONVILLE	FL	32225-8128	9047250526	9047254726	In-Center Hemo, In-Center Hemo Self Care, PD Services,	16	10-2850	Y
INDIAN RIVER DIALYSIS CENTER	2150 45TH ST	UNIT 102	VERO BEACH	FL	32967-6281	7725672529	7725672587	In-Center Hemo, PD Services,	16	10-2851	Y
WINTER PARK DIALYSIS	3727 N GOLDENROD RD	STE 101	WINTER PARK	FL	32792-8611	4076575262	4076778641	In-Center Hemo,	12	10-2859	Y
WEST PENSACOLA DIALYSIS CENTER	598 N FAIRFIELD DR	STE 100	PENSACOLA	FL	32506-4320	8504536066	8504536681	In-Center Hemo,	16	10-2845	Y
CAPE CORAL SOUTH DIALYSIS	3046 DEL PRADO BLVD S	STE 4A	CAPE CORAL	FL	33904-7232	2395490339	2395491349	In-Center Hemo, PD Services,	18	10-2847	Y
WEST BEACH DIALYSIS CENTER	16201 PANAMA CITY BEACH PKWY	STE 102	PANAMA CITY BEACH	FL	32413-5301	8502330837	8502338436	In-Center Hemo,	8	10-2863	Y
MIRAMAR KIDNEY CENTER	2501 DYKES RD	STE 200	MIRAMAR	FL	33027-4217	9544316939	9544316993	In-Center Hemo, PD Services,	16	10-2866	Y
WESLEY CHAPEL DIALYSIS	2255 GREEN HEDGES WAY		WESLEY CHAPEL	FL	33544-8183	8139730153	8139730673	PD Services,	6	10-2887	Y
AVE MARIA DIALYSIS	5340 USEPPA DR		AVE MARIA	FL	34142-5051	2393040198	2393481723	In-Center Hemo,	16	10-2890	Y
SOUTH DADE KIDNEY CENTER	11040 SW 184TH ST		CUTLER BAY	FL	33157-6602	3052591516	3052591769	In-Center Hemo, PD Services,	23	68-2508	Y
EAST TAMPA DIALYSIS	1701 E 9TH AVE		YBOR CITY	FL	33605-3801	8132471820	8132473129	In-Center Hemo, Nocturnal Hemo,	21	10-2886	Y
POINCIANA DIALYSIS	1002 CYPRESS PKWY		KISSIMMEE	FL	34759-3328	3216975658	3216975435	In-Center Hemo,	21	10-2898	Y
BRANDON EAST DIALYSIS	114 E BRANDON BLVD		BRANDON	FL	33511-5219	8136572783	8136572521	In-Center Hemo, In-Center Hemo Self Care, PD Services,	20	10-2779	Y
MIAMI CAMPUS DIALYSIS	1951 NW 7TH AVE	STE 500	MIAMI	FL	33136-1121	3053258956	3053258748	In-Center Hemo, PD Services, Nocturnal Hemo,	33	10-2656	Y
ORLANDO DIALYSIS	116 STURTEVANT ST		ORLANDO	FL	32806-2021	4074269212	4074267476	In-Center Hemo,	23	10-2623	Y
OCOEE DIALYSIS	11140 W COLONIAL DR	STE 5	OCOEE	FL	34761-3300	4078770626	4078770603	In-Center Hemo,	18	10-2639	Y
ORLANDO NORTH DIALYSIS	5135 ADANSON ST	STE 700	ORLANDO	FL	32804-1338	4075393998	4075395708	In-Center Hemo,	16	10-2707	Y
PLANTATION DIALYSIS	7061 CYPRESS RD	STE 103	PLANTATION	FL	33317-2243	9545832100	9545842463	In-Center Hemo,	25	10-2536	Y
SEBASTIAN DIALYSIS	1424 US HWY 1	STE C	SEBASTIAN	FL	32958-1619	7725899182	7725899959	In-Center Hemo, Acute Hemo 1:1, PD Services,	16	10-2727	Y
ORLANDO EAST DIALYSIS	11616 LAKE UNDERHILL RD	STE 206	ORLANDO	FL	32825-4466	4073841175	4073841421	In-Center Hemo, In-Center Hemo Self Care,	21	10-2660	Y
ST. PETERSBURG DIALYSIS	1117 ARLINGTON AVE N		ST PETERSBURG	FL	33705-1521	7278969029	7278967269	In-Center Hemo, PD Services,	20	10-2773	Y
ORANGE CITY DIALYSIS	2575 S VOLUSIA AVE	STE 400	ORANGE CITY	FL	32763-9116	3867740101	3867740249	In-Center Hemo,	16	10-2775	Y
MIAMI EAST DIALYSIS	1250 NW 7TH ST	STE 106	MIAMI	FL	33125-3744	3055471496	3055471516	In-Center Hemo,	16	10-2784	Y
TEMPLE TERRACE DIALYSIS	11306 N 53RD ST		TEMPLE TERRACE	FL	33617-2214	8139892062	8139893658	In-Center Hemo, PD Services,	24	10-2748	Y
ORLANDO HOME TRAINING DIALYSIS	116 STURTEVANT ST	STE 2	ORLANDO	FL	32806-2021	4078491567	4078491657	PD Services,	0	10-2772	Y
PERRY DIALYSIS	118 W MAIN ST		PERRY	FL	32347-2656	8505846012	8505846040	In-Center Hemo,	16	10-2790	Y
FORT MYERS NORTH DIALYSIS	16101 N CLEVELAND AVE		NORTH FORT MYERS	FL	33903-2148	2396564403	2396561886	In-Center Hemo,	12	10-2788	Y
MELBOURNE DIALYSIS	2235 S BABCOCK ST		MELBOURNE	FL	32901-5305	3219566252	3219566464	In-Center Hemo, PD Services,	16	10-2816	Y
ST PETERSBURG SOUTH DIALYSIS	2850 34TH ST S		ST PETERSBURG	FL	33711-3817	7278644050	7278640013	In-Center Hemo,	20	10-2803	Y

MIAMI GARDENS DIALYSIS	3363 NW 167TH ST		MIAMI GARDENS	FL	33056-4254	3056279311	3056289389	In-Center Hemo,	16	10-2839	Y
TALLAHASSEE WEST DIALYSIS	5857 W TENNESSEE ST		TALLAHASSEE	FL	32304-9218	8503500002	8503500120	In-Center Hemo, PD Services,	24	10-2673	Y
DAYTONA SOUTH DIALYSIS	1801 S NOVA RD	STE 306	SOUTH DAYTONA	FL	32119-1775	3863223625	3863223695	In-Center Hemo, Nocturnal Hemo,	16	10-2614	Y
DAYTONA BEACH DIALYSIS	578 HEALTH BLVD		DAYTONA BEACH	FL	32114-1492	3862587322	3862580191	In-Center Hemo, PD Services,	20	10-2521	Y
TAMPA WEST DIALYSIS	4515 GEORGE RD	STE 300	TAMPA	FL	33634-7300	8138844008	8138841465	In-Center Hemo,	20	10-2679	Y
FORT MYERS DIALYSIS	4220 EXECUTIVE CIRCLE	STE 38	FORT MYERS	FL	33916-7966	2392743681	2392746168	In-Center Hemo, PD Services,	34	10-2513	Y
LEHIGH ACRES DIALYSIS	2814 LEE BLVD	STE 16	LEHIGH ACRES	FL	33971-1561	2393687169	2393687541	In-Center Hemo,	12	10-2618	Y
KISSIMMEE DIALYSIS	802 N JOHN YOUNG PKWY		KISSIMMEE	FL	34741-4912	4078474423	4078475973	In-Center Hemo,	25	10-2569	Y
NEW SMYRNA BEACH DIALYSIS	110 S ORANGE ST		NEW SMYRNA BEACH	FL	32168-7153	3864090025	3864090410	In-Center Hemo, In-Center Hemo Self Care,	12	10-2696	Y
LAKE WALES DIALYSIS	1125 BRYN MAWR AVE		LAKE WALES	FL	33853-4333	8636799851	8636799856	In-Center Hemo,	12	10-2712	Y
GREATER MIAMI DIALYSIS	160 NW 176TH ST	STE 100	MIAMI	FL	33169-5023	3056536033	3056530118	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care, PD Services,	20	10-2586	Y
LAKELAND DIALYSIS	515 E BELLA VISTA ST		LAKELAND	FL	33805-3005	8636885463	8636887150	In-Center Hemo,	16	10-2524	Y
PLANT CITY DIALYSIS	1211 W REYNOLDS ST	STE 1	PLANT CITY	FL	33563-4321	8137522136	8137576729	In-Center Hemo, PD Services,	17	10-2554	Y
WINTER HAVEN DIALYSIS	1625 UNITY WAY NW		WINTER HAVEN	FL	33881-5226	8632948851	8632945212	In-Center Hemo, Acute Hemo 1:1, PD Services,	20	10-2545	Y
BROWARD DIALYSIS	1500 N FEDERAL HWY	STE 100	FT LAUDERDALE	FL	33304-5600	9543968990	9543966988	In-Center Hemo,	21	10-2555	Y
BRADENTON DIALYSIS	3501 CORTEZ RD W	STE 104	BRADENTON	FL	34210-3104	9417274209	9417538386	In-Center Hemo, PD Services,	17	10-2646	Y
DELAND DIALYSIS	350 E NEW YORK AVE		DELAND	FL	32724-5510	3867382570	3867389576	In-Center Hemo, PD Services,	20	10-2573	Y
BOYNTON-NORTH DELRAY DIALYSIS	2655 W ATLANTIC AVE		DELRAY BEACH	FL	33445-4400	5612792626	5612792921	In-Center Hemo,	22	10-2617	Y
LAKE WORTH DIALYSIS	2459 S CONGRESS AVE	STE 100	PALM SPRINGS	FL	33406-7616	5614391532	5614391018	In-Center Hemo, PD Services,	25	10-2637	Y
PALM COAST DIALYSIS	13 KINGSWOOD DR	STE A	PALM COAST	FL	32137-4614	3864454445	3864453312	In-Center Hemo, PD Services,	22	10-2728	Y
FORT MYERS SOUTH DIALYSIS	8850 GLADIOLUS DR		FORT MYERS	FL	33908-5102	2394151661	2394157440	In-Center Hemo, PD Services,	22	10-2744	Y
FOUR FREEDOMS DIALYSIS	289 SW RANGE AVE	STE A	MADISON	FL	32340-2351	8509733852	8509739861	In-Center Hemo, In-Center Hemo Self Care,	16	10-2737	Y
TALLAHASSEE SOUTH DIALYSIS	2410 S ADAMS ST		TALLAHASSEE	FL	32301-6325	8502248757	8502248766	In-Center Hemo,	20	10-2765	Y
SUN CITY CENTER DIALYSIS	783 CORTARO DR		RUSKIN	FL	33573-6812	8136332847	8136332972	In-Center Hemo, PD Services,	16	10-2642	Y
TAMPA CENTRAL DIALYSIS	4204 N MACDILL AVE	SOUTH BLDG	TAMPA	FL	33607-6342	8138713202	8138713903	In-Center Hemo,	20	10-2605	Y
ZEPHYRHILLS DIALYSIS	36819 EILAND BLVD	UNIT 2	ZEPHYRHILLS	FL	33542-0001	8137887041	8137887236	In-Center Hemo, PD Services,	24	10-2593	Y
BARTOW DIALYSIS	1190 E CHURCH ST		BARTOW	FL	33830-4117	8635331601	8635338144	In-Center Hemo,	16	10-2626	Y
ORMOND BEACH DIALYSIS	495 S NOVA RD	STE 109	ORMOND BEACH	FL	32174-8444	3866762405	3866766738	In-Center Hemo,	17	10-2638	Y
LAKELAND SOUTH DIALYSIS	4774 S FLORIDA AVE		LAKELAND	FL	33813-2181	8636460462	8636470802	In-Center Hemo, PD Services,	20	10-2764	Y
MIAMI NORTH DIALYSIS	860 NE 125TH ST		NORTH MIAMI	FL	33161-5743	3058937887	3058934429	In-Center Hemo,	17	10-2776	Y
BONITA SPRINGS DIALYSIS	9134 BONITA BEACH RD SE		BONITA SPRINGS	FL	34135-4281	2399490444	2399490450	In-Center Hemo,	16	10-2752	Y
ORLANDO SOUTHWEST DIALYSIS	6925 LAKE ELLENOR DR	STE 650	ORLANDO	FL	32809-4670	4078521751	4078521748	In-Center Hemo,	18	10-2750	Y
QUINCY DIALYSIS	878 STRONG RD		QUINCY	FL	32351-5243	8508751570	8508751572	In-Center Hemo,	20	10-2627	Y
TALLAHASSEE DIALYSIS	1607 PHYSICIANS DR		TALLAHASSEE	FL	32308-4620	8508788776	8508789004	In-Center Hemo,	27	10-2624	Y
SOUTH BEACH DIALYSIS	1711 ALTON RD		MIAMI BEACH	FL	33139-2411	3056954175	3056954179	In-Center Hemo, Acute Hemo 1:1, PD Services,	20	10-2718	Y
PALMETTO ARTIFICIAL KIDNEY CENTER	7150 W 20TH AVE	STE 109	HIALEAH	FL	33016-5509	3058278399	3058271892	In-Center Hemo, PD Services,	15	10-2665	Y
RENOVATION OF LIFE DIALYSIS	14505 COMMERCE WAY	STE 600	MIAMI LAKES	FL	33016-1530	3053628399	3053628351	In-Center Hemo,	16	68-2512	Y
GREATER TAMPA AT HOME PD	4204 N MACDILL AVE	STE 1B NORTH BLDG	TAMPA	FL	33607-6364	8138728216	8138728469	PD Services	4	10-2885	Y
JACKSONVILLE SOUTH DIALYSIS CENTER	14965 OLD SAINT AUGUSTINE RD	UNIT 114	JACKSONVILLE	FL	32258-9481	9048809494	9048800295	In-Center Hemo, PD Services,	16	10-2873	Y
PINELLAS WEST SHORE DIALYSIS	3451 66TH ST N	STE A	ST PETERSBURG	FL	33710-1568	7273458389	7273458410	In-Center Hemo, PD Services,	12	10-2889	Y
WINTER GARDEN DIALYSIS	1222 WINTER GARDEN VINELAND RD	BLDG 3 STE 100	WINTER GARDEN	FL	34787-4449	4078770364	4078773641	In-Center Hemo,	16	10-2880	Y
KENDALL KIDNEY CENTER	8364 MILLS DR	STE 1740	MIAMI	FL	33183-4806	3052733783	3052733873	In-Center Hemo, Home Hemo, PD Services,	17	10-2897	Y
GATEWAY DIALYSIS	5705 LEE BLVD		LEHIGH ACRES	FL	33971-6342	2394795251	2394795275	In-Center Hemo,	16	10-2888	Y
ORLANDO PARK DIALYSIS	5397 W COLONIAL DR	STE 120	ORLANDO	FL	32808-7647	4075323109	4075324881	In-Center Hemo,	24	10-2884	Y
PALM BREEZE DIALYSIS	14942 TAMIAMI TRL	STE E	NORTH PORT	FL	34287-2705	9414290443	9414292240	In-Center Hemo,	16	10-2892	Y
PORT SAINT JOE DIALYSIS	3871 HIGHWAY 98 E	STE 101	PORT ST JOE	FL	32456-5318	8502292662	8502292675	In-Center Hemo,	12	68-2505	Y
CAPE CORAL NORTH DIALYSIS	1315 SE 8TH TERRACE		CAPE CORAL	FL	33990-3213	2397728599	2397729421	In-Center Hemo,	12	68-2501	Y
CARROLLWOOD DIALYSIS	14358 N DALE MABRY HWY		TAMPA	FL	33618-2018	8139603751	8139617312	In-Center Hemo, Nocturnal Hemo,	16	68-2520	Y
LAKE VISTA DIALYSIS	3187 US HWY 98 N		LAKELAND	FL	33805-2103	8636032130	8636865687	In-Center Hemo, PD Services,	24	68-2517	Y
PLANTATION HOME TRAINING (PD)	8144 W BROWARD BLVD		PLANTATION	FL	33324-2000	9544739138	9544732941	PD Services,	3	68-2543	Y
KEYS GATE DIALYSIS	1982 NE 8TH ST		HOMESTEAD	FL	33033-4704	3052473506	3052473859	In-Center Hemo, PD Services, Home Hemo,	16	68-2564	Y

DORAL KIDNEY CENTER	7755 NW 48TH ST	STE 120	DORAL	FL	33166-5401	3054365279	3054368087	In-Center Hemo,	12	68-2527	Y
KENNEDY BOULEVARD DIALYSIS	2205 W KENNEDY BLVD		TAMPA	FL	33606-1536	8132543638	8132543809	In-Center Hemo,	20	68-2596	Y
KISSIMMEE HOME TRAINING PD	1203 N CENTRAL AVE	STE A	KISSIMMEE	FL	34741-4407	4075189232	4075189350	PD Services, Home Hemo,	4	68-2538	Y
PALATKA DIALYSIS	326 ZEAGLER DR		PALATKA	FL	32177-3817	3863299458	3863299340	In-Center Hemo, PD Services,	16	68-2532	Y
MEMORIAL PLAZA DIALYSIS	3901 UNIVERSITY BLVD S	STE 111	JACKSONVILLE	FL	32216-4374	9047310247	9047314046	In-Center Hemo, PD Services,	18	68-2516	Y
LAUDERHILL DIALYSIS	2916 N STATE ROAD 7		LAUDERDALE LAKES	FL	33313-1912	9547316044	9547316078	In-Center Hemo,	20	68-2535	Y
DOWNTOWN PENSACOLA DIALYSIS	700 E CERVANTES ST	STE A	PENSACOLA	FL	32501-3210	8504331534	8504331538	In-Center Hemo,	20	68-2529	Y
GAINESVILLE NEWBERRY DIALYSIS	1177 NW 64TH TER		GAINESVILLE	FL	32605-4218	3523313240	3523313245	In-Center Hemo,	18	68-2592	Y
SILVER SPRINGS SHORES DIALYSIS	9310 SPRING RD		OCALA	FL	34472-2913	3526870403	3526872527	In-Center Hemo,	20	68-2530	Y
DEERFIELD BEACH DIALYSIS	1983 W HILLSBORO BLVD		DEERFIELD BEACH	FL	33442-1418	9544263350	9544265275	In-Center Hemo,	12	68-2540	Y
JACKSONVILLE ARLINGTON DIALYSIS	929 UNIVERSITY BLVD N		JACKSONVILLE	FL	32211-5529	9047431689	9047431570	In-Center Hemo, PD Services,	16	68-2526	Y
HOME OPTIONS OF PENSACOLA (PD)	812 CREIGHTON RD		PENSACOLA	FL	32504-7028	8509699082	8504752635	PD Services,	4	68-2534	Y
BUENA VENTURA LAKES DIALYSIS	1998 E OSCEOLA PKWY		KISSIMMEE	FL	34743-8600	4073481271	4073481407	In-Center Hemo, PD Services,	20	68-2563	Y
MANASOTA DIALYSIS	6960 PROFESSIONAL PKWY E	UNITS 4 & 5	SARASOTA	FL	34240-8428	9413622864	9419074720	In-Center Hemo, PD Services,	12	68-2574	Y
JUPITER DIALYSIS	630 MAPLEWOOD DR	STE 300	JUPITER	FL	33458-5571	5617481750	5617481585	In-Center Hemo,	16	68-2586	Y
PORT ORANGE DIALYSIS	3997 S NOVA RD	RIVERWOOD PLAZA	PORT ORANGE	FL	32127-9296	3867617961	3867632150	In-Center Hemo, PD Services	16		Y
GAINESVILLE HOME DIALYSIS	4960 W NEWBERRY RD	STE 280	GAINESVILLE	FL	32607-2201	3523784960	3523711552	PD Services,	3	68-2531	Y
OVIEDO DIALYSIS	7560 RED BUG LAKE RD	STE 1048	OVIEDO	FL	32765-6591	4073660211	4073664269	In-Center Hemo,	20	68-2549	Y
OCOEE HOME TRAINING (PD)	1552 BOREN DR	STE 100	OCOEE	FL	34761-4216	4078772012	4078772040	PD Services,		68-2550	Y
GOLDEN GLADES DIALYSIS	15600 NW 15TH AVE	STE D	MIAMI GARDENS	FL	33169-5609	3056211328	3056216272	In-Center Hemo, PD Services,	20	68-2556	Y
USF DIALYSIS	10770 N 46TH ST	STE A100	TAMPA	FL	33617-3465	8136327918	8136327952	In-Center Hemo, PD Services,	29	10-2636	Y
ADVANCED DIALYSIS CENTER OF FORT LAUDERDALE	911 E OAKLAND PARK BLVD		OAKLAND PARK	FL	33334-2725	9543187000	9543187001	In-Center Hemo,	23	10-2878	Y
PEMBROKE PINES DIALYSIS	10970 PINES BLVD		PEMBROKE PINES	FL	33026-5208	9544356145	9544427350	In-Center Hemo,	22	10-2647	Y
FORT LAUDERDALE DIXIE DIALYSIS	1299 E COMMERCIAL BLVD	STE 100	OAKLAND PARK	FL	33334-4806	9547766056	9547768088	In-Center Hemo, PD Services,	20	10-2701	Y
HALLANDALE DIALYSIS	2655 HOLLYWOOD BLVD		HOLLYWOOD	FL	33020-4840	9549259909	9549275852	In-Center Hemo,	22	10-2601	Y
SOUTH FLORIDA DIALYSIS	1 OAKWOOD BLVD	STE 100	HOLLYWOOD	FL	33020-1937	9548947500	9548947700	In-Center Hemo, PD Services,	21	10-2680	Y
DAVIE CITY DIALYSIS	7950 SW 30TH ST		DAVIE	FL	33328-1979	9545772778	9545772710	In-Center Hemo,	15	10-2808	Y
DADELAND DIALYSIS	9175 SW 87TH AVE		MIAMI	FL	33176-2302	3052733830	3052733804	In-Center Hemo, PD Services,	18	10-2738	Y
ST AUGUSTINE DIALYSIS	264 SOUTHPARK CIR E		SAINT AUGUSTINE	FL	32086-5137	9048080445	9048080446	In-Center Hemo,	18	10-2692	Y
KEY WEST DIALYSIS	1122 KEY PLZ		KEY WEST	FL	33040-4076	3052948453	3052943421	In-Center Hemo, PD Services,	16	10-2543	Y
HOME OPTIONS OF PENSACOLA AT HOME	812 CREIGHTON RD		PENSACOLA	FL	32504-7028	8509699082	8504752635	Home Hemo		68-2534	Y
GAINESVILLE HOME AT HOME	4960 W NEWBERRY RD	STE 280	GAINESVILLE	FL	32607-2201	3523784960	3523711552	Home Hemo		68-2531	Y
JACKSONVILLE ARLINGTON AT HOME	929 UNIVERSITY BLVD N		JACKSONVILLE	FL	32211-5529	9047431689	9047431570	Home Hemo		68-2526	Y
MEMORIAL PLAZA AT HOME	3901 UNIVERSITY BLVD S	STE 111	JACKSONVILLE	FL	32216-4374	9047310247	9047314046	Home Hemo		68-2516	N
NORTH PALM BEACH AT HOME	2841 PGA BLVD		PALM BEACH GARDENS	FL	33410-2910	5616305081	5616301535	Home Hemo		10-2634	Y
SOUTH DADE KIDNEY AT HOME	11040 SW 184TH ST	PROMENADE PLAZA	CUTLER BAY	FL	33157-6602	3052591516	3052591769	Home Hemo	0	68-2508	N
PANAMA CITY AT HOME	615 N HIGHWAY 231		PANAMA CITY	FL	32405-4704	8507851233	8509138048	Home Hemo		10-2514	Y
WESLEY CHAPEL AT HOME	2255 GREEN HEDGES WAY		WESLEY CHAPEL	FL	33544-8183	8139730153	8139730673	Home Hemo	0	10-2887	Y
JACKSONVILLE SOUTH AT HOME	14965 OLD SAINT AUGUSTINE RD	UNIT 114	JACKSONVILLE	FL	32258-9481	9048809494	9048800295	Home Hemo		10-2873	N
GREATER TAMPA AT HOME	4204 N MACDILL AVE	STE 1B NORTH BLDG	TAMPA	FL	33607-6364	8138728216	8138728469	Home Hemo		10-2885	Y
SANTA ROSA AT HOME	5819 HIGHWAY 90		MILTON	FL	32583-1763	8506238299	8506239616	Home Hemo		10-2726	Y
ST PETERSBURG SOUTH AT HOME	2850 34TH ST S		ST PETERSBURG	FL	33711-3817	7278644050	7278640013	Home Hemo		10-2803	Y
GREATER MIAMI AT HOME	160 NW 176TH ST	STE 100	MIAMI	FL	33169-5023	3056536033	3056530118	Home Hemo		10-2586	Y
OCALA RKCHD AT HOME	2860 SE 1ST AVE		OCALA	FL	34471-0406	3526228758	3526228658	Home Hemo,		10-2825	Y
COMPLETE CARE AT HOME	7467 W SAMPLE RD		CORAL SPRINGS	FL	33065-4754	9547530184	9547553644	Home Hemo		10-2645	N
INTERAMERICAN AT HOME	7815 CORAL WAY	STE 115	MIAMI	FL	33155-6541	3052614823	3052647263	Home Hemo		10-2532	Y
WEST PENSACOLA AT HOME	598 N FAIRFIELD DR	STE 100	PENSACOLA	FL	32506-4320	8504536066	8504536681	Home Hemo	0	10-2845	N
REGENCY AT HOME	9535 REGENCY SQUARE BLVD N		JACKSONVILLE	FL	32225-8128	9047250526	9047254726	Home Hemo	0	10-2850	N
CRYSTAL RIVER AT HOME	7435 W GULF TO LAKE HWY		CRYSTAL RIVER	FL	34429-7834	3525648400	3525640147	Home Hemo		10-2720	Y
NEW PORT RICHEY KIDNEY AT HOME	7421 RIDGE RD		PORT RICHEY	FL	34668-6933	7278468401	7278440100	Home Hemo		10-2590	Y

GULF BREEZE AT HOME	1519 MAIN ST		DUNEDIN	FL	34698-4650	7277384425	7277363353	Home Hemo	0	10-2693	Y
HUNTERS CREEK AT HOME	14050 TOWN LOOP BLVD	STE 104B	ORLANDO	FL	32837-6190	4078519850	4078519967	Home Hemo	0	10-2740	Y
LAKELAND SOUTH AT HOME	4774 S FLORIDA AVE	STE 1	LAKELAND	FL	33813-2181	8636460462	8636470802	Home Hemo		10-2764	Y
WEST TALLAHASSEE AT HOME	5857 W TENNESSEE ST		TALLAHASSEE	FL	32304-9218	8503500048	8503500666	Home Hemo		10-2673	Y
BRADENTON AT HOME	3501 CORTEZ RD W	STE 104	BRADENTON	FL	34210-3104	9417274209	9417538386	Home Hemo		10-2646	Y
MIAMI CAMPUS AT HOME	1951 NW 7TH AVE	STE 500	MIAMI	FL	33136-1121	3053258956	3053258748	Home Hemo		10-2656	Y
DAYTONA BEACH AT HOME	578 HEALTH BLVD		DAYTONA BEACH	FL	32114-1492	3862587719	3862587524	Home Hemo		10-2521	Y
SUN CITY CENTER AT HOME	783 CORTARO DR		RUSKIN	FL	33573-6812	8136332847	8136332972	Home Hemo		10-2642	Y
NAPLES RENAL CENTER	6625 HILLWAY CIR		NAPLES	FL	34112-8756	2397759454	2397321391	In-Center Hemo, PD Services,	19	10-2809	Y
LAKEWOOD RANCH DIALYSIS	8470 COOPER CREEK BLVD		UNIVERSITY PARK	FL	34201-2020	9413590676	9413587012	In-Center Hemo,	12	10-2733	Y
DELTONA DIALYSIS	1200 DELTONA BLVD	STE 26	DELTONA	FL	32725-6389	3865740225	3865746460	In-Center Hemo, PD Services,	21	10-2616	Y
NORTH BREVARD DIALYSIS	250 HARRISON ST	STE 110	TITUSVILLE	FL	32780-5026	3213831345	3212684875	In-Center Hemo,	12	10-2654	Y
PLANTATION HT AT HOME	8144 W BROWARD BLVD		PLANTATION	FL	33324-2000	9544739138	9544732941	Home Hemo		68-2543	Y
BAY BREEZE AT HOME	11550 ULMERTON RD		LARGO	FL	33778-1501	7275844047	7275844790	Home Hemo	0	10-2742	Y
PALATKA AT HOME	326 ZEAGLER DR		PALATKA	FL	32177-3817	3863299458	3863299340	Home Hemo	0	68-2532	Y
GOLDEN GLADES AT HOME	15600 NW 15TH AVE	STE D	MIAMI GARDENS	FL	33169-5609	3056211328	3056216272	Home Hemo			N
KISSIMMEE HT AT HOME	1203 N CENTRAL AVE	STE A	KISSIMMEE	FL	34741-4407	4075189232	4075189350	Home Hemo		68-2538	Y
ST AUGUSTINE HT AT HOME	252 SOUTHPARK CIR E		ST AUGUSTINE	FL	32086-5137	9048231594	9048081437	Home Hemo		68-2561	Y
DELTONA AT HOME	1200 DELTONA BLVD	STE 26	DELTONA	FL	32725-6389	3865740225	3865746460	Home Hemo	1	10-2616	Y
LAKE MARY AT HOME	39 SKYLINE DR	STE 1001	LAKE MARY	FL	32746-7123	4078338667	4078338672	Home Hemo	1	68-2567	Y
CLAY COUNTY AT HOME	1784 BLANDING BLVD		MIDDLEBURG	FL	32068-3807	9042911537	9042829869	Home Hemo		68-2572	Y
BUENA VENTURA LAKES AT HOME	1998 E OSCEOLA PKWY		KISSIMMEE	FL	34743-8600	4073481271	4073481407	Home Hemo		68-2563	Y
MANASOTA AT HOME	6960 PROFESSIONAL PKWY E	UNITS 4-5	SARASOTA	FL	34240-8428	9413622864	9419074720	Home Hemo		68-2574	Y
OCALA WEST HT AT HOME	8615 SW 103RD STREET RD		OCALA	FL	34481-9622	3528543099	3528543480	Home Hemo		68-2573	Y
BRIGHT AT HOME	2000 HARTMAN RD		FORT PIERCE	FL	34947-4412	7724671117	7725959340	Home Hemo	22	10-2754	Y
LYNN HAVEN AT HOME	404 E 24TH ST		LYNN HAVEN	FL	32444-4881	8502712937	8502710326	Home Hemo		68-2582	Y
CAPE CORAL HT AT HOME	3637 DEL PRADO BLVD S	STE 202	CAPE CORAL	FL	33904-7199	2395427076	2395427037	Home Hemo		68-2595	Y
LEESBURG AT HOME	8425 US HWY 441	STE 104	LEESBURG	FL	34788-4038	3524350082	3524350380	Home Hemo		10-2551	Y
PALM COAST HT AT HOME	80 PINNACLES DR	STE 1000	PALM COAST	FL	32164-2916	3865867399	3865862975	Home Hemo		68-2610	Y
LYNN HAVEN DIALYSIS	404 E 24TH ST		LYNN HAVEN	FL	32444-4881	8502712937	8502710326	In-Center Hemo, PD Services,	12	68-2582	Y
WINTER HAVEN SOUTH DIALYSIS	7220 CYPRESS GARDENS BLVD		WINTER HAVEN	FL	33884-3217	8633245040	8633248492	In-Center Hemo, PD Services,	12	68-2552	Y
LAKE MARY DIALYSIS	39 SKYLINE DR	STE 1001	LAKE MARY	FL	32746-7123	4078338667	4078338672	In-Center Hemo, PD Services,	20	68-2567	Y
BEACH BOULEVARD DIALYSIS	14444 BEACH BLVD	STE B	JACKSONVILLE	FL	32250-2079	9049929254	9049928835	In-Center Hemo, PD Services,	16	68-2560	Y
COLUMBIA COUNTY DIALYSIS	1389 W US HIGHWAY 90	STE 100	LAKE CITY	FL	32055-6130	3864660197	3862928992	In-Center Hemo, PD Services,	16	68-2568	Y
CLAY COUNTY DIALYSIS	1784 BLANDING BLVD		MIDDLEBURG	FL	32068-3807	9042911537	9042829869	PD Services, In-Center Hemo,	16	68-2572	Y
ST AUGUSTINE HOME TRAINING (PD)	252 SOUTHPARK CIR E		ST AUGUSTINE	FL	32086-5137	9048231594	9048081437	PD Services,	3	68-2561	Y
DUNN AVENUE DIALYSIS	1215 DUNN AVE	STE 8	JACKSONVILLE	FL	32218-4897	9047573540	9047513499	In-Center Hemo, PD Services,	16	68-2566	Y
LAND O LAKES DIALYSIS	2100 VIA BELLA BLVD	STE 104	LAND O LAKES	FL	34639-5429	8139488157	8139499071	In-Center Hemo,	20	68-2598	Y
WELLINGTON DIALYSIS	573 N STATE ROAD 7		ROYAL PALM BEACH	FL	33411-3524	5617934285	5617847090	In-Center Hemo, Home Hemo, PD Services	16	68-2633	Y
WEST BOYNTON DIALYSIS	10150 HAGEN RANCH RD	STE 101	BOYNTON BEACH	FL	33437-3776	5617366096	5617386190	In-Center Hemo, PD Services,	16	68-2577	Y
FALKENBURG DIALYSIS	3140 S FALKENBURG RD	STE 101	RIVERVIEW	FL	33578-2594	8133721625	8133721615	In-Center Hemo, PD Services	20	68-2630	Y
OCALA WEST HOME TRAINING (PD-ICHD)	8615 SW 103RD STREET RD		OCALA	FL	34481-9622	3528543099	3528543480	PD Services, In-Center Hemo,	2	68-2573	Y
BAYSHORE DIALYSIS	16151 SLATER RD		NORTH FORT MYERS	FL	33917-6502	2397311006	2397311070	In-Center Hemo,	16	68-2616	Y
LAKE SEMINOLE DIALYSIS	10799 PARK BLVD		SEMINOLE	FL	33772-5420	7273190180	7273190175	In-Center Hemo,	20	68-2612	Y
TAMPA BAY DIALYSIS	2301 W MARTIN LUTHER KING JR BLVD		TAMPA	FL	33604-6405	8138767023	8138791530	In-Center Hemo,	24	68-2594	Y
EAST TALLAHASSEE HOME TRAINING	2417 MILL CREEK CT	STE 3	TALLAHASSEE	FL	32308-4395	8502970435	8505230715	PD Services,		68-2602	Y
CAPE CORAL HOME TRAINING	3637 DEL PRADO BLVD S	STE 202	CAPE CORAL	FL	33904-7199	2395427022	2395427037	PD Services,		68-2595	Y
TRINITY DIALYSIS	2870 BUND AVE		NEW PORT RICHEY	FL	34655-1849	7273727742	7273727551	In-Center Hemo	20	68-2629	Y
ORLANDO AIRPORT DIALYSIS	5778 S SEMORAN BLVD	STE A	ORLANDO	FL	32822-4819	4072823835	4072829520	In-Center Hemo,	24	68-2618	Y
BROOKSVILLE DIALYSIS	7326 BROAD ST		BROOKSVILLE	FL	34601-3114	3525406185	3527998190	In-Center Hemo, PD Services,	16	68-2621	Y
OSLO DIALYSIS	100 S US HIGHWAY 1		VERO BEACH	FL	32962-3630	7725678496	7725625735	In-Center Hemo,	16	68-2615	Y
PALM COAST HOME TRAINING-FL	80 PINNACLES DR	STE 1000	PALM COAST	FL	32164-2916	3865867399	3865862975	PD Services,		68-2610	Y
HERNANDO HOME TRAINING (PD)	4251 MARINER BLVD		SPRING HILL	FL	34609-2416	3526862755	3526830720	PD Services,		68-2622	Y
JACKSONVILLE WESTSIDE DIALYSIS	5276 BLANDING BLVD	STE 26	JACKSONVILLE	FL	32210-8176	9045736405	9049089975	In-Center Hemo, PD Services,	20	68-2627	Y

ALAFAYA DIALYSIS	12001 SCIENCE DR	STE 110	ORLANDO	FL	32826-2913	4072828202	4072089391	In-Center Hemo	20		Y
WILDWOOD DIALYSIS	4713 E SR 44	STE 900	WILDWOOD	FL	34785-7462	3523301103	3523301106	In-Center Hemo, PD Services	12		Y
HERNANDO HT AT HOME	4251 MARINER BLVD		SPRING HILL	FL	34609-2416	3526862755	3526830720	Home Hemo	0	68-2622	Y
FALKENBURG AT HOME	3140 S FALKENBURG RD	STE 101	RIVERVIEW	FL	33578-2594	8133721625	8133721615	Home Hemo		68-2630	Y
DIALYSIS CENTER OF MIDDLE GEORGIA-MACON	747 2ND ST		MACON	GA	31201-6835	4787424211	4787422735	In-Center Hemo, In-Center Hemo Self Care, Acute Hemo 1:1, PD Services, Acute PD	20	11-2583	Y
DIALYSIS CENTER OF MIDDLE GEORGIA-WARNER ROBINS	509 N HOUSTON RD		WARNER ROBINS	GA	31093-8844	4783281800	4789295499	In-Center Hemo, In-Center Hemo Self Care, PD Services	12	11-2620	Y
ELBERTON DIALYSIS CENTER	894 ELBERT ST		ELBERTON	GA	30635-2628	7062839833	7062839844	In-Center Hemo, In-Center Hemo Self Care	18	11-2545	Y
WASHINGTON DIALYSIS CENTER	154 WASHINGTON PLZ		WASHINGTON	GA	30673-2074	7066785855	7066786903	In-Center Hemo, In-Center Hemo Self Care	25	11-2527	Y
EAST POINT DIALYSIS CENTER	2669 CHURCH ST		EAST POINT	GA	30344-3115	4047651780	4047659939	In-Center Hemo, In-Center Hemo Self Care	28	11-2655	Y
MCDONOUGH DIALYSIS CENTER	114 DUNN ST		MCDONOUGH	GA	30253-2347	7708984999	7708980059	In-Center Hemo, In-Center Hemo Self Care	18	11-2651	Y
NEPHROLOGY CENTER OF SOUTH AUGUSTA	1631 GORDON HWY	STE 1B	AUGUSTA	GA	30906-2221	7067908300	7067909944	In-Center Hemo, In-Center Hemo Self Care, PD Services	19	11-2671	Y
PERRY DIALYSIS CENTER	1027 KEITH DR		PERRY	GA	31069-2948	4789877120	4789883095	In-Center Hemo, In-Center Hemo Self Care	11	11-2683	Y
BAKERS FERRY DIALYSIS	3645 BAKERS FERRY RD SW		ATLANTA	GA	30331-3712	4046911932	4046912786	In-Center Hemo, In-Center Hemo Self Care, PD Services	20	11-2729	Y
IRIS CITY DIALYSIS	521 N EXPRESSWAY	STE 1509	GRIFFIN	GA	30223-2073	7702283177	7702298431	In-Center Hemo, PD Services	28	11-2711	Y
FOREST PARK DIALYSIS CENTER	380 FOREST PKWY	STE C	FOREST PARK	GA	30297-2107	4043610646	4043610727	In-Center Hemo, In-Center Hemo Self Care	18	11-2692	Y
NEPHROLOGY CENTER OF STATESBORO	4B COLLEGE PLZ		STATESBORO	GA	30458-4928	9126814028	9128713615	In-Center Hemo, In-Center Hemo Self Care	18	11-2584	N
BUCKHEAD DIALYSIS	1575 NORTHSIDE DR NW	STE 365	ATLANTA	GA	30318-4210	4043518266	4043519345	In-Center Hemo, Home Hemo, In-Center Hemo Self Care	18	11-2578	Y
JONESBORO DIALYSIS	129 KING ST		JONESBORO	GA	30236-3656	7704712381	7704778027	In-Center Hemo, In-Center Hemo Self Care, PD Services	20	11-2517	Y
SOUTHWEST ATLANTA DIALYSIS CENTER	3620 MARTIN LUTHER KING DR SW		ATLANTA	GA	30331-3711	4046967303	4046991656	In-Center Hemo, In-Center Hemo Self Care	30	11-2523	Y
LINDEN DIALYSIS	121 LINDEN AVE NE		ATLANTA	GA	30308-2432	4048179700	4048176644	In-Center Hemo, In-Center Hemo Self Care, PD Services	28	11-2566	Y
FORT VALLEY DIALYSIS CENTER	557 BLUEBIRD BLVD		FORT VALLEY	GA	31030-5083	4788257208	4788253114	In-Center Hemo, In-Center Hemo Self Care	13	11-2559	Y
MILLEDGEVILLE DIALYSIS	400 S WAYNE ST		MILLEDGEVILLE	GA	31061-3446	4784539489	4784533100	In-Center Hemo, In-Center Hemo Self Care, PD Services	12	11-2571	Y
MOULTRIE DIALYSIS CENTER	2419 S MAIN ST		MOULTRIE	GA	31768-6531	2298901221	2298901226	In-Center Hemo, In-Center Hemo Self Care,	10	11-2603	Y
COLUMBUS DIALYSIS	6228 BRADLEY PARK DR	STE B	COLUMBUS	GA	31904-3604	7065968222	7065968381	In-Center Hemo, In-Center Hemo Self Care	22	11-2573	Y
BUENA VISTA DIALYSIS	102 E BURKHALTER AVE	STE A	BUENA VISTA	GA	31803-9701	2296495017	2296496410	In-Center Hemo, In-Center Hemo Self Care	12	11-2598	N
DECATUR DIALYSIS CENTER	1987 CANDLER RD		DECATUR	GA	30032-4212	4042861700	4042861710	In-Center Hemo, In-Center Hemo Self Care	20	11-2633	Y
EAST MACON DIALYSIS CENTER	165 EMERY HWY	STE 101	MACON	GA	31217-3666	4787551144	4787551127	In-Center Hemo, In-Center Hemo Self Care, PD Services	24	11-2602	Y
ELLIJAY DIALYSIS	449 INDUSTRIAL BLVD	STE 240	ELLIJAY	GA	30540-6724	7062761417	7062761454	In-Center Hemo, In-Center Hemo Self Care, PD Services	12	11-2709	Y
GAINESVILLE DIALYSIS	2545 FLINTRIDGE RD	STE 130	GAINESVILLE	GA	30501-7428	7705367194	7705351597	In-Center Hemo, PD Services	19	11-2693	Y
NEWNAN DIALYSIS	242 BULLSBORO DR		NEWNAN	GA	30263-1295	7703045850	7703045855	In-Center Hemo, In-Center Hemo Self Care, PD Services	21	11-2689	Y
EAST GEORGIA DIALYSIS	1989 STAMBUK LN		STATESBORO	GA	30458-2642	9128715394	9126814330	In-Center Hemo, In-Center Hemo Self Care, PD Services	29	11-2710	Y
COBB DIALYSIS	3865 MEDICAL PARK DR		AUSTELL	GA	30106-1109	7707328616	7707328605	In-Center Hemo	16	11-2581	Y
NORTHLAKE DIALYSIS	1350 MONTREAL RD	STE 200	TUCKER	GA	30084-8144	6784060825	6784060830	In-Center Hemo, In-Center Hemo Self Care, PD Services	19	11-2695	Y
PAULDING DIALYSIS	4019 JOHNS RD		DALLAS	GA	30132-3420	7704453571	7704453898	In-Center Hemo, PD Services	16	11-2594	Y
SWEETWATER DIALYSIS	7117 S SWEETWATER RD		LITHIA SPRINGS	GA	30122-2446	6789453600	6789453623	In-Center Hemo, Nocturnal Hemo, PD Services	17	11-2706	Y
CENTENNIAL ATLANTA DIALYSIS	418 DECATUR ST SE		ATLANTA	GA	30312-1801	4045241606	4045253502	In-Center Hemo, In-Center Hemo Self Care	18	11-2660	Y
KIDNEY DIALYSIS CENTER	640 MARTIN LUTHER KING JR BLVD		MACON	GA	31201-3206	4787425850	4787425860	In-Center Hemo, In-Center Hemo Self Care, PD Services	24	11-2803	Y
SNAPFINGER DIALYSIS	5255 SNAPFINGER PARK DR	STE 115	DECATUR	GA	30035-4066	7709810558	7709814828	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care, PD Services	24	11-2646	Y
EAST DEKALB DIALYSIS	2853 CANDLER RD	STE 203	DECATUR	GA	30034-1421	4042410402	4043280232	In-Center Hemo, In-Center Hemo Self Care, PD Services	16	11-2715	Y
VIDALIA FIRST STREET DIALYSIS	906 E 1ST ST		VIDALIA	GA	30474-4207	9125388908	9125388909	In-Center Hemo, In-Center Hemo Self Care	21	11-2723	Y
GROVEPARK DIALYSIS	794 MCDONOUGH RD		JACKSON	GA	30233-1572	7705040365	7705048761	In-Center Hemo, PD Services	12	11-2741	Y
WEST GEORGIA DIALYSIS	1216 STARK AVE		COLUMBUS	GA	31906-2500	7063200103	7063201906	In-Center Hemo, In-Center Hemo Self Care, PD Services	20	11-2742	Y
LAKE HEARN DIALYSIS	1150 LAKE HEARN DR NE	STE 100	ATLANTA	GA	30342-1566	4048479850	4048479261	In-Center Hemo, In-Center Hemo Self Care	20	11-2745	Y
DIALYSIS OF LITHONIA	2485 PARK CENTRAL BLVD	STE A	DECATUR	GA	30035-3903	6784189808	6784189802	In-Center Hemo, PD Services, Hemo Self Care Training	24	11-2746	Y
BUFORD DIALYSIS	1550 BUFORD HWY	STE 1E	BUFORD	GA	30518-3666	7708312379	7708316983	In-Center Hemo, PD Services	21	11-2760	Y
SNELLVILLE DIALYSIS	2135 MAIN ST E	STE 130	SNELLVILLE	GA	30078-6424	7709793117	7709793640	In-Center Hemo, Home Hemo, PD Services	18	11-2806	Y
SUGARLOAF DIALYSIS	1705 BELLE MEADE CT	STE 110	LAWRENCEVILLE	GA	30043-5895	7705132833	7705137611	In-Center Hemo, PD Services	20	11-2758	Y
SOUTHSTAR ADAMSVILLE DIALYSIS	3651 BAKERS FERRY RD SW		ATLANTA	GA	30331-3712	4044721856	4044723970	In-Center Hemo, In-Center Hemo Self Care	20	11-2790	Y
SOUTHERN CRESCENT DIALYSIS CENTER	275 UPPER RIVERDALE RD SW	STE B	RIVERDALE	GA	30274-2556	7709077022	7709077587	In-Center Hemo, In-Center Hemo Self Care	20	11-2771	Y
MEDLOCK BRIDGE DIALYSIS	10680 MEDLOCK BRIDGE RD	STE 103	DULUTH	GA	30097-8420	7706222167	7706225542	In-Center Hemo, Nocturnal Hemo, PD Services	16	11-2778	Y
MOUNTAIN PARK DIALYSIS	5235 MEMORIAL DR		STONE MOUNTAIN	GA	30083-3112	4042961344	4042964706	In-Center Hemo, In-Center Hemo Self Care	16	11-2777	Y
ATHENS EAST DIALYSIS	2026 S MILLEDGE AVE	STE A2	ATHENS	GA	30605-6480	7065493082	7065493802	In-Center Hemo, In-Center Hemo Self Care, PD Services	19	11-2789	Y

SPIVEY PERITONEAL AND HOME DIALYSIS CENTER	7444 HANOVER PKWY	STE 150	STOCKBRIDGE	GA	30281-7847	7705070988	7703899432	PD Services		11-2774	Y
TIFTON DIALYSIS	624 LOVE AVE		TIFTON	GA	31794-4406	2293821497	2293864748	In-Center Hemo, PD Services	14	11-2794	Y
UNION CITY DIALYSIS	6851 SHANNON PKWY	STE 200	UNION CITY	GA	30291-2049	7707749033	7707743189	In-Center Hemo, In-Center Hemo Self Care, PD Services	20	11-2788	Y
SATILLA RIVER DIALYSIS	308 CARSWELL AVE		WAYCROSS	GA	31501-4762	9122851663	9122853078	In-Center Hemo, In-Center Hemo Self Care, PD Services	16	11-2817	Y
NORTH HENRY DIALYSIS	3548 HIGHWAY 138 SE		STOCKBRIDGE	GA	30281-4170	7705077169	6782899223	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care	16	11-2784	Y
CORDELE DIALYSIS CENTER	1013 E 16TH AVE		CORDELE	GA	31015-1539	2292730163	2292735849	In-Center Hemo, In-Center Hemo Self Care, PD Services	20	11-2796	Y
POOLER DIALYSIS	54 TRADERS WAY		POOLER	GA	31322-4158	9127481018	9127484187	In-Center Hemo, PD Services	16	11-2811	Y
ROME DIALYSIS	15 JOHN MADDOX DR NW		ROME	GA	30165-1413	7062912656	7062356571	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care, PD Services	20	11-2505	Y
OAK STREET DIALYSIS	2704 N OAK ST	BLDG H	VALDOSTA	GA	31602-1723	2292474857	2292458658	In-Center Hemo, In-Center Hemo Self Care	23	11-2515	Y
SOUTHERN LANE DIALYSIS	1840 SOUTHERN LN		DECATUR	GA	30033-4033	4043258884	4043258879	In-Center Hemo, In-Center Hemo Self Care	16	11-2596	Y
CANDLER COUNTY DIALYSIS	325 CEDAR ST		METTER	GA	30439-4043	9126856604	9126855540	In-Center Hemo, In-Center Hemo Self Care	20	11-2624	Y
JESUP DIALYSIS	301 PEACHTREE ST		JESUP	GA	31545-0245	9124278946	9124273164	In-Center Hemo, In-Center Hemo Self Care	16	11-2532	Y
DOUGLAS DIALYSIS	190 WESTSIDE DR	STE A	DOUGLAS	GA	31533-3534	9123843439	9123836324	In-Center Hemo, In-Center Hemo Self Care, PD Services	23	11-2535	Y
EASTLAKE DIALYSIS	1757 CANDLER RD		DECATUR	GA	30032-3276	4042892313	4042892450	In-Center Hemo, In-Center Hemo Self Care, PD Services	20	11-2553	Y
WYLDS ROAD DIALYSIS	1815 WYLDS RD		AUGUSTA	GA	30909-4430	7067330522	7067330432	In-Center Hemo, In-Center Hemo Self Care, PD Services	20	11-2579	Y
DOUGLASVILLE DIALYSIS	3899 LONGVIEW DR		DOUGLASVILLE	GA	30135-1373	7709498403	7709498406	In-Center Hemo, PD Services	20	11-2526	Y
BRUNSWICK DIALYSIS	53 SCRANTON CONNECTOR		BRUNSWICK	GA	31525-1862	9122648657	9122656542	In-Center Hemo, In-Center Hemo Self Care, PD Services	24	11-2514	Y
ATLANTA DIALYSIS	567 NORTH AVE NE	STE 200	ATLANTA	GA	30308-2721	4048531662	4048533674	In-Center Hemo, PD Services	28	11-2561	Y
ATLANTA EAST DIALYSIS	1308 MORELAND AVE SE		ATLANTA	GA	30316-3224	4046275511	4046275522	In-Center Hemo, In-Center Hemo Self Care	23	11-2611	N
BRUNSWICK SOUTH DIALYSIS	2930 SPRINGDALE RD		BRUNSWICK	GA	31520-4838	9122671507	9122679768	In-Center Hemo, In-Center Hemo Self Care	16	11-2608	Y
THOMASTON DIALYSIS	1065 US HIGHWAY 19 NORTH		THOMASTON	GA	30286-2233	7066486364	7066483505	In-Center Hemo, In-Center Hemo Self Care, Acute Hemo 1:1, Acute PD, PD Services	23	11-2557	Y
PIEDMONT DIALYSIS	105 COLLIER RD NW	STE B	ATLANTA	GA	30309-1730	4043556055	4043528376	In-Center Hemo, In-Center Hemo Self Care, Acute Hemo 1:1, PD Services	21	11-2567	N
ATHENS WEST DIALYSIS	1747 LANGFORD DR	BLDG 500	WATKINSVILLE	GA	30677-7370	7065831785	7065831943	In-Center Hemo, In-Center Hemo Self Care, PD Services	28	11-2513	Y
ATLANTA AIRPORT DIALYSIS	2685 METROPOLITAN PKWY SW	STE F	ATLANTA	GA	30315-7926	4047612630	4047612618	In-Center Hemo, In-Center Hemo Self Care, PD Services	20	11-2568	Y
LAURENS COUNTY DIALYSIS	2400 BELLEVUE RD	STE 8	DUBLIN	GA	31021-2856	4782725190	4782752433	In-Center Hemo, In-Center Hemo Self Care, PD Services	26	11-2546	Y
PONCE CITY DIALYSIS	567 NORTH AVE NE	STE 100	ATLANTA	GA	30308-2721	4047459580	4047459155	In-Center Hemo, In-Center Hemo Self Care	25	11-2562	Y
NORTH FULTON DIALYSIS	1250 NORTHMEADOW PKWY	STE 120	ROSWELL	GA	30076-4914	7705692888	7705692861	In-Center Hemo, In-Center Hemo Self Care, PD Services	20	11-2617	Y
ATLANTA WEST DIALYSIS	2538 MARTIN LUTHER KING JR DR SW		ATLANTA	GA	30311-1779	4046991300	4046991144	In-Center Hemo	20	11-2643	Y
BAXLEY DIALYSIS	539 FAIR ST		BAXLEY	GA	31513-0112	9123660202	9123660333	In-Center Hemo, In-Center Hemo Self Care	13	11-2638	Y
FAYETTEVILLE DIALYSIS	1279 HIGHWAY 54 W	STE 110	FAYETTEVILLE	GA	30214-4551	6788179974	6788179930	In-Center Hemo, In-Center Hemo Self Care, PD Services	19	11-2657	Y
CUMMING DIALYSIS	911 MARKET PLACE BLVD	STE 3	CUMMING	GA	30041-7938	6785136486	6789475446	In-Center Hemo, In-Center Hemo Self Care	12	11-2681	Y
ATLANTA SOUTH DIALYSIS	3158 EAST MAIN ST	STE A	EAST POINT	GA	30344-4800	4047615593	4047610622	In-Center Hemo, In-Center Hemo Self Care	18	11-2678	N
EFFINGHAM NORTH DIALYSIS	1451 GA HWY 21 S	STE A	SPRINGFIELD	GA	31329-5244	9127544289	9127546564	In-Center Hemo, In-Center Hemo Self Care	12	11-2661	Y
WILLIAMS STREET DIALYSIS	2812 WILLIAMS ST		SAVANNAH	GA	31404-4134	9123545005	9123537509	In-Center Hemo, In-Center Hemo Self Care	20	11-2636	Y
DERENNE DIALYSIS	5303 MONTGOMERY ST		SAVANNAH	GA	31405-5138	9123521354	9123527489	In-Center Hemo, In-Center Hemo Self Care, PD Services	26	11-2639	Y
ABERCORN DIALYSIS	11706 MERCY BLVD	BLDG 9	SAVANNAH	GA	31419-1751	9129616006	9129619257	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care	12	11-2631	Y
MONTEZUMA DIALYSIS	114 DEVAUGHN AVE		MONTEZUMA	GA	31063-1708	4784727099	4784727128	In-Center Hemo, In-Center Hemo Self Care	12	11-2724	Y
WRIGHTSVILLE DIALYSIS	2240 W ELM ST		WRIGHTSVILLE	GA	31096-2016	4788648701	4788648716	In-Center Hemo, In-Center Hemo Self Care	12	11-2725	Y
LORING HEIGHTS DIALYSIS	1575 NORTHSIDE DR NW	STE 405	ATLANTA	GA	30318-4211	4043527125	4043527148	In-Center Hemo, In-Center Hemo Self Care	20	11-2727	Y
HINESVILLE DIALYSIS	522 ELMA G MILES PKWY		HINESVILLE	GA	31313-4021	9123684850	9123687247	In-Center Hemo, In-Center Hemo Self Care	16	11-2555	Y
ST. MARY'S DIALYSIS	2714 OSBORNE RD		SAINT MARYS	GA	31558-4049	9128827507	9128827523	In-Center Hemo, In-Center Hemo Self Care, PD Services	16	11-2558	Y
AMERICUS DIALYSIS	227 N LEE ST		AMERICUS	GA	31709-3525	2299282257	2299280695	In-Center Hemo, In-Center Hemo Self Care, PD Services	19	11-2528	Y
KENNESTONE DIALYSIS	200 COBB PKWY N	STE 318 BLDG 300	MARIETTA	GA	30062-3558	6787971110	6787971176	In-Center Hemo, PD Services	20	11-2810	Y
SHAMROCK DIALYSIS	1016 CLAXTON DAIRY RD	STE 1A	DUBLIN	GA	31021-7971	4782754200	4782754225	In-Center Hemo, In-Center Hemo Self Care, PD Services	16	11-2813	Y
SUNRISE ON CENTRAL DIALYSIS	540 CENTRAL AVE		ATLANTA	GA	30312-2735	4045819314	4046814718	In-Center Hemo, PD Services, Nocturnal Hemo	19	11-2852	Y
ARBOR PLACE DIALYSIS	9559 HIGHWAY 5	STE 1	DOUGLASVILLE	GA	30135-1573	6783910993	6783910977	In-Center Hemo	13	11-2807	Y
GEORGIA DIALYSIS FOR ADOLESCENTS AND PEDIATRICS	4434 HUGH HOWELL RD		TUCKER	GA	30084-4905	7704917187	7704917192	In-Center Hemo, PD Services	16	11-2816	Y
PEACHTREE CITY DIALYSIS	2830 W HWY 54	BLDG 100 STE J AND K	PEACHTREE CITY	GA	30269-1026	6783649165	6783649823	In-Center Hemo, In-Center Hemo Self Care, PD Services	16	11-2815	Y
CONYERS DIALYSIS	1501 MILSTEAD RD NE		CONYERS	GA	30012-3838	7707618097	7707618141	In-Center Hemo, PD Services	17	11-2828	Y
MCAFEE DIALYSIS	1987 CANDLER RD	STE C	DECATUR	GA	30032-4212	4042848596	4042848595	In-Center Hemo, PD Services	20	11-2841	Y
COLONIAL SPRINGS DIALYSIS	2840 EAST WEST CONNECTOR	STE 350	AUSTELL	GA	30106-6813	7702222236	7702224907	In-Center Hemo, PD Services	17	11-2829	Y

WALTON COUNTY DIALYSIS	225 PLAZA DR		MONROE	GA	30655-3184	7702076942	7702676811	In-Center Hemo, PD Services	12	11-2863	Y
MAGNOLIA OAKS DIALYSIS	2377 HWY 196 W		HINESVILLE	GA	31313-8036	9123682710	9123682714	In-Center Hemo, PD Services	20	11-2831	Y
NORTH CARROLLTON DIALYSIS	195 PARKWOOD CIRCLE		CARROLLTON	GA	30117-8756	7708328959	7708328796	In-Center Hemo	12	11-2840	Y
DARIEN DIALYSIS	5873 HIGHWAY 17		DARIEN	GA	31305-4015	9124371211	9124371244	In-Center Hemo	8	11-2848	Y
LAKE HARTWELL DIALYSIS	1065 E FRANKLIN ST		HARTWELL	GA	30643-2205	7063763285	7063761674	In-Center Hemo, PD Services	8	11-2854	Y
VALDOSTA HOME TRAINING	401 NORTHSIDE DR	STE A	VALDOSTA	GA	31602-1872	2292479286	2292479190	PD Services	3	11-2857	Y
ALBANY DIALYSIS	244 CORDELE RD	STE 165	ALBANY	GA	31705-2407	2294466412	2294837806	In-Center Hemo, PD Services	13	85-2519	Y
SAVANNAH GATEWAY DIALYSIS	5973 OGEECHEE RD		SAVANNAH	GA	31419-8901	9129251920	9129252935	In-Center Hemo, PD Services	13	11-2859	Y
MCDUFFIE DIALYSIS	621 MCNEIL CIRCLE		THOMSON	GA	30824-8060	7065953054	7065953907	In-Center Hemo	17	11-2855	Y
MCFARLAND DIALYSIS	6225 ATLANTA HWY	STE 117	ALPHARETTA	GA	30004-8799	7705691275	7704751932	In-Center Hemo, PD Services	16	11-2870	Y
OLD NATIONAL DIALYSIS	5615 OLD NATIONAL HWY	STE A	COLLEGE PARK	GA	30349-3811	4047629243	4047625304	In-Center Hemo, PD Services	17	11-2875	Y
TRI COUNTY DIALYSIS	2540 FLAT SHOALS RD		ATLANTA	GA	30349-4314	7709916479	7709915206	In-Center Hemo, PD Services	17	11-2877	Y
TURNER HILL DIALYSIS	7301 STONECREST CONCOURSE	STE 101	LITHONIA	GA	30038-6902	7704848475	7704848916	In-Center Hemo, PD Services	20	11-2866	Y
WEST HIRAM DIALYSIS	76 HIGHLAND PAVILION CT	STE 129	HIRAM	GA	30141-3170	6783841180	6783840662	In-Center Hemo, PD Services	13	11-2867	Y
BUCKHEAD HOME TRAINING (PD)	1575 NORTHSIDE DR NW	STE 355	ATLANTA	GA	30318-4210	4043521870	4043523107	PD Services	4	11-2851	Y
SOUTH FULTON HOME TRAINING (PD)	1275 E CLEVELAND AVE	1ST FLR	EAST POINT	GA	30344-3433	4043059080	4043059084	PD Services	3	11-2880	Y
COLUMBUS HOME TRAINING (PD/HHD)	1200 BROOKSTONE CENTRE PKWY	STE 111	COLUMBUS	GA	31904-2988	7063222935	7063174862	PD Services	4	11-2869	Y
MERIWETHER GREENVILLE DIALYSIS	4130 WHITE HOUSE PKWY		WARM SPRINGS	GA	31830-2214	7066553642	7066553754	In-Center Hemo, PD Services	11	11-2881	Y
VICTORY DIALYSIS	2401 SHELBY ST		COLUMBUS	GA	31903-3360	7066825327	7066826059	In-Center Hemo	12	11-2876	Y
LOCUST GROVE DIALYSIS	521 STANLEY K TANGER BLVD		LOCUST GROVE	GA	30248-2591	7709141432	7709577565	In-Center Hemo, PD Services	12	11-2892	Y
QUITMAN DIALYSIS	101 E DAVIS ST		QUITMAN	GA	31643-1407	2292639483	2292636948	In-Center Hemo	12		Y
FLINT RIVER DIALYSIS	700 GORDON AVE		BAINBRIDGE	GA	39819-5713	2292460173	2292460177	In-Center Hemo	19		Y
CAIRO DIALYSIS	1182 5TH ST SE		CAIRO	GA	39828-3141	2293770852	2293778804	In-Center Hemo	12		Y
CAMILLA DIALYSIS	251 US HWY 19 N		CAMILLA	GA	31730-1410	2295222045	2295222049	In-Center Hemo	12		Y
RED HILLS DIALYSIS	201 OLD ALBANY RD		THOMASVILLE	GA	31792-4010	2292265931	2292275195	In-Center Hemo	40		Y
THOMAS COUNTY HOME TRAINING	708 S BROAD ST		THOMASVILLE	GA	31792-6107	2292264541	2292275194	PD Services	0		Y
TROUP COUNTY DIALYSIS	140 GLENN BASS RD		LA GRANGE	GA	30240-5809	7068820193	7068821895	In-Center Hemo, PD Services	33	11-2858	Y
CONYERS AT HOME	1501 MILSTEAD RD NE		CONYERS	GA	30012-3838	7707618097	7707618141	Home Hemo		11-2828	Y
ARBOR PLACE AT HOME	9559 HWY 5	STE 1	DOUGLASVILLE	GA	30135-1573	6783910993	6783910977	Home Hemo		11-2807	Y
IRIS CITY AT HOME	521 N EXPRESSWAY VILLAGE	STE 1509	GRIFFIN	GA	30223-2073	7702283177	7702298431	Home Hemo		11-2711	Y
VALDOSTA HT AT HOME	401 NORTHSIDE DR	STE A	VALDOSTA	GA	31602-1871	2292479286	2292479190	Home Hemo		11-2857	Y
SNAPFINGER AT HOME	5255 SNAPFINGER PARK DR	STE 115	DECATUR	GA	30035-4084	7709810558	7709814828	Home Hemo		11-2646	Y
TROUP COUNTY AT HOME	140 GLENN BASS RD		LA GRANGE	GA	30240-5809	7068453282	7068453474	Home Hemo		11-2858	Y
TIFTON AT HOME	624 LOVE AVE		TIFTON	GA	31794-4406	2293821497	2293864748	Home Hemo		11-2794	Y
LINDEN AT HOME	121 LINDEN AVE NE		ATLANTA	GA	30308-2432	4048179700	4048176644	Home Hemo		11-2566	Y
MAGNOLIA OAKS AT HOME	2377 HIGHWAY 196 W	BLDG A MAGNOLIA OAKS	HINESVILLE	GA	31313-8036	9123682710	9123682714	Home Hemo		11-2831	Y
POOLER AT HOME	54 TRADERS WAY		POOLER	GA	31322-4158	9127481018	9127484187	Home Hemo		11-2811	Y
UNION CITY AT HOME (GA)	6851 SHANNON PARKWAY	STE 200	UNION CITY	GA	30291-2049	7707749033	7707743189	Home Hemo		11-2788	Y
KENNESTONE AT HOME	200 COBB PKWY N	STE 318	MARIETTA	GA	30062-3558	6787971110	6787971176	Home Hemo		11-2810	Y
ATHENS EAST AT HOME	2026 S MILLEDGE AVE	STE A2	ATHENS	GA	30605-6480	7065493082	7065493802	Home Hemo	0	11-2789	Y
DERENNE AT HOME	5303 MONTGOMERY ST		SAVANNAH	GA	31405-5138	9123521354	9123527489	Home Hemo	0	11-2639	Y
BRUNSWICK AT HOME	53 SCRANTON CONNECTOR		BRUNSWICK	GA	31525-1862	9122648657	9122656542	Home Hemo	0	11-2514	Y
SPIVEY PERITONEAL AND HOME AT HOME	7444 HANNOVER PKWY S	STE 150	STOCKBRIDGE	GA	30281-7847	7705070988	7703899432	Home Hemo	0	11-2774	Y
LITHONIA AT HOME	2485 PARK CENTRAL BLVD		DECATUR	GA	30035-3902	6784189808	6784189802	Home Hemo		11-2746	Y
EAST MACON AT HOME	165 EMERY HWY	STE 101	MACON	GA	31217-3666	4787551144	4787551127	Home Hemo		11-2602	Y
WEST GEORGIA AT HOME	1216 STARK AVE		COLUMBUS	GA	31906-2500	7063200103	7063201906	Home Hemo		11-2742	Y
BUFORD AT HOME	1550 BUFORD HWY	STE 1E	BUFORD	GA	30518-3666	7708312379	7708316983	Home Hemo		11-2760	Y
CORDELE AT HOME	1013 E 16TH AVE		CORDELE	GA	31015-1539	2292730163	2292735849	Home Hemo		11-2796	Y
EAST GEORGIA AT HOME	1989 STAMBUK LN		STATESBORO	GA	30458-2642	9128715394	9126814107	Home Hemo		11-2710	Y
ROME AT HOME	15 JOHN MADDOX DR NW		ROME	GA	30165-1413	7062912656	7062356571	Home Hemo, Staff Assisted Home Hemo		11-2505	Y
NORTH FULTON AT HOME	1250 NORTHMEADOW PKWY	STE 120	ROSWELL	GA	30076-4914	7705692888	7705692861	Home Hemo		11-2617	Y
MIDATLANTA HOME AT HOME	418 DECATUR ST SE	STE B	ATLANTA	GA	30312-1801	4046140641	4045243651	Home Hemo	5	11-2842	Y
ATLANTA AT HOME	567 NORTH AVE NE	STE 200	ATLANTA	GA	30308-2721	4048531662	4048533674	Home Hemo, Staff Assisted Home Hemo		11-2561	Y
WEST HIRAM AT HOME	76 HIGHLAND PAVILION CT	STE 129	HIRAM	GA	30141-3170	6783841180	6783840662	Home Hemo		11-2867	Y
WALTON COUNTY AT HOME	225 PLAZA DR		MONROE	GA	30655-3184	7702076942	7702676811	Home Hemo		11-2863	Y
COLUMBUS HT AT HOME	1200 BROOKSTONE CENTRE PKWY	STE 111	COLUMBUS	GA	31904-2988	7063222935	7063174862	Home Hemo		11-2869	Y

TURNER HILL AT HOME	7301 STONECREST CONCOURSE	STE 101	LITHONIA	GA	30038-6902	7704848475	7704848916	Home Hemo		11-2866	Y
NORTH CARROLLTON AT HOME	195 PARKWOOD CIR		CARROLLTON	GA	30117-8756	7708328959	7708328796	Home Hemo		11-2840	Y
CARTERSVILLE RENAL CENTER	419 E MAIN ST		CARTERSVILLE	GA	30121-3349	6787211045	6787211252	In-Center Hemo, PD Services	13	11-2691	Y
AUSTELL RENAL CENTER	3642 MARATHON CIR		AUSTELL	GA	30106- 6821	7704394170	7704394252	In-Center Hemo	12	11-2825	Y
NORTHWEST GEORGIA DIALYSIS	260 HOSPITAL RD		CANTON	GA	30114-2409	6788803939	7704799466	In-Center Hemo, Home Hemo, PD Services	19	11-2765	Y
GREENSBORO DIALYSIS	1220 SILOAM RD		GREENSBORO	GA	30642-2810	7064537222	7064530022	In-Center Hemo, PD Services	15	11-2640	Y
EAST COBB DIALYSIS	4880 LOWER ROSWELL RD	STE 770	MARIETTA	GA	30068-4375	7703210675	7705098283	In-Center Hemo	13	11-2572	Y
OLD NATIONAL AT HOME	5615 OLD NATIONAL HWY	STE A	COLLEGE PARK	GA	30349-3811	4047629243	4047625304	Home Hemo		11-2875	N
ELLIJAY HT AT HOME	449 INDUSTRIAL BLVD	STE 245	ELLIJAY	GA	30540-3772	7062766040	7062766041	Home Hemo		11-2872	Y
MILLER AT HOME	213 DELORES ST		COLQUITT	GA	39837-3528	2297581985	2297582555	Home Hemo	1	11-2898	Y
SAVANNAH RIVERSIDE AT HOME	540 E OGLETHORPE AVE		SAVANNAH	GA	31401-4121	9122363053	9122381024	Home Hemo		11-2891	Y
KIDNEY DIALYSIS CENTER AT HOME	640 MARTIN LUTHER KING JR BLVD		MACON	GA	31201-3206	4787425850	4787425860	Home Hemo		11-2803	Y
SOUTHWEST ATLANTA HOME AT HOME	3201 ATLANTA INDUSTRIAL PKWY NW	STE 101	ATLANTA	GA	30331-1045	4046911162	4046960900	Home Hemo		85-2501	Y
TRI COUNTY AT HOME	2540 FLAT SHOALS RD		ATLANTA	GA	30349-4314	7709916479	7709915206	Home Hemo		11-2877	Y
EAST COBB AT HOME	4880 LOWER ROSWELL RD	STE 770	MARIETTA	GA	30068-4375	7703210675	7705098282	Home Hemo	1	11-2572	Y
SAVANNAH RIVERSIDE DIALYSIS	540 E OGLETHORPE AVE		SAVANNAH	GA	31401-4121	9122363053	9122381024	In-Center Hemo, PD Services	16	11-2891	Y
ELLIJAY HOME TRAINING (PD-HHD)	449 INDUSTRIAL BLVD	STE 245	ELLIJAY	GA	30540-3772	7062766040	7062766041	PD Services		11-2872	Y
SOUTHWEST ATLANTA HOME TRAINING	3201 ATLANTA INDUSTRIAL PKWY NW	STE 101	ATLANTA	GA	30331-1045	4046911162	4046960900	PD Services		85-2501	Y
BRASELTON DIALYSIS	1241 FRIENDSHIP RD	STE 130	BRASELTON	GA	30517-5609	7709656056	7709658185	In-Center Hemo	13	85-2514	Y
NEWTON COUNTY DIALYSIS	10132 CARLIN DR		COVINGTON	GA	30014-3651	7703858008	7703857287	In-Center Hemo, PD Services	17	11-2883	Y
SUMTER COUNTY DIALYSIS	1432 E FORSYTH ST		AMERICUS	GA	31709-3808	2299249709	2299246002	In-Center Hemo	12	11-2885	Y
MILLER DIALYSIS	213 DELORES ST		COLQUITT	GA	39837-3528	2297581985	2297582555	In-Center Hemo, PD Services,	12	11-2898	Y
CHAPEL WOODS DIALYSIS	2460 WESLEY CHAPEL RD	STE 25D	DECATUR	GA	30035-3420	7709871439	6784187948	In-Center Hemo	17	85-2510	Y
SENOIA DIALYSIS	105 VILLAGE CIRCLE		SENOIA	GA	30276-3494	7705990242	7705993540	In-Center Hemo, PD Services	13	85-2518	Y
TOWN PARK DIALYSIS	401 TOWN PARK BLVD		EVANS	GA	30809-3487	7068549502	7068559982	In-Center Hemo, Home Hemo, PD Services	16	85-2520	Y
NORTHEAST GEORGIA HOME TRAINING (PD)	1485 JESSE JEWELL PKWY NE	STE 260	GAINESVILLE	GA	30501-3801	7702970547	7705364267	PD Services	0	85-2526	Y
TARA BOULEVARD DIALYSIS	6540 TARA BLVD	STE 200	JONESBORO	GA	30236-1228	7709688279	7709688744	In-Center Hemo	12	85-2525	Y
CENTER HILL DIALYSIS	2045 DONALD LEE HOLLOWELL PKWY NW		ATLANTA	GA	30318-4701	4047921611	4047990816	In-Center Hemo	13	85-2527	Y
ROCKBRIDGE DIALYSIS	8032 ROCKBRIDGE RD		LITHONIA	GA	30058-5882	6785268340	7704824671	In-Center Hemo, PD Services	13	85-2534	Y
NORTH ATLANTA HOME TRAINING (PD)	980 JOHNSON FERRY RD	STE 410A	ATLANTA	GA	30342-1626	4042563537	4042563541	PD Services		112820	Y
THOMAS COUNTY HT AT HOME	708 S BROAD ST		THOMASVILLE	GA	31792-6107	2292275002	2292275194	Home Hemo	12		Y
RAINBOW-WAILUKU DIALYSIS	80 MAHALANI ST		WAILUKU	HI	96793-2531	8082980555	8086334884	In-Center Hemo, PD Services, Nocturnal Hemo	11	12-2526	Y
RAINBOW DIALYSIS-LAHAINA	305 KEAWE ST	STE 503	LAHAINA	HI	96761-2734	8086618372	8086619484	In-Center Hemo	6	12-2528	Y
RAINBOW-WAILUKU AT HOME	80 MAHALANI ST	STE 100	WAILUKU	HI	96793-2531	8882980555		Home Hemo		12-2526	Y
HARLAN DIALYSIS	1213 GARFIELD AVE		HARLAN	IA	51537-2057	7127554217	7127552398	In-Center Hemo, In-Center Hemo Self Care	6	16-2528	Y
SHENANDOAH DIALYSIS	300 PERSHING AVE		SHENANDOAH	IA	51601-2355	7122465220	7122465226	In-Center Hemo, In-Center Hemo Self Care	12	16-2527	Y
CENTRAL DES MOINES DIALYSIS	1215 PLEASANT ST	STE 106	DES MOINES	IA	50309-1409	5152415715	5152415782	In-Center Hemo	20	16-2501	Y
WEST DES MOINES DIALYSIS	6800 LAKE DR	STE 185	WEST DES MOINES	IA	50266-2544	5152212944	5152211903	In-Center Hemo, PD Services	10	16-2506	Y
CRESTON DIALYSIS	1700 W TOWNLINE ST		CRESTON	IA	50801-1054	6417825202	6417825228	In-Center Hemo	8	16-2514	Y
ATLANTIC DIALYSIS	1500 E 10TH ST		ATLANTIC	IA	50022-1935	7122437485	7122437486	In-Center Hemo	6	16-2520	Y
NEWTON DIALYSIS	204 N 4TH AVE E	STE 134	NEWTON	IA	50208-3135	6417922600	6417922701	In-Center Hemo	8	16-2523	Y
BUCHANAN COUNTY DIALYSIS	1600 1ST ST E		INDEPENDENCE	IA	50644-3155	3193347437	3193347414	In-Center Hemo	12	16-2544	Y
CEDAR VALLEY WAVERLY DIALYSIS	220 10th ST SW		WAVERLY	IA	50677-2930	3193528019	3193528032	In-Center Hemo	16	16-2542	Y
BLACK HAWK DIALYSIS	3421 W 9TH ST		WATERLOO	IA	50702-5401	3192728700	3192728695	In-Center Hemo	18	16-2541	Y
CEDAR VALLEY DIALYSIS	1661 W RIDGEWAY AVE		WATERLOO	IA	50701-4541	3192266425	3192266421	In-Center Hemo, PD Services	24	16-2516	Y
WEST UNION DIALYSIS	405 HIGHWAY 150 N		WEST UNION	IA	52175-1003	5634225734	5634225830	In-Center Hemo	16	16-2526	Y
RIVERPOINT DIALYSIS UNIT	501 SW 7TH ST	STE B	DES MOINES	IA	50309-4538	5152831300	5152831316	In-Center Hemo, PD Services	16	16-2529	Y
EAST DES MOINES DIALYSIS	1301 PENNSYLVANIA AVE	STE 208	DES MOINES	IA	50316-2365	5152625995	5152628350	In-Center Hemo, In-Center Hemo Self Care, PD Services	16	16-2533	Y
PERRY DIALYSIS	610 10TH ST	STE L100	PERRY	IA	50220-2221	5154652657	5154652874	In-Center Hemo	8	16-2534	Y
COUNCIL BLUFFS DIALYSIS CENTER	300 W BROADWAY	STE 150	COUNCIL BLUFFS	IA	51503-9077	7123880261	7123880269	In-Center Hemo, PD Services	24	16-2539	Y
PELLA DIALYSIS	1117 HAZEL ST		PELLA	IA	50219-1338	6416288826	6416288830	In-Center Hemo, PD Services	9	16-2566	Y
GRUNDY CENTER DIALYSIS	101 E J AVENUE		GRUNDY CENTER	IA	50638-2031	3198254730	3198254733	In-Center Hemo	8	16-2545	N
CEDAR RAPIDS DIALYSIS	5945 COUNCIL ST NE		CEDAR RAPIDS	IA	52402-5858	3192947088	3192944196	In-Center Hemo, PD Services	12	16-2552	Y

SIOUX CITY DIALYSIS	5865 SUNNYBROOK DR		SIOUX CITY	IA	51106-4203	7122748068	7122763877	In-Center Hemo, PD Services	12	16-2561	Y
GREEN COUNTRY DIALYSIS	5250 UTICA RIDGE RD		DAVENPORT	IA	52807-3872	5633557913	5633554007	In-Center Hemo, PD Services	12	16-2554	Y
ANKENY DIALYSIS	2625 N ANKENY BLVD		ANKENY	IA	50023-4704	5159633174	5159643620	In-Center Hemo, PD Services	12	16-2557	Y
FIVE SEASONS DIALYSIS	1002 4TH AVE SE	STE A	CEDAR RAPIDS	IA	52403-2425	3193631538	3193640982	In-Center Hemo	16	16-2558	Y
OTTUMWA DIALYSIS	1005 PENNSYLVANIA AVE	STE 101	OTTUMWA	IA	52501-6408	6416821531	6416820794	In-Center Hemo	12	16-2560	Y
AMES MARY GREELEY DIALYSIS	2322 E 13TH ST		AMES	IA	50010-5669	5152396800	5152338151	In-Center Hemo, PD Services	16	16-2549	Y
MARSHALLTOWN MARY GREELEY DIALYSIS	3120 S 2ND ST		MARSHALLTOWN	IA	50158-4614	6417521819	6417524836	In-Center Hemo	24	16-2548	Y
IOWA FALLS MARY GREELEY DIALYSIS	701 WASHINGTON AVE	STE E	IOWA FALLS	IA	50126-2109	6416485241	6416483628	In-Center Hemo	8	16-2547	Y
EAST DES MOINES AT HOME	1301 PENNSYLVANIA AVE	STE 208	DES MOINES	IA	50316-2365	5152625995	5152628242	Home Hemo		16-2533	Y
EA MOTTO DIALYSIS	1228 E RUSHOLME ST	STE 1000	DAVENPORT	IA	52803-2459	5633220101	5633222092	In-Center Hemo	24	16-2559	Y
RENAL CENTER OF FORT DODGE	2520 9TH AVE SOUTH		FORT DODGE	IA	50501-5440	5155746200	5155746078	In-Center Hemo, PD Services	16	16-2550	Y
RENAL CENTER OF STORM LAKE	1426 LAKE AVE		STORM LAKE	IA	50588-1910	7127326900	7127326906	In-Center Hemo, PD Services	16	16-2518	Y
CEDAR RAPIDS AT HOME	5945 COUNCIL ST N E		CEDAR RAPIDS	IA	52402-5858	3192947088	3192944196	Home Hemo	1		Y
TREASURE VALLEY DIALYSIS CENTER	3045 E ST LUKES ST	STE 105	MERIDIAN	ID	83642-6303	2088872174	2088879437	In-Center Hemo	17	13-2513	Y
NAMPA DIALYSIS CENTER	846 PARKCENTRE WAY		NAMPA	ID	83651-1790	2084675180	2084674475	In-Center Hemo, Home Hemo, In-Center Hemo Self Care	15	13-2501	Y
TABLE ROCK DIALYSIS CENTER	5610 W GAGE ST	STE B	BOISE	ID	83706-1332	2086588111	2086588127	In-Center Hemo, In-Center Hemo Self Care	25	13-2502	Y
TWIN FALLS DIALYSIS CENTER	582 POLE LINE RD		TWIN FALLS	ID	83301-3042	2087332006	2087332051	In-Center Hemo	24	13-2505	Y
BURLEY DIALYSIS CENTER	741 N OVERLAND AVE		BURLEY	ID	83318-3440	2086775483	2086775498	In-Center Hemo, Home Hemo	12	13-2503	Y
GATE CITY DIALYSIS CENTER	2001 BENCH RD		POCATELLO	ID	83201-2033	2086371090	2086370750	In-Center Hemo, In-Center Hemo Self Care	18	13-2506	Y
NAMPA DIALYSIS CENTER PD	846 PARKCENTRE WAY		NAMPA	ID	83651-1790	2084675180	2084674475	PD Services		13-2501	Y
TABLE ROCK DIALYSIS CENTER PD	5610 W GAGE ST	STE B	BOISE	ID	83706-1349	2086588125	2086588131	PD Services		13-2502	Y
TWIN FALLS DIALYSIS CENTER PD	582 POLE LINE RD		TWIN FALLS	ID	83301-3042	2087332006	2087332051	PD Services		13-2505	Y
TREASURE VALLEY DIALYSIS CENTER PD	3045 E ST LUKES ST	STE 105	MERIDIAN	ID	83642-6303	2088872174	2088879437	PD Services		13-2513	Y
GATE CITY DIALYSIS CENTER PD	2001 BENCH RD		POCATELLO	ID	83201-2033	2086371090	2087851709	PD Services		13-2506	Y
BURLEY DIALYSIS CENTER PD	741 N OVERLAND AVE		BURLEY	ID	83318-3440	2086775483	2086775498	PD Services		13-2503	Y
SNAKE RIVER DIALYSIS PD	1491 PARKWAY DR		BLACKFOOT	ID	83221-1667	2087851720	2087851709	PD Services		13-2524	Y
SNAKE RIVER DIALYSIS CENTER	1491 PARKWAY DR		BLACKFOOT	ID	83221-1667	2087851720	2087851709	In-Center Hemo	14	13-2524	Y
CALDWELL DIALYSIS CENTER	4716 BEACON LN		CALDWELL	ID	83605-4834	2084548260	2084548204	In-Center Hemo	12	13-2518	Y
FRUITLAND DIALYSIS (PD ONLY)	815 NW 13TH ST		FRUITLAND	ID	83619-2316	2084523600	2084523609	PD Services	0	13-2533	Y
MOSCOW DIALYSIS	212 RODEO DR	STE 110	MOSCOW	ID	83843-9798	2088825925	2088825926	In-Center Hemo, In-Center Hemo Self Care, PD Services	8	13-2521	Y
CALDWELL DIALYSIS CENTER PD	821 S SMEED PKWY		CALDWELL	ID	83605-5130	2084548260	2084548204	PD Services	0	13-2518	Y
MOSCOW AT HOME	212 RODEO DR	STE 110	MOSCOW	ID	83843-9791	2088825925	2088825926	Home Hemo		13-2521	Y
TABLE ROCK AT HOME	5610 W GAGE ST	STE B	BOISE	ID	83706-1349	2086588125	2086588131	Home Hemo	0	13-2502	Y
TWIN FALLS AT HOME	582 POLE LINE RD		TWIN FALLS	ID	83301-3042	2087332006	2087332051	Home Hemo	0	13-2505	Y
GATE CITY AT HOME	2001 BENCH RD		POCATELLO	ID	83201-2033	2086371090	2086371097	Home Hemo	0	13-2506	Y
Caldwell At Home	821 S SMEED PKWY		CALDWELL	ID	83605-5130	2084548260	2084548204	Home Hemo		13-2518	Y
LEWISTON DIALYSIS	730 21ST STREET		LEWISTON	ID	83501-3323			In-Center Hemo			N
TREASURE VALLEY AT HOME	3045 E ST LUKES ST	STE 105	MERIDIAN	ID	83642-6303	2088872174	2088879437	Home Hemo	1		Y
FRUITLAND DIALYSIS	815 NW 13TH ST		FRUITLAND	ID	83619-2316	2084523600	2084523609	In-Center Hemo	12	13-2533	Y
SYRINGA HOME TRAINING-ID	1070 N CURTIS RD	STE 125	BOISE	ID	83706-1249	2083754027	2083754239	PD Services		13-2532	Y
SYRINGA HOME AT HOME	1070 N CURTIS RD	STE 125	BOISE	ID	83706-1249	2083754027	2083754239	Home Hemo		13-2532	Y
LOGAN SQUARE DIALYSIS	2838 N KIMBALL AVE		CHICAGO	IL	60618-7524	7733423738	7733428186	In-Center Hemo, In-Center Hemo Self Care	28	14-2534	Y
LAKE COUNTY DIALYSIS SERVICES	565 LAKEVIEW PKWY	STE 176	VERNON HILLS	IL	60061-1822	8479180592	8475491281	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care	18	14-2552	Y
LINCOLN PARK DIALYSIS	2484 N ELSTON AVE		CHICAGO	IL	60647-2002	7732784403	7734896986	In-Center Hemo, In-Center Hemo Self Care	25	14-2528	Y
SKYLINE HOME DIALYSIS	7009 W BELMONT AVE		CHICAGO	IL	60634-4533	7736377303	7736377343	PD Services	0	14-2560	Y
TRC CHILDREN'S DIALYSIS CENTER	1333 N KINGSBURY ST		CHICAGO	IL	60642-2687	3126422631	3126422695	In-Center Hemo, In-Center Hemo Self Care, Acute Hemo 1:1, Acute PD, PD Services	8	14-2604	Y
EMERALD DIALYSIS	710 W 43RD ST		CHICAGO	IL	60609-3435	7738435668	7735238225	In-Center Hemo, In-Center Hemo Self Care	24	14-2529	Y
OLYMPIA FIELDS DIALYSIS CENTER	4557 LINCOLN HWY	STE B	MATTESON	IL	60443-2385	7085031112	7085031116	In-Center Hemo, In-Center Hemo Self Care	24	14-2548	Y
GRANITE CITY DIALYSIS CENTER	9 AMERICAN VLG		GRANITE CITY	IL	62040-3706	6184525858	6184526868	In-Center Hemo, In-Center Hemo Self Care, PD Services	20	14-2537	Y
SAUGET DIALYSIS	2061 GOOSE LAKE RD		SAUGET	IL	62206-2822	6183327801	6183327815	In-Center Hemo, In-Center Hemo Self Care	24	14-2561	Y
CHURCHVIEW DIALYSIS	417 WARE AVE		ROCKFORD	IL	61107-6413	8153974123	8153973059	In-Center Hemo, In-Center Hemo Self Care, PD Services	24	14-2640	Y
FREEPORT DIALYSIS	1028 S KUNKLE BLVD		FREEPORT	IL	61032-6914	8152322477	8152330824	In-Center Hemo, In-Center Hemo Self Care	10	14-2642	Y
ROCKFORD DIALYSIS	3339 N ROCKTON AVE		ROCKFORD	IL	61103-2839	8156364493	8156374814	In-Center Hemo, In-Center Hemo Self Care	22	14-2647	Y
WHITESIDE DIALYSIS	2600 N LOCUST	STE D	STERLING	IL	61081-4602	8156263173	8156263948	In-Center Hemo, In-Center Hemo Self Care	15	14-2648	Y
CHICAGO HEIGHTS DIALYSIS	177 W JOE ORR RD	STE B	CHICAGO HEIGHTS	IL	60411-1733	7087559000	7087559017	In-Center Hemo, In-Center Hemo Self Care	16	14-2635	Y

BENTON DIALYSIS	1151 ROUTE 14 W		BENTON	IL	62812-1500	6184354850	6184354852	In-Center Hemo, In-Center Hemo Self Care, PD Services	13	14-2608	Y
CENTRALIA DIALYSIS	1231 STATE ROUTE 161		CENTRALIA	IL	62801-6739	6185332535	6185333911	In-Center Hemo, PD Services	14	14-2609	Y
MARION DIALYSIS	324 S 4TH ST		MARION	IL	62959-1241	6189978410	6189978415	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care, PD Services	13	14-2570	Y
MOUNT VERNON DIALYSIS	4102 N WATER TOWER PL		MOUNT VERNON	IL	62864-6583	6182443407	6182426137	In-Center Hemo, In-Center Hemo Self Care, PD Services	16	14-2541	Y
METRO EAST DIALYSIS	5105 W MAIN ST		BELLEVILLE	IL	62226-4728	6182339018	6182335647	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care, PD Services	36	14-2527	Y
OLNEY DIALYSIS CENTER	117 N BOONE ST		OLNEY	IL	62450-2109	6183934234	6183934614	In-Center Hemo, In-Center Hemo Self Care	7	14-2674	Y
STONY CREEK DIALYSIS	6246 W 95TH ST		OAK LAWN	IL	60453-2702	7082339027	7082339429	In-Center Hemo, In-Center Hemo Self Care	14	14-2661	Y
BEVERLY DIALYSIS	8109 SOUTH WESTERN AVE		CHICAGO	IL	60620-5939	7737780173	7737780193	In-Center Hemo, In-Center Hemo Self Care, PD Services	16	14-2638	Y
EMERALD DIALYSIS PD	710 W 43RD ST		CHICAGO	IL	60609-3435	7738435668	7735238225	PD Services		14-2529	Y
OLYMPIA FIELDS DIALYSIS PD	4557B LINCOLN HWY	STE B	MATTESON	IL	60443-2318	7086790531	7086790535	PD Services		14-2548	Y
LAKE COUNTY DIALYSIS PD	565 LAKEVIEW PKWY	STE 176	VERNON HILLS	IL	60061-1882	8479180812	8479180831	PD Services		14-2552	Y
CHICAGO HEIGHTS PD	177B W JOE ORR RD		CHICAGO HEIGHTS	IL	60411-1733	7087559000	7087559017	PD Services		14-2635	N
LITTLE VILLAGE DIALYSIS PD	2335 WEST CERMAK ROAD		CHICAGO	IL	60608-3811	7735232939	7735233797	PD Services		14-2668	Y
MARYVILLE HOME DIALYSIS (PD)	2102 VADALABENE DR	STE B	MARYVILLE	IL	62062-5632	6182881521	6182881759	PD Services	0	14-2686	Y
KANKAKEE COUNTY DIALYSIS PD	581 WILLIAM R LATHAM SR DR	STE 104	BOURBONNAIS	IL	60914-2439	8159364577	8159363756	PD Services	0	14-2685	Y
MARYVILLE DIALYSIS	2102 VADALABENE DR	STE 1	MARYVILLE	IL	62062-5632	6182881196	6182881294	In-Center Hemo, In-Center Hemo Self Care	14	14-2634	Y
MONTCLARE DIALYSIS CENTER	7009 W BELMONT AVE		CHICAGO	IL	60634-4533	7738896051	7738896030	In-Center Hemo, In-Center Hemo Self Care	16	14-2649	Y
ROXBURY DIALYSIS CENTER	622 ROXBURY RD		ROCKFORD	IL	61107-5089	8153970713	8153970796	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care, PD Services	16	14-2665	Y
DIXON KIDNEY CENTER	1131 N GALENA AVE		DIXON	IL	61021-1015	8152840595	8152840547	In-Center Hemo, In-Center Hemo Self Care, PD Services, Acute Hemo 1:1	13	14-2651	Y
SYCAMORE DIALYSIS	2200 GATEWAY DR		SYCAMORE	IL	60178-3113	8157580205	8157580244	In-Center Hemo, In-Center Hemo Self Care	12	14-2639	Y
MT GREENWOOD DIALYSIS	3401 W 111TH ST		CHICAGO	IL	60655-3329	7734450558	7734450829	In-Center Hemo	16	14-2660	Y
LAKE VILLA DIALYSIS	37809 N IL ROUTE 59		LAKE VILLA	IL	60046-7332	8472454872	8472454873	In-Center Hemo, In-Center Hemo Self Care	12	14-2666	Y
LITTLE VILLAGE DIALYSIS	2335 W CERMAK RD		CHICAGO	IL	60608-3811	7735232939	7735233797	In-Center Hemo, In-Center Hemo Self Care, PD Services	16	14-2668	Y
KANKAKEE COUNTY DIALYSIS	581 WILLIAM R LATHAM SR DR	STE 104	BOURBONNAIS	IL	60914-2439	8159363088	8159363756	In-Center Hemo, In-Center Hemo Self Care	14	14-2685	Y
LAKE VILLA DIALYSIS PD	37809 N IL RTE 59		LAKE VILLA	IL	60046-7332	8472454872	8472454873	PD Services	0	14-2666	Y
WEST SIDE DIALYSIS	1600 W 13TH ST	STE 3	CHICAGO	IL	60608-1306	3122439286	3127332466	In-Center Hemo	12	14-2783	Y
WAYNE COUNTY DIALYSIS	303 NW 11TH ST	STE 1	FAIRFIELD	IL	62837-1203	6188427204	6188427279	In-Center Hemo, In-Center Hemo Self Care, PD Services	8	14-2688	Y
EDWARDSVILLE DIALYSIS	235 S BUCHANAN ST		EDWARDSVILLE	IL	62025-2108	6186929217	6186929439	In-Center Hemo	8	14-2701	Y
VANDALIA DIALYSIS	301 MATTES AVE		VANDALIA	IL	62471-2061	6182831366	6182831390	In-Center Hemo, In-Center Hemo Self Care, PD Services	8	14-2693	Y
MACON COUNTY DIALYSIS	1090 W MCKINLEY AVE		DECATUR	IL	62526-3208	2178779351	2178772137	In-Center Hemo, In-Center Hemo Self Care	23	14-2584	Y
EFFINGHAM DIALYSIS	904 MEDICAL PARK DR	STE 1	EFFINGHAM	IL	62401-2193	2173429558	2173421049	In-Center Hemo, In-Center Hemo Self Care, PD Services	16	14-2580	Y
JACKSONVILLE DIALYSIS	1515 W WALNUT ST		JACKSONVILLE	IL	62650-1150	2172433042	2172431365	In-Center Hemo, In-Center Hemo Self Care	14	14-2581	Y
LITCHFIELD DIALYSIS	915 ST FRANCES WAY		LITCHFIELD	IL	62056-1775	2173242200	2173242077	In-Center Hemo, In-Center Hemo Self Care	12	14-2583	Y
MATTOON DIALYSIS	6051 DEVELOPMENT DR		CHARLESTON	IL	61920-9467	2173452550	2173455770	In-Center Hemo, In-Center Hemo Self Care, PD Services	18	14-2585	Y
SPRINGFIELD CENTRAL DIALYSIS	600 N GRAND AVE W		SPRINGFIELD	IL	62702-2538	2175280556	2175284065	In-Center Hemo, In-Center Hemo Self Care	21	14-2586	Y
TAYLORVILLE DIALYSIS	901 W SPRESSER ST		TAYLORVILLE	IL	62568-1831	2178245460	2178245967	In-Center Hemo, In-Center Hemo Self Care	10	14-2587	Y
LINCOLN DIALYSIS	2100 5TH ST		LINCOLN	IL	62656-9115	2177326798	2177327076	In-Center Hemo, In-Center Hemo Self Care	14	14-2582	Y
CARPENTERSVILLE DIALYSIS (PD)	2203 RANDALL RD		CARPENTERSVILLE	IL	60110-3355	8474266456	8474264795	PD Services		14-2598	Y
SPRINGFIELD MONTVALE DIALYSIS	2930 MONTVALE DR	STE A	SPRINGFIELD	IL	62704-5376	2177932781	2177932845	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care	17	14-2590	Y
DECATUR EAST WOOD DIALYSIS	794 E WOOD ST		DECATUR	IL	62523-1155	2174256403	2174258724	In-Center Hemo, In-Center Hemo Self Care, PD Services	18	14-2599	Y
ALTON DIALYSIS	309 HOMER ADAMS PKWY		ALTON	IL	62002-5929	6184620186	6184620213	In-Center Hemo, In-Center Hemo Self Care, PD Services	16	14-2619	Y
RUSHVILLE DIALYSIS	112 SULLIVAN DRIVE		RUSHVILLE	IL	62681-1293	2173222652	2173224893	In-Center Hemo, In-Center Hemo Self Care	8	14-2620	Y
ILLINI RENAL DIALYSIS	507 E UNIVERSITY AVE		CHAMPAIGN	IL	61820-3828	2173787800	2173787820	In-Center Hemo, In-Center Hemo Self Care, PD Services	12	14-2633	Y
HUNTLEY DIALYSIS PD	10370 HALIGUS RD	STE 100	HUNTLEY	IL	60142-9545	8476698145	8476698165	PD Services		14-2828	Y
HARVEY DIALYSIS	16641 S HALSTED ST	STE A	HARVEY	IL	60426-6174	7082109500	7082109510	In-Center Hemo	18	14-2698	Y
WOODRIDGE HOME DIALYSIS PD	7425 JANES AVE	STE 103	WOODRIDGE	IL	60517-2335	6309680081	6309680129	PD Services		14-2696	Y
GRAND CROSSING DIALYSIS	7319 S COTTAGE GROVE AVE		CHICAGO	IL	60619-1909	7737833491	7737836046	In-Center Hemo	12	14-2728	Y
BIG OAKS DIALYSIS	5623 W TOUHY AVE		NILES	IL	60714-4019	8476473140	8476475006	In-Center Hemo	12	14-2712	Y
WEST LAWN DIALYSIS	7000 S PULASKI RD		CHICAGO	IL	60629-5842	7732845324	7732845616	In-Center Hemo	12	14-2719	Y
ROBINSON DIALYSIS	1215 N ALLEN ST	STE B	ROBINSON	IL	62454-1100	6185447092	6185447370	In-Center Hemo	9	14-2714	Y
PALOS PARK DIALYSIS	13155 S LA GRANGE RD		ORLAND PARK	IL	60462-1162	7089230928	7089230945	In-Center Hemo	12	14-2732	Y
BARRINGTON CREEK DIALYSIS (Chronic Only)	28160 W NORTHWEST HWY		LAKE BARRINGTON	IL	60010-2324	8473811325	8473811793	In-Center Hemo	12	14-2736	Y
SPRINGFIELD SOUTH DIALYSIS	2930 S 6TH ST		SPRINGFIELD	IL	62703-5944	2175281745	2175288972	In-Center Hemo, PD Services	12	14-2733	Y

DANVILLE HOME TRAINING	3 POLAND RD		DANVILLE	IL	61834-7463	2174460583	2174420796	PD Services	0	14-2734	Y
SILVERBRIDGE HOME TRAINING	2410 ALFT LN	STE 101	ELGIN	IL	60124-8090	8472895628	8476953764	PD Services	0	14-2757	Y
DRIFTWOOD DIALYSIS	1808 S WEST AVE		FREEPORT	IL	61032-6712	8152320295	8152321635	In-Center Hemo, PD Services	10	14-2747	Y
SHILOH DIALYSIS	1095 N GREEN MOUNT RD		BELLEVILLE	IL	62221-3303	6186281108	6186281459	In-Center Hemo, PD Services	14	14-2753	Y
RED BUD DIALYSIS	1500 E MARKET ST	LOT 4	RED BUD	IL	62278-2143	6182823444	6182823578	In-Center Hemo, PD Services	8	14-2772	Y
LAWNDALE DIALYSIS	3934 W 24TH ST		CHICAGO	IL	60623-3371	7732770578	7735421381	In-Center Hemo	16	14-2768	Y
CRIMSON RIDGE HOME TRAINING (PD)	2540 HAUSER ROSS DR	STE 200	SYCAMORE	IL	60178-3171	8157483508	8157483825	PD Services	0	14-2748	Y
COAL CITY HOME TRAINING (PD ONLY)	993 E DIVISION ST	STE A	COAL CITY	IL	60416-9483	8156340820	8156340844	PD Services		14-2804	Y
MOLINE HOME TRAINING PD	4650 38TH AVE		MOLINE	IL	61265-6706	3097364260	3097364296	PD Services	2	14-2762	Y
NEW LENOX HOME TRAINING	1890 SILVER CROSS BLVD	STE 465	NEW LENOX	IL	60451-9545	8154624258	8154624290	PD Services	3	14-2785	Y
BARRINGTON CREEK DIALYSIS (PD ONLY)	28160 W NORHTWEST HWY		LAKE BARRINGTON	IL	60010-2324	8473811673	8473811802	PD Services		14-2736	Y
TAZEWELL COUNTY DIALYSIS	1021 COURT ST	STE A	PEKIN	IL	61554-4817	3094781000	3093461369	In-Center Hemo, PD Services	8	14-2767	Y
TIMBER CREEK DIALYSIS	1001 S ANNIE GLIDDEN RD		DEKALB	IL	60115-8250	8157483074	8157483148	In-Center Hemo	12	14-2763	Y
RENAL CENTER WEST JOLIET (PD)	1051 ESSINGTON RD	STE 160	JOLIET	IL	60435-2893	8157253275	8157253833	PD Services		14-2742	Y
FLOSSMOOR HOME DIALYSIS	19720 GOVERNORS HWY	STE 2	FLOSSMOOR	IL	60422-2075	7087997239	7087991252	PD Services	4	14-2775	Y
CHICAGO RIDGE DIALYSIS	10511 S HARLEM AVE		CHICAGO RIDGE	IL	60415-1291	7083612863	7083612954	In-Center Hemo	16	14-2793	Y
SALEM HOME TRAINING	1201 RICKER RD		SALEM	IL	62881-4263	6187400778	6187400779	PD Services		14-2807	Y
ADAMS COUNTY DIALYSIS	436 N 10TH ST		QUINCY	IL	62301-4152	2172237913	2172231369	In-Center Hemo, Acute Hemo 1:1, PD Services	18	14-2711	Y
PITTSFIELD DIALYSIS	640 W WASHINGTON ST		PITTSFIELD	IL	62363-1350	2172852780	2172854549	In-Center Hemo	5	14-2708	Y
JERSEYVILLE DIALYSIS	917 S STATE ST		JERSEYVILLE	IL	62052-2344	6184989532	6184981012	In-Center Hemo, PD Services	9	14-2636	Y
STONECREST DIALYSIS	1302 E STATE ST		ROCKFORD	IL	61104-2228	8159685794	8159688669	In-Center Hemo	12	14-2615	Y
CRYSTAL SPRINGS DIALYSIS	720 COG CIRCLE	STE A	CRYSTAL LAKE	IL	60014-7301	8154594945	8154594836	In-Center Hemo	16	14-2716	Y
COBBLESTONE DIALYSIS	836 DUNDEE AVE	STE A	ELGIN	IL	60120-3068	8478889386	8478889394	In-Center Hemo	16	14-2715	Y
KENWOOD DIALYSIS	4259 S COTTAGE GROVE AVE	STE 100	CHICAGO	IL	60653-2929	7732853621	7739245670	In-Center Hemo, Nocturnal Hemo	32	14-2717	Y
STONY ISLAND DIALYSIS	8725 S STONY ISLAND AVE		CHICAGO	IL	60617-2709	7732217320	7732217410	In-Center Hemo	32	14-2718	Y
WOODLAWN DIALYSIS	5060 S STATE ST		CHICAGO	IL	60609-5328	7732851840	7732853485	In-Center Hemo	32	14-2721	Y
KENWOOD HOME TRAINING (PD)	4259 S COTTAGE GROVE AVE	STE 200	CHICAGO	IL	60653-2929	7739245948	7739246061	PD Services	0	14-2720	Y
BEVERLY DIALYSIS PD	8109 S WESTERN AVE		CHICAGO	IL	60620-5939	7737780173	7737780193	PD Services		14-2638	Y
KENWOOD PEDIATRIC HOME PROGRAM (PD)	4259 S COTTAGE GROVE AVE	STE 200	CHICAGO	IL	60653-2929	7739245948	7739246061	PD Services		14-2720	Y
RENAL CENTER WEST JOLIET	1051 ESSINGTON RD	STE 160	JOLIET	IL	60435-2893	8157253275	8157253833	In-Center Hemo, PD Services	29	14-2742	Y
RENAL CENTER NEW LENOX	1890 SILVER CROSS BVLD	PAVILION A STE 150	NEW LENOX	IL	60451-9528	8153203049	8153203241	In-Center Hemo	19	14-2741	Y
MORRIS DIALYSIS	1551 CREEK DR		MORRIS	IL	60450-6857	8154160475	8154160547	In-Center Hemo	9	14-2740	Y
SILVERBRIDGE HT AT HOME	2410 ALFT LN	STE 101	ELGIN	IL	60124-8090	8472895628	8476953764	Home Hemo	0	14-2757	Y
LAKE COUNTY AT HOME	565 LAKEVIEW PKWY	STE 176	VERNON HILLS	IL	60061-1857	8479180592	8149180831	Home Hemo		14-2552	Y
DRIFTWOOD AT HOME	1808 S WEST AVE		FREEPORT	IL	61032-6712	8152320295	8152321635	Home Hemo		14-2747	Y
RENAL CENTER WEST JOLIET AT HOME	1051 ESSINGTON RD	STE 160	JOLIET	IL	60435-2893	8157253275	8157253899	Home Hemo		14-2742	Y
CRIMSON RIDGE HT AT HOME	2540 HAUSER ROSS DR	STE 200	SYCAMORE	IL	60178-3171	8157483508	8157483825	Home Hemo	0	14-2748	Y
DANVILLE HT AT HOME	3 POLAND RD		DANVILLE	IL	61834-7463	2174460583	2174420796	Home Hemo		14-2734	Y
SPRINGFIELD SOUTH AT HOME	2930 S 6TH ST		SPRINGFIELD	IL	62703-5944	2175281745	2175288972	Home Hemo		14-2733	Y
BARRINGTON CREEK AT HOME	28160 W NORTHWEST HWY		LAKE BARRINGTON	IL	60010-2324	8473811673	8473811802	Home Hemo		14-2736	Y
KENWOOD HT AT HOME	4259 S COTTAGE GROVE AVE	STE 200	CHICAGO	IL	60653-2929	7739245948	7739246061	Home Hemo	0	14-2720	Y
ADAMS COUNTY AT HOME	436 N 10TH ST		QUINCY	IL	62301-2601			Home Hemo		14-2711	Y
BEVERLY AT HOME	8109 SOUTH WESTERN AVE		CHICAGO	IL	60620-5939	7737780173	7737780193	Home Hemo		14-2638	Y
WOODRIDGE HOME AT HOME	7425 JANES AVE	STE 103	WOODRIDGE	IL	60517-2356	6309680081	6309680129	Home Hemo		14-2696	Y
OLYMPIA FIELDS AT HOME	4557 LINCOLN HWY	STE B	MATTESON	IL	60443-2354	7086790531	7086790535	Home Hemo		14-2548	Y
MOUNT VERNON AT HOME	4102 N WATER TOWER PLACE		MOUNT VERNON	IL	62864-6295	6182443407	6182426137	Home Hemo		14-2541	Y
EFFINGHAM AT HOME	904 MEDICAL PARK DR	STE 1	EFFINGHAM	IL	62401-2193	2173424007	2173423140	Home Hemo	0	14-2580	Y
SPRINGFIELD CENTRAL AT HOME	600 N GRAND AVE W		SPRINGFIELD	IL	62702-2538	2177883688	2177885573	Home Hemo		14-2586	N
DECATUR EAST WOOD AT HOME	794 E WOOD ST		DECATUR	IL	62523-1155	2174256403	2174258724	Home Hemo		14-2599	Y
ILLINI RENAL AT HOME	507 E UNIVERSITY AVE		CHAMPAIGN	IL	61820-3828	2173787800	2173563567	Home Hemo		14-2633	Y
METRO EAST AT HOME	5105 W MAIN ST		BELLEVILLE	IL	62226-4728	6182339018	6182335647	Home Hemo		14-2527	Y
MARION AT HOME	324 S 4TH ST		MARION	IL	62959-1241	6189978410	6189978415	Home Hemo		14-2570	Y
ROXBURY AT HOME	622 ROXBURY RD		ROCKFORD	IL	61107-5089	8153970713	8153970796	Home Hemo		14-2665	Y

SYCAMORE AT HOME	2200 GATEWAY DR		SYCAMORE	IL	60178-3113	8157580205	8157580244	Home Hemo		14-2639	N
MARYVILLE HOME AT HOME	2102 VADALABENE DR	STE B	MARYVILLE	IL	62062-5632	6182881521	6182881759	Home Hemo		14-2686	Y
LAKE VILLA AT HOME	37809 N IL ROUTE 59		LAKE VILLA	IL	60046-7332	8472454872	8472454873	Home Hemo		14-2666	Y
KANKAKEE COUNTY AT HOME	581 WILLIAM R LATHAM SR DR	STE 104	BOURBONNAIS	IL	60914-2439	8159364577	8159363756	Home Hemo		14-2685	Y
MATTOON AT HOME	6051 DEVELOPMENT DR		CHARLESTON	IL	61920-9467	2173452550	2173455770	Home Hemo		14-2585	Y
LOOP RENAL AT HOME	1101 S CANAL ST		CHICAGO	IL	60607-4901	3122606053	3126621359	Home Hemo		14-2505	Y
TAZEWELL COUNTY AT HOME	1021 COURT ST	STE A	PEKIN	IL	61554-4807	3094781000	3093461369	Home Hemo		14-2767	N
ARLINGTON HEIGHTS RENAL CENTER	17 W GOLF RD		ARLINGTON HEIGHTS	IL	60005-3905	8474372188	8474371891	In-Center Hemo	18	14-2628	Y
HAZEL CREST RENAL CENTER	3470 W 183RD ST		HAZEL CREST	IL	60429-2428	7087993101	7087993320	In-Center Hemo, Nocturnal Hemo	20	14-2622	Y
LOOP RENAL CENTER	1101 S CANAL ST		CHICAGO	IL	60607-4901	3123412543	3123419498	In-Center Hemo	28	14-2505	Y
COUNTRY HILLS DIALYSIS	4215 W 167TH ST		COUNTRY CLUB HILLS	IL	60478-2017	7082061845	7089577521	In-Center Hemo	24	14-2575	Y
SOUTH HOLLAND RENAL CENTER	16110 LA SALLE ST		SOUTH HOLLAND	IL	60473-1299	7083317697	7083317698	In-Center Hemo	24	14-2544	Y
WAUKEGAN RENAL CENTER	3350 GRAND AVE	STE 100	WAUKEGAN	IL	60085-2206	8477820640	8475999563	In-Center Hemo	24	14-2577	Y
BUFFALO GROVE DIAYLSIS	1291 W DUNDEE RD		BUFFALO GROVE	IL	60089-4009	8472539400	8472539484	In-Center Hemo	16	14-2650	Y
EVANSTON RENAL CENTER	1922 DEMPSTER ST		EVANSTON	IL	60202-1016	8478695336	8478695313	In-Center Hemo	18	14-2511	Y
SCHAUMBURG RENAL CENTER	1156 S ROSELLE RD		SCHAUMBURG	IL	60193-4072	8475244310	8475244311	In-Center Hemo	22	14-2654	Y
WAUKEGAN HOME TRAINING	3350 GRAND AVE	STE 101	WAUKEGAN	IL	60085-2206	8475996057	8475999052	PD Services		14-2567	Y
ARLINGTON HEIGHTS PD	17 W GOLF RD		ARLINGTON HEIGHTS	IL	60005-3905	8474372188	8474371891	PD Services		14-2626	Y
LOOP RENAL CENTER PD	1101 S CANAL ST		CHICAGO	IL	60607-4901	3122606053	3126621359	PD Services		14-2505	Y
CARPENTERSVILLE DIALYSIS	2203 RANDALL RD		CARPENTERSVILLE	IL	60110-3355	8474266456	8474264795	In-Center Hemo	13	14-2598	Y
MARENGO CITY DIALYSIS	910 GREENLEE ST	STE B	MARENGO	IL	60152-8200	8155685800	8155685900	In-Center Hemo	13	14-2643	Y
GARFIELD KIDNEY CENTER	3250 W FRANKLIN BLVD		CHICAGO	IL	60624-1509	7736381160	7736382020	In-Center Hemo	16	14-2777	Y
FLOSSMOOR HOME AT HOME	19720 GOVERNORS HWY	STE 2	FLOSSMOOR	IL	60422-2075	7087997239	7087991252	Home Hemo	1	14-2775	Y
SALEM HT AT HOME	1201 RICKER RD		SALEM	IL	62881-4263	6187400778	6187400779	Home Hemo		14-2807	Y
NEW LENOX HT AT HOME	1890 SILVER CROSS BLVD	STE 465	NEW LENOX	IL	60451-9524	8154624258	8154624290	Home Hemo	0	14-2785	Y
SCHAUMBURG RENAL AT HOME	1156 S ROSELLE RD		SCHAUMBURG	IL	60193-4072	8475244310	8475244311	Home Hemo			Y
ALTON AT HOME	309 HOMER ADAMS PKWY		ALTON	IL	62002-5929	6184620186	6184620213	Home Hemo	1		Y
DIXON KIDNEY AT HOME	1131 N GALENA AVE		DIXON	IL	61021-1015	8152840595	8152840547	Home Hemo	1	14-2651	Y
CHICAGO RIDGE DIALYSIS PD	10511 S HARLEM AVE		CHICAGO RIDGE	IL	60415-1291	7083612863	7083612954	PD Services	0	14-2793	Y
ALSIP HOME TRAINING (PD)	11500 S PULASKI RD		ALSIP	IL	60803-1610	7083857145	7083857487	PD Services	4	14-2808	Y
HUNTLEY DIALYSIS	10370 HALIGUS RD	STE 100	HUNTLEY	IL	60142-9582	8476698145	8476698165	In-Center Hemo	12	14-2828	Y
BELVIDERE DIALYSIS	1751 HENRY LUCKOW LN		BELVIDERE	IL	61008-1702	8155440311	8155449292	In-Center Hemo	12	142795	Y
TINLEY PARK DIALYSIS	16767 80TH AVE		TINLEY PARK	IL	60477-2361	7084294738	7084294984	In-Center Hemo	12	14-2810	Y
PARK MANOR DIALYSIS	9505 S COLFAX AVE		CHICAGO	IL	60617-4976	7739785237	7739785549	In-Center Hemo	16	14-2831	Y
NORTHSIDE HOME TRAINING	2550 W ADDISON ST	STE A4	CHICAGO	IL	60618-5939	7732812217	7735492580	PD Services		14-2811	Y
MATTESON HOME TRAINING	4747 LINCOLN MALL DR	STE 225	MATTESON	IL	60443-3811	7086791050	7086791088	PD Services		14-2805	Y
VERMILION COUNTY DIALYSIS	26 E WEST NEWELL RD		DANVILLE	IL	61834-7488	2174311470	2174311753	In-Center Hemo		14-2812	Y
SCHAUMBURG RENAL CENTER (PD)	1156 S ROSELLE RD		SCHAUMBURG	IL	60193-4072	8475244310	8475244311	PD Services		14-2654	Y
MACHESNEY PARK DIALYSIS	7170 N PERRYVILLE RD		MACHESNEY PARK	IL	61115-7700	8158858132	8158858178	In-Center Hemo	12	14-2806	Y
CALUMET CITY DIALYSIS	1200 SIBLEY BLVD		CALUMET CITY	IL	60409-2327	7088626454	7088626540	In-Center Hemo	16	14-2817	Y
MONTGOMERY COUNTY DIALYSIS	1822 SENATOR MILLER DR		HILLSBORO	IL	62049-2401	2175323000	2175323009	In-Center Hemo, PD Services	8	14-2813	Y
WASHINGTON HEIGHTS DIALYSIS	10620 S HALSTED ST		CHICAGO	IL	60628-2310	7737798149	7737798195	In-Center Hemo	16	14-2835	Y
FOREST CITY DIALYSIS	198 N SPRINGFIELD AVE		ROCKFORD	IL	61101-5086	8159628914	8159628952	In-Center Hemo	12	14-2825	Y
O'FALLON DIALYSIS	1941 FRANK SCOTT PKWY E	STE B	SHILOH	IL	62269-7387	6186220592	6186220650	In-Center Hemo	12	14-2818	Y
COLLINSVILLE DIALYSIS	101 LANTER CT		COLLINSVILLE	IL	62234-6124	6183442016	6183442102	In-Center Hemo	8	14-2822	Y
CRAWFORD COUNTY HOME TRAINING	1302 E MAIN ST	UNIT G	ROBINSON	IL	62454-3753	6185449050	6185449013	PD Services		14-2833	Y
FOXPOINT DIALYSIS	1300 SCHAEFER RD	STE J	GRANITE CITY	IL	62040-6859	6184518730	6184518738	In-Center Hemo	12	14-2838	Y
SUN HEALTH DIALYSIS	2121 ONEIDA ST	STE 104	JOLIET	IL	60435-6546	8157449300	8157449347	In-Center Hemo		14-2553	Y
CRAWFORD COUNTY HOME AT HOME	1302 E MAIN ST	UNIT G	ROBINSON	IL	62454-3753	6185449050	6185449013	Home Hemo		14-2833	Y
COMPREHENSIVE RENAL CARE-GARY	4802 BROADWAY		GARY	IN	46408-4509	2198871199	2198871605	In-Center Hemo, Home Hemo, In-Center Hemo Self Care	40	15-2521	Y
COMPREHENSIVE RENAL CARE-HAMMOND	222 DOUGLAS ST		HAMMOND	IN	46320-1960	2199321199	2199322393	In-Center Hemo, In-Center Hemo Self Care	32	15-2522	Y
COMPREHENSIVE RENAL CARE-VALPARAISO	606 LINCOLNWAY		VALPARAISO	IN	46383-5728	2195311299	2195311094	In-Center Hemo, In-Center Hemo Self Care	22	15-2527	Y

COMPREHENSIVE RENAL CARE-MICHIGAN CITY	9836 WEST 400 NORTH		MICHIGAN CITY	IN	46360-2910	2198781989	2198789569	In-Center Hemo, In-Center Hemo Self Care	16	15-2546	Y
COMPREHENSIVE RENAL CARE-MUNSTER	9100 CALUMET AVE		MUNSTER	IN	46321-2806	2198361299	2198369447	In-Center Hemo, In-Center Hemo Self Care, PD Services	24	15-2549	Y
COMPREHENSIVE RENAL CARE-EAST CHICAGO	4320 FIR ST	UNIT 404	EAST CHICAGO	IN	46312-3078	2193971199	2193971625	In-Center Hemo, In-Center Hemo Self Care	12	15-2561	Y
BATESVILLE DIALYSIS CENTER	232 STATE ROAD 129 S		BATESVILLE	IN	47006-7694	8129345666	8129345657	In-Center Hemo	12	152507	Y
LAWRENCEBURG DIALYSIS CENTER	721 RUDOLPH WAY		GREENDALE	IN	47025-8378	8125374240	8125374671	In-Center Hemo, In-Center Hemo Self Care, PD Services	16	15-2511	Y
MADISON DIALYSIS CENTER	220 CLIFTY DR	UNIT K	MADISON	IN	47250-1669	8122652278	8122656458	In-Center Hemo, In-Center Hemo Self Care, Acute Hemo 1:1	9	15-2514	Y
MERRILLVILLE DIALYSIS	9223 TAFT ST		MERRILLVILLE	IN	46410-6911	2197939035	2197939171	In-Center Hemo, In-Center Hemo Self Care	16	15-2581	Y
TELL CITY DIALYSIS CENTER	1602 MAIN ST		TELL CITY	IN	47586-1310	8125471140	8125471150	In-Center Hemo, In-Center Hemo Self Care, PD Services	12	15-2574	Y
EAST EVANSVILLE DIALYSIS	1312 PROFESSIONAL BLVD		EVANSVILLE	IN	47714-8007	8124916300	8124017554	In-Center Hemo, In-Center Hemo Self Care	25	15-2569	Y
NORTH EVANSVILLE DIALYSIS	1151 W BUENA VISTA RD		EVANSVILLE	IN	47710-3334	8124010140	8124010151	In-Center Hemo, In-Center Hemo Self Care	24	15-2536	Y
VINCENNES DIALYSIS	700 WILLOW ST	STE 101	VINCENNES	IN	47591-1029	8128820546	8128820938	In-Center Hemo, In-Center Hemo Self Care	20	15-2592	Y
JASPER DIALYSIS	671 3RD AVE	STE A	JASPER	IN	47546-3653	8124821791	8124821865	In-Center Hemo, In-Center Hemo Self Care, PD Services	16	15-2523	Y
DAVIESS COUNTY DIALYSIS	310 NE 14TH ST		WASHINGTON	IN	47501-2137	8122549950	8122549960	In-Center Hemo, In-Center Hemo Self Care	14	15-2568	Y
EAST EVANSVILLE DIALYSIS PD	1312 PROFESSIONAL BLVD		EVANSVILLE	IN	47714-8007	8124916304	8124022620	PD Services	0	15-2569	Y
COMPREHENSIVE RENAL CARE-GARY PD	4802 BROADWAY		GARY	IN	46408-4509	2198871199	2198871605	PD Services		15-2521	Y
COMPREHENSIVE RENAL CARE-HAMMOND PD	222 DOUGLAS ST		HAMMOND	IN	46320-1960	2199321199	2199322393	PD Services		15-2522	Y
COMPREHENSIVE RENAL CARE-VALPARAISO PD	606 LINCOLNWAY		VALPARAISO	IN	46383-5728	2195311299	2195311094	PD Services		15-2527	Y
COMPREHENSIVE RENAL CARE-MICHIGAN CITY PD	9836 WEST 400 NORTH		MICHIGAN CITY	IN	46360-2910	2198781989	2198789569	PD Services		15-2546	Y
MERRILLVILLE DIALYSIS PD	9223 TAFT ST		MERRILLVILLE	IN	46410-6911	2197939035	2197939171	PD Services	0	15-2581	Y
NEW ALBANY DIALYSIS	2669 CHARLESTOWN RD	STE F	NEW ALBANY	IN	47150-2573	8125421250	8125421403	In-Center Hemo, In-Center Hemo Self Care	12	15-2589	Y
LA PORTE DIALYSIS	1406 E LINCOLNWAY	STE A	LA PORTE	IN	46350-8047	2193243080	2193249815	In-Center Hemo, Home Hemo, PD Services	12	15-2684	Y
WESTVIEW DIALYSIS	3749 COMMERCIAL DR	LAFAYETTE PLACE SHOPPING CENTER	INDIANAPOLIS	IN	46222-1676	3172994693	3172995461	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care, PD Services	17	15-2596	Y
PRINCETON DIALYSIS	2227 SHERMAN DR		PRINCETON	IN	47670-1062	8123852906	8123853293	In-Center Hemo, In-Center Hemo Self Care	12	15-2629	Y
FRANKLIN DIALYSIS	1140 W JEFFERSON ST	STE A	FRANKLIN	IN	46131-2101	3177364304	3177365787	In-Center Hemo, In-Center Hemo Self Care, PD Services	14	152603	Y
CORYDON DIALYSIS CENTER	1937 OLD HWY 135 NW		CORYDON	IN	47112-2013	8127385200	8127384935	In-Center Hemo, In-Center Hemo Self Care	12	15-2619	Y
WHITEWATER VALLEY DIALYSIS	2302 CHESTER BLVD		RICHMOND	IN	47374-1221	7659355128	7659355749	In-Center Hemo, PD Services	12	15-2680	Y
GREENSBURG DIALYSIS	1531 N COMMERCE EAST DR	STE 6	GREENSBURG	IN	47240-3259	8126626570	8126626572	In-Center Hemo, In-Center Hemo Self Care, PD Services	9	15-2615	Y
CHESTERTON DIALYSIS	711 PLAZA DR	STE 6	CHESTERTON	IN	46304-5506	2199266049	2199299201	In-Center Hemo, In-Center Hemo Self Care	12	15-2628	Y
INDY SOUTH DIALYSIS	972 EMERSON PKWY	STE E	GREENWOOD	IN	46143-6202	3178810641	3178815451	In-Center Hemo, In-Center Hemo Self Care, PD Services	12	15-2616	Y
CARMEL DIALYSIS	180 E CARMEL DR		CARMEL	IN	46032-2633	3175758916	3175759136	In-Center Hemo, PD Services	12	15-2620	Y
HOOSIER HILLS DIALYSIS	143 S KINGSTON DR		BLOOMINGTON	IN	47408-6342	8123331697	8123331945	In-Center Hemo, PD Services	12	15-2642	Y
FREEDOM DIALYSIS (PD)	800 N MAIN ST		EVANSVILLE	IN	47711-5052	8124235368	8124235419	PD Services	13	15-2690	Y
NORTH VERNON DIALYSIS	2340 N STATE HWY 7		NORTH VERNON	IN	47265-7183	8123528150	8123528204	In-Center Hemo	10	15-2636	Y
PORTAGE DIALYSIS	5823 US HIGHWAY 6		PORTAGE	IN	46368-4851	2197640564	2197640809	In-Center Hemo, In-Center Hemo Self Care, PD Services	16	15-2630	Y
ST. JOHN DIALYSIS	10033 WICKER AVE	STE 6	SAINT JOHN	IN	46373-8777	2193655043	2193655385	In-Center Hemo, In-Center Hemo Self Care, PD Services	16	15-2627	Y
NEWBURGH DIALYSIS	4311 HIGHWAY 261	STE A	NEWBURGH	IN	47630-2653	8128532010	8128533601	In-Center Hemo	16	15-2644	Y
JEFFERSONVILLE DIALYSIS	365 QUARTERMASTER CT		JEFFERSONVILLE	IN	47130-3670	8122882296	8122884153	In-Center Hemo, PD Services	12	15-2651	Y
SCOTTSBURG DIALYSIS	1619 W MCCLAIN AVE		SCOTTSBURG	IN	47170-1161	8127525249	8127526313	In-Center Hemo	8	15-2646	Y
INDY EAST DIALYSIS	1208 N ARLINGTON AVE		INDIANAPOLIS	IN	46219-3203	3173536315	3173536358	In-Center Hemo, PD Services, Nocturnal Hemo	16	15-2661	Y
AVON DIALYSIS	9210 ROCKVILLE RD	STE D	INDIANAPOLIS	IN	46234-2670	3172092544	3172092741	In-Center Hemo, PD Services	12	15-2645	Y
PAOLI DIALYSIS	555 WEST LONGEST ST		PAOLI	IN	47454-9670	8127233571	8127234823	In-Center Hemo, PD Services	12	15-2652	Y
CARMEL HEALTH AND LIVING DIALYSIS	118 MEDICAL DR	STE 114	CARMEL	IN	46032-2923	3178449045	3178449097	In-Center Hemo	6	15-2650	Y
SUMMIT CITY DIALYSIS	3233 E COLISEUM BLVD		FORT WAYNE	IN	46805-1561	2603731599	2603731555	In-Center Hemo	24	15-2653	Y
FORT WAYNE SOUTH DIALYSIS	302 E PETTIT AVE		FORT WAYNE	IN	46806-3007	2604560451	2604589269	In-Center Hemo	20	15-2647	Y
FORT WAYNE WEST DIALYSIS	4916 ILLINOIS RD	STE 118	FORT WAYNE	IN	46804-5116	2604340483	2604351527	In-Center Hemo, PD Services	12	15-2648	Y
APPLESEED DIALYSIS	1833 MAGNAVOX WAY		FORT WAYNE	IN	46804-1539	2604321036	2604322085	PD Services, In-Center Hemo	4	15-2649	Y
VINCENNES HOME DIALYSIS	700 WILLOW ST	STE 102	VINCENNES	IN	47591-1028	8128869034	8128869036	PD Services	0	15-2662	Y
BROWNSBURG DIALYSIS	124 E NORTHFIELD DR	STE N	BROWNSBURG	IN	46112-2601	3178583561	3178584967	In-Center Hemo	10	15-2656	Y
EAGLE HIGHLANDS DIALYSIS	6925 SHORE TER		INDIANAPOLIS	IN	46254-4675	3172950423	3172950245	In-Center Hemo, Nocturnal Hemo, PD Services	16	15-2658	Y

SOUTH BEND WEST DIALYSIS	5660 NIMTZ PKWY		SOUTH BEND	IN	46628-6205	5742317570	5742317571	In-Center Hemo	12	15-2659	Y
MISHAWAKA DIALYSIS	1420 TRINITY PL		MISHAWAKA	IN	46545-5005	5742317204	5742317205	In-Center Hemo, PD Services	16	15-2655	Y
MUNCIE DIALYSIS	820 E MCGALLIARD RD		MUNCIE	IN	47303-2081	7652821266	7652821218	In-Center Hemo, PD Services	12	15-2665	Y
BRAZIL DIALYSIS	115 S MURPHY AVE		BRAZIL	IN	47834-8296	8124428481	8124428490	In-Center Hemo	9	15-2683	Y
TERRE HAUTE DIALYSIS	504 6TH AVE		TERRE HAUTE	IN	47807-1025	8122318560	8122328501	In-Center Hemo, PD Services	13	15-2689	Y
MISHAWAKA AT HOME	1420 TRINITY PL		MISHAWAKA	IN	46545-5005	5742433764	5742317205	Home Hemo	0	15-2655	Y
PAOLI AT HOME	555 WEST LONGEST ST		PAOLI	IN	47454-9670	8127233571	8127234823	Home Hemo		15-2652	Y
APPLESEED AT HOME	1833 MAGNAVOX WAY		FORT WAYNE	IN	46804-1539	2604321036	2604322085	Home Hemo		15-2649	Y
FORT WAYNE WEST AT HOME	4916 ILLINOIS RD	STE 118	FORT WAYNE	IN	46804-5116	2604340483	2604351527	Home Hemo	0	15-2648	Y
AVON AT HOME	9210 ROCKVILLE RD	STE D	INDIANAPOLIS	IN	46234-2670	3172092544	3172092741	Home Hemo	0	15-2645	Y
HOOSIER HILLS AT HOME	143 S KINGSTON DR		BLOOMINGTON	IN	47408-6342	8123331697	8123331945	Home Hemo		15-2642	Y
PORTAGE AT HOME	5823 US HIGHWAY 6		PORTAGE	IN	46368-4851	2197640564	2197640809	Home Hemo		15-2630	Y
INDY SOUTH AT HOME	972 EMERSON PKWY	STE E	GREENWOOD	IN	46143-6202	3178817109	3178817132	Home Hemo		15-2616	Y
EAST EVANSVILLE AT HOME	1312 PROFESSIONAL BLVD		EVANSVILLE	IN	47714-8007	8124916304	8124022620	Home Hemo	0	15-2569	Y
WESTVIEW AT HOME	3749 COMMERCIAL DR	STE B	INDIANAPOLIS	IN	46222-1676	3172914214	3172917427	Home Hemo	0	15-2596	Y
FRANKLIN (IN) AT HOME	1140 W JEFFERSON ST	STE A	FRANKLIN	IN	46131-2101	3177364304	3177365787	Home Hemo	0	15-2603	Y
COMPREHENSIVE RENAL CARE-HAMMOND AT HOME	222 DOUGLAS ST		HAMMOND	IN	46320-1960	2199321199	2199317098	Home Hemo	0	15-2522	Y
GREENSBURG AT HOME	1531 N COMMERCE EAST DR	STE 6	GREENSBURG	IN	47240-3259	8126637381	8126626572	Home Hemo	0	15-2615	Y
PLAINFIELD RENAL AT HOME	8110 NETWORK DR		PLAINFIELD	IN	46168-9024	3178388089	3178389062	Home Hemo		15-2637	Y
VINCENNES HOME AT HOME	700 WILLOW ST	STE 102	VINCENNES	IN	47591-1028	8128869034	8128869036	Home Hemo	0	15-2662	Y
BLUE RIVER VALLEY RENAL CENTER	2309 S MILLER ST	SUITE 100	SHELBYVILLE	IN	46176-9350	3173980486	3173980493	In-Center Hemo	12	15-2545	Y
MARION COUNTY DIALYSIS	3834 S EMERSON AVE	BLDG B	INDIANAPOLIS	IN	46203-5902	3177873171	3177868319	In-Center Hemo	24	15-2512	Y
QUAD COUNTIES DIALYSIS	528 N GRANDSTAFF DR		AUBURN	IN	46706-1660	2609270100	2609271196	In-Center Hemo	9	15-2539	Y
KENDALLVILLE RENAL CENTER	602 N SAWYER RD		KENDALLVILLE	IN	46755- 2566	2605990423	2605990447	In-Center Hemo	20	15-2625	Y
PLAINFIELD RENAL CENTER	8110 NETWORK DR		PLAINFIELD	IN	46168-9024	3178388089	3178389062	In-Center Hemo, Nocturnal Hemo, PD Services	24	15-2637	Y
INDY EAST AT HOME	1208 N ARLINGTON AVE		INDIANAPOLIS	IN	46219-3203	3173536315	3173536358	Home Hemo	1	15-2661	Y
EAGLE HIGHLANDS AT HOME	6925 SHORE TER		INDIANAPOLIS	IN	46254-4675	3172950423	3172950245	Home Hemo	1	15-2658	Y
MUNCIE AT HOME	820 E MCGALLIARD RD		MUNCIE	IN	47303-2081	7652821266	7652821218	Home Hemo			Y
JASPER AT HOME	671 3RD AVE	STE A	JASPER	IN	47546-3653	8124821791	8124721865	Home Hemo		15-2523	Y
ELKHART AT HOME	1401 N MICHIGAN ST		ELKHART	IN	46514-2209	5742625295	5742628895	Home Hemo		15-2664	Y
IRISH AT HOME	4350 S IRONWOOD DR		SOUTH BEND	IN	46614-3073	5742994529	5742994737	Home Hemo		15-2668	Y
FORT WAYNE NORTH DIALYSIS	415 E DUPONT RD		FORT WAYNE	IN	46825-2051	2606370431	2606376641	In-Center Hemo, Nocturnal Hemo	12	152681	Y
IRISH DIALYSIS	4350 S IRONWOOD DR		SOUTH BEND	IN	46614-3073	5742994529	5742994737	In-Center Hemo, PD Services	20	15-2668	Y
ELKHART DIALYSIS	1401 N MICHIGAN ST		ELKHART	IN	46514-2209	5742625295	5742628895	In-Center Hemo, PD Services	12	15-2664	Y
THREE RIVERS DIALYSIS	6721 OLD TRAIL RD	STE 100	FORT WAYNE	IN	46809-2655	2604788582	2604788566	In-Center Hemo, PD Services	12	15-2676	Y
SPRING STREET DIALYSIS	1601 SPRING ST		JEFFERSONVILLE	IN	47130-2903	8122842098	8122842680	In-Center Hemo	13	15-2666	Y
EAGLES DIALYSIS	5301 PEARL DR		EVANSVILLE	IN	47712-8111	8124670161	8124670139	In-Center Hemo	13	15-2682	Y
FREEDOM DIALYSIS	800 N MAIN ST		EVANSVILLE	IN	47711-5052	8124235368	8124235419	In-Center Hemo	13	15-2690	Y
SULLIVAN DIALYSIS	2232 N HOSPITAL BLVD	STE 1	SULLIVAN	IN	47882-7674	8122685593	8122685693	In-Center Hemo	13	15-2685	Y
INDY CAPITOL DIALYSIS	2140 N CAPITOL AVE		INDIANAPOLIS	IN	46202-1225	3179217536	3179217572	In-Center Hemo	16	15-2688	Y
UNIVERSITY DIALYSIS OF INDY	550 UNIVERSITY BLVD	STE 1115	INDIANAPOLIS	IN	46202-5149	3176358729	3176359512	In-Center Hemo	31	15-2686	Y
HOME DIALYSIS OF INDIANAPOLIS	8803 N MERIDIAN ST	STE 150	INDIANAPOLIS	IN	46260-5376	3175741798	3175741825	PD Services	0	15-2687	Y
THREE RIVERS AT HOME	6721 OLD TRAIL RD	STE 100	FORT WAYNE	IN	46809-2655	2604788582	2064788566	Home Hemo			Y
PRATT DIALYSIS CENTER	203 WATSON ST	STE 110	PRATT	KS	67124-3092	6206727006	6206727063	In-Center Hemo, PD Services	12	17-2537	Y
WICHITA DIALYSIS CENTER PD	909 N TOPEKA ST		WICHITA	KS	67214-3620	3162694531	3162650842	PD Services		17-2503	Y
WICHITA DIALYSIS CENTER	909 N TOPEKA ST		WICHITA	KS	67214-3620	3162639090	3162650842	In-Center Hemo, Nocturnal Hemo	23	17-2503	Y
EAST WICHITA DIALYSIS CENTER	320 N HILLSIDE ST		WICHITA	KS	67214-4918	3166843200	3166846298	In-Center Hemo, In-Center Hemo Self Care	24	17-2519	Y
INDEPENDENCE DIALYSIS CENTER	801 W MYRTLE ST		INDEPENDENCE	KS	67301-3239	6203316117	6203316484	In-Center Hemo	12	17-2511	Y
GARDEN CITY DIALYSIS CENTER	2308 E KANSAS AVE		GARDEN CITY	KS	67846-6959	6202609852	6202710148	In-Center Hemo, Acute Hemo 1:1, Acute PD, PD Services	17	17-2514	Y
RENAL TREATMENT CENTER-WINFIELD	1315 E 4TH AVE		WINFIELD	KS	67156-2457	6202214100	6202212272	In-Center Hemo	12	17-2526	Y
PARSONS DIALYSIS CENTER	1902 S US HIGHWAY 59 BLDG B		PARSONS	KS	67357-4948	6204211081	6204211598	In-Center Hemo, PD Services	12	17-2530	Y
RENAL TREATMENT CENTER-NEWTON	1223 WASHINGTON RD		NEWTON	KS	67114-4855	3162839950	3162834478	In-Center Hemo	12	17-2529	Y
RENAL TREATMENT CENTER-DERBY	250 W RED POWELL DR		DERBY	KS	67037-2626	3167882899	3167886404	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care	18	17-2533	Y
MAIZE DIALYSIS CENTER	10001 W GRADY AVE		MAIZE	KS	67101-3747	3167731400	3167731412	In-Center Hemo, Nocturnal Hemo, PD Services	24	17-2548	Y
JOHNSON COUNTY DIALYSIS	10453 W 84TH TER		LENEXA	KS	66214-1641	9134922044	9134922451	In-Center Hemo, In-Center Hemo Self Care, PD Services	26	17-2501	Y
WYANDOTTE COUNTY DIALYSIS	5001 STATE AVE		KANSAS CITY	KS	66102-3459	9132875724	9135961370	In-Center Hemo	21	17-2523	Y

NE WICHITA DIALYSIS CENTER	2630 N WEBB RD	STE 100 BLDG 100	WICHITA	KS	67226-8174	3166365719	3166365738	In-Center Hemo, In-Center Hemo Self Care	12	17-2542	Y
LEAVENWORTH DIALYSIS	501 OAK ST		LEAVENWORTH	KS	66048-2646	9136511431	9136515143	In-Center Hemo, In-Center Hemo Self Care, PD Services	12	17-2545	Y
WYANDOTTE CENTRAL DIALYSIS	3737 STATE AVE		KANSAS CITY	KS	66102-3830	9132330536	9132330903	In-Center Hemo, In-Center Hemo Self Care, PD Services	15	17-2544	Y
OLATHE DIALYSIS	732 W FRONTIER LN		OLATHE	KS	66061-7202	9133904937	9133905194	In-Center Hemo, In-Center Hemo Self Care	12	17-2541	Y
WYANDOTTE WEST DIALYSIS	11014 HASKELL AVE		KANSAS CITY	KS	66109-4404	9137219780	9137219818	In-Center Hemo, In-Center Hemo Self Care	17	17-2536	Y
LENEXA DIALYSIS	8630 HALSEY ST		LENEXA	KS	66215-2880	9138941100	9138946915	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care, PD Services	17	17-2509	Y
PAOLA DIALYSIS	1605 E PEORIA ST		PAOLA	KS	66071-1893	9132948417	9132949132	In-Center Hemo	12	17-2553	Y
NALL DIALYSIS	10787 NALL AVE	STE 130	OVERLAND PARK	KS	66211-1375	9136492671	9136492869	In-Center Hemo, PD Services	13	17-2555	Y
ANDOVER DIALYSIS	626 S ANDOVER RD	STE 900	ANDOVER	KS	67002-8910	3167332984	3167334138	In-Center Hemo, PD Services	16	17-2557	Y
DIALYSIS CENTER OF HUTCHINSON	1901 N WALDRON ST		HUTCHINSON	KS	67502-1129	6207280440	6207280499	In-Center Hemo, PD Services	20	17-2546	Y
TOPEKA DIALYSIS	634 SW MULVANE ST	STE 300	TOPEKA	KS	66606-1678	7852342277	7852342396	In-Center Hemo	50	17-2508	Y
OTTAWA DIALYSIS	1320 S ASH	STE 206	OTTAWA	KS	66067-3413	7852425300	7852427615	In-Center Hemo	12	17-2510	Y
LAWRENCE DIALYSIS	330 ARKANSAS ST	STE 100	LAWRENCE	KS	66044-1394	7858432000	7858430574	In-Center Hemo	15	17-2524	Y
SABETHA DIALYSIS	106 N 12TH ST		SABETHA	KS	66534-1810	7852840100	7852840101	In-Center Hemo	10	17-2534	Y
DC OF HUTCHINSON AT HOME	1901 N WALDRON ST		HUTCHINSON	KS	67502-1129	6207280440	6207280499	Home Hemo		17-2546	Y
TOPEKA AT HOME	634 SW MULVANE ST	STE 300	TOPEKA	KS	66606-1678	7852342277	7852342396	Home Hemo		17-2508	Y
WICHITA AT HOME	909 N TOPEKA ST		WICHITA	KS	67214-3620	3162694531	3162642676	Home Hemo		17-2503	Y
LENEXA AT HOME	8630 HALSEY ST		LENEXA	KS	66215-2880	9138941100	9138946915	Home Hemo		17-2509	Y
RTC-GARDEN CITY AT HOME	2308 E KANSAS AVE		GARDEN CITY	KS	67846-6959	6202609852	6202710148	Home Hemo		17-2514	Y
JOHNSON COUNTY AT HOME	10453 W 84TH TER		LENEXA	KS	66214-1641	9134922044	9134922451	Home Hemo			N
LAWRENCE HT AT HOME	3510 CLINTON PKWY	STE 110	LAWRENCE	KS	66047-2145			Home Hemo		17-2559	Y
EMPORIA AT HOME	1616 INDUSTRIAL RD	STE 2004	EMPORIA	KS	66801-6222	6203408043	6203408063	Home Hemo		17-2561	Y
TOPEKA DIALYSIS PD	634 SW MULVANE ST	STE 300	TOPEKA	KS	66606-1678	7852343512	7853574906	PD Services		17-2508	Y
LAWRENCE HOME TRAINING	3510 CLINTON PKWY	STE 110	LAWRENCE	KS	66047-2145	7858410490	7858308697	PD Services	6	17-2559	Y
GARDNER DIALYSIS	328 E MAIN ST		GARDNER	KS	66030-1314	9138848488	9138848243	In-Center Hemo	16	17-2560	Y
EMPORIA DIALYSIS	1616 INDUSTRIAL RD	STE 2004	EMPORIA	KS	66801-6222	6203408043	6203408063	In-Center Hemo, PD Services	13	17-2561	Y
DIALYSIS OF CENTRAL KENTUCKY	2807 RING ROAD		ELIZABETHTOWN	KY	42701-9114	2707351883	2703608982	In-Center Hemo, In-Center Hemo Self Care, PD Services	17	18-2504	Y
TAYLOR COUNTY DIALYSIS CENTER	1595 OLD LEBANON RD		CAMPBELLSVILLE	KY	42718-3372	2704650787	2707893626	In-Center Hemo, In-Center Hemo Self Care, PD Services	13	18-2518	Y
OWENSBORO DIALYSIS CENTER	1930 E PARRISH AVE		OWENSBORO	KY	42303-1443	2709260120	2706919865	In-Center Hemo, In-Center Hemo Self Care, PD Services	25	18-2547	Y
EASTERN KENTUCKY DIALYSIS	167 WEDDINGTON BRANCH RD		PIKEVILLE	KY	41501-3204	6064324477	6064324201	In-Center Hemo, In-Center Hemo Self Care, PD Services	12	18-2538	Y
PAINTSVILLE DIALYSIS CENTER	4750 S KY ROUTE 321		HAGERHILL	KY	41222-9012	6067891101	6067897818	In-Center Hemo, In-Center Hemo Self Care, PD Services	12	18-2548	Y
RAVEN ROCK DIALYSIS	483 GATEWAY INDUSTRIAL PARK		JENKINS	KY	41537-9209	6068322070	6068322345	In-Center Hemo, In-Center Hemo Self Care, PD Services	11	18-2566	Y
GARDENSIDE DIALYSIS	70 N GARDENMILE RD		HENDERSON	KY	42420-5529	2708300050	2708300051	In-Center Hemo, In-Center Hemo Self Care	15	18-2544	Y
TURFWAY PD TRAINING	11 SPIRAL DR	STE 15A	FLORENCE	KY	41042-1394	8596472802	8596476012	PD Services	4	18-2586	Y
MADISONVILLE DIALYSIS CENTER	255 E NORTH ST		MADISONVILLE	KY	42431-1641	2708217824	2708216659	In-Center Hemo, In-Center Hemo Self Care, PD Services	20	18-2597	Y
BARDSTOWN DIALYSIS CENTER	210 W JOHN FITCH AVE		BARDSTOWN	KY	40004-1115	5023501130	5023501125	In-Center Hemo, In-Center Hemo Self Care	10	18-2568	Y
LOUISVILLE DIALYSIS	8037 DIXIE HWY		LOUISVILLE	KY	40258-1344	5029379111	5029373911	In-Center Hemo, In-Center Hemo Self Care	24	18-2570	Y
LEITCHFIELD DIALYSIS	912 WALLACE AVE	STE 106	LEITCHFIELD	KY	42754-2405	2702300163	2702300173	In-Center Hemo	10	18-2574	Y
LAGRANGE DIALYSIS	240 PARKER DR		LA GRANGE	KY	40031-1200	5022225527	5022256356	In-Center Hemo, In-Center Hemo Self Care	12	18-2572	Y
TURFWAY DIALYSIS	11 SPIRAL DR	STE 15	FLORENCE	KY	41042-1394	8593711263	8596476085	In-Center Hemo, In-Center Hemo Self Care	16	18-2582	Y
SPRINGHURST DIALYSIS	10201 CHAMPION FARMS DR		LOUISVILLE	KY	40241-6150	5024252131	5024252151	In-Center Hemo, In-Center Hemo Self Care, PD Services	18	18-2577	Y
WEST BROADWAY DIALYSIS	720 W BROADWAY		LOUISVILLE	KY	40202-2240	5025842059	5025842835	In-Center Hemo, PD Services	24	18-2581	Y
RADCLIFF DIALYSIS	180 E LINCOLN TRAIL BLVD		RADCLIFF	KY	40160-1254	2703522252	2703525380	In-Center Hemo	12	18-2611	Y
MEADOWS EAST DIALYSIS	2529 SIX MILE LN		LOUISVILLE	KY	40220-2934	5024994384	5024994990	In-Center Hemo, In-Center Hemo Self Care	12	18-2592	Y
MAYSVILLE DIALYSIS	489 TUCKER DR		MAYSVILLE	KY	41056-9111	6067590923	6067594915	In-Center Hemo, In-Center Hemo Self Care, PD Services	12	18-2589	Y
COLD SPRING DIALYSIS	430 CROSS ROADS BLVD		COLD SPRING	KY	41076-2341	8594413981	8594414582	In-Center Hemo, In-Center Hemo Self Care	12	18-2583	Y
WILLIAMSTOWN DIALYSIS	103 BARNES RD	STE A	WILLIAMSTOWN	KY	41097-9468	8598230500	8598230588	In-Center Hemo	12	18-2595	Y
HOPKINSVILLE DIALYSIS	115 N VIRGINIA ST		HOPKINSVILLE	KY	42240-3143	2708875622	2708869784	In-Center Hemo, In-Center Hemo Self Care, PD Services	17	18-2519	Y
CRESTVIEW HILLS DIALYSIS	400 CENTRE VIEW BLVD		CRESTVIEW HILLS	KY	41017-3478	8593415561	8593415746	In-Center Hemo, In-Center Hemo Self Care, PD Services	21	18-2529	Y
SOUTH HILLS DIALYSIS	525 ALEXANDRIA PIKE	STE 120	SOUTHGATE	KY	41071-3243	8594425539	8594425587	In-Center Hemo, In-Center Hemo Self Care	16	18-2542	Y
CHRISTIAN COUNTY DIALYSIS	200 BURLEY AVE		HOPKINSVILLE	KY	42240-8725	2707070701	2707070780	In-Center Hemo, In-Center Hemo Self Care	13	18-2549	Y
SOUTH WILLIAMSON DIALYSIS	204 APPALACHIAN PLAZA		SOUTH WILLIAMSON	KY	41503-9404	6062376221	6062376223	In-Center Hemo, In-Center Hemo Self Care, PD Services	17	18-2598	Y
HAMBURG DIALYSIS	1745 ALYSHEBA WAY		LEXINGTON	KY	40509-9013	8595430084	8595430619	In-Center Hemo, Home Hemo, PD Services	12	18-2601	Y
BOURBON COUNTY DIALYSIS	213 LETTON DR	PARIS TOWNE SQUARE	PARIS	KY	40361-2251	8599881117	8599881978	In-Center Hemo	10	18-2603	Y

VERSAILLES DIALYSIS	480 LEXINGTON RD	STE E	VERSAILLES	KY	40383-1918	8592560110	8592560115	In-Center Hemo	12	18-2606	Y
SHEPHERDSVILLE DIALYSIS CENTER	150 BROOKS WAY	STE 15	BROOKS	KY	40109-6105	5029552153	5029552174	In-Center Hemo, In-Center Hemo Self Care	12	18-2600	Y
DIALYSIS OF WARREN COUNTY	391 SUWANNEE TRAIL ST		BOWLING GREEN	KY	42103-7956	2707465805	2707465375	In-Center Hemo, PD Services	15	18-2615	Y
12TH STREET COVINGTON DIALYSIS	1500 JAMES SIMPSON JR WAY	STE 1100	COVINGTON	KY	41011-0801	8592614345	8592614378	In-Center Hemo	17	18-2604	Y
GENERAL BUTLER DIALYSIS	329 FLOYD DR	STE B	CARROLLTON	KY	41008-8258	5027324713	5027328352	In-Center Hemo	8	18-2616	Y
SHELBYVILLE ROAD DIALYSIS	4600 SHELBYVILLE RD	STE 310	LOUISVILLE	KY	40207-3326	5028934791	5028934793	In-Center Hemo	12	18-2614	Y
HI HAT HOME TRAINING	17721 KY ROUTE 122		HI HAT	KY	41636-6224	6063776393	6063772674	PD Services	2	18-2617	N
LOUISA DIALYSIS	2145 HWY 2565		LOUISA	KY	41230-9166	6066383403	6066383404	In-Center Hemo, Acute Hemo 1:1, Acute PD, PD Services, Home Hemo	15	18-2580	Y
KENTUCKY HOME TRAINING	2130 NICHOLASVILLE RD	STE 5	LEXINGTON	KY	40503-2520	8592779911	8592778450	PD Services	4	18-2627	Y
HI HAT HOME AT HOME	17721 KY STATE RTE 122		HI HAT	KY	41636-6224	6063776393	6063772674	Home Hemo		18-2617	Y
KENTUCKY HT AT HOME	2130 NICHOLASVILLE RD	STE 5	LEXINGTON	KY	40503-2520	8592779911	8592778450	Home Hemo		18-2627	Y
WEST BROADWAY AT HOME	720 W BROADWAY	STE 200	LOUISVILLE	KY	40202-3245	5025830740	5025830745	Home Hemo	0	18-2581	Y
TURFWAY AT HOME	11 SPIRAL DR	STE 15A	FLORENCE	KY	41042-1357	8592821749	8596476012	Home Hemo		18-2586	Y
MAYSVILLE AT HOME	489 TUCKER DR		MAYSVILLE	KY	41056-9111	6067590923	6067594915	Home Hemo		18-2589	Y
OWENSBORO HOME DIALYSIS	3250 KIDRON VALLEY WAY		OWENSBORO	KY	42303-2398	2706919605	2706919563	PD Services	0	18-2626	Y
PORTLAND DIALYSIS	2118 PORTLAND AVE		LOUISVILLE	KY	40212-1032	5027764371	5027727259	In-Center Hemo	13	18-2630	Y
SHELBY COUNTY DIALYSIS	50 CHURCH VIEW ST		SHELBYVILLE	KY	40065-1663	5026470127	5026334991	In-Center Hemo, PD Services	13	18-2635	Y
WALTON DIALYSIS	13250 SERVICE RD		WALTON	KY	41094-9565	8594850321	8594850327	In-Center Hemo, PD Services	13	18-2636	Y
BRIDGEVIEW DIALYSIS	2480 US HWY 41 N	STE J	HENDERSON	KY	42420-2376	2708308061	2708312925	In-Center Hemo	13	18-2637	Y
LOST RIVER DIALYSIS	737 DISHMAN LN		BOWLING GREEN	KY	42101-4098	2708461054	2708462866	In-Center Hemo	12		Y
WALTON AT HOME	13250 SERVICE RD		WALTON	KY	41094-9565	8594850321	8594850327	Home Hemo			Y
EASTERN KENTUCKY AT HOME	167 WEDDINGTON BRANCH RD		PIKEVILLE	KY	41501-3204	6064324477	6064324201	Home Hemo		18-2538	Y
MEMORIAL DIALYSIS CENTER	4427 S ROBERTSON ST		NEW ORLEANS	LA	70115-6308	5048991103	5048991956	In-Center Hemo, In-Center Hemo Self Care, PD Services	22	19-2608	Y
KENNER REGIONAL DIALYSIS CENTER	200 W ESPLANADE AVE	STE 100	KENNER	LA	70065-2473	5044710931	5044710317	In-Center Hemo, Nocturnal Hemo	14	19-2599	Y
WESTBANK CHRONIC RENAL CENTER	3631 BEHRMAN PL		NEW ORLEANS	LA	70114-0906	5043660808	5043673816	In-Center Hemo, Nocturnal Hemo, PD Services	29	19-2507	Y
FLEUR DE LIS DIALYSIS	5555 BULLARD AVE	STE 110	NEW ORLEANS	LA	70128-3450	5042402696	5042402877	In-Center Hemo, PD Services	21	19-2523	Y
SLIDELL KIDNEY CARE	662 ROBERT BLVD		SLIDELL	LA	70458-1648	9856495197	9856495218	In-Center Hemo, PD Services	23	19-2556	Y
DIALYSIS SYSTEMS OF COVINGTON	210 GREENBRIAR BLVD		COVINGTON	LA	70433-7235	9858751915	9858751918	In-Center Hemo, PD Services	12	19-2613	Y
DIALYSIS SYSTEMS OF HAMMOND	15799 PROFESSIONAL PLZ		HAMMOND	LA	70403-1452	9855428827	9855426351	In-Center Hemo, PD Services	13	19-2626	N
WASHINGTON PARISH DIALYSIS	724 WASHINGTON ST		FRANKLINTON	LA	70438-1790	9857951111	9857950000	In-Center Hemo	14	19-2615	Y
BOGALUSA KIDNEY CARE	2108 AVENUE F		BOGALUSA	LA	70427-5027	9857357811	9857351501	In-Center Hemo	15	19-2540	Y
USE 4401-BROADMOOR DIALYSIS PD	1815 E 70 ST		SHREVEPORT	LA	71105-5301	3187950572	3187978143	PD Services		19-2695	N
OAKWOOD DIALYSIS CENTER	148 HECTOR AVE		GRETNA	LA	70056-2531	5043761603	5043762364	In-Center Hemo	19	19-2683	Y
NORTHSHORE KIDNEY CENTER	106 MEDICAL CENTER DR		SLIDELL	LA	70461-5503	9856906018	9856906074	In-Center Hemo	8	19-2666	N
METAIRIE DIALYSIS CENTER	7100 AIRLINE DR		METAIRIE	LA	70003-5950	5047311969	5047318533	In-Center Hemo, Nocturnal Hemo, PD Services	12	19-2678	Y
RIVER PARISHES DIALYSIS	2880 W AIRLINE HWY		LA PLACE	LA	70068-2922	9854797505	9854797510	In-Center Hemo	12	19-2681	Y
MARRERO DIALYSIS	1908 JUTLAND DR		HARVEY	LA	70058-2359	5043476224	5043476257	In-Center Hemo	17	19-2694	Y
CRESCENT CITY DIALYSIS CENTER	3909 BIENVILLE ST	STE 1B	NEW ORLEANS	LA	70119-5151	5044837117	5044838937	In-Center Hemo, PD Services	17	19-2696	Y
NEW ORLEANS UPTOWN DIALYSIS	1401 FOUCHER ST # 4		NEW ORLEANS	LA	70115-3515	5048978530	5048978790	In-Center Hemo, In-Center Hemo Self Care, Acute Hemo 1:1, PD Services, Nocturnal Hemo	20	19-2581	Y
CHATEAU DIALYSIS	720 VILLAGE RD		KENNER	LA	70065-2751	5044692796	5044697587	In-Center Hemo, PD Services, Acute Hemo 1:1	16	19-2534	Y
DONALDSONVILLE DIALYSIS	101 PLIMSOL DR		DONALDSONVILLE	LA	70346	2254731139	2254731128	In-Center Hemo	16	19-2572	N
DERIDDER DIALYSIS	239 E 1ST ST		DERIDDER	LA	70634-4105	3374620950	3374601933	In-Center Hemo	12	19-2598	Y
MONROE NORTH	2344 STERLINGTON RD		MONROE	LA	71203-3044	3186990001	3186990005	In-Center Hemo, PD Services	16	192627	N
LAKE CHARLES SOUTHWEST DIALYSIS	300 18th ST		LAKE CHARLES	LA	70601-7342	3374336831	3374336613	In-Center Hemo, In-Center Hemo Self Care, PD Services	20	19-2597	Y
SULPHUR DIALYSIS	944 BEGLIS PKWY		SULPHUR	LA	70663-5102	3376260774	3376262803	In-Center Hemo	12	19-2612	Y
MONROE JACKSON STREET-ACUTE	309 JACKSON ST	STE 383	MONROE	LA	71201-7407	3189664405	3189665280	Acute Hemo 1:1, Acute PD, In-Center Hemo	20	19-2654	N
MAGNOLIA DIALYSIS	1125 S BURNSIDE AVE		GONZALES	LA	70737-4248	2256444490	2256449032	In-Center Hemo, Nocturnal Hemo	17	19-2551	Y
BROADMOOR DIALYSIS	1815 E 70TH ST		SHREVEPORT	LA	71105-5301	3187977940	3187978143	In-Center Hemo, PD Services	13	19-2695	Y
RED RIVER DIALYSIS	9205 LINWOOD AVE		SHREVEPORT	LA	71106-7006	3186030548	3186038905	In-Center Hemo	13	19-2711	Y
ESSEN LANE DIALYSIS	7703 PICARDY AVE		BATON ROUGE	LA	70808-4338	2257698669	2257660095	In-Center Hemo, PD Services	21	19-2716	Y
MID CITY DIALYSIS	2902 FLORIDA BLVD		BATON ROUGE	LA	70802-2723	2253878558	2253878250	In-Center Hemo	13	19-2725	Y
SCOTLANDVILLE DIALYSIS	7797 HOWELL BLVD		BATON ROUGE	LA	70807-5583	2253576929	2253551008	In-Center Hemo	17	19-2720	Y
WESTWEGO DIALYSIS	1 WESTBANK EXPRESSWAY		WESTWEGO	LA	70094-4156	5043476942	5043476957	In-Center Hemo, PD Services	12	19-2713	Y
NOLA DIALYSIS	5646 READ BLVD	STE 150	NEW ORLEANS	LA	70127-3106	5042482137	5042481832	In-Center Hemo, PD Services	14	19-2715	Y
ALGIERS DIALYSIS	2924 GENERAL DEGAULLE DR		NEW ORLEANS	LA	70114-6440	5043670006	5043670340	In-Center Hemo	13	19-2719	Y
RIVER BEND DIALYSIS	1057 PAUL MAILLARD RD	ST B1350	LULING	LA	70070-4349	9853311156	9853311112	In-Center Hemo, Acute Hemo 1:1, Acute PD	15	19-2707	Y

GARDEN DISTRICT DIALYSIS	2620 JENA ST		NEW ORLEANS	LA	70115-6325	5042696004	5042696011	In-Center Hemo, PD Services	16	19-2689	Y
WESTBANK AT HOME	3631 BEHRMAN PL		NEW ORLEANS	LA	70114-0906	5043660808	5043673816	Home Hemo		19-2507	Y
NEW ORLEANS UPTOWN AT HOME	3434 PRYTANIA ST	STE 260	NEW ORLEANS	LA	70115-3532	5048972551	5048973049	Home Hemo	0	19-2581	N
BROADMOOR AT HOME	1815 E 70TH ST		SHREVEPORT	LA	71105-5301	3187950572	3187978143	Home Hemo	4	19-2695	Y
SLIDELL KIDNEY CARE AT HOME	662 ROBERT BLVD		SLIDELL	LA	70458-1648	9856495197	9856495218	Home Hemo	0	19-2556	Y
LAKE CHARLES SOUTHWEST AT HOME	300 18th ST		LAKE CHARLES	LA	70601-7342	3374336831	3374336613	Home Hemo		19-2597	Y
EAST BATON ROUGE DIALYSIS	1333 ONEAL LANE		BATON ROUGE	LA	70816-1957	2252261444	2252729857	In-Center Hemo, Nocturnal Hemo, PD Services	24	19-2616	Y
HOUMA DIALYSIS	108 PICONE RD		HOUMA	LA	70363-7051	9858688187	9858794639	In-Center Hemo, PD Services	15	19-2509	Y
ESSEN LANE AT HOME	7703 PICARDY AVE		BATON ROUGE	LA	70808-4338	2257698669	2257660095	Home Hemo		19-2716	Y
FREMAUX DIALYSIS	1566 SHORTCUT HWY		SLIDELL	LA	70458-8126	9856439237	9857260400	In-Center Hemo	13	19-2724	Y
YOUNGSVILLE DIALYSIS	314 YOUNGSVILLE HWY	STE 125	LAFAYETTE	LA	70508-4524	3378375044	3378375609	In-Center Hemo, PD Services	13	19-2721	Y
MARIGNY DIALYSIS	2345 ST CLAUDE AVE		NEW ORLEANS	LA	70117-8352	5049474197	5049439545	In-Center Hemo	19	19-2717	Y
WALKER SOUTH DIALYSIS	28375 WALKER RD S		WALKER	LA	70785-6029	2256642099	2257916079	In-Center Hemo	13	192729	Y
EARHART DIALYSIS	7730 EARHART BLVD		NEW ORLEANS	LA	70125-2504	5048611256	5048615082	In-Center Hemo, PD Services	15	19-2738	Y
PRAIRIEVILLE DIALYSIS	17123 COMMERCE CENTRE DR		PRAIRIEVILLE	LA	70769-3481	2256731127	2256731126	In-Center Hemo	17	19-2736	Y
GENTILLY DIALYSIS	4720 PARIS AVE		NEW ORLEANS	LA	70122-2553	5042839098	5042823888	In-Center Hemo	21	19-2735	Y
PDI-FITCHBURG	551 ELECTRIC AVE		FITCHBURG	MA	01420-5371	9783434100	9783434559	In-Center Hemo, PD Services	19	22-2536	Y
PDI-WORCESTER	19 GLENNIE ST	STE A	WORCESTER	MA	01605-3918	5084219539	5084216653	In-Center Hemo, PD Services	26	22-2564	Y
BOSTON DIALYSIS	660 HARRISON AVE		BOSTON	MA	02118-2304	6178597000	6178594579	In-Center Hemo, Acute Hemo 1:1, PD Services	37	22-2526	Y
BROOKLINE DIALYSIS	322 WASHINGTON ST		BROOKLINE	MA	02445-6850	6177347794	6177346999	In-Center Hemo, PD Services	25	22-2529	Y
NORTHEAST CAMBRIDGE DIALYSIS	799 CONCORD AVE		CAMBRIDGE	MA	02138-1048	6175477700	6178644724	In-Center Hemo, PD Services	18	22-2533	Y
NEW BEDFORD DIALYSIS	237-B STATE RD		NORTH DARTMOUTH	MA	02747-2612	5089920629	5089991319	In-Center Hemo, PD Services	22	22-2530	Y
WEYMOUTH DIALYSIS	330 LIBBEY INDUSTRIAL PKWY	STE 900	WEYMOUTH	MA	02189-3122	7813317700	7813313046	In-Center Hemo, In-Center Hemo Self Care, PD Services	27	22-2517	Y
WOBURN DIALYSIS	23 WARREN AVE		WOBURN	MA	01801-7906	7819357700	7819337690	In-Center Hemo, PD Services	16	22-2520	Y
WELLINGTON CIRCLE DIALYSIS CENTER	10 CABOT RD	STE 103B	MEDFORD	MA	02155-5173	7813069740	7813069745	In-Center Hemo, PD Services	17	22-2542	Y
SALEM NORTHEAST DIALYSIS	207 HIGHLAND AVE		SALEM	MA	01970-1829	9787442075	9785421976	In-Center Hemo, PD Services	22	22-2543	Y
BURLINGTON REGIONAL DIALYSIS	31 MALL RD	STE 1B	BURLINGTON	MA	01803-4138	7812703580	7812703653	In-Center Hemo, PD Services	17	22-2556	Y
MA TAX ALLOCATIONS				MA				In-Center Hemo			Y
PDI-WORCESTER AT HOME	19 GLENNIE ST	STE A	WORCESTER	MA	01605-3918	5084219539	5084216653	Home Hemo		22-2564	Y
BOSTON AT HOME	660 HARRISON AVE		BOSTON	MA	02118-2304	6178597000	6178594579	Home Hemo		22-2526	Y
WEYMOUTH AT HOME	330 LIBBEY INDUSTRIAL PKWY	STE 900	WEYMOUTH	MA	02189-3122	7813317700	7813313046	Home Hemo		22-2517	Y
NEW BEDFORD AT HOME	237-B STATE RD		DARTMOUTH	MA	02747-2612	5089920629	5089991319	Home Hemo		22-2530	Y
WELLINGTON CIRCLE AT HOME	10 CABOT RD	STE 103B	MEDFORD	MA	02155-5173	7813069740	7813069745	Home Hemo		22-2542	Y
BROOKLINE AT HOME	322 WASHINGTON ST		BROOKLINE	MA	02445-6850	6177347794	6177346999	Home Hemo		22-2529	Y
NORTH ANDOVER RENAL AT HOME	201 SUTTON ST		NORTH ANDOVER	MA	01845-1612	9789751119	9789750444	Home Hemo		22-2545	Y
AMESBURY RENAL CENTER	24 MORRILL PLACE		AMESBURY	MA	01913-3530	9783887100	9783883666	In-Center Hemo	17	22-2532	N
NORTH ANDOVER RENAL CENTER	201 SUTTON ST		NORTH ANDOVER	MA	01845-1612	9789751119	9789750444	In-Center Hemo, PD Services	22	22-2545	Y
SALEM NORTHEAST AT HOME	207 HIGHLAND AVE		SALEM	MA	01970-1829	9785421993	9785421977	Home Hemo			Y
BURLINGTON REGIONAL AT HOME	31 MALL RD	STE 1B	BURLINGTON	MA	01803-4138	7812703580	7812703683	Home Hemo			Y
BALTIMORE COUNTY DIALYSIS CENTER	3689 OFFUTT RD	STE A	RANDALLSTOWN	MD	21133-3515	4109222475	4109221506	In-Center Hemo, In-Center Hemo Self Care	28	21-2546	Y
CARROLL COUNTY DIALYSIS FACILITY	193 STONER AVE	STE 120	WESTMINSTER	MD	21157-5782	4108711762	4108711766	In-Center Hemo, In-Center Hemo Self Care, PD Services	19	21-2537	Y
RIVERTOWNE DIALYSIS	6169 LIVINGSTON RD		OXON HILL	MD	20745-3006	3018394105	3018394106	In-Center Hemo	16	21-2621	Y
HARFORD ROAD DIALYSIS CENTER	5800 HARFORD RD		BALTIMORE	MD	21214-1847	4104441544	4104442787	In-Center Hemo, In-Center Hemo Self Care, Acute Hemo 1:1, PD Services	19	21-2605	Y
BERTHA SIRK DIALYSIS CENTER	5820 YORK RD	STE 10	BALTIMORE	MD	21212-3620	4105329311	4105325833	In-Center Hemo, Home Hemo, In-Center Hemo Self Care	16	21-2543	Y
GREENSPRING DIALYSIS CENTER	4701 MOUNT HOPE DR	STE C	BALTIMORE	MD	21215-3246	4105850467	4105850491	In-Center Hemo, In-Center Hemo Self Care	36	21-2551	Y
DULANEY TOWSON DIALYSIS CENTER	113 WEST RD	STE 201	TOWSON	MD	21204-2318	4108253690	4108253697	In-Center Hemo, In-Center Hemo Self Care	14	21-2612	Y
DOWNTOWN DIALYSIS CENTER	821 N EUTAW ST	STE 401	BALTIMORE	MD	21201-6304	4103833455	4103833468	In-Center Hemo, In-Center Hemo Self Care, PD Services	31	21-2522	Y
EASTON DIALYSIS CENTER	500 CADMUS LN	STE 201	EASTON	MD	21601-3857	4108228659	4108225138	In-Center Hemo, PD Services	15	21-2512	Y
BERLIN DIALYSIS CENTER	9952 NORTH MAIN ST	BLDG #3	BERLIN	MD	21811-1049	4106411321	4106411538	In-Center Hemo, In-Center Hemo Self Care, Acute Hemo 1:1, Acute PD, PD Services	18	21-2520	Y
ROCKVILLE DIALYSIS CENTER	15204 OMEGA DR	STE 110	ROCKVILLE	MD	20850-4813	3019472427	2406832440	In-Center Hemo	17	21-2511	Y
CHESTERTOWN DIALYSIS CENTER	100 BROWN ST		CHESTERTOWN	MD	21620-1435	4107789555	4107789623	In-Center Hemo, In-Center Hemo Self Care, Acute Hemo 1:1, Acute PD	9	21-2565	Y
WHEATON DIALYSIS CENTER	11941 GEORGIA AVE		WHEATON	MD	20902-2001	3019499620	3019499783	In-Center Hemo, PD Services	24	21-2576	Y

OWINGS MILLS DIALYSIS CENTER	11221 DOLFIELD BLVD	STE 118	OWINGS MILLS	MD	21117-3254	4103632019	4103632047	In-Center Hemo, In-Center Hemo Self Care	25	21-2574	Y
KIDNEY CARE OF LARGO	1300 MERCANTILE LN	STE 194	UPPER MARLBORO	MD	20774-5339	3019254100	3019254810	In-Center Hemo, In-Center Hemo Self Care	29	21-2530	Y
KIDNEY CARE OF LAUREL	14631 LAUREL BOWIE RD	UNITS 100-105	LAUREL	MD	20707-4403	3017253559	3017253599	In-Center Hemo, PD Services	18	21-2538	Y
RENAL CARE OF BOWIE	4861 TESLA DR	STES G-H	BOWIE	MD	20715-4318	3018095342	3018095539	In-Center Hemo, In-Center Hemo Self Care, PD Services	24	21-2626	Y
TAKOMA PARK DIALYSIS	1502 UNIVERSITY BLVD E		HYATTSVILLE	MD	20783-4620	3014081202	3014349278	In-Center Hemo	21	21-2590	Y
RENAL CARE OF LANHAM	4451 PARLIAMENT PL	STE R	LANHAM	MD	20706-1872	3014297300	3014592409	In-Center Hemo, PD Services	30	21-2552	Y
RENAL CARE OF SEAT PLEASANT	6274 CENTRAL AVE		SEAT PLEASANT	MD	20743-6128	3013366274	3013363946	In-Center Hemo, In-Center Hemo Self Care, PD Services	21	21-2640	Y
KIDNEY HOME CENTER PD	2270 ROLLING RUN DR	STE 600	BALTIMORE	MD	21244-1864	4102650618	4102650614	PD Services	8	21-2659	Y
PIKESVILLE DIALYSIS	6609 REISTERSTOWN RD	STE 100	BALTIMORE	MD	21215-2662	4103581745	4103581526	In-Center Hemo	22	21-2636	Y
CAMBRIDGE DIALYSIS CENTER	704 CAMBRIDGE PLAZA		CAMBRIDGE	MD	21613-2531	4102282791	4102211298	In-Center Hemo, In-Center Hemo Self Care, Acute Hemo 1:1, PD Services	22	21-2639	Y
GERMANTOWN DIALYSIS	20111 CENTURY BLVD	STE C	GERMANTOWN	MD	20874-9165	3015404601	3015402908	In-Center Hemo, Nocturnal Hemo, PD Services	22	21-2638	Y
SETON DRIVE DIALYSIS	4800 SETON DR		BALTIMORE	MD	21215-3210	4105850446	4105850448	In-Center Hemo	12	21-2653	Y
NORTHWEST DIALYSIS CENTER	2245 ROLLING RUN DR	STE 1	WINDSOR MILL	MD	21244-1858	4102650158	4109444686	In-Center Hemo, Nocturnal Hemo	15	21-2655	Y
ABERDEEN DIALYSIS	780 W BEL AIR AVE		ABERDEEN	MD	21001-2236	4102739333	4102739337	In-Center Hemo	15	21-2650	Y
WASHINGTON COUNTY DIALYSIS	246 EASTERN BLVD N	STE 104	HAGERSTOWN	MD	21740-5965	3017977839	3013939046	PD Services	2	21-2667	Y
CALVERTON DIALYSIS	4780 CORRIDOR PL	STE C	BELTSVILLE	MD	20705-1165	3015950231	3015953439	In-Center Hemo, PD Services	12	21-2663	Y
CATONSVILLE NORTH DIALYSIS	5401 BALTIMORE NATIONAL PIKE		BALTIMORE	MD	21229-2102	4108694618	4108694704	In-Center Hemo, In-Center Hemo Self Care	25	21-2634	Y
LAKESIDE DIALYSIS	10401 HOSPITAL DR	STE G02	CLINTON	MD	20735-3113	3018566550	3018565693	In-Center Hemo, In-Center Hemo Self Care, PD Services	15	21-2564	Y
SILVER SPRING DIALYSIS	8040 GEORGIA AVE	STE 150	SILVER SPRING	MD	20910-4959	3016088961	3016088966	In-Center Hemo, PD Services	27	21-2593	Y
FALLS ROAD DIALYSIS	1423 CLARKVIEW RD	STE 500	BALTIMORE	MD	21209-2189	4108284643	4108238305	In-Center Hemo	12	21-2588	Y
WHITESQUARE DIALYSIS	1 NASHUA CT STE E		BALTIMORE	MD	21221-3131	4106875580	4106878559	In-Center Hemo, PD Services	18	21-2523	Y
25TH STREET DIALYSIS	920 E 25TH ST		BALTIMORE	MD	21218-5503	4102351611	4102353721	In-Center Hemo	21	21-2595	Y
BEL AIR DIALYSIS	2225 OLD EMMORTON RD	STE 105	BEL AIR	MD	21015-6122	4105152078	4105153425	In-Center Hemo, PD Services, Nocturnal Hemo	24	21-2594	Y
PASADENA DIALYSIS	8037 GOVERNOR RITCHIE HWY	STE A	PASADENA	MD	21122-7121	4105904615	4107666718	In-Center Hemo, PD Services	30	21-2613	Y
FREDERICK DIALYSIS	140 THOMAS JOHNSON DR	STE 100	FREDERICK	MD	21702-4475	3016950900	3016952808	In-Center Hemo, PD Services	27	21-2598	Y
DUNDALK DIALYSIS	14 COMMERCE ST		DUNDALK	MD	21222-4307	4102849000	4102845584	In-Center Hemo	12	21-2616	Y
CEDAR LANE DIALYSIS	6334 CEDAR LN	STE 101	COLUMBIA	MD	21044-3898	4105315390	4105317958	In-Center Hemo, In-Center Hemo Self Care	13	21-2628	Y
GLEN BURNIE DIALYSIS	6934 AVIATION BLVD	STE J-M	GLEN BURNIE	MD	21061-2593	4105536951	4107660513	In-Center Hemo	30	21-2631	Y
SOUTHERN MARYLAND DIALYSIS	9211 STUART LN	4TH FL	CLINTON	MD	20735-2712	3018566602	3018566623	In-Center Hemo, In-Center Hemo Self Care	13	21-2563	Y
HOWARD COUNTY DIALYSIS	5999 HARPERS FARM RD	STE 110E	COLUMBIA	MD	21044-3023	4109974244	4107308235	In-Center Hemo, In-Center Hemo Self Care	24	21-2516	Y
CATONSVILLE DIALYSIS	1581 SULPHUR SPRING RD	STE 112	BALTIMORE	MD	21227-2599	4102427766	4102425788	In-Center Hemo	30	21-2528	Y
MERCY DIALYSIS	315 N CALVERT ST	STE 300	BALTIMORE	MD	21202-3611	4103321122	4103321151	In-Center Hemo	30	21-2542	Y
HARBOR PARK DIALYSIS	111 CHERRY HILL RD		BALTIMORE	MD	21225-1392	4103543037	4103543095	In-Center Hemo	21	21-2556	Y
LANDOVER DIALYSIS	1200 MERCANTILE LN	STE 105	UPPER MARLBORO	MD	20774-5389	3013222861	3013225829	In-Center Hemo, Nocturnal Hemo	22	21-2545	Y
MD TAX ALLOCATIONS	6830 HOSPITAL DR	STE 106	BALTIMORE	MD	21237-4375			In-Center Hemo			N
MT. RAINIER DIALYSIS	2303 VARNUM ST		MT RAINIER	MD	20712-1459	3012775350	3019856875	In-Center Hemo, PD Services	16	21-2720	Y
DISTRICT HEIGHTS DIALYSIS	5701 SILVER HILL RD		DISTRICT HEIGHTS	MD	20747-1102	3018170010	3018170019	In-Center Hemo, PD Services	18	21-2657	Y
FOREST LANDING DIALYSIS	2220 COMMERCE RD	STE 1	FOREST HILL	MD	21050-2560	4106386020	4106387180	In-Center Hemo	24	21-2668	Y
CHARLES COUNTY DIALYSIS	4475 REGENCY PL	STE 102 & 103	WHITE PLAINS	MD	20695-3072	3019329874	3016382846	In-Center Hemo, PD Services	15	21-2672	Y
GLEN BURNIE HOME TRAINING	6934 AVIATION BLVD	STE H	GLEN BURNIE	MD	21061-2593	4107604976	4107611040	PD Services	6	21-2674	Y
ANNAPOLIS DIALYSIS	1127 WEST ST	STE 100	ANNAPOLIS	MD	21401-3615	4106266139	4102681294	In-Center Hemo, PD Services	16	21-2682	Y
ROCK CREEK DIALYSIS	5544 NORBECK RD		ROCKVILLE	MD	20853-2441	3014602090	3014602094	In-Center Hemo, PD Services	12	21-2678	Y
PG COUNTY SOUTH DIALYSIS	5442 SAINT BARNABAS RD		OXON HILL	MD	20745-3622	3018940572	3016301389	In-Center Hemo, PD Services	22	21-2675	Y
DEER CREEK HOME TRAINING	602 S ATWOOD RD	STE 106	BEL AIR	MD	21014-4198	4108384613	4108384924	PD Services	4	21-2673	Y
CORAL HILLS DIALYSIS	4797 MARLBORO PIKE		CAPITOL HEIGHTS	MD	20743-5213	3014201513	3014203912	In-Center Hemo, PD Services	19	21-2683	Y
FORESTVILLE DIALYSIS	3424 DONNELL DR		FORESTVILLE	MD	20747-3209	3015680381	3017361704	In-Center Hemo, PD Services	19	21-2695	Y
MIDDLEBROOK DIALYSIS	12401 MIDDLEBROOK RD	STE 160	GERMANTOWN	MD	20874-1523	3015406020	3015406030	In-Center Hemo, PD Services	21	21-2625	Y
BALLENGER CREEK DIALYSIS	5205 CHAIRMANS CT	STE 101	FREDERICK	MD	21703-2915	3016626572	3016440676	In-Center Hemo	28	21-2654	Y
GLEN BURNIE HT AT HOME	6934 AVIATION BLVD	STE H	GLEN BURNIE	MD	21061-2593	4107604976	4107611040	Home Hemo		21-2674	Y
MIDDLEBROOK AT HOME	12401 MIDDLEBROOK RD		GERMANTOWN	MD	20874-1525	3015406020	3015406030	Home Hemo	0	21-2625	N
KIDNEY HOME AT HOME	2270 ROLLING RUN DR	STE 600	BALTIMORE	MD	21244-1858	4102650618	4102650614	Home Hemo	0	21-2659	Y
LANHAM AT HOME	4451 PARLIAMENT PL	STE M	LANHAM	MD	20706-1801	3014297310	3014592040	Home Hemo	0	21-2552	Y
GERMANTOWN AT HOME	20111 CENTURY BLVD	STE C	GERMANTOWN	MD	20874-9165	3015404601	3015402908	Home Hemo	0	21-2638	Y
LAKESIDE AT HOME	10401 HOSPITAL DR	SUITE GO2	CLINTON	MD	20735-3168	3018566550	3018566593	Home Hemo		21-2564	N
FREDERICK AT HOME	140 THOMAS JOHNSON DR	STE 100	FREDERICK	MD	21702-4475	3016950900	3016952808	Home Hemo	0	21-2598	Y
CARROLL COUNTY AT HOME	193 STONER AVE	STE 120	WESTMINSTER	MD	21157-5782	4108711762	4108711766	Home Hemo		21-2537	N

WINDSOR DIALYSIS	2707 N ROLLING RD	STE 104-105	WINDSOR MILL	MD	21244-2157	4109442649	4109442726	In-Center Hemo	18	21-2632	Y
ANNAPOLIS AT HOME	1127 WEST ST	STE 100	ANNAPOLIS	MD	21401-3615	4102631346	4102632325	Home Hemo	0	21-2682	Y
CHARLES COUNTY AT HOME	4475 REGENCY PL	STE 102 & 103	WHITE PLAINS	MD	20695-3072	3019329874	3016382846	Home Hemo		21-2672	Y
KIDNEY HOME DOWNTOWN AT HOME	200 SAINT PAUL ST	STE 5	BALTIMORE	MD	21202-2025	4102445638	4102446405	Home Hemo	1	21-2702	Y
FRIENDLY FARMS HOME DIALYSIS (PD-HHD)	10905 FORT WASHINGTON RD	STE 307	FORT WASHINGTON	MD	20744-5843	3012920540	3012923493	Home Hemo, PD Services	4	21-2714	Y
EASTERN BOULEVARD DIALYSIS	246 EASTERN BLVD N	STE 105	HAGERSTOWN	MD	21740-5965	3017454251	3017974637	In-Center Hemo	16	21-2691	Y
KIDNEY HOME DOWNTOWN	200 SAINT PAUL ST	STE 5	BALTIMORE	MD	21202-2025	4102445638	4102446405	PD Services	4	21-2702	Y
GREENBELT HOME TRAINING (PD ONLY)	10210 GREENBELT RD	STE 100	LANHAM	MD	20706-6223	3017940142	3017944857	PD Services	4	21-2710	Y
QUEEN ANNE HOME TRAINING	125 SHOREWAY DR	STE 330	QUEENSTOWN	MD	21658-1683	4108274527	4108273148	PD Services	2	21-2689	Y
ODENTON DIALYSIS	1360 BLAIR DR	STE L & M	ODENTON	MD	21113-1343	4106743918	4106728947	In-Center Hemo	19	21-2711	Y
BRANDYWINE DIALYSIS	7651 MATAPEAKE BUSINESS DR	STE 206	BRANDYWINE	MD	20613-3038	3017827863	3017823731	In-Center Hemo, PD Services	22	21-2698	Y
GLENARDEN DIALYSIS	9701 PHILADELPHIA CT	STE A	LANHAM	MD	20706-4400	3019183830	3013065129	In-Center Hemo	24	21-2699	Y
LARGO TOWN CENTER DIALYSIS	1101 MERCANTILE LN	STE 104	LARGO	MD	20774-5360	3013417480	3017737206	In-Center Hemo, Nocturnal Hemo	22	21-2713	Y
BRIGGS CHANEY DIALYSIS	13875 OUTLET DR		SILVER SPRING	MD	20904-4971	3018908976	3018901505	In-Center Hemo	18	21-2706	Y
RIDGE ROAD DIALYSIS	530 E RIDGEVILLE BLVD		MOUNT AIRY	MD	21771-5252	3018295683	3018295254	In-Center Hemo	13	21-2725	Y
LAUREL LAKES DIALYSIS	14500 LAUREL PL		LAUREL	MD	20707-4961	3014975454	3017762531	In-Center Hemo	13	21-2724	Y
GAITHERSBURG DIALYSIS	202 PERRY PKWY	STE 3	GAITHERSBURG	MD	20877-2172	3019870912	3019476115	In-Center Hemo	16	21-2728	Y
GOOD SAMARITAN DIALYSIS	5601 LOCH RAVEN BLVD		BALTIMORE	MD	21239-2945	4434444095	4434444098	In-Center Hemo, PD Services	53	21-2722	Y
UNION MEMORIAL DIALYSIS	201 E UNIVERSITY PKWY		BALTIMORE	MD	21218-2829	4105544535	4105544544	In-Center Hemo, PD Services	27	21-2721	Y
GOOD SAMARITAN DIALYSIS (WALKER)	5601 LOCH RAVEN BLVD		BALTIMORE	MD	21239-2945	4434444478	4434444959	In-Center Hemo	53	21-2722	Y
DEER CREEK HT AT HOME	602 S ATWOOD RD	STE 106	BEL AIR	MD	21014-4198	4108384613	4108384924	Home Hemo	1	21-2673	Y
FRIENDLY FARM HOME AT HOME	10905 FORT WASHINGTON RD	STE 307	FORT WASHINGTON	MD	20744-5812	3012920540	3012923493	Home Hemo		21-2714	Y
GOOD SAMARITAN AT HOME	5601 LOCH RAVEN BLVD		BALTIMORE	MD	21239-2945	4434444095	4434444098	Home Hemo		21-2722	Y
CAMBRIDGE AT HOME	704 CAMBRIDGE PLZ		CAMBRIDGE	MD	21613-2531	4102282791	4102211298	Home Hemo	22	212639	Y
EASTERN MAINE DIALYSIS	11 SHORT ST		ELLSWORTH	ME	04605-1718	2076679294	2076679414	In-Center Hemo	12	20-2514	Y
LINCOLN LAKES REGIONAL DIALYSIS	250 ENFIELD RD		LINCOLN	ME	04457-0367	2077946095	2077946190	In-Center Hemo	8	20-2513	Y
BOYD DIALYSIS	925 UNION ST	STE 1	BANGOR	ME	04401-3051	2079411298	2079411304	In-Center Hemo, PD Services	21	20-2512	Y
BOYD AT HOME	925 UNION ST		BANGOR	ME	04401-3051	2079411298	2079411304	Home Hemo		20-2512	Y
NEW CENTER DIALYSIS	7700 2ND AVE		DETROIT	MI	48202-2411	3138709473	3138711742	In-Center Hemo, In-Center Hemo Self Care	17	23-2529	Y
CLARKSTON DIALYSIS	6770 DIXIE HWY	STE 205	CLARKSTON	MI	48346-2089	2486200958	2486201204	In-Center Hemo, In-Center Hemo Self Care, PD Services	22	23-2575	Y
YPSILANTI DIALYSIS	2766 WASHTENAW RD		YPSILANTI	MI	48197-1506	7345289280	7345281139	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care, PD Services	16	23-2568	Y
JACKSON DIALYSIS	234 W LOUIS GLICK HWY		JACKSON	MI	49201-1326	5178411712	5178411724	In-Center Hemo, PD Services	21	23-2571	Y
GRAND BLANC DIALYSIS CENTER	3625 GENESYS PKWY		GRAND BLANC	MI	48439-8070	8109538800	8109538808	In-Center Hemo, In-Center Hemo Self Care, PD Services	16	23-2569	Y
SOUTHFIELD WEST DIALYSIS	21900 MELROSE AVE	STE 4	SOUTHFIELD	MI	48075-7967	2483568079	2483568151	In-Center Hemo	18	23-2604	Y
DAVISON DIALYSIS	1011 S STATE RD		DAVISON	MI	48423-1903	8106588224	8106588232	In-Center Hemo, In-Center Hemo Self Care	15	23-2605	Y
WEST BLOOMFIELD DIALYSIS	6010 W MAPLE RD	STE 215	WEST BLOOMFIELD	MI	48322-4406	2485391025	2485392986	In-Center Hemo, In-Center Hemo Self Care	9	23-2661	Y
FLUSHING DIALYSIS	3469 PIERSON PL	STE A	FLUSHING	MI	48433-2704	8107335004	8107335384	In-Center Hemo, PD Services, In-Center Hemo Self Care	12	23-2601	Y
BRIGHTON DIALYSIS	7960 GRAND RIVER RD	STE 210	BRIGHTON	MI	48114-7336	8102256288	8102256291	In-Center Hemo, In-Center Hemo Self Care, PD Services	13	23-2551	Y
MACOMB KIDNEY CENTER	28295 SCHOENHERR RD	STE A	WARREN	MI	48088-4300	5865588160	5865588159	In-Center Hemo, In-Center Hemo Self Care	20	23-2540	Y
NORTH OAKLAND DIALYSIS	450 N TELEGRAPH RD	STE 600	PONTIAC	MI	48341-1037	2483332230	2483339589	In-Center Hemo, In-Center Hemo Self Care, PD Services	36	23-2511	Y
NOVI DIALYSIS	27150 PROVIDENCE PKWY	STE A	NOVI	MI	48374-1272	2484496947	2484496995	In-Center Hemo, In-Center Hemo Self Care	21	23-2549	Y
CORNERSTONE DIALYSIS	23857 GREENFIELD RD		SOUTHFIELD	MI	48075-3122	2485696111	2485691049	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care, PD Services	25	23-2512	Y
OAK PARK DIALYSIS	13481 W 10 MILE RD		OAK PARK	MI	48237-4633	2485829750	2485829760	In-Center Hemo, In-Center Hemo Self Care	20	23-2613	Y
SAGINAW DIALYSIS	311 HOYT AVE		SAGINAW	MI	48607-1105	9897715094	9897715053	In-Center Hemo, In-Center Hemo Self Care	13	23-2586	Y
FLINT DIALYSIS CENTER	2 HURLEY PLZ	STE 115	FLINT	MI	48503-5904	8102399920	8102626676	In-Center Hemo, In-Center Hemo Self Care	20	23-2608	Y
HALLWOOD DIALYSIS CENTER	4929 CLIO RD	STE B	FLINT	MI	48504-1897	8107874496	8107874602	In-Center Hemo, In-Center Hemo Self Care	16	23-2609	Y
PARK PLAZA DIALYSIS	G1075 N BALLENGER HWY		FLINT	MI	48504-4431	8102358468	8102359144	In-Center Hemo, In-Center Hemo Self Care	15	23-2610	Y
STATE FAIR DIALYSIS	19800 WOODWARD AVE		DETROIT	MI	48203-5102	3138938610	3138938865	In-Center Hemo	21	23-2578	Y
BATTLE CREEK DIALYSIS	220 E GOODALE AVE		BATTLE CREEK	MI	49037-2728	2699688401	2699688410	In-Center Hemo, In-Center Hemo Self Care, PD Services	20	23-2617	Y
PDI-GRAND RAPIDS	801 CHERRY ST SE		GRAND RAPIDS	MI	49506-1440	6164585100	6164585200	In-Center Hemo, In-Center Hemo Self Care, PD Services	36	23-2565	Y
PDI-GRAND RAPIDS EAST	1230 EKHART ST NE		GRAND RAPIDS	MI	49503-1372	6167428930	6167420456	In-Center Hemo, In-Center Hemo Self Care, Nocturnal Hemo	25	23-2588	Y

PDI-GRAND HAVEN	16964 ROBBINS RD		GRAND HAVEN	MI	49417-2796	6168472825	6168474428	In-Center Hemo, In-Center Hemo Self Care	12	23-2563	Y
PDI-HIGHLAND PARK	64 VICTOR ST		HIGHLAND PARK	MI	48203-3128	3138527700	3138527704	In-Center Hemo, In-Center Hemo Self Care	28	23-2570	Y
PDI-CADIEUX	6150 CADIEUX ROAD		DETROIT	MI	48224-2006	3136409295	3136409314	In-Center Hemo, In-Center Hemo Self Care, PD Services	32	23-2584	Y
DOWNRIVER KIDNEY CENTER	5600 ALLEN RD		ALLEN PARK	MI	48101-2604	3133825933	3133825942	In-Center Hemo, In-Center Hemo Self Care	24	23-2592	Y
WESTLAND DIALYSIS	36588 FORD RD		WESTLAND	MI	48185-3769	7347211030	7347210833	In-Center Hemo, In-Center Hemo Self Care	16	23-2622	Y
FASHION SQUARE DIALYSIS	5641 BAY RD		SAGINAW	MI	48604-2509	9892491350	9892491170	In-Center Hemo	13	23-2719	Y
BALLENGER POINTE DIALYSIS	2262 S BALLENGER HWY		FLINT	MI	48503-3447	8102329004	8102358006	In-Center Hemo, In-Center Hemo Self Care, PD Services	20	23-2624	Y
ROCHESTER HILLS DIALYSIS	1886 W AUBURN RD	STE 100	ROCHESTER HILLS	MI	48309-3865	2482997901	2482997883	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care	20	23-2628	Y
COMMERCE TOWNSHIP DIALYSIS	120 W COMMERCE RD		COMMERCE TOWNSHIP	MI	48382-3915	2483634862	2483635238	In-Center Hemo	12	23-2637	Y
CHELSEA DIALYSIS	1620 COMMERCE PARK DR	STE 200	CHELSEA	MI	48118-2136	7344759710	7344759720	In-Center Hemo, In-Center Hemo Self Care, PD Services	9	23-2632	Y
EAST DEARBORN DIALYSIS	13200 W WARREN AVE		DEARBORN	MI	48126-2410	3135820131	3135820881	In-Center Hemo, Home Hemo, In-Center Hemo Self Care, PD Services	16	23-2631	Y
CLINTON TOWNSHIP DIALYSIS	15918 19 MILE RD	STE 110	CLINTON TOWNSHIP	MI	48038-1101	5864129195	5864129196	In-Center Hemo, In-Center Hemo Self Care, PD Services	16	23-2647	Y
FENTON DIALYSIS	17420 SILVER PKWY		FENTON	MI	48430-4429	8107509200	8107509210	In-Center Hemo, In-Center Hemo Self Care	12	23-2635	Y
WALKER DIALYSIS	2680 WALKER AVE NW	STE A	WALKER	MI	49544-1385	6167351172	6167351383	In-Center Hemo	17	23-2690	Y
IONIA DIALYSIS	2622 HEARTLAND BLVD		IONIA	MI	48846-8757	6165220265	6165220298	In-Center Hemo, In-Center Hemo Self Care, PD Services	12	23-2638	Y
GROSSE POINTE DIALYSIS	18000 E WARREN AVE	STE 100	DETROIT	MI	48224-1336	3133435371	3133436015	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care, PD Services	24	23-2643	Y
KALAMAZOO WEST DIALYSIS	1040 N 10TH ST	STE 100	KALAMAZOO	MI	49009-6149	2693534366	2693534793	In-Center Hemo, In-Center Hemo Self Care	6	23-2641	Y
KALAMAZOO CENTRAL DIALYSIS	535 S BURDICK ST	STE 110	KALAMAZOO	MI	49007-5261	2693430251	2693430266	In-Center Hemo, In-Center Hemo Self Care, PD Services	10	23-2639	Y
ORCHARD SQUARE DIALYSIS	1900 S TELEGRAPH RD	STE 200	BLOOMFIELD HILLS	MI	48302-0238	2484510954	2484510681	In-Center Hemo	20	23-2656	Y
RIVERWOOD DIALYSIS	24467 W 10 MILE RD		SOUTHFIELD	MI	48033-2931	2483523137	2483523827	In-Center Hemo	16	23-2665	Y
MUSKEGON DIALYSIS	1250 MERCY DR	STE 201	MUSKEGON	MI	49444-1830	2317370075	2317330606	In-Center Hemo, In-Center Hemo Self Care, PD Services	28	23-2562	Y
LUDINGTON DIALYSIS	7 N ATKINSON DR	STE 210	LUDINGTON	MI	49431-1953	2318434609	2318439209	In-Center Hemo, In-Center Hemo Self Care	17	23-2572	Y
SCHAEFFER DRIVE DIALYSIS	18100 SCHAEFER HWY		DETROIT	MI	48235-2600	3138614354	3138614369	In-Center Hemo, In-Center Hemo Self Care	20	23-2583	Y
REDFORD DIALYSIS	22711 GRAND RIVER AVE		DETROIT	MI	48219-3113	3132550171	3132558036	In-Center Hemo, In-Center Hemo Self Care, PD Services	32	23-2543	Y
KRESGE DIALYSIS	4145 CASS AVE		DETROIT	MI	48201-1707	3138334330	3138334257	In-Center Hemo, In-Center Hemo Self Care	32	23-2545	Y
MOTOR CITY DIALYSIS HOME TRAINING	4727 SAINT ANTOINE ST	STE 101	DETROIT	MI	48201-1461	3138316842	3138316415	PD Services	0	23-2539	Y
GREENVIEW DIALYSIS	18544 W 8 MILE RD		SOUTHFIELD	MI	48075-4194	2485691729	2485692471	In-Center Hemo, In-Center Hemo Self Care	24	23-2600	Y
ROMULUS DIALYSIS	31470 ECORSE RD		ROMULUS	MI	48174-1963	7347225455	7347225682	In-Center Hemo, In-Center Hemo Self Care	12	23-2596	Y
NEWAYGO COUNTY DIALYSIS	1317 W MAIN ST		FREMONT	MI	49412-1478	2319244535	2319244865	In-Center Hemo, In-Center Hemo Self Care	14	23-2607	Y
DEARBORN HOME DIALYSIS PD	22030 PARK ST		DEARBORN	MI	48124-2854	3137927343	3137928341	PD Services		23-2653	Y
DEARBORN DIALYSIS	1185 MONROE ST		DEARBORN	MI	48124-2814	3132748100	3132748103	In-Center Hemo, In-Center Hemo Self Care	25	23-2520	Y
GARDEN WEST DIALYSIS	5715 N VENOY RD		WESTLAND	MI	48185-2830	7342619418	7342611371	In-Center Hemo, In-Center Hemo Self Care	24	23-2550	Y
SOUTHGATE DIALYSIS	14752 NORTHLINE RD		SOUTHGATE	MI	48195-2467	7342840005	7342840124	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care, Acute Hemo 1:1	30	23-2535	Y
OAKWOOD RENAL SERVICES	18100 OAKWOOD BLVD	STE 206	DEARBORN	MI	48124-4085	3134387959	3134387960	In-Center Hemo	18	23-2702	Y
LANSING HOME TRAINING (PD)	4530 S HAGADORN RD	STE B	EAST LANSING	MI	48823-5304	5173338450	5173338449	PD Services	0	23-2646	Y
BURTON DIALYSIS	4015 DAVISON RD		BURTON	MI	48509-1401	8107151312	8107151356	In-Center Hemo, PD Services	12	23-2663	Y
MT MORRIS DIALYSIS	6141 N SAGINAW RD		MOUNT MORRIS	MI	48458-2403	8107878134	8107878527	In-Center Hemo	13	23-2672	Y
TOWN CENTER DIALYSIS	323 N MICHIGAN AVE		SAGINAW	MI	48602-4240	9897913624	9897913841	In-Center Hemo, PD Services	13	23-2680	Y
NORTON SHORES DIALYSIS	955 SEMINOLE RD		NORTON SHORES	MI	49441-4341	2317800246	2317800261	In-Center Hemo	12	23-2689	Y
APPLE AVENUE DIALYSIS	2480 E APPLE AVE	UNIT E	MUSKEGON	MI	49442-4471	2317730597	2317777050	In-Center Hemo, PD Services	17	23-2678	Y
ANN ARBOR DIALYSIS	3147 OAK VALLEY DR		ANN ARBOR	MI	48103-9248	7342135269	7342226073	In-Center Hemo	16	23-2687	Y
RIVERVIEW DIALYSIS	18236 FORT ST		RIVERVIEW	MI	48193-7439	7342834513	7342834570	In-Center Hemo	21	23-2686	Y
HARPER WOODS DIALYSIS	19265 VERNIER RD		HARPER WOODS	MI	48225-1010	3136400271	3136407683	In-Center Hemo	24	23-2684	Y
SPARTAN DIALYSIS	4530 S HAGADORN RD	STE A	EAST LANSING	MI	48823-5304	5173338414	5173338430	In-Center Hemo	12	23-2706	Y
EAST CHINA DIALYSIS	4180 HOSPITAL DR		EAST CHINA	MI	48054-2232	8103260032	8103260151	In-Center Hemo, PD Services	13	23-2718	Y
BLOOMFIELD HILLS HOME DIALYSIS	42886 WOODWARD AVE		BLOOMFIELD HILLS	MI	48304-5033	2483347501	2483347384	PD Services		23-2697	Y
GRAYLING HOME TRAINING (PD)	125 E MICHIGAN AVE		GRAYLING	MI	49738-1740	9893440805	9893440785	PD Services		23-2692	Y
BAD AXE-MI	897 N VAN DYKE RD		BAD AXE	MI	48413-7912	9892697657	9892697645	In-Center Hemo, PD Services	13	23-2698	Y
BELTLINE HOME TRAINING	330 E BELTLINE AVE NE	STE 210	GRAND RAPIDS	MI	49506-1267	6162857081	6162857096	PD Services		23-2693	Y
BAY CITY DIALYSIS	3170 S PROFESSIONAL DR		BAY CITY	MI	48706-2839	9896868782	9896868563	In-Center Hemo	16	23-2531	Y
GLADWIN DIALYSIS	673 QUARTER ST		GLADWIN	MI	48624-1954	9892460128	9892460175	In-Center Hemo, PD Services	19	23-2649	Y

MIDLAND DIALYSIS	4901 JEFFERSON AVE		MIDLAND	MI	48640-2905	9898397770	9898397777	In-Center Hemo, PD Services	24	23-2541	Y
WEST BRANCH DIALYSIS	599 COURT ST		WEST BRANCH	MI	48661-9310	9893458422	9893458431	In-Center Hemo, PD Services	14	23-2534	Y
GAYLORD DIALYSIS	1989 WALDEN DR		GAYLORD	MI	49735-8241	9897316418	9897314776	In-Center Hemo	12	23-2556	Y
CASS CITY DIALYSIS	6757 MAIN ST		CASS CITY	MI	48726-1556	9898725544	9898725692	In-Center Hemo	16	23-2573	Y
ALPENA DIALYSIS	301 OXBOW DR		ALPENA	MI	49707-1447	9893563128	9893580072	In-Center Hemo, Acute Hemo 1:1, Acute PD, PD Services	19	23-2553	Y
ALMA DIALYSIS	1730 WRIGHT AVE		ALMA	MI	48801-1024	9894632366	9894632667	In-Center Hemo, PD Services	17	23-2676	Y
GREENVILLE DIALYSIS	101 S GREENVILLE WEST DR		GREENVILLE	MI	48838-1598	6162259500	6162259007	In-Center Hemo	10	23-2677	Y
MT PLEASANT DIALYSIS	404 S CRAPO ST		MT PLEASANT	MI	48858-2944	9897798724	9897798894	In-Center Hemo	15	23-2675	Y
FLINT DIALYSIS PD	2 HURLEY PLAZA		FLINT	MI	48503-5904	8102399920	8107609950	PD Services		23-2608	Y
ALMA DIALYSIS PD	1730 WRIGHT AVE		ALMA	MI	48801-1024	9894632366	9894632667	PD Services		23-2676	Y
GLADWIN AT HOME	673 QUARTER ST		GLADWIN	MI	48624-1954	9892460128	9892460175	Home Hemo		23-2649	Y
MIDLAND AT HOME (MI)	4901 JEFFERSON AVE		MIDLAND	MI	48640-2905	9898397770	9898397777	Home Hemo		23-2541	Y
ALPENA AT HOME	301 OXBOW DR		ALPENA	MI	49707-1447	9893563128	9893580072	Home Hemo		23-2553	Y
ALMA AT HOME	1730 WRIGHT AVE		ALMA	MI	48801-1024	9894632366	9894632667	Home Hemo		23-2676	Y
TOWN CENTER AT HOME	323 N MICHIGAN AVE		SAGINAW	MI	48602-4240	9897913624	9897913841	Home Hemo		23-2680	Y
IONIA AT HOME	2622 HEARTLAND BLVD		IONIA	MI	48846-8757	6165220265	6165220298	Home Hemo		23-2638	N
WEST BLOOMFIELD AT HOME	6010 W MAPLE RD STE 215		WEST BLOOMFIELD	MI	48322-4406	2485391025	2485392986	Home Hemo		23-2661	Y
CORNERSTONE AT HOME	23857 GREENFIELD RD		SOUTHFIELD	MI	48075-3122	2485696360	2485693304	Home Hemo	0	23-2512	Y
BALLENGER POINTE AT HOME	2262 S BALLENGER HWY		FLINT	MI	48503-3447	8102329004	8102358006	Home Hemo	0	23-2624	Y
GRAND RAPIDS AT HOME (CHERRY STREET)	801 CHERRY ST SE		GRAND RAPIDS	MI	49506-1440	6164585100	6164585200	Home Hemo		23-2565	Y
KALAMAZOO WEST AT HOME	1040 N 10TH ST		KALAMAZOO	MI	49009-6149	2693534366	2693534865	Home Hemo	0	23-2641	Y
LANSING HOME TRAINING AT HOME	4530 S HAGADORN RD	STE B	EAST LANSING	MI	48823-5304	5173338450	5173338430	Home Hemo		23-2646	Y
CLINTON TOWNSHIP AT HOME	15918 19 MILE RD	STE 110	CLINTON TOWNSHIP	MI	48038-1101	5864129195	5864129196	Home Hemo		23-2647	Y
GROSSE POINTE AT HOME	18000 E WARREN AVE	STE 100	DETROIT	MI	48224-1336	3133435371	3133436015	Home Hemo		23-2643	Y
YPSILANTI AT HOME	2766 WASHTENAW RD		YPSILANTI	MI	48197-1506	7345289280	7345289075	Home Hemo		23-2568	Y
DEARBORN HOME AT HOME	22030 PARK ST		DEARBORN	MI	48124-2854	3137927343	3137928341	Home Hemo	0	23-2653	Y
MUSKEGON AT HOME	1250 MERCY DR	STE 201	MUSKEGON	MI	49444-1881	2317370075	2317330606	Home Hemo		23-2562	Y
BELTLINE AT HOME	330 E BELTLINE AVE NE	STE 210	GRAND RAPIDS	MI	49506-1267	6162857081		Home Hemo		23-2693	Y
GRAYLING HT AT HOME	125 E MICHIGAN AVE		GRAYLING	MI	49738-1740	9893440805	9893440785	Home Hemo		23-2692	Y
GRAND BLANC HT AT HOME	8195 S SAGINAW ST	STE C	GRAND BLANC	MI	48439-1885	8106951078	8106956942	Home Hemo		23-2711	Y
RIVERBEND AT HOME	415 S TELEGRAPH RD		MONROE	MI	48161-1611	7342415704	7344575361	Home Hemo		23-2704	Y
BLOOMFIELD HILLS HOME AT HOME	42886 WOODWARD AVE		BLOOMFIELD HILLS	MI	48304-5033	2483347501	2483347384	Home Hemo		23-2697	Y
STARRWOOD HT AT HOME	3425 STARR RD	STE A	ROYAL OAK	MI	48073-2100	2485490260	2485490228	Home Hemo		23-2710	Y
ALGER HEIGHTS AT HOME	705 28TH ST		GRAND RAPIDS	MI	49548-1303	6164750553	6164754266	Home Hemo			Y
PARTRIDGE CREEK AT HOME	46360 GRATIOT AVE		CHESTERFIELD	MI	48051-2800	5869495417	5869495691	Home Hemo		23-2713	Y
CLINTON STREET DIALYSIS MIDC			OAK PARK	MI	48237-4633	2485829750	2485829760	In-Center Hemo			N
ROGERS CITY DIALYSIS	194 E ERIE ST		ROGERS CITY	MI	49779-1612	9897340373	9897340383	In-Center Hemo	12	23-2696	Y
ROSCOMMON DIALYSIS	10450 N ROSCOMMON RD		ROSCOMMON	MI	48653-9296	9892750362	9892750409	In-Center Hemo, PD Services	13	23-2705	Y
RIVERBEND DIALYSIS	415 S TELEGRAPH RD		MONROE	MI	48161-1611	7342415704	7344575361	In-Center Hemo, PD Services	13	23-2704	Y
ALGER HEIGHTS DIALYSIS	705 28TH ST SE		GRAND RAPIDS	MI	49548-1303	6164750553	6164754266	In-Center Hemo, PD Services	20	23-2714	Y
STARRWOOD DIALYSIS	3425 STARR RD	STE B	ROYAL OAK	MI	48073-2100	2485490208	2485490240	In-Center Hemo	17	23-2708	Y
STARRWOOD HOME TRAINING (PD-HHD)	3425 STARR RD	STE A	ROYAL OAK	MI	48073-2100	2485490260	2485490228	PD Services		23-2710	Y
GRAND BLANC HOME TRAINING (PD)	8195 S SAGINAW ST	STE C	GRAND BLANC	MI	48439-1885	8106951078	8106956942	PD Services		23-2711	Y
PARTRIDGE CREEK DIALYSIS	46360 GRATIOT AVE		CHESTERFIELD	MI	48051-2800	5869495417	5869495691	In-Center Hemo, PD Services	24	23-2713	Y
MID VALLEY PD HOME TRAINING	1205 N MICHIGAN AVE		SAGINAW	MI	48602-4729	9897719381	9897719407	PD Services		23-2717	Y
ARDEN HILLS DIALYSIS UNIT	3900 NORTHWOODS DR	STE 110	ARDEN HILLS	MN	55112-6911	6514833159	6514839156	In-Center Hemo, In-Center Hemo Self Care	12	24-2518	Y
BURNSVILLE DIALYSIS UNIT	501 E NICOLLET BLVD	STE 150	BURNSVILLE	MN	55337-6784	9528921117	9528926644	In-Center Hemo, In-Center Hemo Self Care	20	24-2515	Y
COON RAPIDS DIALYSIS UNIT	3960 COON RAPIDS BLVD NW	STE 309	COON RAPIDS	MN	55433-2598	7634218717	7634214789	In-Center Hemo, In-Center Hemo Self Care	16	24-2514	Y
EDINA DIALYSIS CENTER	6565 FRANCE AVE S	STE 109	EDINA	MN	55435-2137	9529208371	9529290539	In-Center Hemo, In-Center Hemo Self Care	12	24-2501	Y
MAPLEWOOD DIALYSIS CENTER	2785 WHITE BEAR AVE N	STE 201	MAPLEWOOD	MN	55109-1320	6517792222	6517799736	In-Center Hemo, In-Center Hemo Self Care	16	24-2512	Y
MINNEAPOLIS DIALYSIS UNIT	825 S EIGHTH ST	STE SL42	MINNEAPOLIS	MN	55404-1208	6123475972	6123475876	In-Center Hemo, In-Center Hemo Self Care	32	24-2503	Y
MINNETONKA DIALYSIS UNIT	17809 HUTCHINS DR		MINNETONKA	MN	55345-4100	9524709944	9524709842	In-Center Hemo, In-Center Hemo Self Care	10	24-2526	Y
ST PAUL DIALYSIS	555 PARK ST	STE 180	SAINT PAUL	MN	55103-2192	6512918855	6512910514	In-Center Hemo, In-Center Hemo Self Care	16	24-2513	Y

UNIVERSITY DIALYSIS UNIT RIVERSIDE	1045 WESTGATE DR	STE 90	SAINT PAUL	MN	55114-1079	6516451847	6516451890	In-Center Hemo, In-Center Hemo Self Care	24	24-2539	Y
WEST ST PAUL DIALYSIS UNIT	1555 LIVINGSTON AVE		WEST ST PAUL	MN	55118-3411	6514552995	6514554368	In-Center Hemo, In-Center Hemo Self Care	20	24-2505	Y
CASS LAKE DIALYSIS	602 3RD ST NW		CASS LAKE	MN	56633-3395	2183354095	2183354188	In-Center Hemo, In-Center Hemo Self Care, PD Services	8	24-2528	Y
FARIBAULT DIALYSIS UNIT	201 LYNDALE AVE S	STE F	FARIBAULT	MN	55021-5758	5073340306	5073328935	In-Center Hemo, In-Center Hemo Self Care	10	24-2508	Y
HOME DIALYSIS UNIT	825 S 8TH ST	STE 1202	MINNEAPOLIS	MN	55404-1223	6123474458	6123417944	PD Services		24-2552	Y
MARSHALL DIALYSIS CENTER	1420 E COLLEGE DR	STE 600	MARSHALL	MN	56258-2065	5075327393	5075325776	In-Center Hemo, In-Center Hemo Self Care	8	24-2502	Y
MONTEVIDEO DIALYSIS CENTER	824 N 11TH ST	MONTEVIDEO HOSPITAL	MONTEVIDEO	MN	56265-1629	3202697451	3202696911	In-Center Hemo, In-Center Hemo Self Care, Acute Hemo 1:1, Acute PD	6	24-2511	Y
RED WING DIALYSIS UNIT	3028 N SERVICE DR		RED WING	MN	55066-1921	6513887711	6513884311	In-Center Hemo, In-Center Hemo Self Care	8	24-2520	Y
REDWOOD FALLS DIALYSIS	1104 E BRIDGE ST		REDWOOD FALLS	MN	56283-1828	5076372076	5076379968	In-Center Hemo, In-Center Hemo Self Care	8	24-2522	Y
ST PAUL CAPITOL DIALYSIS	555 PARK ST	STE 230	SAINT PAUL	MN	55103-2193	6512213318	6512244187	In-Center Hemo, In-Center Hemo Self Care	16	24-2533	Y
RIVER CITY DIALYSIS	1970 NORTHWESTERN AVE S		STILLWATER	MN	55082-6567	6514300067	6514300140	In-Center Hemo, In-Center Hemo Self Care	12	24-2535	Y
WOODBURY DIALYSIS	1850 WEIR DR	STE 3	WOODBURY	MN	55125-2260	6517304522	6517305089	In-Center Hemo, In-Center Hemo Self Care	12	24-2536	Y
BLOOMINGTON DIALYSIS UNIT OF TRC	8591 LYNDALE AVE S		BLOOMINGTON	MN	55420-2237	9527035888	9527035889	In-Center Hemo, In-Center Hemo Self Care	20	24-2547	Y
WYOMING DIALYSIS	5657 257TH ST		WYOMING	MN	55092-8072	6514088938	6514628176	In-Center Hemo, In-Center Hemo Self Care	12	24-2531	Y
PIPESTONE DIALYSIS	916 4TH AVE SW		PIPESTONE	MN	56164-1890	5078256623	5078256627	In-Center Hemo, In-Center Hemo Self Care	7	24-2541	Y
MINNEAPOLIS NE DIALYSIS	1049 10TH AVE SE		MINNEAPOLIS	MN	55414-1312	6123316088	6123316090	In-Center Hemo, In-Center Hemo Self Care	12	24-2553	Y
ST LOUIS PARK DIALYSIS CENTER	3505 LOUISIANA AVE S		ST LOUIS PARK	MN	55426-4121	9522851400	9522851406	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care	28	24-2554	Y
ST PAUL CAPITAL DIALYSIS PD	555 PARK ST	STE 110	SAINT PAUL	MN	55103-2110	6512213437	6512245012	PD Services	5	24-2565	Y
ST LOUIS PARK DIALYSIS CENTER PD	3505 LOUISIANA AVE S		ST LOUIS PARK	MN	55426-4121	9522851421	9522851406	PD Services	0	24-2554	Y
RED WING DIALYSIS UNIT PD	3028 N SERVICE DR	C/O BETH CLEMENS	RED WING	MN	55066-1921	6513887711	6513884311	PD Services		24-2520	Y
MAPLE GROVE DIALYSIS UNIT PD	15655 GROVE CIR N		MAPLE GROVE	MN	55369-4489	7634202804	7634207162	PD Services			Y
MONTEVIDEO DIALYSIS PD	824 N 11TH ST		MONTEVIDEO	MN	56265-1629	3202697451	3202696911	PD Services	0	24-2511	Y
EAGAN DIALYSIS UNIT	2750 BLUE WATER RD	SUITE 300	EAGAN	MN	55121-1773	6516880132	6516880905	In-Center Hemo, In-Center Hemo Self Care	16	24-2557	Y
EDEN PRAIRIE DIALYSIS	14852 SCENIC HEIGHTS RD	STE 255 BLDG B	EDEN PRAIRIE	MN	55344-2320	9529342411	9529343851	In-Center Hemo, In-Center Hemo Self Care	12	24-2556	Y
RICHFIELD DIALYSIS	6601 LYNDALE AVE S	STE 150	RICHFIELD	MN	55423-2490	6128692118	6128692219	In-Center Hemo, In-Center Hemo Self Care	12	24-2563	Y
NEW HOPE DIALYSIS CENTER	5640 INTERNATIONAL PKWY		NEW HOPE	MN	55428-3047	7635370300	7635370340	In-Center Hemo, In-Center Hemo Self Care	12	24-2564	Y
RICHFIELD DIALYSIS	6601 LYNDALE AVE S	STE 150	RICHFIELD	MN	55423-2490	6128617846	6128617973	PD Services	0	24-2563	Y
SCOTT COUNTY DIALYSIS	7456 S PARK DR		SAVAGE	MN	55378-3635	9522264766	9522264770	In-Center Hemo, In-Center Hemo Self Care	12	24-2567	Y
COTTAGE GROVE DIALYSIS	8800 E POINT DOUGLAS RD S	STE 100	COTTAGE GROVE	MN	55016-4160	6514595655	6514596696	In-Center Hemo, In-Center Hemo Self Care	12	24-2566	Y
MINNEAPOLIS UPTOWN DIALYSIS	3601 LYNDALE AVE S		MINNEAPOLIS	MN	55409-1103	6128254583	6128254651	In-Center Hemo, In-Center Hemo Self Care	12	24-2568	Y
HIGHLAND PARK DIALYSIS	1559 7TH ST W		SAINT PAUL	MN	55102-4243	6512227139	6512243655	In-Center Hemo, In-Center Hemo Self Care	12	24-2573	Y
SUN RAY DIALYSIS UNIT	1744 OLD HUDSON RD		SAINT PAUL	MN	55106-6118	6517935191	6517746520	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care	12	24-2574	Y
WESTWOOD HILLS DIALYSIS	7525 WAYZATA BLVD		SAINT LOUIS PARK	MN	55426-1621	9525461401	9525440583	In-Center Hemo	12	24-2576	Y
EAST RIVER ROAD DIALYSIS	5301 E RIVER RD	STE 117	FRIDLEY	MN	55421-3778	7635715556	7635717882	In-Center Hemo, In-Center Hemo Self Care	12	24-2569	Y
MAPLE GROVE DIALYSIS UNIT	15655 GROVE CIR N		MAPLE GROVE	MN	55369-4489	7634202804	7634207162	In-Center Hemo, In-Center Hemo Self Care	12	24-2571	Y
EAST VALLEY DIALYSIS	14050 PILOT KNOB RD	STE 100	APPLE VALLEY	MN	55124-6647	9524234062	9524236974	In-Center Hemo, PD Services	12	24-2589	Y
ROBBINSDALE DIALYSIS	3461 W BROADWAY AVE		ROBBINSDALE	MN	55422-2955	7635214865	7635226754	In-Center Hemo	16	24-2582	Y
DIALYSIS AT MANKATO CLINIC	1400 MADISON AVE	STE 400	MANKATO	MN	56001-5476	5073850432	5073851584	In-Center Hemo, PD Services	12	24-2585	Y
PARK RAPIDS DIALYSIS	110 7TH ST W		PARK RAPIDS	MN	56470-1872	2187321000	2187324598	In-Center Hemo, PD Services	8	24-2587	Y
MOORHEAD DIALYSIS	1710 CENTER AVE W		DILWORTH	MN	56529-1309	2182333354	2182333482	In-Center Hemo, PD Services	12	24-2584	Y
CENTRAL AVENUE DIALYSIS	10994 BALTIMORE ST NE		BLAINE	MN	55449-4601	7637865026	7637864138	In-Center Hemo, PD Services	12	24-2591	Y
DIALYSIS AT MANKATO CLINIC AT HOME	1400 MADISON AVE	STE 400	MANKATO	MN	56001-5476	5073850432	5073851584	Home Hemo		24-2585	Y
MOORHEAD AT HOME	1710 CENTER AVE W	STE 100	DILWORTH	MN	56529-1309	2182333354	2182333482	Home Hemo			N
ROBBINSDALE AT HOME	3461 WEST BROADWAY AVE		ROBBINSDALE	MN	55422-2955	7635214865	7635226754	Home Hemo		24-2582	Y
RED WING AT HOME	3028 N SERVICE DR	ATTN BETH CLEMENS	RED WING	MN	55066-1921	6513887711	6513884311	Home Hemo		24-2520	Y
MAPLE GROVE AT HOME	15655 GROVE CIR N		MAPLE GROVE	MN	55369-4489	7634204741	7634207162	Home Hemo		24-2571	N
UNIVERSITY UNIT RIVERSIDE AT HOME	1045 WESTGATE DR	STE 90	SAINT PAUL	MN	55114-1079	6516451869	6516451878	Home Hemo		24-2539	Y
HOME DIALYSIS UNIT AT HOME	825 S 8TH ST	STE 1224	MINNEAPOLIS	MN	55404-1223	6123309907	6123309912	Home Hemo	0	24-2552	Y
ST PAUL CAPITOL AT HOME	555 PARK ST	STE 210	SAINT PAUL	MN	55103-2193	6512210896	6512212659	Home Hemo	0	24-2565	Y
EAST VALLEY AT HOME	14050 PILOT KNOB RD	STE 100	APPLE VALLEY	MN	55124-6647	9524234062	9524236974	Home Hemo		24-2589	Y
NORTHFIELD AT HOME	2004 JEFFERSON RD		NORTHFIELD	MN	55057-3253	5076456762	5076452372	Home Hemo		24-2588	Y

ROCHESTER AT HOME	2660 S BROADWAY	STE A	ROCHESTER	MN	55904-6264	5072881617	5072890672	Home Hemo			Y
NORTHFIELD DIALYSIS	2004 JEFFERSON RD		NORTHFIELD	MN	55057-3253	5076456762	5076452372	In-Center Hemo, PD Services	8	24-2588	Y
HISTORICAL HASTINGS DIALYSIS	1828 MARKET BLVD		HASTINGS	MN	55033-3494	6514382155	6514382164	In-Center Hemo, PD Services	8	24-2594	Y
MARSHALL HOME TRAINING (PD/HHD)	1420 E COLLEGE DR	STE 900	MARSHALL	MN	56258-2091	5075321077	5075327512	PD Services	0	24-2599	Y
GLENCOE DIALYSIS	1123 HENNEPIN AVE N		GLENCOE	MN	55336-2234	3208641901	3208643361	In-Center Hemo, PD Services	8	24-2596	Y
ROCHESTER DIALYSIS	2660 S BROADWAY	STE A	ROCHESTER	MN	55904-6264	5072881617	5072890672	In-Center Hemo, PD Services	12	24-2600	Y
APOLLO DIALYSIS	30 25TH AVE S		ST CLOUD	MN	56301-6285	3202598592	3202598903	In-Center Hemo	12	24-2598	N
MILLE LACS DIALYSIS	245 ISLE ST W		ISLE	MN	56342	3206763593	3206763316	In-Center Hemo, PD Services	8	24-2597	N
LARPENTEUR AVE DIALYSIS	1739 LEXINGTON AVE N		ROSEVILLE	MN	55113-6522	6514899260	6514899119	In-Center Hemo, Home Hemo, PD Services	12	24-2603	Y
MANKATO UPTOWN DIALYSIS	1802 COMMERCE DR		NORTH MANKATO	MN	56003-1800	5073879095	5073454947	In-Center Hemo, PD Services	16	24-2697	Y
LAKEVILLE DIALYSIS	20184 HERITAGE DR		LAKEVILLE	MN	55044-6855	9529855438	9524699742	In-Center Hemo, PD Services	8	24-2605	Y
NEW ULM DIALYSIS	701 N BROADWAY		NEW ULM	MN	56073-1201	5073541216	5073540416	In-Center Hemo	13	24-2606	Y
SOUTH COUNTY DIALYSIS	4145 UNION RD		SAINT LOUIS	MO	63129-1064	3148941851	3148943879	In-Center Hemo, PD Services	12	26-2574	Y
ST LOUIS DIALYSIS CENTER	2610 CLARK AVE		SAINT LOUIS	MO	63103-2502	3145340909	3145340661	In-Center Hemo, PD Services	25	26-2503	Y
CRYSTAL CITY DIALYSIS CENTER	960 S TRUMAN BLVD		FESTUS	MO	63028-3714	6369375761	6369375774	In-Center Hemo, PD Services	12	26-2524	Y
BLUFF CITY DIALYSIS CENTER	2400 LUCY LEE PKWY	STE E	POPLAR BLUFF	MO	63901-2429	5736862321	5736860847	In-Center Hemo, PD Services	12	26-2526	N
HOPE AGAIN DIALYSIS CENTER	1207 STATE ROUTE VV		KENNETT	MO	63857-3823	5738880222	5738880019	In-Center Hemo	16	26-2534	Y
CRESTWOOD DIALYSIS	9560 WATSON RD	STE A	SAINT LOUIS	MO	63126-1541	3148420322	3148420351	In-Center Hemo, Nocturnal Hemo, PD Services	12	26-2591	Y
HAMPTON AVENUE DIALYSIS	1425 HAMPTON AVE		SAINT LOUIS	MO	63139-3115	3147814022	3147814063	In-Center Hemo	12	26-2607	Y
LAMPLIGHTER DIALYSIS	12654 LAMPLIGHTER SQUARE SHPG CTR		SAINT LOUIS	MO	63128-2746	3147297979	3147297958	In-Center Hemo, PD Services	16	26-2606	Y
RTC-COLUMBIA DIALYSIS	1701 E BROADWAY	STE G102	COLUMBIA	MO	65201-8029	5734420573	5734423498	In-Center Hemo, Nocturnal Hemo	12	26-2611	Y
GRANDVIEW DIALYSIS	13812 S US HIGHWAY 71		GRANDVIEW	MO	64030-3685	8167631179	8167631390	In-Center Hemo, PD Services	12	26-2644	Y
NORTH ST LOUIS COUNTY DIALYSIS	13119 NEW HALLS FERRY RD		FLORISSANT	MO	63033-3228	3148383252	3148382129	In-Center Hemo	14	26-2625	Y
EASTLAND DIALYSIS	19101 E VALLEY VIEW PKWY	STE E	INDEPENDENCE	MO	64055-6907	8167956018	8167959572	In-Center Hemo, PD Services	20	26-2626	Y
EUREKA DIALYSIS CENTER	419 MERAMEC BLVD		EUREKA	MO	63025-3906	6365872063	6365872778	In-Center Hemo, Home Hemo, PD Services	13	26-2628	Y
ROLLA DIALYSIS	1503 E 10TH ST		ROLLA	MO	65401-3696	5733646475	5733649254	In-Center Hemo, PD Services	16	26-2536	Y
HOSPITAL HILL DIALYSIS	900 E 21ST ST		KANSAS CITY	MO	64108-2703	8168429286	8162210169	In-Center Hemo	21	26-2551	Y
WASHINGTON SQUARE DIALYSIS	1112 WASHINGTON SQ		WASHINGTON	MO	63090-5336	6363908233	6363902771	In-Center Hemo, In-Center Hemo Self Care, PD Services	16	26-2562	Y
FLORISSANT DIALYSIS	10887 W FLORISSANT AVE		SAINT LOUIS	MO	63136-2405	3145245737	3145245752	In-Center Hemo, Nocturnal Hemo, PD Services	20	26-2561	Y
ST. CHARLES DIALYSIS	2125 BLUESTONE DR		SAINT CHARLES	MO	63303-6704	6369408840	6369400797	In-Center Hemo	12	26-2568	Y
SHREWSBURY DIALYSIS	7303 WATSON RD	STE 7	SAINT LOUIS	MO	63119-4405	3147525913	3148322527	In-Center Hemo, PD Services	12	26-2572	Y
ST. LOUIS WEST DIALYSIS	400 N LINDBERGH BLVD		SAINT LOUIS	MO	63141-7814	3149890886	3149890596	In-Center Hemo, Nocturnal Hemo	21	26-2583	Y
ST. LOUIS WEST PD DIALYSIS	9632 OLIVE BLVD		OLIVETTE	MO	63132-3002	3145698902	3149957071	PD Services	0	26-2585	Y
ST. LOUIS DIALYSIS	324 DE BALIVIERE AVE		SAINT LOUIS	MO	63112-1804	3143679111	3143679248	In-Center Hemo, In-Center Hemo Self Care, Nocturnal Hemo	32	26-2527	Y
HAZELWOOD DIALYSIS	637 DUNN RD	STE 125	HAZELWOOD	MO	63042-1757	3148954419	3148954578	In-Center Hemo	12	26-2589	Y
LIBERTY	2525 GLENN HENDREN DR		LIBERTY	MO	64068-9625	8167814422	8167922101	In-Center Hemo, In-Center Hemo Self Care	14	26-2530	Y
NORTHLAND DIALYSIS	2750 CLAY EDWARDS DR	STE 100	NORTH KANSAS CITY	MO	64116-3257	8168422056	8162216091	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care, PD Services	21	26-2504	Y
LAKE ST. LOUIS DIALYSIS	200 BREVCO PLZ	STE 201	LAKE SAINT LOUIS	MO	63367-2950	6365614799	6365614533	In-Center Hemo, In-Center Hemo Self Care, PD Services	14	26-2541	Y
CAMERON DIALYSIS	1003 W 4TH ST		CAMERON	MO	64429-1466	8166326056	8166326058	In-Center Hemo, In-Center Hemo Self Care, PD Services	11	26-2578	Y
CHILLICOTHE DIALYSIS	588 E BUSINESS 36		CHILLICOTHE	MO	64601-3721	6607071092	6607070491	In-Center Hemo, In-Center Hemo Self Care, PD Services	9	26-2580	Y
ST. JOSEPH DIALYSIS	5514 CORPORATE DR	STE 100	SAINT JOSEPH	MO	64507-7754	8166711948	8166711909	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care, PD Services	25	26-2576	Y
ST. PETERS DIALYSIS	300 FIRST EXECUTIVE AVE	STE A	SAINT PETERS	MO	63376-1655	6364416070	6364416367	In-Center Hemo, Nocturnal Hemo	12	26-2599	Y
PLATTE WOODS DIALYSIS	7667 NW PRAIRIE VIEW RD		KANSAS CITY	MO	64151-1544	8167465542	8167465654	In-Center Hemo, In-Center Hemo Self Care	14	26-2596	Y
DEXTER DIALYSIS	2010 N OUTER RD		DEXTER	MO	63841-8001	5736243452	5736243188	In-Center Hemo	8	26-2635	Y
SWOPE DIALYSIS	4407 E 50TH TER		KANSAS CITY	MO	64130-2855	8169241201	8169241799	In-Center Hemo	19	26-2651	Y
TIMBERLAKE DIALYSIS	12110 HOLMES RD		KANSAS CITY	MO	64145-1707	8169423827	8169423153	In-Center Hemo	12	26-2634	Y
VILLA OF WATERBURY	929 WATERBURY FALLS DR		O FALLON	MO	63368-2202	6363290697	6363291089	In-Center Hemo	6	26-2636	Y
VILLA OF ST JOHN	9030 SAINT CHARLES ROCK RD		SAINT LOUIS	MO	63114-4246	3144291724	3144276499	In-Center Hemo	6	26-2639	Y
MAPLE VALLEY DIALYSIS	649 MAPLE VALLEY DR		FARMINGTON	MO	63640-1993	5737470946	5737470536	In-Center Hemo, PD Services	12	26-2640	Y
BOWLES AVENUE DIALYSIS	1011 BOWLES AVE	STE 210	FENTON	MO	63026-2387	6363267130	6363268011	In-Center Hemo, PD Services	12	26-2649	Y
TOWN AND COUNTRY WEST DIALYSIS	12855 N 40 DR	STE LL4	SAINT LOUIS	MO	63141-8657	3145420049	3145420057	In-Center Hemo, PD Services	12	26-2648	Y
CHAMBERS DIALYSIS	10241 LEWIS AND CLARK BLVD		SAINT LOUIS	MO	63136-5505	3148685982	3148685918	In-Center Hemo, PD Services, Nocturnal Hemo	20	26-2646	Y
ARNOLD DIALYSIS	102 RICHARDSON XING		ARNOLD	MO	63010-6023	6364675619	6364675997	In-Center Hemo, PD Services	8	26-2647	Y
SPRINGFIELD NORTH DIALYSIS	1007 E KEARNEY ST		SPRINGFIELD	MO	65803-3433	4178739926	4178651602	In-Center Hemo, PD Services	12	26-2656	Y
SOUTH CITY DIALYSIS	3740 S JEFFERSON AVE		SAINT LOUIS	MO	63118-3905	3146646687	3147721614	In-Center Hemo	12	26-2654	Y
COLUMBIA HOME TRAINING	3320 BLUFF CREEK DR	STE 105	COLUMBIA	MO	65201-3501	5734431084	5732562155	PD Services	0	26-2655	Y

KANSAS AVENUE DIALYSIS	604 KANSAS AVE		CLINTON	MO	64735-3069	6608900830	6608900789	In-Center Hemo, PD Services	13	26-2663	Y
HANNIBAL DIALYSIS	119 PROGRESS RD		HANNIBAL	MO	63401-6628	5734060165	5734060144	In-Center Hemo, PD Services	15	26-2637	Y
SIKESTON JAYCEE REGIONAL DIALYSIS	135 PLAZA DR STE 101		SIKESTON	MO	63801-5148	5734727230	5734727214	In-Center Hemo, Acute Hemo 1:1, Acute PD, PD Services	18	26-2643	Y
COLUMBIA HT AT HOME	3320 BLUFF CREEK DR	STE 105	COLUMBIA	MO	65201-3501	5734431084	5732562155	Home Hemo	0	26-2655	Y
TOWN & COUNTY WEST AT HOME	12855 N 40 DR	STE 340	SAINT LOUIS	MO	63141-8665	3148780015	3148780028	Home Hemo	0	26-2648	Y
HANNIBAL AT HOME	119 PROGRESS RD		HANNIBAL	MO	63401-2204	5734060165	5734060144	Home Hemo		26-2637	Y
LAKE ST. LOUIS HOME AT HOME	200 BREVCO PLZ	STE 202	LAKE ST LOUIS	MO	63367-2950	6366254460	6366254463	Home Hemo	3	26-2641	Y
BLUFF CITY AT HOME	2400 LUCY LEE PKWY	STE E	POPLAR BLUFF	MO	63901-2427	5736862321	5736860847	Home Hemo		26-2526	N
NORTHLAND AT HOME	2750 CLAY EDWARDS DR	STE 515	NORTH KANSAS CITY	MO	64116-3258	8168420076	8168423522	Home Hemo		26-2504	Y
SOUTH COUNTY AT HOME	4145 UNION RD		SAINT LOUIS	MO	63129-1064	3148941851	3148943879	Home Hemo		26-2574	Y
ST JOSEPH AT HOME	5514 CORPORATE DR	STE 100	SAINT JOSEPH	MO	64507-7752	8166711948	8166711909	Home Hemo		26-2576	Y
ST. LOUIS WEST AT HOME	9632 OLIVE BLVD		OLIVETTE	MO	63132-3002	3145698902	3149957071	Home Hemo, Staff Assisted Home Hemo		26-2585	Y
FLORISSANT AT HOME	100887 W FLORISSANT AVE		SAINT LOUIS	MO	63136-2405	3145245737	3145245748	Home Hemo		26-2561	Y
KANSAS CITY RENAL AT HOME	4333 MADISON AVE	STE 200	KANSAS CITY	MO	64111-3429	8167560645	8167561726	Home Hemo		26-2564	Y
LEES SUMMIT RENAL AT HOME	100 NE MISSOURI RD		LEES SUMMIT	MO	64086-4702	8165243312	8165243321	Home Hemo		26-2617	Y
HOPE AGAIN AT HOME	1207 STATE ROUTE VV		KENNETT	MO	63857-3823	5738880222	5738880019	Home Hemo		26-2534	N
SPRINGFIELD NORTH AT HOME	1007 E KEARNEY ST		SPRINGFIELD	MO	65803-3433	4178739926	4178651602	Home Hemo	0	26-2656	Y
KANSAS CITY RENAL CENTER	4333 MADISON AVE	STE 100	KANSAS CITY	MO	64111-3429	8167560645	8167561726	In-Center Hemo, PD Services	24	26-2564	Y
BUTLER RENAL CENTER	601 W NURSERY ST		BUTLER	MO	64730-1872	6606796513	6606796517	In-Center Hemo	10	26-2588	N
HARRISONVILLE RENAL CENTER	308 GALAXIE AVE		HARRISONVILLE	MO	64701-2084	8163802004	8163807692	In-Center Hemo, PD Services	12	26-2523	Y
MARSHALL RENAL CENTER	359 W MORGAN ST		MARSHALL	MO	65340-1929	6608869080	6608869033	In-Center Hemo	8	26-2581	Y
LEES SUMMIT RENAL CENTER	100 NE MISSOURI RD	STE 100	LEES SUMMIT	MO	64086-4702	8165243312	8165243321	In-Center Hemo, Home Hemo, Nocturnal Hemo, PD Services	17	26-2617	Y
WESTPORT RENAL CENTER	3947 BROADWAY ST		KANSAS CITY	MO	64111-2516	8165311181	8165311186	In-Center Hemo	24	26-2631	Y
HARRISONVILLE RENAL AT HOME	308 GALAXIE AVE		HARRISONVILLE	MO	64701-2084	8163802004	8163807692	Home Hemo	1		N
ARNOLD AT HOME	102 RICHARDSON XING		ARNOLD	MO	63010-6023	6364675619	6364675997	Home Hemo	1		Y
CHAMBERS AT HOME	10241 LEWIS AND CLARK BLVD		SAINT LOUIS	MO	63136-5505	3148685982	3148685918	Home Hemo	1		Y
BOWLES AVENUE AT HOME	1011 BOWLES AVE	STE 210	FENTON	MO	63026-2387	6363267130	6363268011	Home Hemo	1		Y
WASHINGTON HT AT HOME	1040 WASHINGTON SQ		WASHINGTON	MO	63090-5302	6362398980	6362391761	Home Hemo		26-2665	Y
EXCELSIOR SPRINGS AT HOME	1745 W JESSE RD		EXCELSIOR SPRINGS	MO	64024-1801	8166372685	8166372635	Home Hemo		26-2662	Y
KANSAS AVENUE AT HOME	604 KANSAS AVE		CLINTON	MO	64735-3069	6608900830	6608900789	Home Hemo	1	26-2663	Y
SIKESTON JAYCEE REGIONAL AT HOME	135 PLAZA DR	STE 101	SIKESTON	MO	63801-5148	5734727230	5734727214	Home Hemo		26-2643	Y
NORTH COUNTY KIDNEY CARE AT HOME	1554 SIERRA VISTA PLZ		SAINT LOUIS	MO	63138-2040	3144380864	3143551847	Home Hemo			Y
NORTH COUNTY KIDNEY CARE DIALYSIS	1554 SIERRA VISTA PLZ		SAINT LOUIS	MO	63138-2040	3144380864	3143551857	In-Center Hemo, PD Services	16	26-2673	Y
EXCELSIOR SPRINGS DIALYSIS	1745 W JESSE JAMES RD		EXCELSIOR SPRINGS	MO	64024-1801	8166372685	8166372635	In-Center Hemo, PD Services	13	26-2662	Y
WASHINGTON HOME TRAINING	1040 WASHINGTON SQ		WASHINGTON	MO	63090-5302	6362398980	6362391761	PD Services	0	26-2665	Y
TRENTON DIALYSIS	1709 E 9TH ST		TRENTON	MO	64683-2641	6603597342	6603597367	In-Center Hemo, PD Services	8	26-2668	N
SHOAL CREEK DIALYSIS	8260 N BOOTH AVE		KANSAS CITY	MO	64158-7201	8167922502	8167922635	In-Center Hemo	16	26-2676	Y
NATURAL BRIDGE DIALYSIS	8980 NATURAL BRIDGE RD		SAINT LOUIS	MO	63121-3917	3144262064	3144262462	In-Center Hemo, Home Hemo, PD Services	20	26-2683	Y
WESTFALL DIALYSIS	8029 WEST FLORISSANT AVE		JENNINGS	MO	63136-1400	3143822869	3143830795	In-Center Hemo, PD Services	20	26-2685	Y
SILVER CREEK DIALYSIS	2011 E 32ND ST	STE 101	JOPLIN	MO	64804-3018	4176279490	4176279459	In-Center Hemo, PD Services	8	26-2687	Y
CROSS KEYS DIALYSIS	14001 NEW HALLS FERRY RD	STE 133	FLORISSANT	MO	63033-2708	3148397416	3148397464	In-Center Hemo	16	26-2686	Y
SINGING RIVER DIALYSIS	4907 TELEPHONE RD		PASCAGOULA	MS	39567-1823	2287620701	2286962955	In-Center Hemo, In-Center Hemo Self Care, PD Services	28	25-2516	Y
OCEAN SPRINGS DIALYSIS	13150 PONCE DE LEON DR		OCEAN SPRINGS	MS	39564-2460	2288183201	2288186468	In-Center Hemo, Nocturnal Hemo, PD Services	16	25-2519	Y
LUCEDALE DIALYSIS	652 MANILA ST		LUCEDALE	MS	39452-5962	6019478701	6019478980	In-Center Hemo, In-Center Hemo Self Care	16	25-2556	Y
OCEAN SPRINGS AT HOME	13150 PONCE DE LEON DR		OCEAN SPRINGS	MS	39564-2460	2288183201	2288186468	Home Hemo		25-2519	Y
JACKSON NORTH AT HOME	571 E BEASLEY RD	STE A	JACKSON	MS	39206-3042	6019564526	6019579202	Home Hemo		25-2501	Y
CANTON RENAL CENTER	620 E PEACE ST		CANTON	MS	39046-4729	6018593382	6018598591	In-Center Hemo	22	25-2521	Y
HAZLEHURST DIALYSIS	201 N HALEY ST		HAZLEHURST	MS	39083-3111	6018945509	6018945514	In-Center Hemo, PD Services	17	25-2551	Y
JACKSON NORTH DIALYSIS	571 E BEASLEY RD	SUITE A	JACKSON	MS	39206-3042	6019571999	6019563165	In-Center Hemo, PD Services	46	25-2501	Y
JACKSON SOUTH DIALYSIS	1015 I 20 FRONTAGE RD		JACKSON	MS	39204-5807	6013739154	6019600749	In-Center Hemo	35	25-2535	Y
JACKSON SOUTHWEST DIALYSIS	1828 RAYMOND RD		JACKSON	MS	39204-4126	6013737897	6013737899	In-Center Hemo	18	25-2533	Y
RENAL CARE OF LEXINGTON	22579 DEPOT ST		LEXINGTON	MS	39095-7339	6628343355	6628343587	In-Center Hemo, PD Services	22	25-2539	Y

BRANDON RENAL CENTER	101 CHRISTIAN DR		BRANDON	MS	39042-2678	6018249764	6018249761	In-Center Hemo, PD Services	24	25-2549	Y
RENAL CARE OF CARTHAGE	312 ELLIS ST		CARTHAGE	MS	39051-3809	6012676856	6012676859	In-Center Hemo	15	25-2562	Y
GULF ISLANDS HT AT HOME	3200 MALLETT RD	STE F	DIBERVILLE	MS	39540-9305	2283549578	2283549580	Home Hemo	0	25-2583	Y
GULF ISLANDS HOME TRAINING	3200 MALLETT RD	STE F	DIBERVILLE	MS	39540-9305	2283549578	2283549580	PD Services	0	25-2583	Y
GREAT FALLS DIALYSIS	3400 10TH AVE S	STE 1	GREAT FALLS	MT	59405-3473	4067270411	4064530080	In-Center Hemo, PD Services, Acute Hemo 1:1, Acute PD	17	27-2509	Y
GREAT FALLS AT HOME	3400 10TH AVE S	STE 1	GREAT FALLS	MT	59405-3473	4067270411	4064530080	Home Hemo	0	27-2509	Y
ASHEVILLE KIDNEY CENTER	1600 CENTRE PARK DR		ASHEVILLE	NC	28805-6206	8282511224	8282514695	In-Center Hemo, In-Center Hemo Self Care, Nocturnal Hemo	52	34-2506	Y
HENDERSONVILLE DIALYSIS CENTER	1250 7TH AVE E		HENDERSONVILLE	NC	28792-2610	8286971602	8286971922	In-Center Hemo, In-Center Hemo Self Care	24	34-2564	Y
SYLVA DIALYSIS CENTER	655 ASHEVILLE HWY		SYLVA	NC	28779-2747	8285863340	8285863350	In-Center Hemo, Home Hemo, In-Center Hemo Self Care, PD Services	16	34-2556	Y
WEAVERVILLE DIALYSIS	329 MERRIMON AVE		WEAVERVILLE	NC	28787-9253	8286581441	8286581563	In-Center Hemo, Home Hemo, In-Center Hemo Self Care	20	34-2604	Y
DIALYSIS CARE OF ANSON COUNTY	923 E CASWELL ST		WADESBORO	NC	28170-2305	7046945545	7046949139	In-Center Hemo, In-Center Hemo Self Care	15	34-2560	Y
DIALYSIS CARE OF EDGECOMBE COUNTY	3206 WESTERN BLVD		TARBORO	NC	27886-1828	2526419004	2526419007	In-Center Hemo, PD Services	35	34-2577	Y
DIALYSIS CARE OF FRANKLIN COUNTY	1706 NC HWY 39 N		LOUISBURG	NC	27549-8329	9194960300	9194960188	In-Center Hemo, In-Center Hemo Self Care, PD Services	27	34-2571	Y
DIALYSIS CARE OF HOKE COUNTY	403 S MAIN ST		RAEFORD	NC	28376-3222	9108756561	9108756652	In-Center Hemo, In-Center Hemo Self Care	28	34-2579	Y
DIALYSIS CARE OF MARTIN COUNTY	100 MEDICAL DR		WILLIAMSTON	NC	27892-2156	2527922386	2527924832	In-Center Hemo, In-Center Hemo Self Care, PD Services	23	34-2584	Y
DIALYSIS CARE OF MONTGOMERY COUNTY	323 W MAIN ST		BISCOE	NC	27209-9528	9104284052	9104284535	In-Center Hemo, In-Center Hemo Self Care	20	34-2583	Y
DIALYSIS CARE OF MOORE COUNTY	16 REGIONAL DR		PINEHURST	NC	28374-8850	9102952124	9102952336	In-Center Hemo, In-Center Hemo Self Care	23	34-2555	Y
DIALYSIS CARE OF RICHMOND COUNTY	771 CHERAW RD		HAMLET	NC	28345-7158	9105825822	9105821320	In-Center Hemo, Home Hemo, In-Center Hemo Self Care, PD Services	30	34-2539	Y
DIALYSIS CARE OF ROCKINGHAM COUNTY	251 W KINGS HWY		EDEN	NC	27288-5009	3366237906	3366237428	In-Center Hemo, PD Services	25	34-2536	Y
DIALYSIS CARE OF ROWAN COUNTY	111 DORSETT DR		SALISBURY	NC	28144-2278	7046372107	7046399272	In-Center Hemo, Home Hemo, In-Center Hemo Self Care, PD Services	34	34-2546	Y
DIALYSIS CARE OF RUTHERFORD COUNTY	226 COMMERCIAL ST		FOREST CITY	NC	28043-2851	8282483660	8282483825	In-Center Hemo, PD Services	30	34-2566	Y
NC PARTNERSHIP ADMINISTRATIVE	205 N MAIN ST		DENTON	NC	27239-6718	3368599647		In-Center Hemo		00-0001	Y
DIALYSIS CARE OF KANNAPOLIS	1607 N MAIN ST		KANNAPOLIS	NC	28081-2317	7049330809	7049326964	In-Center Hemo, In-Center Hemo Self Care, PD Services	30	34-2592	Y
SEDC BURGAW DIALYSIS CENTER	704 S DICKERSON ST		BURGAW	NC	28425-4904	9102599925	9102597067	In-Center Hemo, Home Hemo, In-Center Hemo Self Care	18	34-2558	Y
SEDC ELIZABETHTOWN DIALYSIS CENTER	101 DIALYSIS DR		ELIZABETHTOWN	NC	28337-9048	9108627022	9108626312	In-Center Hemo, In-Center Hemo Self Care, PD Services	26	34-2578	Y
SEDC JACKSONVILLE DIALYSIS CENTER	14 OFFICE PARK DR		JACKSONVILLE	NC	28546-7325	9103536888	9103536839	In-Center Hemo, In-Center Hemo Self Care, Acute Hemo 1:1, Acute PD, PD Services	32	34-2532	Y
SEDC KENANSVILLE DIALYSIS CENTER	305 BEASLEY ST		KENANSVILLE	NC	28349-8798	9102960748	9102961658	In-Center Hemo, Home Hemo, In-Center Hemo Self Care	17	34-2535	Y
SEDC SHALLOTTE DIALYSIS CENTER	4770 SHALLOTTE AVE		SHALLOTTE	NC	28470-6596	9107545563	9107545569	In-Center Hemo, Home Hemo, In-Center Hemo Self Care, PD Services	10	34-2582	Y
SEDC WHITEVILLE DIALYSIS CENTER	608 PECAN LN		WHITEVILLE	NC	28472-2949	9106420233	9106426239	In-Center Hemo, In-Center Hemo Self Care, Acute Hemo 1:1, Acute PD, PD Services	26	34-2521	Y
SEDC WILMINGTON DIALYSIS CENTER	2215 YAUPON DR		WILMINGTON	NC	28401-7334	9103430664	9103430674	In-Center Hemo, In-Center Hemo Self Care, PD Services, Nocturnal Hemo	34	34-2511	Y
CHEROKEE DIALYSIS CENTER	53 ECHOTA CHURCH RD		CHEROKEE	NC	28719-9702	8284976866	8284972598	In-Center Hemo, In-Center Hemo Self Care	20	34-2602	Y
BURLINGTON DIALYSIS	873 HEATHER RD		BURLINGTON	NC	27215-6288	3365703494	3362278615	In-Center Hemo, In-Center Hemo Self Care, PD Services	24	34-2567	Y
WAYNESVILLE DIALYSIS CENTER	11 PARK TERRACE DR		CLYDE	NC	28721-7445	8286272907	8286272924	In-Center Hemo, In-Center Hemo Self Care	19	34-2629	Y
COPPERFIELD DIALYSIS	1030 VINEHAVEN DR NE		CONCORD	NC	28025-2438	7047957552	7047957569	In-Center Hemo, In-Center Hemo Self Care	27	34-2631	Y
CHADBOURN DIALYSIS CENTER	210 STRAWBERRY BLVD		CHADBOURN	NC	28431-1418	9106543190	9106545747	In-Center Hemo, In-Center Hemo Self Care	17	34-2628	Y
REIDSVILLE DIALYSIS	1307 FREEWAY DR		REIDSVILLE	NC	27320-7104	3363486857	3363486861	In-Center Hemo, In-Center Hemo Self Care, PD Services	27	34-2640	Y
SOUTHERN PINES DIALYSIS CENTER	209 WINDSTAR PL		SOUTHERN PINES	NC	28387-7086	9106926218	9106929473	In-Center Hemo, In-Center Hemo Self Care	15	34-2638	Y
MAXTON DIALYSIS	202 E DR MARTIN LUTHER KING JR DR		MAXTON	NC	28364-1861	9108442693	9108442696	In-Center Hemo, In-Center Hemo Self Care, PD Services	14	34-2651	Y
MCDOWELL COUNTY DIALYSIS	100 SPAULDING RD	STE 2	MARION	NC	28752-5116	8286599790	8286599794	In-Center Hemo, PD Services	13	34-2645	Y
SMOKY MOUNTAIN DIALYSIS	1611 ANDREWS RD		MURPHY	NC	28906-5100	8288354910	8288357394	In-Center Hemo	13	34-2649	Y
GREENE COUNTY DIALYSIS CENTER	1025 KINGOLD BLVD		SNOW HILL	NC	28580-1616	2527479987	2527479990	In-Center Hemo, In-Center Hemo Self Care	21	34-2650	Y
MAYLAND DIALYSIS CENTER	575 ALTAPASS HWY		SPRUCE PINE	NC	28777-3012	8287668122	8287656946	In-Center Hemo	9	34-2660	Y
WALLACE DIALYSIS	5650 S NC 41 HWY		WALLACE	NC	28466-6094	9102856424	9102856928	In-Center Hemo, In-Center Hemo Self Care, PD Services	15	34-2659	Y
ELIZABETH CITY DIALYSIS	1840 W CITY DR		ELIZABETH CITY	NC	27909-9632	2523382217	2523384051	In-Center Hemo, In-Center Hemo Self Care, PD Services	29	34-2515	Y
DURHAM DIALYSIS	201 HOOD ST		DURHAM	NC	27701-3715	9196800002	9196800012	In-Center Hemo, In-Center Hemo Self Care	28	34-2550	Y
WILSON DIALYSIS	2833 WOOTEN BLVD SW		WILSON	NC	27893-8625	2522061471	2522067157	In-Center Hemo, In-Center Hemo Self Care, PD Services	40	34-2507	Y

GOLDSBORO DIALYSIS	2609 HOSPITAL RD		GOLDSBORO	NC	27534-9424	9197341410	9197317346	In-Center Hemo, In-Center Hemo Self Care, PD Services	24	34-2531	Y
ROXBORO DIALYSIS	1005 RIDGE RD		ROXBORO	NC	27573-4513	3365985196	3365985054	In-Center Hemo, In-Center Hemo Self Care	37	34-2562	Y
MT OLIVE DIALYSIS	105 MICHAEL MARTIN RD		MOUNT OLIVE	NC	28365-1112	9196580878	9196580873	In-Center Hemo, In-Center Hemo Self Care	15	34-2573	Y
GOLDSBORO SOUTH DIALYSIS	1704 WAYNE MEMORIAL DR		GOLDSBORO	NC	27534-2240	9197396505	9197396506	In-Center Hemo, In-Center Hemo Self Care	25	34-2587	Y
DURHAM WEST DIALYSIS	4307 WESTERN PARK PL		DURHAM	NC	27705-1204	9193840712	9193840853	In-Center Hemo, Home Hemo, Nocturnal Hemo, In-Center Hemo Self Care	30	34-2616	Y
CHARLOTTE EAST DIALYSIS	5627 ALBEMARLE RD		CHARLOTTE	NC	28212-3611	7045353962	7045314878	In-Center Hemo, PD Services	34	34-2627	Y
FOREST HILLS DIALYSIS	1605 MEDICAL PARK DR W		WILSON	NC	27893-2799	2522650020	2522650645	In-Center Hemo	36	34-2637	Y
VANCE COUNTY DIALYSIS	854 S BECKFORD DR		HENDERSON	NC	27536-3487	2524924239	2524925713	In-Center Hemo, In-Center Hemo Self Care	35	34-2543	Y
EDENTON DIALYSIS	312 MEDICAL ARTS DR		EDENTON	NC	27932-8607	2524820763	2524820863	In-Center Hemo, In-Center Hemo Self Care	17	34-2541	Y
AHOSKIE DIALYSIS	129 HERTFORD COUNTY HIGH RD		AHOSKIE	NC	27910-8131	2523323896	2523323971	In-Center Hemo, In-Center Hemo Self Care, PD Services	26	34-2570	Y
UNION COUNTY DIALYSIS	615 COMFORT LN		MONROE	NC	28112-5599	7042250944	7042259233	In-Center Hemo, Home Hemo, In-Center Hemo Self Care, PD Services	28	34-2526	Y
SOUTH CHARLOTTE DIALYSIS	6450 BANNINGTON RD		CHARLOTTE	NC	28226-1327	7045429499	7045428234	In-Center Hemo, In-Center Hemo Self Care	23	34-2523	Y
NORTH CHARLOTTE DIALYSIS CENTER	6620 OLD STATESVILLE RD		CHARLOTTE	NC	28269-6768	7045991355	7045991511	In-Center Hemo	37	34-2663	Y
MARSHVILLE DIALYSIS CENTER	7260 E MARSHVILLE BLVD		MARSHVILLE	NC	28103-1191	7046245000	7046245040	In-Center Hemo	12	34-2666	Y
CHARLOTTE DIALYSIS	2321 W MOREHEAD ST	STE 102	CHARLOTTE	NC	28208-5145	7043335535	7043333862	In-Center Hemo, In-Center Hemo Self Care, PD Services	36	34-2548	Y
WAKE FOREST DIALYSIS CENTER	11001 INGLESIDE PL		RALEIGH	NC	27614-8577	9195560968	9195567497	In-Center Hemo, PD Services	22	34-2675	Y
HARRISBURG DIALYSIS CENTER	3310 PERRY ST		CONCORD	NC	28027-3901	7047921144	7047921164	In-Center Hemo, PD Services	25	34-2670	Y
CAPE FEAR DIALYSIS	3005 ENTERPRISE DR		WILMINGTON	NC	28405-2181	9107968684	9107997758	In-Center Hemo	32	34-2685	Y
SOUTHPORT DIALYSIS CENTER	1513 N HOWE ST	STE 15	SOUTHPORT	NC	28461-2770	9104540272	9104540277	In-Center Hemo, In-Center Hemo Self Care	11	34-2669	Y
BREVARD DIALYSIS	102 COLLEGE STATION DR	STE 10	BREVARD	NC	28712-3355	8288844075	8288844073	In-Center Hemo, PD Services	9	34-2693	Y
CARTHAGE DIALYSIS	165 SAVANNAH GARDEN DR		CARTHAGE	NC	28327-6161	9109471052	9109471060	In-Center Hemo	12	34-2679	Y
MINT HILL DIALYSIS	11308 HAWTHORNE DR		MINT HILL	NC	28227-9300	7045732549	7045453747	In-Center Hemo	16	34-2692	Y
SOUTHPOINT DIALYSIS	415 W NC HWY 54		DURHAM	NC	27713-7516	9195445536	9195445667	In-Center Hemo	16	34-2683	Y
SANDHILLS DIALYSIS	809 S LONG DR	STE B	ROCKINGHAM	NC	28379-4317	9108959924	9109975042	In-Center Hemo	16	34-2690	Y
NORTH BURLINGTON DIALYSIS	2019 N CHURCH ST		BURLINGTON	NC	27217-2928	3362273450	3362272084	In-Center Hemo, PD Services	22	34-2686	Y
LUMBEE RIVER DIALYSIS	11016 RED SPRINGS RD		RED SPRINGS	NC	28377-8060	9108433205	9108431694	In-Center Hemo	10	34-2698	Y
BILTMORE HOME TRAINING (PD ONLY)	10 MCDOWELL ST	STE 110	ASHEVILLE	NC	28801-4104	8282552839	8282518366	PD Services	10	34-2695	Y
FRANKLIN TOWNSHIP DIALYSIS	80 WESTGATE PLZ		FRANKLIN	NC	28734-1422	8283691957	8285246576	In-Center Hemo, PD Services	9	34-2696	Y
BULL CITY DIALYSIS	1306 MORREENE RD		DURHAM	NC	27705-4509	9193814865	9193816033	In-Center Hemo, PD Services	16		Y
VANCE COUNTY DIALYSIS PD	854 S BECKFORD DR		HENDERSON	NC	27536-3487	2524924239	2524925713	PD Services		34-2543	Y
DURHAM WEST DIALYSIS PD	4307 WESTERN PARK PL		DURHAM	NC	27705-1204	9193840712	9193840853	PD Services		34-2616	Y
ROXBORO DIALYSIS PD	1005 RIDGE RD		ROXBORO	NC	27573-4513	3365985196	3365985054	PD Services		34-2562	Y
DIALYSIS CARE OF MOORE COUNTY PD	16 REGIONAL DR		PINEHURST	NC	28374-8850	9102952124	9102952336	PD Services		34-2555	Y
WAKE FOREST AT HOME	11001 INGLESIDE PL		RALEIGH	NC	27614-8577	9195560968	9195567497	Home Hemo		34-2675	N
BURLINGTON AT HOME	873 HEATHER RD		BURLINGTON	NC	27215-6288	3365703494	3365703605	Home Hemo		34-2567	Y
DIALYSIS CARE OF MOORE COUNTY AT HOME	16 REGIONAL DR		PINEHURST	NC	28374-8850	9102952124	9102952336	Home Hemo	0	34-2555	Y
ASHEVILLE KIDNEY AT HOME	1600 CENTERPARK DR		ASHEVILLE	NC	28805-6206	8282511678	8282517099	Home Hemo	0	34-2506	Y
REIDSVILLE AT HOME	1307 FREEWAY DR		REIDSVILLE	NC	27320-7104	3363486857	3363486861	Home Hemo	0	34-2640	Y
SEDC-WILMINGTON AT HOME	2215 YAUPON DR		WILMINGTON	NC	28401-7334	9103430664	9103430674	Home Hemo	0	34-2511	Y
DIALYSIS CARE OF KANNAPOLIS AT HOME	1607 N MAIN ST		KANNAPOLIS	NC	28081-2317	7049330809	7049326964	Home Hemo	0	34-2592	Y
DURHAM WEST AT HOME	4307 WESTERN PARK PL	STE 101	DURHAM	NC	27705-1225	9193840785	9193840853	Home Hemo	0	34-2616	Y
WILSON AT HOME	2833 WOTEN BLVD SW		WILSON	NC	27893-2799	2522341637	2522341651	Home Hemo	0	34-2507	Y
GOLDSBORO AT HOME	2609 HOSPITAL RD		GOLDSBORO	NC	27534-9424	9197341410	9197317346	Home Hemo		34-2531	Y
CHARLOTTE EAST AT HOME	5627 ALBEMARLE RD		CHARLOTTE	NC	28212-3611	7045315941	7045314409	Home Hemo		34-2627	Y
DIALYSIS CARE OF MARTIN COUNTY AT HOME	100 MEDICAL DR		WILLIAMSTON	NC	27892-2156	2527922386	2527924832	Home Hemo		34-2584	Y
NEW RIVER AT HOME	111 YOPP RD		JACKSONVILLE	NC	28540-3509	9109890157	9109890328	Home Hemo		34-2700	Y
ALBEMARLE AT HOME	101 DAVITA LN		ELIZABETH CITY	NC	27909-3314	2523380151	2523380567	Home Hemo		34-2708	Y
SURF CITY DIALYSIS	22807 US HIGHWAY 17 N		HAMPSTEAD	NC	28443-3178	9103290706	9103290841	In-Center Hemo	10	34-2703	Y
SAMPSON COUNTY HOME TRAINING	331 NORTH BLVD		CLINTON	NC	28328-1911	9105902777	9105921646	PD Services	5	34-2712	Y
NEW RIVER DIALYSIS	111 YOPP RD		JACKSONVILLE	NC	28540-3509	9109890157	9109890328	In-Center Hemo, PD Services	18	34-2700	Y
KERR LAKE DIALYSIS	1274 RUIN CREEK RD		HENDERSON	NC	27537-4168	2524310233	2524310252	In-Center Hemo, Home Hemo, PD Services	16	34-2704	Y
ALAMANCE COUNTY DIALYSIS	829 S MAIN ST		GRAHAM	NC	27253-4706	3362299169	3362296378	In-Center Hemo, PD Services	10	34-2709	Y
HUNTERSVILLE DIALYSIS	9622 KINCEY AVE		HUNTERSVILLE	NC	28078-9140	7049123890	7049481177	In-Center Hemo	14	34-2707	Y

LELAND DIALYSIS	1220 MAGNOLIA VILLAGE WAY		LELAND	NC	28451-9464	9103710391	9103713304	In-Center Hemo, PD Services	10	342716	Y
NEW HANOVER DIALYSIS	3147 S 17TH ST		WILMINGTON	NC	28412-1030	9107946110	9107944288	In-Center Hemo	12	342717	Y
ALBEMARLE DIALYSIS	101 DAVITA LANE		ELIZABETH CITY	NC	27909-3314	2523380151	2523380567	In-Center Hemo, PD Services	14	34-2708	Y
RESEARCH TRIANGLE PARK DIALYSIS	4021 STIRRUP CREEK DR	STE 400	DURHAM	NC	27703-9352	9192064606	9192241449	In-Center Hemo, PD Services	10	342718	Y
COASTAL PLAINS DIALYSIS	209 NC HWY 111 S		GOLDSBORO	NC	27534-9253	9197785766	9197517672	In-Center Hemo, PD Services	12	34-2723	Y
SHARPSBURG DIALYSIS	191 SE RAILROAD ST		SHARPSBURG	NC	27878	2524461791	2524461796	In-Center Hemo, PD Services	10		Y
GLEN RAVEN DIALYSIS	2210 W WEBB AVE		BURLINGTON	NC	27217-1068	3365389820	3365389826	In-Center Hemo	27		Y
COASTAL PLAINS AT HOME	209 NC HWY 111 S		GOLDSBORO	NC	27534-9253	9197785766	9197517672	Home Hemo		34-2723	Y
FARGO DIALYSIS CENTER	4474 23RD AVE S	STE M	FARGO	ND	58104-8795	7012813900	7012822635	In-Center Hemo, PD Services	12	35-2502	Y
OAKES DIALYSIS	413 S 7TH ST		OAKES	ND	58474-1920	7017422110	7017422177	In-Center Hemo, In-Center Hemo Self Care, PD Services	8	35-2504	Y
FARGO AT HOME	4474 23RD AVE S	STE M	FARGO	ND	58104-8795	7012813900	7012822635	Home Hemo		35-2502	Y
SCOTTSBLUFF DIALYSIS CENTER	820 W 42ND ST	STE 1600	SCOTTSBLUFF	NE	69361-4704	3082203572	3082203592	In-Center Hemo, In-Center Hemo Self Care, Acute Hemo 1:1, Acute PD, PD Services	16	28-2502	Y
GRAND ISLAND DIALYSIS	203 E STOLLEY PARK RD	STE G	GRAND ISLAND	NE	68801-8207	3083844067	3083820461	In-Center Hemo	12	28-2522	Y
MCCOOK DIALYSIS CENTER	801 W C ST	STE 4	MC COOK	NE	69001-3592	3083451916	3083451928	In-Center Hemo, PD Services	8	28-2517	Y
HASTINGS DIALYSIS CENTER	1900 N SAINT JOSEPH AVE		HASTINGS	NE	68901-2652	4024634893	4024637049	In-Center Hemo, PD Services	12	28-2501	Y
CAPITAL CITY DIALYSIS	307 N 46TH ST		LINCOLN	NE	68503-3714	4024665123	4024668351	In-Center Hemo, In-Center Hemo Self Care, PD Services	12	28-2503	Y
SOUTH LINCOLN DIALYSIS	3401 PLANTATION DR	STE 140	LINCOLN	NE	68516-4712	4024216011	4024216052	In-Center Hemo, In-Center Hemo Self Care	8	28-2526	Y
OMAHA WEST DIALYSIS	13014 W DODGE RD		OMAHA	NE	68154-2148	4024458950	4024458955	In-Center Hemo, PD Services	21	28-2506	Y
OMAHA CENTRAL DIALYSIS	144 S 40TH ST		OMAHA	NE	68131-3004	4025580818	4025582286	In-Center Hemo	17	28-2516	Y
DODGE COUNTY DIALYSIS	1949 E 23RD AVE S		FREMONT	NE	68025-2452	4027217005	4027217480	In-Center Hemo	12	28-2512	Y
SORENSEN PARK DIALYSIS	6212 N 73RD PLAZA	STE 100	OMAHA	NE	68134-1801	4025714147	4025739208	In-Center Hemo	12	28-2514	Y
OMAHA SOUTH DIALYSIS	3339 L ST		OMAHA	NE	68107-2500	4027340772	4027340891	In-Center Hemo	20	28-2511	Y
CORNHUSKER DIALYSIS	505 CORNHUSKER RD	STE 107	BELLEVUE	NE	68005-7911	4022922813	4022922823	In-Center Hemo	12	28-2518	Y
OMAHA FLORENCE DIALYSIS	7454 N 30TH ST		OMAHA	NE	68112-2722	4024510723	4024530228	In-Center Hemo, PD Services	12	28-2531	Y
OMAHA HARRISON DIALYSIS	6610 S 168TH ST	STE 8	OMAHA	NE	68135-5412	4028964609	4028961439	In-Center Hemo, PD Services	12	28-2529	Y
OMAHA HOME TRAINING (PD)	8021 CASS ST		OMAHA	NE	68114-3525	4023932346	4023911185	PD Services	6	28-2533	Y
N.E. NEBRASKA DIALYSIS	1603 W PROSPECT AVE		NORFOLK	NE	68701-3683	4023792913	4023792952	In-Center Hemo, Acute Hemo 1:1	12	28-2530	Y
GRAND ISLAND AT HOME	203 E STOLLEY PARK RD	STE G	GRAND ISLAND	NE	68801-8207	3083844067	3083820461	Home Hemo		28-2522	Y
OMAHA WEST AT HOME	13014 W DODGE RD		OMAHA	NE	68154-2148	4024458950	4024458955	Home Hemo		28-2506	Y
CAPITAL CITY AT HOME	307 N 46TH ST		LINCOLN	NE	68503-3714	4024665123	8668914864	Home Hemo	0	28-2503	Y
OMAHA HT AT HOME	8021 CASS ST		OMAHA	NE	68114-3525	4023932346	4023911185	Home Hemo		28-2533	Y
BEATRICE DIALYSIS	5200 HOSPITAL PKWY		BEATRICE	NE	68310-6909	4022237848	4022281760	In-Center Hemo, PD Services	8	282534	Y
NASHUA DIALYSIS	38 TYLER ST	STE 100	NASHUA	NH	03060-2912	6035981665	6035981174	In-Center Hemo, Nocturnal Hemo, PD Services	22	30-2507	Y
DERRY DIALYSIS	1 ACTION BLVD	STE 2	LONDONDERRY	NH	03053-3428	6034219724	6034219731	In-Center Hemo, PD Services	13	30-2511	Y
BEDFORD DIALYSIS	15 CONSTITUTION DR	STE 1C	BEDFORD	NH	03110-6002	6034711904	6034711907	In-Center Hemo, PD Services	13	30-2513	Y
ROCKINGHAM COUNTY DIALYSIS	18 PELHAM RD	STE 1	SALEM	NH	03079-4818	6038709487	6038709498	In-Center Hemo	10	30-2517	Y
NASHUA AT HOME	38 TYLER ST	STE 100	NASHUA	NH	03060-2912	6035981665	6035981174	Home Hemo		30-2507	Y
ROCKINGHAM COUNTY AT HOME	18 PELHAM RD	STE 1	SALEM	NH	03079-4818	6038709487	6038709498	Home Hemo		30-2517	Y
ATLANTIC ARTIFICIAL KIDNEY CENTER	6 INDUSTRIAL WAY W	STE B	EATONTOWN	NJ	07724-2258	7324601414	7324600080	In-Center Hemo, PD Services	27	31-2537	Y
SOMERSET DIALYSIS CENTER	240 CHURCHILL AVE		SOMERSET	NJ	08873-3451	7329375000	7329375872	In-Center Hemo, In-Center Hemo Self Care, PD Services	18	31-2574	Y
NEPTUNE DIALYSIS CENTER	2180 BRADLEY AVE		NEPTUNE	NJ	07753-4427	7327752725	7327750500	In-Center Hemo, In-Center Hemo Self Care	18	31-2567	Y
MIDDLETOWN DIALYSIS CENTER	500 STATE ROUTE 35	UNION SQUARE PLAZA	RED BANK	NJ	07701-5038	7325769900	7325769908	In-Center Hemo, In-Center Hemo Self Care	15	31-2569	Y
BRICKTOWN DIALYSIS CENTER	525 JACK MARTIN BLVD	FL 2	BRICK	NJ	08724-7737	7328369669	7328369709	In-Center Hemo, In-Center Hemo Self Care	18	31-2562	Y
BRIDGEWATER DIALYSIS CENTER	2121 US HIGHWAY 22		BOUND BROOK	NJ	08805-1546	7324697202	7324697078	In-Center Hemo, In-Center Hemo Self Care	15	31-2530	Y
HACKETTSTOWN DIALYSIS	657 WILLOW GROVE ST	WEST WING MEDICAL PLAZA STE 202	HACKETTSTOWN	NJ	07840-1868	9086840630	9086840636	In-Center Hemo, Acute Hemo 1:1, PD Services	14	31-2589	Y
PENNSAUKEN DIALYSIS CENTER	7024 KAIGHNS AVE		PENNSAUKEN	NJ	08109-4417	8564861145	8564864338	In-Center Hemo, In-Center Hemo Self Care, PD Services	21	31-2593	Y
HOLMDEL DIALYSIS	668 N BEERS ST	STE 201	HOLMDEL	NJ	07733-1511	7327396676	7327396739	In-Center Hemo, In-Center Hemo Self Care	15	31-2510	Y
DELRAN DIALYSIS	8008 ROUTE 130		DELRAN	NJ	08075-1869	8567640800	8567640917	In-Center Hemo, In-Center Hemo Self Care	13	31-2521	Y
CHERRY HILL DIALYSIS	1030 KINGS HWY N	STE 100	CHERRY HILL	NJ	08034-1907	8563210111	8564820263	In-Center Hemo, In-Center Hemo Self Care, PD Services	19	31-2513	Y
SUMMIT DIALYSIS	1139 SPRUCE DR		MOUNTAINSIDE	NJ	07092-2221	9082327800	9082329188	In-Center Hemo, In-Center Hemo Self Care, PD Services	22	31-2528	Y
FREEHOLD DIALYSIS	300 CRAIG RD		MANALAPAN	NJ	07726-8742	7323031589	7323031895	In-Center Hemo, In-Center Hemo Self Care, PD Services	18	31-2517	Y

SHORE DIALYSIS	300 W SYLVANIA AVE	STE 1	NEPTUNE	NJ	07753-6017	7329883684	7329882054	In-Center Hemo, PD Services	16	31-2520	Y
EAST ORANGE DIALYSIS	14-20 PROSPECT ST		EAST ORANGE	NJ	07017-2238	9736722025	9736751381	In-Center Hemo, In-Center Hemo Self Care, PD Services	21	31-2522	Y
PERTH AMBOY DIALYSIS	530 NEW BRUNSWICK AVE		PERTH AMBOY	NJ	08861-3654	7323242406	7323240534	In-Center Hemo, In-Center Hemo Self Care	24	31-2540	Y
OLD BRIDGE DIALYSIS	3 HOSPITAL PLZ	STE 101	OLD BRIDGE	NJ	08857-3084	7323601034	7323601476	In-Center Hemo, In-Center Hemo Self Care	9	31-2541	Y
EDISON DIALYSIS	29 MERIDIAN RD		EDISON	NJ	08820-2823	7322059883	7322059890	In-Center Hemo, In-Center Hemo Self Care, PD Services	20	31-2559	Y
PLAINFIELD DIALYSIS	1200 RANDOLPH RD	MUHLENBURG CAMPUS	PLAINFIELD	NJ	07060-3361	9087576030	9087576282	In-Center Hemo, In-Center Hemo Self Care	20	31-2558	Y
WILLINGBORO DIALYSIS	230 VAN SCIVER PKWY		WILLINGBORO	NJ	08046-1131	6098713431	6098714122	In-Center Hemo, In-Center Hemo Self Care	18	31-2584	Y
BURLINGTON NORTH DIALYSIS	1164 E ROUTE 130		BURLINGTON	NJ	08016-2954	6097479840	6097479846	In-Center Hemo, In-Center Hemo Self Care	13	31-2548	Y
LUMBERTON DIALYSIS	1261 ROUTE 38	STE B	HAINESPORT	NJ	08036-2702	6099144420	6098453099	In-Center Hemo, In-Center Hemo Self Care, PD Services	20	31-2508	Y
WOODBRIDGE DIALYSIS	541 MAIN ST	ATTN DAVITA DIALYSIS	WOODBRIDGE	NJ	07095-1104	7327500639	7327500612	In-Center Hemo, PD Services	19	31-2629	Y
NEW BRUNSWICK DIALYSIS	303 GEORGE ST	STE G-8	NEW BRUNSWICK	NJ	08901-2020	7329374791	7329374795	In-Center Hemo, PD Services	18	31-2621	Y
DURHAM CORNERS DIALYSIS	241 DURHAM AVE		SOUTH PLAINFIELD	NJ	07080-2504	9082222971	9087530783	In-Center Hemo, PD Services	18	31-2607	Y
PRINCETON JUNCTION DIALYSIS	88 PRINCETON HIGHTSTOWN RD	STE 102	PRINCETON JUNCTION	NJ	08550-1100	6097990084	6092757441	In-Center Hemo, PD Services	13	31-2610	Y
MATAWAN DIALYSIS	764 HIGHWAY 34	STE A	MATAWAN	NJ	07747-6614	7325831085	7325663632	In-Center Hemo, PD Services	19	31-2649	Y
DIALYSIS AT DEBORAH	107 TRENTON RD		BROWNS MILLS	NJ	08015-3203	6098933950	6098933704	In-Center Hemo, PD Services	16	31-2648	Y
MILLBURN DIALYSIS	25 E WILLOW ST	STE 2	MILLBURN	NJ	07041-1416	9733797309	9733795175	In-Center Hemo, PD Services	18	31-2645	Y
EAST BRUNSWICK DIALYSIS	629 CRANBURY RD	STE 101	EAST BRUNSWICK	NJ	08816-4096	7322381909	7329678173	In-Center Hemo, PD Services	19	31-2638	Y
WEST ORANGE DIALYSIS	375 MOUNT PLEASANT AVE	STE 340	WEST ORANGE	NJ	07052-2750	9732437069	9737311348	In-Center Hemo, PD Services	19	31-2636	Y
WALL TOWNSHIP HOME TRAINING (PD)	5100 BELMAR BLVD	STE 1	WALL TOWNSHIP	NJ	07727-4028	7329382780	7329382654	PD Services		31-2646	Y
RADBURN DIALYSIS	15-00 POLLITT DR		FAIR LAWN	NJ	07410-2732	2017961385	2017940150	In-Center Hemo, PD Services	21	31-2637	Y
TETERBORO DIALYSIS	502 RT 46 W		TETERBORO	NJ	07608-1118	2012880249	2012882640	In-Center Hemo, PD Services	18	31-2632	Y
NORTH HALEDON DIALYSIS	953 BELMONT AVE		NORTH HALEDON	NJ	07508-2548	9734274675	9734230906	In-Center Hemo, PD Services	19	31-2633	Y
EAST PATERSON DIALYSIS	680 BROADWAY	STE 103	PATERSON	NJ	07514-1524	9733578079	9732791825	In-Center Hemo	18	31-2643	Y
DIALYSIS AT PALISADES MEDICAL CENTER	7650 RIVER RD	STE 150	NORTH BERGEN	NJ	07047-6526	2018611031	2017582794	In-Center Hemo, PD Services	19	31-2652	Y
RAHWAY DIALYSIS	800 HARRISON ST		RAHWAY	NJ	07065-3512	7323810973	7326800376	In-Center Hemo, PD Services	18	31-2669	Y
ST JOSEPH'S PATERSON DIALYSIS	11 GETTY AVE	275 HOSPITAL PLAZA	PATERSON	NJ	7503	9736843490	9732472740	In-Center Hemo, PD Services	60	31-2614	Y
ST JOSEPH'S SJRMC DIALYSIS	703 MAIN ST		PATERSON	NJ	07503-2621	9737543570	9737542882	In-Center Hemo	8	31-2613	Y
ST JOSEPH'S WAYNE DIALYSIS	57 WILLOWBROOK BLVD	2ND FLOOR	WAYNE	NJ	07470-7045	9738902792	9738902796	In-Center Hemo	20	31-2597	Y
HACKENSACK DIALYSIS	113 ESSEX ST		MAYWOOD	NJ	07607-1020	2018433875	2018430632	In-Center Hemo, Nocturnal Hemo, PD Services	36	31-2615	Y
LINCOLN PARK DIALYSIS CENTER	6 FRASSETTO WAY	STE A	LINCOLN PARK	NJ	07035-2055	9738720099	9738720230	In-Center Hemo	20	31-2531	Y
HILLSIDE DIALYSIS	1529 N BROAD ST		HILLSIDE	NJ	07205-1603	9734741199	9734741198	In-Center Hemo, PD Services	20	31-2587	Y
JERSEY CITY DIALYSIS	1310 5TH ST		NORTH BERGEN	NJ	07047-1710	2017709220	2017709225	In-Center Hemo, PD Services	18	31-2545	Y
PARKSIDE DIALYSIS	580 FRELINGHUYSEN AVE		NEWARK	NJ	07114-1361	9736242226	9736245547	In-Center Hemo	18	31-2581	Y
LOURDES CAMDEN DIALYSIS	1601 HADDON AVE		CAMDEN	NJ	08103-3109	8565410647	8565412698	In-Center Hemo, PD Services	22	31-2622	Y
LOURDES MT. LAUREL DIALYSIS	130 GAITHER DR	STE 172	MOUNT LAUREL	NJ	08054-1715	8562224195	8562354842	In-Center Hemo	20	31-2617	Y
LOURDES INNOVA DIALYSIS	3716 CHURCH RD		MOUNT LAUREL	NJ	08054-1104	8562220386	8562350592	In-Center Hemo	24	31-2594	Y
FAIR LAWN DIALYSIS	18-01 POLLITT DR		FAIR LAWN	NJ	07410-2813	2017963873	2017033543	In-Center Hemo	20	31-2616	Y
ST JOSEPH'S PATERSON AT HOME	11 GETTY AVE		PATERSON	NJ	07503-2806	9732472701	9732472730	Home Hemo		31-2614	Y
HILLSIDE AT HOME	1529 N BROAD ST		HILLSIDE	NJ	07205-1603	9734741199	9734741198	Home Hemo		31-2587	Y
PENNSAUKEN AT HOME	7024 KAIGHNS AVE		PENNSAUKEN	NJ	08109-4417	8564861145	8564864338	Home Hemo		31-2593	Y
PLAINFIELD AT HOME	1200 RANDOLPH RD	KENYAN HOUSE	PLAINFIELD	NJ	07060-3361	9087576030	9087576282	Home Hemo		31-2558	Y
WILLINGBORO AT HOME	230 VAN SCIVER PKWY		WILLINGBORO	NJ	08046-1131	6098713431	6098714122	Home Hemo	0	31-2584	Y
ATLANTIC AKC AT HOME	6 INDUSTRIAL WAY W	STE B	EATONTOWN	NJ	07724-2258	7324601414	7324600080	Home Hemo	0	31-2537	Y
WEST ORANGE AT HOME	375 MOUNT PLEASANT AVE		WEST ORANGE	NJ	07052-2724	9732437069	9737311348	Home Hemo		31-2636	Y
MARLTON AT HOME	769 E RTE 70	STE C100	MARLTON	NJ	08053-2361	8567977044	8567977049	Home Hemo		31-2590	Y
MARLTON DIALYSIS	769 E ROUTE 70	STE C100	MARLTON	NJ	08053-2370	8567977044	8567977049	In-Center Hemo, PD Services	15	31-2590	Y
LAWRENCEVILLE RENAL CENTER	1840 PRINCETON AVE		LAWRENCEVILLE	NJ	08648-4518	6092780999	6092780070	In-Center Hemo	12	31-2604	Y
EAST BRUNSWICK AT HOME	629 CRANBURY RD	STE 101	EAST BRUNSWICK	NJ	08816-4031	7322381909	7329678173	Home Hemo	0	31-2638	Y

HACKENSACK AT HOME	113 ESSEX ST		MAYWOOD	NJ	07607-1020	2013680610	2018430632	Home Hemo	1	31-2615	Y
RADBURN AT HOME	15-00 POLLITT DR		FAIR LAWN	NJ	07410-2732	2017961385	2017940150	Home Hemo		31-2637	Y
MILLBURN AT HOME	25 E WILLOW ST	STE 2	MILLBURN	NJ	07041-1416	9733797309	9733795175	Home Hemo		31-2645	Y
WALL TOWNSHIP HT AT HOME	5100 BELMAR BLVD	STE 1	WALL TOWNSHIP	NJ	07727-4028	7329382780	7329382654	Home Hemo		31-2646	Y
ATLANTIC COUNTY AT HOME	400 W BLACK HORSE PIKE	STE 3	PLEASANTVILLE	NJ	08232-2636	6096467202	6096467962	Home Hemo		31-2651	Y
JERSEY CITY GRAND HOME AT HOME	422 GRAND ST		JERSEY CITY	NJ	07302-4240	2013326413	2015368093	Home Hemo		31-2653	Y
METUCHEN AT HOME	319 LAKE AVE		METUCHEN	NJ	08840-1804	7329065714	7329062373	Home Hemo		31-2654	Y
VINELAND AT HOME	1318 S MAIN RD	STE 3B	VINELAND	NJ	08360-6516	8566910875	8566921615	Home Hemo	1	31-2566	Y
JERSEY CITY SUMMIT AT HOME	418 SUMMIT AVE		JERSEY CITY	NJ	07306-3101	2014208431	2014590967	Home Hemo		31-2671	Y
JERSEY CITY SUMMIT DIALYSIS	418 SUMMIT AVE		JERSEY CITY	NJ	07306-3101	2014208431	2014590967	In-Center Hemo, PD Services	21	31-2671	Y
METUCHEN DIALYSIS	319 LAKE AVE		METUCHEN	NJ	08840-1804	7329065714	7329062373	In-Center Hemo, PD Services	10	31-2654	Y
ATLANTIC COUNTY DIALYSIS	400 W BLACK HORSE PIKE	STE 3	PLEASANTVILLE	NJ	08232-2636	6096467202	6096467962	In-Center Hemo, PD Services	13	31-2651	Y
MAIN STREET DIALYSIS	668 MAIN ST		LUMBERTON	NJ	08048-5016	6092657865	6092676876	In-Center Hemo, Nocturnal Hemo	10	31-2644	Y
HILLSBOROUGH DIALYSIS	220 TRIANGLE RD		HILLSBOROUGH	NJ	08844-8102	9083690398	9083692151	In-Center Hemo, PD Services	10	31-2672	Y
OCEAN COUNTY DIALYSIS	635 BAY AVE	STE 215	TOMS RIVER	NJ	08753-3349	7323412730	7325574186	In-Center Hemo, PD Services, Home Hemo		31-2661	Y
BROOKLAWN DIALYSIS	700 CRESCENT BLVD	STE 10B	BROOKLAWN	NJ	08030-2797	8564561230	8567427094	In-Center Hemo, PD Services	18	31-2675	Y
JERSEY CITY GRAND HOME DIALYSIS	422 GRAND ST		JERSEY CITY	NJ	07302-4240	2013326413	2015368093	PD Services		31-2653	Y
MONROE TOWNSHIP DIALYSIS	298 APPLEGARTH RD		MONROE TOWNSHIP	NJ	08831-3754	6094094259	6093957697	In-Center Hemo, PD Services	10	31-2655	Y
HAMILTON STREET DIALYSIS	920 HAMILTON ST	STE C-3	SOMERSET	NJ	08873-3600	7322201593	7324480567	In-Center Hemo, PD Services			Y
LYNDHURST DIALYSIS	554-A NEW YORK AVE		LYNDHURST	NJ	07071-1532	2019334782	2018047545	In-Center Hemo, PD Services	19	31-2670	Y
JACKSON TOWNSHIP DIALYSIS	260 N COUNTY LINE RD	STE 120	JACKSON	NJ	08527-4473	7323642055	7329011905	In-Center Hemo, PD Services	10		Y
MILLVILLE DIALYSIS	3 ELIZABETH ST		MILLVILLE	NJ	08332-2509	8563274580	8563274584	In-Center Hemo	18	31-2599	Y
VINELAND DIALYSIS	1318 S MAIN RD	STE 3B	VINELAND	NJ	08360-6516	8566910875	8566920306	In-Center Hemo, PD Services	18	31-2566	Y
BRIDGETON DIALYSIS	333 IRVING AVE		BRIDGETON	NJ	08302-2123	8565754200	8564530174	In-Center Hemo	17	31-2673	Y
BAYONNE RENAL CENTER	434-436 BROADWAY		BAYONNE	NJ	07002-3628	2014361664	2014365133	In-Center Hemo, PD Services	21	31-2561	Y
RENAL CENTER OF ENGLEWOOD	300 GRAND AVE	STE 103	ENGLEWOOD	NJ	07631-6300	2017313149	2017313172	PD Services		31-2631	Y
RENAL CENTER OF NEWARK	571 CENTRAL AVE		NEWARK	NJ	07107-1463	9734844994	9734844434	In-Center Hemo, PD Services	18	31-2570	Y
RENAL CENTER OF BRICK	150 BRICK BLVD		BRICK	NJ	08723-7125			In-Center Hemo			Y
RENAL CENTER OF MORRISTOWN	100 MADISON AVE		MORRISTOWN	NJ	07960-6136	9735388201	9735388203	In-Center Hemo, PD Services	11	31-2624	Y
RENAL CENTER OF SUCCASUNNA	175 RIGHTER RD		SUCCASUNNA	NJ	07876-1324	9735843294	9735843298	In-Center Hemo	12	31-2623	Y
RENAL CENTER OF NEWTON	7 EAST CLINTON ST		NEWTON	NJ	07860-1801	9739400965	9739400969	In-Center Hemo, PD Services	21	31-2572	Y
RENAL CENTER OF SOMERVILLE	1 ROUTE 206 NORTH		SOMERVILLE	NJ	8876			In-Center Hemo			Y
RENAL CENTER OF PASSAIC	10 CLIFTON BLVD	STE 1	CLIFTON	NJ	7011			In-Center Hemo			Y
RENAL CENTER OF SEWELL	660 WOODBURY-GLASSBORO RD	STE 29 TIMBERLINE SHOPPING CENTER	SEWELL	NJ	08080-3732	8564641172	8564645281	In-Center Hemo, PD Services	21	31-2565	Y
RENAL CENTER OF TRENTON	601 HAMILTON AVE		TRENTON	NJ	08629-1915	6093932388	6093937927	In-Center Hemo, PD Services	18	31-2571	Y
RENAL CENTER OF WESTWOOD	363 OLD HOOK RD		WESTWOOD	NJ	07675-3201	2016646649	2016645542	In-Center Hemo, PD Services	16	31-2523	Y
RENAL CENTER OF HAMILTON	1013 WHITE HORSE AVE		HAMILTON TOWNSHIP	NJ	08610-1424	6094383002	6094383011	In-Center Hemo, PD Services	19	31-2657	Y
RENAL CENTER OF MONROE	300 OVERLOOK DR		MONROE TOWNSHIP	NJ	08831-5589	6096428124	6096428128	In-Center Hemo, PD Services			Y
RENAL CENTER OF WESTWOOD AT HOME	363 OLD HOOK RD		WESTWOOD	NJ	07675-3201	2016646649	2016645542	Home Hemo		31-2523	Y
RENAL CENTER OF NEWTON AT HOME	7 E CLINTON ST		NEWTON	NJ	07860-1801	9739400965		Home Hemo		31-2572	Y
LYNDHURST AT HOME	554-A NEW YORK AVE		LYNDHURST	NJ	07071-1532	2019334782	2018047545	Home Hemo			Y
FOUR CORNERS DIALYSIS CENTER	801 W BROADWAY		FARMINGTON	NM	87401-5650	5053252827	5053267425	In-Center Hemo, PD Services	36	32-2503	Y
SHIPROCK DIALYSIS CENTER	US HWY 491 N	PO BOX 2156	SHIPROCK	NM	87420-2156	5053684125	5053684235	In-Center Hemo	20	32-2515	Y
MESILLA VALLEY DIALYSIS	2550 S TELSHOR BLVD		LAS CRUCES	NM	88011-4907	5755223519	5755225481	In-Center Hemo, PD Services	13	32-2544	Y
ARTESIA DIALYSIS	1903 W MAIN ST		ARTESIA	NM	88210-3718	5757468818	5757469229	In-Center Hemo, PD Services	12	32-2537	Y
ARTESIA AT HOME	1903 W MAIN ST		ARTESIA	NM	88210-3718	5757468818	5757469229	Home Hemo		32-2537	N
LAS CRUCES RENAL AT HOME	3961 E LOHMAN AVE	STE 29	LAS CRUCES	NM	88011-8272	5755329437	5755217348	Home Hemo		32-2527	Y
LAS CRUCES RENAL CENTER	3961 E LOHMAN AVE	STE 29	LAS CRUCES	NM	88011-8272	5755329437	5755217348	In-Center Hemo, PD Services	20	32-2527	Y
LOS ALAMOS DIALYSIS	3917 WEST RD	STE G-02	LOS ALAMOS	NM	87544-2275	5056620629	5056619033	In-Center Hemo, PD Services	4	32-2555	Y
DEL NORTE DIALYSIS	5201 SAN MATEO BLVD NE		ALBUQUERQUE	NM	87109-2414	5058844820	5058889407	In-Center Hemo, PD Services	17	322549	Y

SOUTH LAS VEGAS DIALYSIS CENTER	2250 S RANCHO DR	STE 115	LAS VEGAS	NV	89102-4456	7027951771	7027951794	In-Center Hemo, In-Center Hemo Self Care	22	29-2512	Y
PAHRUMP DIALYSIS CENTER	330 S LOLA LN	STE 100	PAHRUMP	NV	89048-0884	7757514300	7757514310	In-Center Hemo, In-Center Hemo Self Care, PD Services	20	29-2511	Y
SPARKS DIALYSIS CENTER	4860 VISTA BLVD	STE 100	SPARKS	NV	89436-2817	7753595432	7753592885	In-Center Hemo, In-Center Hemo Self Care	21	29-2505	Y
LAS VEGAS DIALYSIS CENTER	150 S VALLEY VIEW BLVD		LAS VEGAS	NV	89107-3110	7028780908	7028788292	In-Center Hemo, In-Center Hemo Self Care	40	29-2501	Y
NORTH LAS VEGAS DIALYSIS CENTER	2065 N LAS VEGAS BLVD		NORTH LAS VEGAS	NV	89030-5801	7026390469	7026390221	In-Center Hemo, In-Center Hemo Self Care	28	29-2504	Y
SUMMERLIN DIALYSIS CENTER	653 N TOWN CENTER DR	STE 70 BLDG 2	LAS VEGAS	NV	89144-0503	7023606908	7023607806	In-Center Hemo, In-Center Hemo Self Care	20	29-2515	Y
SOUTH MEADOWS DIALYSIS CENTER	10085 DOUBLE R BLVD	STE 160	RENO	NV	89521-4867	7758524200	7758524263	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care	24	29-2526	Y
RENO DIALYSIS CENTER	1500 E 2ND ST	STE 101	RENO	NV	89502-1189	7753292479	7753292106	In-Center Hemo, In-Center Hemo Self Care, PD Services	25	29-2518	Y
CARSON CITY DIALYSIS CENTER	3246 N CARSON ST	STE 110	CARSON CITY	NV	89706-0248	7758866450	7758866452	In-Center Hemo, In-Center Hemo Self Care, PD Services	24	29-2539	Y
SIERRA ROSE DIALYSIS CENTER	685 SIERRA ROSE DR		RENO	NV	89511-2060	7758296580	7758296581	In-Center Hemo, In-Center Hemo Self Care	18	29-2520	Y
SOUTHERN HILLS DIALYSIS CENTER	9280 W SUNSET RD	STE 110	LAS VEGAS	NV	89148-4861	7023183167	7023183196	In-Center Hemo, In-Center Hemo Self Care	23	29-2521	Y
SIENA HENDERSON DIALYSIS CENTER	2865 SIENNA HEIGHTS DR	STE 141	HENDERSON	NV	89052-4168	7022600348	7024079672	In-Center Hemo, In-Center Hemo Self Care	17	29-2524	Y
FALLON DIALYSIS	1103 NEW RIVER PKWY		FALLON	NV	89406-6899	7754282077	7754282184	In-Center Hemo, In-Center Hemo Self Care, PD Services	21	29-2528	Y
THE NEVADA DIALYSIS CENTER	1510 W WARM SPRINGS RD	STE 100	HENDERSON	NV	89014-3586	7024512131	7024515502	In-Center Hemo, In-Center Hemo Self Care	20	29-2534	Y
DESERT SPRINGS DIALYSIS	2110 E FLAMINGO RD	STE 108	LAS VEGAS	NV	89119-5191	7026969768	7027916926	In-Center Hemo, In-Center Hemo Self Care	18	29-2525	Y
LAS VEGAS PEDIATRICS DIALYSIS CENTER	7271 W SAHARA AVE	STE 120	LAS VEGAS	NV	89117-2862	7022273049	7022278882	In-Center Hemo, PD Services	4	29-2536	Y
CENTENNIAL DIALYSIS CENTER	8775 DEER SPRINGS WAY		LAS VEGAS	NV	89149-0416	7023952488	7026455007	In-Center Hemo, In-Center Hemo Self Care	20	29-2531	Y
FIVE STAR DIALYSIS CENTER	2400 TECH CENTER CT		LAS VEGAS	NV	89128-0804	7028693771	7028696366	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care, PD Services	28	29-2538	Y
MOUNTAIN VIEW DIALYSIS	2881 BUSINESS PARK CT	STE 130	LAS VEGAS	NV	89128-9019	7023419551	7023419484	In-Center Hemo, In-Center Hemo Self Care, PD Services	20	29-2510	N
ANTHEM VILLAGE DIALYSIS	2530 ANTHEM VILLAGE DR		HENDERSON	NV	89052-5548	7026140590	7026147419	In-Center Hemo, In-Center Hemo Self Care	18	29-2522	Y
WINNEMUCCA DIALYSIS	830 FAIRGROUNDS RD		WINNEMUCCA	NV	89445-2011	7756233234	7756231361	In-Center Hemo, PD Services	12	29-2546	Y
CHEYENNE DIALYSIS	3291 N BUFFALO DR BLDG A	STE 150	LAS VEGAS	NV	89129-7441	7023961045	7023961530	In-Center Hemo, PD Services	26	29-2548	Y
EAST SUNRISE DIALYSIS	1750 E DESERT INN RD	STE 100	LAS VEGAS	NV	89169-3202	7024747052	7024744019	In-Center Hemo	21	29-2554	Y
LAKE MEAD DIALYSIS	713 E LAKE MEAD BLVD		NORTH LAS VEGAS	NV	89030-6751	7026420216	7026335128	In-Center Hemo	25	29-2553	Y
CHEYENNE AT HOME	3291 N BUFFALO DR	BLDG A STE 150	LAS VEGAS	NV	89129-7441	7023961045	7023961530	Home Hemo		29-2548	Y
CARSON CITY AT HOME	3246 N CARSON ST	STE 110	CARSON CITY	NV	89706-1677	7758866450	7758866452	Home Hemo		29-2539	Y
RENO AT HOME	1500 EAST 2ND STREET	STE 103	RENO	NV	89502-1189	7753292100	7753292428	Home Hemo		29-2518	Y
FIVE STAR AT HOME	2400 TECH CENTER CT		LAS VEGAS	NV	89128-0804	7028693771	7028696366	Home Hemo		29-2538	Y
LAS VEGAS AT HOME	3100 W CHARLESTON BLVD	STE 100	LAS VEGAS	NV	89102-1992	7028780908	7028788292	Home Hemo		29-2501	N
SIERRA ROSE AT HOME	685 SIERRA ROSE DR		RENO	NV	89511-2060	7758258642	7758258657	Home Hemo		29-2520	Y
GREEN VALLEY AT HOME	1489 W WARM SPRNGS	STE 122	HENDERSON	NV	89014-7637	7024508877	7024508887	Home Hemo		29-2517	Y
GREEN VALLEY DIALYSIS	1489 W WARM SPRINGS RD	STE 122	HENDERSON	NV	89014-7637	7024508877	7024508887	In-Center Hemo, Home Hemo, PD Services	18	29-2517	Y
LAS VEGAS RENAL CENTER	2333 RENAISSANCE DR		LAS VEGAS	NV	89119-6191	7027408580	7027408684	In-Center Hemo	14	29-2507	Y
SPRING VALLEY DIALYSIS	3855 S JONES BLVD STE	STE 101	LAS VEGAS	NV	89103-2296	7022480379	7022480323	In-Center Hemo, PD Services	17	29-2547	Y
PELICAN POINT DIALYSIS	7316 W CHEYENNE AVE		LAS VEGAS	NV	89129-6201	7023950227	7023951540	In-Center Hemo	25	29-2552	Y
DYKER HEIGHTS DIALYSIS CENTER	1435 86TH ST		BROOKLYN	NY	11228-3435	7182565800	7182564835	In-Center Hemo, In-Center Hemo Self Care	20	33-2596	Y
PORT CHESTER DIALYSIS AND RENAL CENTER	38 BULKLEY AVE		PORT CHESTER	NY	10573-3902	9149378800	9149379093	In-Center Hemo, In-Center Hemo Self Care	15	33-2559	Y
WHITE PLAINS DIALYSIS CENTER	200 HAMILTON AVE	STE 13B	WHITE PLAINS	NY	10601-1859	9143284900	9143281425	In-Center Hemo, In-Center Hemo Self Care	24	33-2599	Y
SOUTH BROOKLYN NEPHROLOGY CENTER	3915 AVENUE V	STE 104	BROOKLYN	NY	11234-5150	7182528440	7182526490	In-Center Hemo, In-Center Hemo Self Care, PD Services	29	33-2516	Y
CLEVE HILL DIALYSIS CENTER	1461 KENSINGTON AVE		BUFFALO	NY	14215-1436	7168318892	7168318890	In-Center Hemo, In-Center Hemo Self Care, PD Services	24	33-2649	Y
RENAL CARE OF BUFFALO	550 ORCHARD PARK RD	BLDG B, STE 104	WEST SENECA	NY	14224-2646	7166770089	7166770096	In-Center Hemo, In-Center Hemo Self Care	24	33-2548	Y
BRONX DIALYSIS CENTER	1615 EASTCHESTER RD		BRONX	NY	10461-2603	7188927700	7188927207	In-Center Hemo, In-Center Hemo Self Care	25	33-2563	Y
CATSKILL DIALYSIS CENTER	139 FORESTBURGH RD		MONTICELLO	NY	12701-2348	8457963300	8457963303	In-Center Hemo, In-Center Hemo Self Care, PD Services	14	33-2546	Y
RIVERDALE DIALYSIS CENTER	170 W 233RD ST		BRONX	NY	10463-5639	7188844300	7188849695	In-Center Hemo, In-Center Hemo Self Care	24	33-2565	Y
SOUTH BRONX DIALYSIS CENTER	1940 WEBSTER AVE	STE 100	BRONX	NY	10457-4261	7187163999	7185837335	In-Center Hemo, In-Center Hemo Self Care	21	33-2506	Y
RICHMOND KIDNEY CENTER	1366 VICTORY BLVD		STATEN ISLAND	NY	10301-3907	7188166200	7188166235	In-Center Hemo, In-Center Hemo Self Care, PD Services	23	33-2525	Y
BOSTON POST ROAD DIALYSIS CENTER	4026 BOSTON RD		BRONX	NY	10475-1122	7188629245	7188629238	In-Center Hemo, In-Center Hemo Self Care, PD Services	25	33-2588	Y
PEEKSKILL CORTLANDT DIALYSIS CENTER	2050 E MAIN ST	STE 15	CORTLANDT MANOR	NY	10567-2502	9147889326	9147889330	In-Center Hemo, In-Center Hemo Self Care	19	33-2574	Y

QUEENS DIALYSIS CENTER	11801 GUY R BREWER BLVD		JAMAICA	NY	11434-2101	7183416711	7185258611	In-Center Hemo, In-Center Hemo Self Care	22	33-2583	Y
LYNBROOK DIALYSIS CENTER	147 SCRANTON AVE		LYNBROOK	NY	11563-2808	5165964101	5165964290	In-Center Hemo, In-Center Hemo Self Care	18	33-2592	Y
PORT WASHINGTON DIALYSIS CENTER	50 SEAVIEW BLVD		PORT WASHINGTON	NY	11050-4615	5164843460	5164847949	In-Center Hemo, In-Center Hemo Self Care	18	33-2591	Y
SOUNDVIEW DIALYSIS CENTER	1622 BRUCKNER BLVD	STE 24	BRONX	NY	10473-4553	7188612334	7188614323	In-Center Hemo, In-Center Hemo Self Care	18	33-2590	Y
YONKERS DIALYSIS CENTER	575 YONKERS AVE		YONKERS	NY	10704-2601	9143772370	9143772970	In-Center Hemo, In-Center Hemo Self Care, PD Services, Nocturnal Hemo	21	33-2602	Y
CELIA DILL DIALYSIS CENTER	667 STONELEIGH AVE	STE 123 BARNS OFFICE CENTER	CARMEL	NY	10512-2454	8452784150	8452796902	In-Center Hemo, In-Center Hemo Self Care, PD Services	16	33-2651	Y
GARDEN CITY DIALYSIS CENTER	1100 STEWART AVE	STE 2	GARDEN CITY	NY	11530-4839	5163570004	5163577377	In-Center Hemo, In-Center Hemo Self Care	31	33-2605	Y
HUDSON VALLEY DIALYSIS CENTER	155 WHITE PLAINS RD		TARRYTOWN	NY	10591-5523	9143327599	9143327571	In-Center Hemo, In-Center Hemo Self Care	20	33-2571	Y
SHEEPSHEAD BAY RENAL CARE CENTER	26 BRIGHTON 11TH ST		BROOKLYN	NY	11235-5304	7187435955	7187435939	In-Center Hemo, In-Center Hemo Self Care	16	33-2604	Y
QUEENS VILLAGE DIALYSIS CENTER	22202 HEMPSTEAD AVE	STE 170	QUEENS VILLAGE	NY	11429-2123	7182176200	7182174191	In-Center Hemo, In-Center Hemo Self Care, PD Services	25	33-2603	Y
EASTCHESTER ROAD DIALYSIS CENTER	1515 JARRETT PL		BRONX	NY	10461-2606	7188224940	7188223083	In-Center Hemo, In-Center Hemo Self Care, PD Services	12	33-2656	Y
BEDFORD PARK DIALYSIS CENTER	3117 WEBSTER AVE	1ST FLR	BRONX	NY	10467-4905	7189201530	7189201520	In-Center Hemo, PD Services, Nocturnal Hemo	21	33-2662	Y
YONKERS EAST DIALYSIS CENTER	5 ODELL PLZ	STE 131	YONKERS	NY	10701-1406	9143760296	9143763510	In-Center Hemo, PD Services	21	33-2669	Y
COLUMBIA UNIVERSITY DIALYSIS CENTER	60 HAVEN AVE	B3	NEW YORK	NY	10032-2604	2129289071	2129272645	In-Center Hemo, In-Center Hemo Self Care, PD Services	24	33-2621	Y
UTICA AVENUE DIALYSIS CENTER	1305 UTICA AVE		BROOKLYN	NY	11203-5911	7186293900	7186296315	In-Center Hemo, In-Center Hemo Self Care, PD Services	30	33-2556	Y
OYSTER BAY DIALYSIS	17 E OLD COUNTRY RD		HICKSVILLE	NY	11801-4270	5166812786	5169337836	In-Center Hemo, In-Center Hemo Self Care, PD Services	17	33-2552	Y
FREEPORT KIDNEY CENTER	351 S MAIN ST		FREEPORT	NY	11520-5114	5166231786	5165465074	In-Center Hemo, In-Center Hemo Self Care	21	33-2529	Y
HUNTINGTON ON BROADWAY DIALYSIS	256 BROADWAY		HUNTINGTON STATION	NY	11746-1403	6314234320	6314232832	In-Center Hemo, In-Center Hemo Self Care, PD Services	18	33-2513	Y
MEDFORD KIDNEY CENTER	1725 N OCEAN AVE		MEDFORD	NY	11763-2649	6312898000	6312898079	In-Center Hemo, In-Center Hemo Self Care, PD Services	10	33-2555	Y
ITHACA DIALYSIS CENTER	201 DATES DR	STE 206	ITHACA	NY	14850-1345	6072721693	6072735580	In-Center Hemo, Acute Hemo 1:1, Acute PD, PD Services	12	33-2536	Y
IVY DIALYSIS	602 IVY ST		ELMIRA	NY	14905-1646	6077374186	6077374446	In-Center Hemo, PD Services	20	33-2735	Y
CORNING DIALYSIS	8 WEST PULTENEY ST	STE 101	CORNING	NY	14830-2267	6079622790	6079622991	In-Center Hemo	10	33-2732	Y
SCHUYLER DIALYSIS	220 STEUBEN ST		MONTOUR FALLS	NY	14865-9740	6072101997	6072101996	In-Center Hemo	4	33-2733	Y
NIAGARA DIALYSIS CENTER	2932 MILITARY RD		NIAGARA FALLS	NY	14304-1252	7162974059	7162974969	In-Center Hemo, PD Services	13	33-2720	Y
SOUTHTOWNS DIALYSIS	4910 CAMP RD	STE 100	HAMBURG	NY	14075-2617	7166494072	7166491937	In-Center Hemo, PD Services	25	33-2679	Y
WILLIAMSBRIDGE HOME DIALYSIS CENTER (PD)	3525 WHITE PLAINS RD	STE A	BRONX	NY	10467-5705	7186521013	7186524096	PD Services		33-2729	Y
WATERS PLACE DIALYSIS CENTER	1733 EASTCHESTER RD		BRONX	NY	10461-2315	7188221968	7188226030	In-Center Hemo, PD Services	24	33-2708	Y
FLORAL PARK HOME DIALYSIS (PD)	1 CISNEY AVE		FLORAL PARK	NY	11001-3249	5164370789	5163279505	PD Services		33-2750	Y
CLINTON HILL DIALYSIS	1275 BEDFORD AVE		BROOKLYN	NY	11216-2711	7186230635	7186230638	In-Center Hemo, Home Hemo, PD Services	28	33-2749	Y
STATEN ISLAND DIALYSIS CENTER	1139 HYLAN BLVD		STATEN ISLAND	NY	10305-2061	7188164913	7188166340	In-Center Hemo, PD Services	18	33-2711	Y
WILLIAMSBRIDGE DIALYSIS CENTER	3525 WHITE PLAINS RD	STE B	BRONX	NY	10467-5705	7185474562	7182312350	In-Center Hemo	25	33-2728	Y
NEWARK WAYNE DIALYSIS	1120 S MAIN ST		NEWARK	NY	14513-2171	3153316958	3153316521	In-Center Hemo, PD Services	14	33-2701	Y
ORANGE DIALYSIS CENTER	100 CRYSTAL RUN RD	STE 102	MIDDLETOWN	NY	10941-4042	8456928220	8456928655	In-Center Hemo, PD Services	20	33-2707	Y
LOWVILLE DIALYSIS CENTER	7785 N STATE ST	STE 1	LOWVILLE	NY	13367-1229	3153773090	3153769983	In-Center Hemo, PD Services	8	33-2709	Y
EAST ROCHESTER DIALYSIS	445 W COMMERCIAL ST		EAST ROCHESTER	NY	14445-2277	5852180517	5852184204	In-Center Hemo	17	33-2730	Y
ATLAS PARK DIALYSIS	8000 COOPER AVE		GLENDALE	NY	11385-7739	7183262789	7184164269	In-Center Hemo	25	33-2769	Y
NIAGARA FALLS KIDNEY CARE CENTER	621 10TH ST		NIAGARA FALLS	NY	14301-1813	7162784639	7162784637	In-Center Hemo, Acute Hemo 1:1	17	33-2682	Y
LONG ISLAND RENAL CARE	3460 GREAT NECK RD		AMITYVILLE	NY	11701-1915	6315326969	6315326968	In-Center Hemo, PD Services	24	33-2670	Y
CENTRAL NEW YORK DIALYSIS CENTER	910 ERIE BLVD E		SYRACUSE	NY	13210-1048	3154108040	3154108030	In-Center Hemo, PD Services	30	33-2615	Y
SUBURBAN DIALYSIS	1542 MAPLE RD		WILLIAMSVILLE	NY	14221-3625	7166363300	7166361893	In-Center Hemo, PD Services	22	33-2600	Y
NORTHTOWNS DIALYSIS CENTER	4041 DELAWARE AVE	STE 150	TONAWANDA	NY	14150-6850	7168718103	7168718107	In-Center Hemo, PD Services	18	33-2597	Y
ORCHARD PARK DIALYSIS	3801 TAYLOR RD		ORCHARD PARK	NY	14127-2232	7162097200	7162097206	In-Center Hemo, PD Services, Nocturnal Hemo	24	33-2608	Y
MIDWOOD DIALYSIS	1915 OCEAN AVE		BROOKLYN	NY	11230-6801	7182587700	7182589273	In-Center Hemo, PD Services	34	33-2598	Y
MILLENNIUM DIALYSIS	1408 OCEAN AVE	2ND FLR	BROOKLYN	NY	11230-3814	7186777600	7186773265	In-Center Hemo	20	33-2635	Y
BOROUGH PARK DIALYSIS	4102 13TH AVE		BROOKLYN	NY	11219-1333	7184352112	7184350354	In-Center Hemo	32	33-2678	Y
JAMESTOWN DIALYSIS CENTER	207 FOOTE AVE		JAMESTOWN	NY	14701-7077	7166648226	7166648349	In-Center Hemo, Acute Hemo 1:1, Acute PD, PD Services	18	33-2703	Y
BRONX RIVER DIALYSIS	1616 BRONXDALE AVE		BRONX	NY	10462-3302	7184309800	7184306854	In-Center Hemo	30	33-2576	Y
NORTHTOWNS AT HOME	4041 DELAWARE AVE	STE 150	TONAWANDA	NY	14150-6850	7168718103	7168718107	Home Hemo		33-2597	Y

CENTRAL NEW YORK AT HOME	910 ERIE BLVD E		SYRACUSE	NY	13210-1048	3154108040	3154108030	Home Hemo		33-2615	Y
SOUTHTOWNS AT HOME	4910 CAMP RD	STE 100	HAMBURG	NY	14075-2617	7166494072	7166491937	Home Hemo		33-2679	Y
BRONX AT HOME	1615 EASTCHESTER RD		BRONX	NY	10461-2603	7188927700	7188927207	Home Hemo		33-2563	N
CLEVE HILL AT HOME	1461 KENSINGTON AVE		BUFFALO	NY	14215-1436	7168318892	7168318890	Home Hemo		33-2649	Y
EASTCHESTER ROAD AT HOME	1515 JARRET PL		BRONX	NY	10461-2606	7188224940	7188223083	Home Hemo		33-2656	Y
WHITE PLAINS AT HOME	200 HAMILTON AVE	STE 13B	WHITE PLAINS	NY	10601-1859	9143284900	9143281425	Home Hemo	0	33-2599	Y
QUEENS VILLAGE AT HOME	22202 HEMPSTEAD AVE	STE 170	QUEENS VILLAGE	NY	11429-2123	7182176200	7182174191	Home Hemo		33-2603	Y
RICHMOND KIDNEY AT HOME	1366 VICTORY BLVD		STATEN ISLAND	NY	10301-3907	7188166200	7188166235	Home Hemo		33-2525	Y
HUNTINGTON ARTIFICIAL KIDNEY AT HOME	256 BROADWAY		HUNTINGTON STATION	NY	11746-1403	6314234320	6314232832	Home Hemo		33-2513	Y
COLUMBIA UNIVERSITY AT HOME	60 HAVEN AVE		NEW YORK	NY	10032-2604	2129289071	2129289936	Home Hemo		33-2621	Y
UTICA AVENUE AT HOME	1305 UTICA AVE		BROOKLYN	NY	11203-5911	7186293900	7186296315	Home Hemo		33-2556	Y
CATSKILL AT HOME	139 FORESTBURGH RD		MONTICELLO	NY	12701-2348	8457963300	8457963303	Home Hemo		33-2546	Y
ORANGE AT HOME	100 CRYSTAL RUN RD	STE 102	MIDDLETOWN	NY	10941-4042	8456928220	8456928655	Home Hemo		33-2707	Y
STATEN ISLAND AT HOME	1139 HYLAN BLVD		STATEN ISLAND	NY	10305-2061	7188164913	7188166340	Home Hemo		33-2711	Y
WATERS PLACE AT HOME	1733 EASTCHESTER RD		BRONX	NY	10461-2315	7188221968	7188226030	Home Hemo	1	33-2708	Y
CELIA DILL AT HOME	667 STONELEIGH AVE	STE 123, BARNS OFFICE CENTER	CARMEL	NY	10512-2454	8452784150	8452796902	Home Hemo	1		Y
NIAGARA AT HOME	2932 MILITARY RD		NIAGARA FALLS	NY	14304-1252	7162974059	7162973867	Home Hemo		33-2720	Y
ITHACA AT HOME	201 DATES DR	STE 206	ITHACA	NY	14850-1345	6072721693	6072770520	Home Hemo		33-2536	Y
WILLIAMSBRIDGE HOME AT HOME	3525 WHITE PLAINS RD	STE A	BRONX	NY	10467-5705	7186521013	7186524096	Home Hemo			Y
BUFFALO DOWNTOWN DIALYSIS	520 ELLICOTT ST	STE 100	BUFFALO	NY	14203-1517	7168455101	7168455106	In-Center Hemo, PD Services	13	33-2768	Y
EAST ISLIP DIALYSIS	200 CARLETON AVE		EAST ISLIP	NY	11730-1222	6315810897	6312243355	In-Center Hemo, PD Services	21	33-2752	Y
MELROSE DIALYSIS	459 E 149TH ST		BRONX	NY	10455-1314	7185854951	7182929823	In-Center Hemo, PD Services	24	33-2761	Y
JAMAICA HILLSIDE DIALYSIS	171-19 HILLSIDE AVE		JAMAICA	NY	11432-4548	7185262051	7187393303	In-Center Hemo	25	33-2766	Y
BROOKLYN CHINATOWN DIALYSIS	730 64TH ST		BROOKLYN	NY	11220-4714	7187590129	7187590191	In-Center Hemo, Home Hemo, PD Services	24	33-2764	Y
DUNKIRK DIALYSIS	3958 VINEYARD DR		DUNKIRK	NY	14048-3522	7163661931	7163662105	In-Center Hemo, PD Services	14	33-2767	Y
SEAWAY DIALYSIS	999 E RIDGE RD	STE 11	ROCHESTER	NY	14621-1936	5852667348	5852664685	In-Center Hemo	24	33-2759	Y
HERTEL AVENUE DIALYSIS	699 HERTEL AVE	STE 380	BUFFALO	NY	14207-2355	7168714172	7164470230	In-Center Hemo	17	33-2757	Y
JULIA AND ISRAEL WALDBAUM DIALYSIS	100 COMMUNITY DR	WALDBAUM DIALYSIS CENTER	GREAT NECK	NY	11021-5501	5164873058	5164874918	In-Center Hemo, PD Services	34	33-2754	Y
FLORAL PARK HOME AT HOME	1 CISNEY AVE		FLORAL PARK	NY	11001-3249	5164370789	5163279505	Home Hemo			Y
OYSTER BAY AT HOME	17 E OLD COUNTRY RD		HICKSVILLE	NY	11801-4270	5166812786	5169337837	Home Hemo			Y
SENECA DIALYSIS	10 ST LAWRENCE DR		TIFFIN	OH	44883-8310	4194431051	4194431142	In-Center Hemo, In-Center Hemo Self Care, PD Services	13	36-2622	Y
EASTGATE DIALYSIS	4435 AICHOLTZ RD		CINCINNATI	OH	45245-1690	5137525544	5137525736	In-Center Hemo, In-Center Hemo Self Care	16	36-2522	Y
SOUTHWEST OHIO DIALYSIS	215 S ALLISON AVE		XENIA	OH	45385-3694	9373761453	9373742930	In-Center Hemo, In-Center Hemo Self Care, PD Services	21	36-2594	Y
PARMA DIALYSIS CENTER	6735 AMES RD		PARMA	OH	44129-5601	4407430690	4407430685	In-Center Hemo, In-Center Hemo Self Care, PD Services	20	36-2620	Y
MIDDLEBURG HEIGHTS DIALYSIS	7360 ENGLE RD		MIDDLEBURG HEIGHTS	OH	44130-3429	4408915645	4408915655	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care, PD Services,	24	36-2572	Y
ROCKY RIVER DIALYSIS	20220 CENTER RIDGE RD	STE 50	ROCKY RIVER	OH	44116-3567	4403565744	4408952680	In-Center Hemo, In-Center Hemo Self Care	20	36-2610	N
WILLOW DIALYSIS CENTER	1675 ALEX DR		WILMINGTON	OH	45177-2446	9373833338	9373833631	In-Center Hemo, In-Center Hemo Self Care, PD Services	19	36-2551	Y
ALLIANCE COMMUNITY DIALYSIS	270 E STATE ST	STE 110	ALLIANCE	OH	44601-4309	3308211657	3308211735	In-Center Hemo, In-Center Hemo Self Care, Acute Hemo 1:1, PD Services	19	36-2669	Y
BELDEN COMMUNITY DIALYSIS	4685 FULTON DR NW		CANTON	OH	44718-2379	3306499300	3304914881	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care, Acute Hemo 1:1, PD Services	44	36-2600	Y
MERCY CANTON DIALYSIS	1320 MERCY DR NW		CANTON	OH	44708-2614	3305804001	3305804595	In-Center Hemo, In-Center Hemo Self Care	18	36-2640	Y
SPRINGBORO DIALYSIS	90 COMMERCIAL WAY		SPRINGBORO	OH	45066-3080	9377040589	9377049118	In-Center Hemo	10	36-2672	Y
DAYTON NORTH DIALYSIS	455 TURNER RD		DAYTON	OH	45415-3630	9372787861	9372788336	In-Center Hemo	44	36-2595	Y
WRIGHT FIELD DIALYSIS	1431 BUSINESS CENTER CT		DAYTON	OH	45410-3300	9372521867	9372522256	In-Center Hemo	15	36-2524	Y
SHAKER SQUARE DIALYSIS	12800 SHAKER BLVD	STE 1	CLEVELAND	OH	44120-2000	2164914867	2164914925	In-Center Hemo, In-Center Hemo Self Care, PD Services	20	36-2560	Y
STRONGSVILLE DIALYSIS	17792 PEARL RD		STRONGSVILLE	OH	44136-6909	4402389270	4402389275	In-Center Hemo, In-Center Hemo Self Care	18	36-2684	Y
ROCKSIDE DIALYSIS	4801 ACORN DR		INDEPENDENCE	OH	44131-2566	2165250990	2165253106	In-Center Hemo, In-Center Hemo Self Care, PD Services	16	36-2731	Y
FAIRBORN DIALYSIS	3070 PRESIDENTIAL DR	STE A	BEAVERCREEK	OH	45324-6273	9374266475	9374262436	In-Center Hemo, In-Center Hemo Self Care	12	36-2683	Y
UPPER SANDUSKY DIALYSIS	111 TARHE TRL		UPPER SANDUSKY	OH	43351-8706	4192090799	4192090921	PD Services, In-Center Hemo	8	36-2864	Y
PARK SIDE DIALYSIS	241 W SCHROCK RD		WESTERVILLE	OH	43081-2874	6148821734	6148824529	In-Center Hemo, PD Services	17	36-2783	Y
ANDOVER DIALYSIS	488 S MAIN ST		ANDOVER	OH	44003-9602	4402936028	4402936219	In-Center Hemo, In-Center Hemo Self Care, PD Services	14	36-2694	Y

PATASKALA DIALYSIS CENTER	642 E BROAD ST		PATASKALA	OH	43062-7627	7409641306	7409642698	In-Center Hemo, In-Center Hemo Self Care	8	36-2709	Y
WAUSEON DIALYSIS CENTER	721 S SHOOP AVE		WAUSEON	OH	43567-1729	4193350695	4193350812	In-Center Hemo, In-Center Hemo Self Care, PD Services	13	36-2706	Y
AMHERST DIALYSIS	3200 COOPER FOSTER PRK RD W		LORAIN	OH	44053-3654	4409891410	4409891417	In-Center Hemo, PD Services	17	36-2766	Y
KETTERING DIALYSIS	5721 BIGGER RD		KETTERING	OH	45440-2752	9374354030	9374354140	In-Center Hemo, In-Center Hemo Self Care, PD Services	16	36-2690	Y
SANDUSKY DIALYSIS CENTER	211 LAKESIDE PARK		SANDUSKY	OH	44870-8639	4196263809	4196265107	In-Center Hemo, In-Center Hemo Self Care, PD Services	17	36-2700	Y
ANDERSON DIALYSIS CENTER	7502 STATE RD	STE 1160	CINCINNATI	OH	45255-2800	5136240400	5136240182	In-Center Hemo, In-Center Hemo Self Care	16	36-2715	Y
POINT PLACE DIALYSIS	4747 SUDER AVE	STE 107	TOLEDO	OH	43611-2869	4197279692	4197279743	In-Center Hemo, In-Center Hemo Self Care	12	36-2712	Y
EATON DIALYSIS	105 E WASHINGTON JACKSON RD		EATON	OH	45320-9789	9374561174	9374561945	In-Center Hemo, In-Center Hemo Self Care, PD Services	12	36-2703	Y
BATAVIA DIALYSIS	4000 GOLDEN AGE DR		BATAVIA	OH	45103-1913	5137350700	5137350087	In-Center Hemo	12	36-2736	Y
EAST GALBRAITH DIALYSIS	3877 E GALBRAITH RD	BLDG C	CINCINNATI	OH	45236-1500	5137915900	5137914738	In-Center Hemo	10	36-2740	N
COLUMBUS WEST DIALYSIS	1395 GEORGESVILLE RD		COLUMBUS	OH	43228-3611	6142798495	6142798715	In-Center Hemo, In-Center Hemo Self Care, PD Services	12	36-2705	Y
GROVE CITY DIALYSIS	4155 KELNOR DR		GROVE CITY	OH	43123-2960	6148010323	6148010539	In-Center Hemo, In-Center Hemo Self Care	8	36-2716	Y
LEBANON DIALYSIS CENTER	918B COLUMBUS AVE		LEBANON	OH	45036-1402	5139340272	5139343410	In-Center Hemo, In-Center Hemo Self Care	16	36-2707	Y
EASTGATE HOME TRAINING	4435 AICHOLTZ RD	STE 800B	CINCINNATI	OH	45245-1692	5137528301	5137528483	PD Services	4	36-2702	Y
DELHI DIALYSIS	5040 DELHI AVE		CINCINNATI	OH	45238-5388	5139225900	5139225909	In-Center Hemo	16	36-2708	Y
US GRANT DIALYSIS	458 HOME ST		GEORGETOWN	OH	45121-1408	9373781323	9373785130	In-Center Hemo	12	36-2735	Y
DUBLIN DIALYSIS	6770 PERIMETER DR		DUBLIN	OH	43016-8063	6147988359	6147988442	In-Center Hemo, In-Center Hemo Self Care	12	36-2728	Y
LOGAN DIALYSIS	12880 GREY ST		LOGAN	OH	43138-9638	7403806049	7403806280	In-Center Hemo, In-Center Hemo Self Care, PD Services	12	36-2732	Y
WADSWORTH DIALYSIS	195 WADSWORTH RD	STE 302	WADSWORTH	OH	44281-9504	3303352300	3303356411	In-Center Hemo, In-Center Hemo Self Care, PD Services	14	36-2730	Y
FOREST FAIR DIALYSIS	1145 KEMPER MEADOW DR		CINCINNATI	OH	45240-4118	5136741691	5136741697	In-Center Hemo	16	36-2734	Y
CHERRY VALLEY DIALYSIS	1627 W MAIN ST		NEWARK	OH	43055-1345	7405221699	7405221555	In-Center Hemo, Home Hemo, In-Center Hemo Self Care, PD Services	29	36-2744	Y
BLUE ASH DIALYSIS	10600 MCKINLEY RD		CINCINNATI	OH	45242-3716	5137338215	5137338293	In-Center Hemo, In-Center Hemo Self Care	18	36-2519	Y
MT. AUBURN DIALYSIS	2109 READING RD		CINCINNATI	OH	45202-1417	5137841800	5137232355	In-Center Hemo, In-Center Hemo Self Care	35	36-2502	Y
FAIRFIELD DIALYSIS	1210 HICKS BLVD		FAIRFIELD	OH	45014-1921	5139391110	5139391202	In-Center Hemo, In-Center Hemo Self Care	14	36-2602	Y
FAIRFIELD HOME TRAINING DIALYSIS	1210 HICKS BLVD		FAIRFIELD	OH	45014-1921	5139391120	5139391150	PD Services	1	36-2608	Y
NORTH RIDGE DIALYSIS	6830 N RIDGE RD		MADISON	OH	44057-2637	4404288377	4404280615	In-Center Hemo, In-Center Hemo Self Care, PD Services	12	36-2614	Y
WESTERN HILLS DIALYSIS	3267 WESTBOURNE DR		CINCINNATI	OH	45248-5110	5133470444	5133470150	In-Center Hemo	17	36-2628	Y
WINTON ROAD DIALYSIS	6550 WINTON RD		CINCINNATI	OH	45224-1327	5135912900	5135910208	In-Center Hemo, In-Center Hemo Self Care	24	36-2611	Y
MARIETTA DIALYSIS	1019 PIKE ST		MARIETTA	OH	45750-3500	7403762622	7403762633	In-Center Hemo, In-Center Hemo Self Care	12	36-2563	Y
ZANESVILLE DIALYSIS	3120 NEWARK RD		ZANESVILLE	OH	43701-9659	7404542911	7404520847	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care, PD Services	22	36-2518	Y
COLUMBUS DIALYSIS	226 GRACELAND BLVD	STE 3-09A	COLUMBUS	OH	43214-1532	6149851732	6147810906	In-Center Hemo, In-Center Hemo Self Care, PD Services	21	36-2543	Y
SILVERTON DIALYSIS	6929 SILVERTON AVE		CINCINNATI	OH	45236-3701	5137930555	5137934183	In-Center Hemo, In-Center Hemo Self Care	16	36-2633	Y
COLUMBUS EAST DIALYSIS	299 OUTERBELT ST		COLUMBUS	OH	43213-1529	6145017224	6145015197	In-Center Hemo, In-Center Hemo Self Care	25	36-2629	Y
SILVERTON HOME TRAINING DIALYSIS	6929 SILVERTON AVE		CINCINNATI	OH	45236-3701	5137934376	5137934183	PD Services	4	36-2634	Y
ASHTABULA DIALYSIS	1614 W 19TH ST		ASHTABULA	OH	44004-3036	4409649777	4409648914	In-Center Hemo, In-Center Hemo Self Care, Acute Hemo 1:1, Acute PD, PD Services	17	36-2554	Y
SWAN CREEK DIALYSIS	5201 AIRPORT HWY		TOLEDO	OH	43615-6800	4192140540	4192140546	In-Center Hemo, In-Center Hemo Self Care, PD Services	17	36-2587	Y
BUTLER COUNTY DIALYSIS	3497 S DIXIE HWY		FRANKLIN	OH	45005-5717	5134221467	5134221634	In-Center Hemo, In-Center Hemo Self Care	20	36-2647	Y
COLUMBUS DOWNTOWN DIALYSIS	415 E MOUND ST		COLUMBUS	OH	43215-5512	6142281773	6142281881	In-Center Hemo	24	36-2650	Y
WHITE OAK DIALYSIS	5520 CHEVIOT RD	STE B	CINCINNATI	OH	45247-7069	5137411062	5137412819	In-Center Hemo, In-Center Hemo Self Care	20	36-2688	Y
WHITE OAK HOME TRAINING DIALYSIS	5520 CHEVIOT RD	STE B	CINCINNATI	OH	45247-7069	5133853580	5133854589	PD Services	8	36-2687	Y
BELPRE DIALYSIS	2906 WASHINGTON BLVD		BELPRE	OH	45714-1848	7404010607	7404010691	In-Center Hemo, In-Center Hemo Self Care, PD Services	12	36-2671	Y
NORTHWOOD DIALYSIS	611 LEMOYNE RD		NORTHWOOD	OH	43619-1811	4196983423	4196985165	In-Center Hemo, In-Center Hemo Self Care, PD Services	13	36-2680	Y
BUTLER COUNTY HOME TRAINING DIALYSIS	7335 YANKEE RD	STE 101	LIBERTY TOWNSHIP	OH	45044-0008	5137552524	5137553268	PD Services	4	36-2689	Y
DARKE COUNTY DIALYSIS	1111 SWEITZER ST	STE B	GREENVILLE	OH	45331-1189	9375487019	9375486519	In-Center Hemo	10	36-2659	Y
ATRIUM DIALYSIS	4421 ROOSEVELT BLVD	STE D	MIDDLETOWN	OH	45044-9024	5134226879	5134226911	In-Center Hemo	16	36-2795	Y
UPPER VALLEY KIDNEY CENTER	3190 N COUNTY RD 25A		TROY	OH	45373-1337	9373323733	9373323794	In-Center Hemo, PD Services	22	36-2796	Y
VILLA OF LAKEWOOD	14050 MADISON AVE		LAKEWOOD	OH	44107-4530	2162213717	2162213742	In-Center Hemo	6	36-2769	N
VILLA OF GREAT NORTHERN	22710 FAIRVIEW CENTER DR	STE 100	FAIRVIEW PARK	OH	44126-3607	4407344630	4407344659	In-Center Hemo, In-Center Hemo Self Care	8	36-2749	Y
OHIO PIKE DIALYSIS	1761 STATE ROUTE 125		AMELIA	OH	45102-2007	5137970713	5137970617	In-Center Hemo	12	36-2739	Y
RIVERS EDGE DIALYSIS	1006 E STATE ST	STE B	ATHENS	OH	45701-2158	7405921364	7405933876	In-Center Hemo, In-Center Hemo Self Care	12	36-2748	Y
NORWOOD DIALYSIS	2300 WALL ST	STE O	CINCINNATI	OH	45212-2789	5135312111	5135310236	In-Center Hemo	25	36-2742	Y
REDBANK VILLAGE DIALYSIS	3960 RED BANK RD	STE 160	CINCINNATI	OH	45227-3421	5132715420	5132715437	In-Center Hemo	12	36-2743	Y
CLERMONT COUNTY DIALYSIS	5901 MONTCLAIR BLVD	STE 100	MILFORD	OH	45150-2547	5132480593	5132481853	In-Center Hemo	12	36-2751	Y
MIAMISBURG DIALYSIS	290 ALEXANDERSVILLE RD		MIAMISBURG	OH	45342-3611	9378650633	9378650735	In-Center Hemo, PD Services	11	36-2785	Y
HIGHLAND COUNTY DIALYSIS	120 ROBERTS LN	STE 4	HILLSBORO	OH	45133-7643	9373933852	9373933950	In-Center Hemo, PD Services	9	36-2750	Y

DOVER COMMUNITY DIALYSIS	899 E IRON AVE		DOVER	OH	44622-2097	3303646309	3303646490	In-Center Hemo, PD Services	16	36-2765	Y
HEART OF MARION DIALYSIS	1221 DELAWARE AVE		MARION	OH	43302-6419	7403750849	7403750869	In-Center Hemo, PD Services	13	36-2823	Y
MASSILLON COMMUNITY DIALYSIS	2112 LINCOLN WAY E		MASSILLON	OH	44646-7034	3308377730	3308377753	In-Center Hemo	12	36-2789	Y
NATIONAL TRAIL DIALYSIS	171 S TUTTLE RD		SPRINGFIELD	OH	45505-1560	9373287399	9373287513	In-Center Hemo, Nocturnal Hemo	17	36-2780	Y
ADENA DIALYSIS	1180 N BRIDGE ST		CHILLICOTHE	OH	45601-1793	7407733733	7407733741	In-Center Hemo, PD Services	17	36-2777	Y
TROTWOOD DIALYSIS	5680 SALEM BEND DR		DAYTON	OH	45426-1462	9378328432	9378379510	In-Center Hemo	12	36-2861	Y
FREMONT REGIONAL DIALYSIS	100 PINNACLE DR		FREMONT	OH	43420-7400	4193320310	4193320296	In-Center Hemo, PD Services	14	36-2791	Y
TWINSBURG DIALYSIS	2592 E AURORA RD	STE 100	TWINSBURG	OH	44087-2148	3304053030	3304258969	In-Center Hemo, PD Services	13	36-2837	Y
LUCAS COUNTY HOME TRAINING	2702 NAVARRE AVE	STE 203	OREGON	OH	43616-3224	4196911514	4196911594	PD Services	2	36-2794	Y
KENTON DIALYSIS	1207 E COLUMBUS ST	KENTON RIDGE CTR	KENTON	OH	43326-1760	4196754075	4196751108	In-Center Hemo, PD Services	10	36-2805	Y
AUBURN ROAD DIALYSIS	7611 AUBURN RD		PAINESVILLE	OH	44077-9608	4403572927	4403572976	In-Center Hemo, PD Services	13	36-2799	Y
HUBER HEIGHTS DIALYSIS	7769 OLD COUNTRY COURT		HUBER HEIGHTS	OH	45424-2097	9372370769	9372371981	In-Center Hemo, PD Services	15	36-2833	Y
KINGSVILLE DIALYSIS	5740 DIBBLE RD		KINGSVILLE	OH	44048-9809	4402241338	4402242601	In-Center Hemo	6	36-2793	Y
COVENTRY DIALYSIS	3235 MANCHESTER RD	STE 9	AKRON	OH	44319-1458	3306459453	3306459484	In-Center Hemo	13	36-2820	Y
FIVE RIVERS DIALYSIS	4750 N MAIN ST		DAYTON	OH	45405-5021	9372785139	9372785722	In-Center Hemo	17	36-2803	Y
BUCKEYE DIALYSIS	3050 S DIXIE DR		KETTERING	OH	45409-1516	9376432337	9376432487	In-Center Hemo	17	36-2792	Y
GALION DIALYSIS	865 HARDING WAY W		GALION	OH	44833-1637	4194620897	4194620927	In-Center Hemo, PD Services	17	36-2816	Y
MID OHIO DIALYSIS	2148 W 4TH ST		ONTARIO	OH	44906-1200	4197474039	4197474046	In-Center Hemo, PD Services	14	36-2804	Y
HARRISON DIALYSIS	10475 HARRISON AVE		HARRISON	OH	45030-1941	5132020373	5132020819	In-Center Hemo	13	36-2806	Y
MEADOWHAWK DIALYSIS	491 COLEMANS XING	COLEMAN'S CROSSING CENTER	MARYSVILLE	OH	43040-7068	9376420676	9376420412	In-Center Hemo	9	36-2807	Y
STEUBENVILLE HOME TRAINING (PD)	1799 SINCLAIR AVE	STE 2	STEUBENVILLE	OH	43953-3328	7403462740	7403462783	PD Services	0	36-2801	Y
AFFINITY PLACE DIALYSIS	7700 AFFINITY DR		CINCINNATI	OH	45231-3566	5135210981	5135211566	In-Center Hemo	17	36-2834	Y
APPLE VALLEY DIALYSIS	1485 COSHOCTON AVE		MOUNT VERNON	OH	43050-1544	7403923436	7403923843	In-Center Hemo, PD Services	9	36-2802	Y
HILLIARD STATION DIALYSIS	2447 HILLIARD ROME RD		HILLIARD	OH	43026-8194	6148763610	6148763144	In-Center Hemo	13	36-2808	Y
CANAL WINCHESTER DIALYSIS	3568 GENDER RD		CANAL WINCHESTER	OH	43110-8007	6148343564	6148343597	In-Center Hemo, PD Services	13	36-2815	Y
KIDNEY CENTER OF BRUNSWICK	3812 CENTER RD	STE 101	BRUNSWICK	OH	44212-3025	3302204502	3302204481	In-Center Hemo, PD Services	16	36-2809	Y
DETROIT ROAD DIALYSIS	7901 DETROIT AVE		CLEVELAND	OH	44102-2828	2169616498	2169616802	In-Center Hemo	24	36-2754	Y
ST V QUADRANGLE DIALYSIS	2302 COMMUNITY COLLEGE AVE		CLEVELAND	OH	44115-3117	2165744805	2165744901	In-Center Hemo	13	36-2756	Y
MIDWEST SPRINGFIELD DIALYSIS	2200 N LIMESTONE ST STE 104		SPRINGFIELD	OH	45503-2692	9373903125	9373906022	In-Center Hemo, PD Services	16	36-2592	Y
MIDWEST FAIRBORN DIALYSIS	1266 N BROAD ST		FAIRBORN	OH	45324-5549	9378790433	9378790589	In-Center Hemo, PD Services	19	36-2645	Y
MIDWEST URBANA DIALYSIS	1430 E US HIGHWAY 36		URBANA	OH	43078-9112	9374844600	9374844407	In-Center Hemo, PD Services	12	36-2729	Y
HOME DIALYSIS OF DAYTON-SOUTH	3030 S DIXIE DR		KETTERING	OH	45409-1516	9372961171	9372961476	PD Services	3	36-2541	Y
HOME DIALYSIS OF DAYTON	627 S EDWIN C MOSES BLVD	STE 2B	DAYTON	OH	45417-3474	9372604506	9374243581	PD Services	4	36-2542	Y
PARMA HEIGHTS DIALYSIS	9050 N CHURCH DR		PARMA HEIGHTS	OH	44130-4701	4408420895	4402920234	In-Center Hemo, PD Services	16	36-2704	Y
HILLIARD DIALYSIS	19133 HILLIARD BLVD		ROCKY RIVER	OH	44116-2907	2167124700	2167124704	In-Center Hemo, PD Services	18	36-2699	Y
CENTER RIDGE DIALYSIS	38630 CENTER RIDGE RD		NORTH RIDGEVILLE	OH	44039-2837	4403272070	4403271563	In-Center Hemo	14	36-2776	Y
STEUBENVILLE DIALYSIS	1799 SINCLAIR AVE	STE 1	STEUBENVILLE	OH	43953-3373	7403462840	7403462846	In-Center Hemo	21	36-2772	Y
PREMIERE KIDNEY CENTER OF NEWARK	65 S TERRACE AVE		NEWARK	OH	43055-1355	7405222955	7405222975	In-Center Hemo, PD Services	21	36-2644	Y
HILLSBORO REGIONAL DIALYSIS	1487 N HIGH ST	STE 1A	HILLSBORO	OH	45133-8496	9373939020	9373939095	In-Center Hemo, PD Services	14	36-2741	Y
MCCARTY LANE DIALYSIS	500 MCCARTY LN		JACKSON	OH	45640-7019	7402861600	7402861615	In-Center Hemo	12	36-2701	Y
HILLIARD AT HOME	19133 HILLIARD BLVD		ROCKY RIVER	OH	44116-2907	2167124700	2167124704	Home Hemo, Staff Assisted Home Hemo		36-2699	Y
AUBURN ROAD AT HOME	7611 AUBURN RD		PAINESVILLE	OH	44077-9608	4403572927	4403572976	Home Hemo		36-2799	Y
FREMONT REGIONAL AT HOME	100 PINNACLE DR		FREMONT	OH	43420-7400	4193320310	4193320296	Home Hemo		36-2791	Y
LUCAS COUNTY HT AT HOME	2702 NAVARRE AVE	STE 203	OREGON	OH	43616-3223	4196911514	4196911594	Home Hemo		36-2794	Y
LINDEN HOME DIALYSIS	1431 BUSINESS CENTER CT		DAYTON	OH	45410-3300	9372521867	9372522256	Home Hemo	2	36-2753	Y
AMHERST AT HOME	3200 COOPER FOSTER PRK RD W		LORAIN	OH	44053-3654	4409891410	4409891417	Home Hemo		36-2766	Y
SHAKER SQUARE AT HOME	12800 SHAKER BLVD	STE 1	CLEVELAND	OH	44120-2000	2164914867	2164914925	Home Hemo		36-2560	Y
CHERRY VALLEY AT HOME	1627 W MAIN ST		NEWARK	OH	43055-1345	7405221699	7405221555	Home Hemo		36-2744	Y
ROCKSIDE AT HOME	4801 ACORN DR		INDEPENDENCE	OH	44131-2566	2165250990	2165253106	Home Hemo		36-2731	Y
WADSWORTH AT HOME	195 WADSWORTH RD STE 302	FOUNDERS HALL 3RD FLOOR	WADSWORTH	OH	44281-9504	3303352300	3303359504	Home Hemo		36-2730	Y

MIDWEST FAIRBORN AT HOME	1266 N BROAD ST		FAIRBORN	OH	45324-5549	9378790433	9378790589	Home Hemo		36-2645	Y
BELDEN COMMUNITY AT HOME	4685 FULTON DR NW		CANTON	OH	44718-2379	3306499300	3304914881	Home Hemo, Staff Assisted Home Hemo		36-2600	Y
WHITE OAK HOME AT HOME	5520 CHEVIOT RD	STE B	CINCINNATI	OH	45247-7069	5133852159	5133854589	Home Hemo	0	36-2687	Y
BELPRE AT HOME	2906 WASHINGTON BLVD		BELPRE	OH	45714-1848	7404010607	7404010691	Home Hemo	0	36-2671	Y
ZANESVILLE AT HOME	3120 NEWARK RD		ZANESVILLE	OH	43701-9659	7404542911	7404520847	Home Hemo	0	36-2518	Y
KETTERING AT HOME	5721 BIGGER RD		KETTERING	OH	45440-2752	9374354030	9374354140	Home Hemo	0	36-2690	Y
STRONGSVILLE AT HOME	17792 PEARL RD		STRONGSVILLE	OH	44136-6909	4402389270	4402389275	Home Hemo	0	36-2684	Y
COLUMBUS WEST HOME TRAINING AT HOME	1391 GEORGESVILLE RD		COLUMBUS	OH	43228-3611	6142798495	6142798715	Home Hemo	3	36-2727	Y
SWAN CREEK AT HOME	5201 AIRPORT HWY		TOLEDO	OH	43615-6800	4192140540	4192140546	Home Hemo	0	36-2587	Y
NORTH RIDGE AT HOME	6830 N RIDGE RD		MADISON	OH	44057-2637	4404288377	4404280615	Home Hemo		36-2614	Y
SUMMIT RENAL AT HOME	73 MASSILLON RD		AKRON	OH	44312-1028	3307331861	3307330788	Home Hemo		36-2613	Y
KIDNEY CENTER OF BRUNSWICK AT HOME	3812 CENTER RD	STE 101	BRUNSWICK	OH	44212-3025	3302204502	3302204481	Home Hemo		36-2809	Y
SOUTHLAND AT HOME	3401 GLENDALE AVE	STE 110	TOLEDO	OH	43614-2490	4193899681	4193899196	Home Hemo		36-2509	Y
MAUMEE BAY AT HOME	3310 DUSTIN RD		OREGON	OH	43616-3302	4196972191	4196972177	Home Hemo		36-2547	Y
FLOWER AT HOME	5308 HARROUN RD	STE 60	SYLVANIA	OH	43560-2114	4198246074	4198823830	Home Hemo		36-2775	Y
STEUBENVILLE HT AT HOME	1799 SINCLAIR AVE	STE 2	STEUBENVILLE	OH	43953-3327	7403462740	7403462783	Home Hemo		36-2801	Y
SANDUSKY AT HOME	211 LAKESIDE DR		SANDUSKY	OH	44870-8639	4196263809	4196265107	Home Hemo		36-2700	Y
KENTON AT HOME	1207 E COLUMBUS ST	KENTON RIDGE CENTER	KENTON	OH	43326-1760	4196754075	4196751108	Home Hemo		36-2805	Y
MID OHIO AT HOME	2148 W 4TH ST		ONTARIO	OH	44906-1200	4197474039	4197474046	Home Hemo		36-2804	Y
HOME DIALYSIS OF DAYTON-SOUTH AT HOME	3030 S DIXIE DR		KETTERING	OH	45409-1516	9372961171	9372961476	Home Hemo	0	36-2541	Y
MUNROE FALLS DIALYSIS	265 N MAIN ST		MUNROE FALLS	OH	44262-1090	3306891400	3306891408	In-Center Hemo	13	36-2651	Y
SUMMIT RENAL CENTER	73 MASSILLON RD		AKRON	OH	44312-1028	3307331861	3307334696	In-Center Hemo, PD Services	19	36-2613	Y
WHITE PONDS DIALYSIS	791 WHITE POND DR		AKRON	OH	44320-4202	3308359083	3308359353	In-Center Hemo, PD Services	22	36-2623	Y
AKRON RENAL CENTER	525 E MARKET ST	BLDG 50	AKRON	OH	44304-1619	3303756848	3303753421	In-Center Hemo	16	36-2719	Y
SOUTHLAND DIALYSIS	3401 GLENDALE AVE	STE 110	TOLEDO	OH	43614-2490	4193899681	4193899196	In-Center Hemo, PD Services	28	36-2509	Y
MAUMEE BAY DIALYSIS	3310 DUSTIN RD		OREGON	OH	43616-3302	4196972191	4196972177	In-Center Hemo, PD Services	18	36-2547	Y
FLOWER DIALYSIS	5308 HARROUN RD	STE 60	SYLVANIA	OH	43560-2114	4198246074	4198823830	In-Center Hemo, PD Services	12	36-2775	Y
THE CHRIST HOSPITAL DIALYSIS	2139 AUBURN AVE	1 WEST	CINCINNATI	OH	45219-2906	5135850314	5135853942	In-Center Hemo	15	36-2822	Y
HOME DIALYSIS SERVICES OF SANDUSKY INC	2819 S HAYES AVE	STE 2	SANDUSKY	OH	44870-5391	4196270477	4196270466	PD Services	0	36-2660	Y
PARMA HEIGHTS AT HOME	9050 N CHURCH DR		PARMA HEIGHTS	OH	44130-4701	4402920231	4402920234	Home Hemo		36-2704	Y
CANAL WINCHESTER AT HOME	3568 GENDER RD		CANAL WINCHESTER	OH	43110-8007	6148343564	6148343597	Home Hemo		362815	Y
GALION AT HOME	865 HARDING WAY W		GALION	OH	44833-1637	4194620897	4194620927	Home Hemo		36-2816	Y
UPPER VALLEY KIDNEY CENTER AT HOME	3190 N COUNTY RD 25A		TROY	OH	45373-1337	9373323733	9373323794	Home Hemo	2	36-2796	Y
PIKE COUNTY AT HOME	609 W EMMITT AVE		WAVERLY	OH	45690-1013	7409411688	7409411713	Home Hemo	1		Y
RIDGE PARK AT HOME	4805 PEARL RD		CLEVELAND	OH	44109-5145	2163986029	2163986053	Home Hemo		36-2828	Y
HEART OF MARION AT HOME	1221 DELAWARE AVE		MARION	OH	43302-6419	7403750849	7403750869	Home Hemo		36-2823	Y
PREMIERE KIDNEY CENTER OF NEWARK AT HOME	65 S TERRACE AVE		NEWARK	OH	43055-1355	7405222955	7405222975	Home Hemo			Y
WEST TOLEDO DIALYSIS	2900 CARSKADDON AVE		TOLEDO	OH	43606-1601	4195310755	4195310957	In-Center Hemo	17	36-2818	Y
MILLERSBURG DIALYSIS	1649 S WASHINGTON ST		MILLERSBURG	OH	44654-8902	3306740476	3306741295	In-Center Hemo, PD Services	9	36-2825	Y
ROSS DIALYSIS	3825 KRAUS LN	STE S	FAIRFIELD	OH	45014-5867	5137380276	5137380305	In-Center Hemo	13	36-2819	Y
PIKE COUNTY DIALYSIS	609 W EMMITT AVE		WAVERLY	OH	45690-1013	7409411688	7409411713	In-Center Hemo, PD Services	9	36-2817	Y
WEST HAMILTON DIALYSIS	1532 MAIN ST		HAMILTON	OH	45013-1078	5137370158	5137373102	In-Center Hemo	17	36-2826	Y
WEST CHESTER DIALYSIS	7760 W VOICE OF AMERICA PARK DR	STE E	WEST CHESTER	OH	45069-3371	5137551510	5137551461	In-Center Hemo	17	36-2824	Y
RIDGE PARK DIALYSIS	4805 PEARL RD		CLEVELAND	OH	44109-5145	2163986029	2163986053	In-Center Hemo, PD Services	14	36-2828	Y
RAVENNA DIALYSIS	600 ENTERPRISE PKWY		RAVENNA	OH	44266-8054	3302975846	3302976357	In-Center Hemo, PD Services	9	36-2838	Y
WOOSTER DIALYSIS	4190 BURBANK RD		WOOSTER	OH	44691-9077	3303451130	3303451336	In-Center Hemo, PD Services	12	36-2840	Y
DAYTON SOUTH DIALYSIS	4700 SPRINGBORO PIKE	STE A	MORAINE	OH	45439-1964	9372947188	9372947370	In-Center Hemo, Nocturnal Hemo	17	36-2821	Y
FALLEN TIMBERS DIALYSIS	4330 KEYSTONE DR		MAUMEE	OH	43537-8795	4198870762	4198870773	In-Center Hemo, PD Services	12	36-2855	Y
MIRACLE MILE DIALYSIS	4925 JACKMAN RD	UNIT# 59	TOLEDO	OH	43613-3574	4194744989	4194745112	In-Center Hemo, PD Services	12	36-2859	Y
HEART OF NEW ALBANY DIALYSIS	6530 W CAMPUS OVAL	STE 100	NEW ALBANY	OH	43054-8726	6148553445	6148559695	In-Center Hemo, PD Services	8	36-2854	Y
WESTERN RIDGE DIALYSIS	6909 GOOD SAMARITAN DR	STE C	CINCINNATI	OH	45247-5209	5133530237	5133530230	In-Center Hemo	15	36-2849	Y

BOETTLER DIALYSIS	1587 BOETTLER RD	STE 130	UNIONTOWN	OH	44685-7823	3308990035	3308964975	In-Center Hemo, PD Services	12	36-2867	Y
MEDINA SQUARE DIALYSIS	740 N COURT ST		MEDINA	OH	44256-1748	3307217824	3307219540	In-Center Hemo	8		Y
MALLORY PARK DIALYSIS	2808 GERMANTOWN ST		DAYTON	OH	45417-4134	9372628427	9372628016	In-Center Hemo	24	36-2860	Y
LAWRENCE COUNTY DIALYSIS	367 COUNTY RD 406	UNIT 11	SOUTH POINT	OH	45680-8766	7408940830	8772881208	In-Center Hemo, PD Services	9	36-2863	Y
BELMONT DIALYSIS	68639 BANNOCK RD		ST CLAIRSVILLE	OH	43950-9736	7406990220	7406990703	In-Center Hemo, PD Services	10	36-2561	Y
CANTON DIALYSIS	2912 W TUSCARAWAS ST		CANTON	OH	44708-4643	3304580150	3304580164	In-Center Hemo, PD Services	27	36-2866	Y
WHITE PONDS AT HOME	791 WHITE POND DR		AKRON	OH	44320-4202	3308359083	3308359353	Home Hemo	1	36-2623	Y
CANTON AT HOME	2912 TUSCARAWAS ST W		CANTON	OH	44708-4643			Home Hemo		36-2866	Y
BOETTLER AT HOME	1587 BOETTLER RD	STE 130	UNIONTOWN	OH	44685-7823	3308990035	3308964975	Home Hemo		36-2867	Y
LAWRENCE COUNTY AT HOME	367 COUNTY RD 406	UNIT 11	SOUTH POINT	OH	45680-8766	7408940830	7408940844	Home Hemo		36-2863	Y
EASTGATE AT HOME	4435 AICHOLTZ RD		CINCINNATI	OH	45245-1690	5137525544	5137525736	Home Hemo		36-2702	Y
UPPER SANDUSKY AT HOME	111 TARHE TRL		UPPER SANDUSKY	OH	43351-8706	4192090799	4192090921	Home Hemo		36-2864	Y
SAPULPA DIALYSIS	9647 RIDGEVIEW ST		TULSA	OK	74131-6205	9182249996	9182249997	In-Center Hemo	16	37-2560	Y
TULSA DIALYSIS CENTER	5636 E SKELLY DR		TULSA	OK	74135-6473	9186600571	9186600562	In-Center Hemo	20	37-2504	Y
BROKEN ARROW DIALYSIS CENTER	1710 N 9TH ST		BROKEN ARROW	OK	74012-8283	9183550657	9183552800	In-Center Hemo	16	37-2516	Y
CLAREMORE DIALYSIS CENTER	202 E BLUE STARR DR		CLAREMORE	OK	74017-4223	9183421119	9183422644	In-Center Hemo, In-Center Hemo Self Care	16	37-2514	Y
TAHLEQUAH DIALYSIS CENTER	1373 E BOONE ST		TAHLEQUAH	OK	74464-3330	9184310665	9184310623	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care, PD Services	20	37-2512	Y
ALTUS DIALYSIS CENTER	205 S PARK LN	STE 130	ALTUS	OK	73521-5756	5804821197	5804821198	In-Center Hemo, PD Services	10	37-2524	Y
DUNCAN DIALYSIS CENTER	2845 W ELK AVE	BLDG 400	DUNCAN	OK	73533-1981	5804708542	5804708891	In-Center Hemo, In-Center Hemo Self Care, PD Services	12	37-2522	Y
NORMAN DIALYSIS CENTER	1818 W LINDSEY ST	STE B104	NORMAN	OK	73069-4184	4053609815	4053609715	In-Center Hemo	12	37-2527	Y
SHAWNEE DIALYSIS CENTER	4409 N KICKAPOO AVE	STE 113	SHAWNEE	OK	74804-1224	4058786762	4058780063	In-Center Hemo, PD Services	16	37-2513	Y
STILLWATER DIALYSIS CENTER	406 E HALL OF FAME AVE	STE 300	STILLWATER	OK	74075-5447	4057070408	4056246405	In-Center Hemo, In-Center Hemo Self Care	12	37-2505	Y
ELK CITY DIALYSIS CENTER	1601 W 2ND ST		ELK CITY	OK	73644-4427	5802252700	5802252701	In-Center Hemo, In-Center Hemo Self Care, PD Services	12	37-2531	Y
NORTHWEST BETHANY DIALYSIS CENTER	7800 NW 23RD ST	STE A	BETHANY	OK	73008-4948	4054958606	4054954356	In-Center Hemo, In-Center Hemo Self Care, PD Services	16	37-2515	Y
EDMOND DIALYSIS CENTER	50 S BAUMANN AVE		EDMOND	OK	73034-5676	4053306646	4053306221	In-Center Hemo, In-Center Hemo Self Care	12	37-2541	Y
MIDWEST CITY DIALYSIS CENTER	7221 E RENO AVE		MIDWEST CITY	OK	73110-4474	4058699600	4058699605	In-Center Hemo	16	37-2511	Y
CENTRAL TULSA DIALYSIS CENTER	1124 S SAINT LOUIS AVE		TULSA	OK	74120-5413	9185855557	9185853536	In-Center Hemo, Home Hemo	26	37-2546	Y
OKMULGEE DIALYSIS CENTER	201 S DELAWARE AVE		OKMULGEE	OK	74447-5528	9187563526	9187561760	In-Center Hemo	16	37-2548	Y
MUSKOGEE COMMUNITY DIALYSIS CENTER	2316 W SHAWNEE ST		MUSKOGEE	OK	74401-2228	9186870016	9186871858	In-Center Hemo	16	37-2549	Y
TRI-STATE DIALYSIS	2510 N MAIN ST		MIAMI	OK	74354-1602	9185401827	9185421282	In-Center Hemo	18	37-2547	Y
STILWELL DIALYSIS CENTER	80851 HWY 59		STILWELL	OK	74960-1636	9186965072	9186965074	In-Center Hemo	20	37-2545	Y
CENTRAL TULSA DIALYSIS CENTER PD	1124 S SAINT LOUIS AVE		TULSA	OK	74120-5413	9183825015	9185870776	PD Services	0	37-2546	Y
CLINTON DIALYSIS CENTER	150 S 31ST ST		CLINTON	OK	73601-9118	5803234349	5803232793	In-Center Hemo, In-Center Hemo Self Care	16	37-2561	Y
DURANT DIALYSIS CENTER	411 WESTSIDE DR		DURANT	OK	74701-2932	5809200808	5809200828	In-Center Hemo, Acute Hemo 1:1, Acute PD	16	37-2565	Y
SOUTHCREST DIALYSIS	10921 E 81ST ST		TULSA	OK	74133-4227	9182498402	9184598794	In-Center Hemo, Nocturnal Hemo	16	37-2567	Y
GREENWOOD DIALYSIS CENTER	1345 N LANSING AVE		TULSA	OK	74106-5911	9185858811	9185855506	In-Center Hemo	12	37-2569	Y
CHICKASHA DIALYSIS	228 S 29TH ST		CHICKASHA	OK	73018-2502	4052249901	4052249909	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care, PD Services	8	37-2572	Y
ANADARKO DIALYSIS CENTER	414 SE 11TH ST		ANADARKO	OK	73005-4442	4052472299	4052474888	In-Center Hemo, In-Center Hemo Self Care	10	37-2575	Y
OWASSO DIALYSIS	9521 N OWASSO EXPY		OWASSO	OK	74055-5414	9183769479	9183762781	In-Center Hemo	16	37-2585	Y
PRYOR DIALYSIS	309 E GRAHAM AVE		PRYOR	OK	74361-2434	9188253100	9188253183	In-Center Hemo	14	37-2529	Y
OKLAHOMA CITY SOUTH DIALYSIS	319 SW 59TH ST		OKLAHOMA CITY	OK	73109-8301	4056343708	4056361211	In-Center Hemo	21	37-2518	Y
HEARTLAND DIALYSIS	925 NE 8TH ST		OKLAHOMA CITY	OK	73104-5800	4052363043	4052392390	In-Center Hemo, PD Services	32	37-2530	Y
ARDMORE DIALYSIS RANCH	2617 CROSSROADS DR		ARDMORE	OK	73401-2574	5804909844	5804909831	In-Center Hemo, PD Services	28	37-2582	Y
ROSE ROCK DIALYSIS	9913 E RENO AVE		MIDWEST CITY	OK	73130-3505	4057321576	4057321062	In-Center Hemo, PD Services, Nocturnal Hemo	12	37-2586	Y
REDBIRD SMITH DIALYSIS	305 S J T STITES ST		SALLISAW	OK	74955-9302	9182350290	9182350351	In-Center Hemo, PD Services	12	37-2592	Y
YUKON DIALYSIS	12801 NW 10TH ST	STE 400	YUKON	OK	73099-4179	4053503017	4053500023	In-Center Hemo	13	37-2601	Y
MID-DEL HOME TRAINING PD	9230 E RENO AVE	STE A	MIDWEST CITY	OK	73130-3320	4057320744	4057320651	PD Services	6	37-2588	Y
GROVE DIALYSIS	1111 NEO LOOP		GROVE	OK	74344-6046	9187864840	9187864931	In-Center Hemo	16	37-2590	N
BERKSHIRE HOME TRAINING PD	4800 W SAN ANTONIO ST	STE 201	BROKEN ARROW	OK	74012-6127	9182499716	9182544173	PD Services	11	37-2591	Y
SOONER DIALYSIS	1561 N PORTER AVE		NORMAN	OK	73071-6621	4053293830	4053293791	In-Center Hemo	20	37-2562	Y
CLEVELAND PD	1059 SE 82ND ST		OKLAHOMA CITY	OK	73149-2999	4055126912	4055126918	PD Services	2	37-2579	Y
BERKSHIRE HT AT HOME	4800 W SAN ANTONIO ST	STE 201	BROKEN ARROW	OK	74012-6127	9182499716	9182544173	Home Hemo		37-2591	Y
ARDMORE RANCH AT HOME	2617 CROSSROADS DR		ARDMORE	OK	73401-2574	5804909844	5804909831	Home Hemo	0	37-2582	Y
SOONER AT HOME	1561 N PORTER AVE		NORMAN	OK	73071-6621	4053293830	4053296250	Home Hemo		37-2562	Y

TULSA AT HOME	5636 E SKELLY DR		TULSA	OK	74135-6473	9186600571	9186600562	Home Hemo	0	37-2504	Y
HEARTLAND AT HOME	925 NE 8TH ST		OKLAHOMA CITY	OK	73104-5800	4052363043	4052392390	Home Hemo	0	37-2530	Y
TAHLEQUAH AT HOME	1373 E BOONE ST		TAHLEQUAH	OK	74464-3330	9184310665	9184310623	Home Hemo		37-2512	Y
LAWTON DIALYSIS	1110 SW B AVE		LAWTON	OK	73501-4229	5805954987	5805957296	In-Center Hemo, PD Services	12	37-2604	Y
MOORE DIALYSIS	620 S SANTA FE AVE	STE C	MOORE	OK	73160-2476	4057992439	4057992409	In-Center Hemo	12	37-2603	Y
SHAWNEE PERITONEAL DIALYSIS	2810 N KICKAPOO ST		SHAWNEE	OK	74804-1798	4052731599	4052731750	PD Services	0	37-2599	N
WAGONER DIALYSIS	402 S WALL ST		WAGONER	OK	74467-5003	9184854363	9184853043	In-Center Hemo, PD Services	12	37-2606	Y
IDABEL DIALYSIS	1319 S LYNN LN		IDABEL	OK	74745-6845	5802861108	5802865064	In-Center Hemo, PD Services	13	37-2602	Y
GARFIELD COUNTY DIALYSIS	204 S VAN BUREN ST	STE A	ENID	OK	73703-5812	5802371264	5802371463	In-Center Hemo, PD Services	12		Y
DT4 DIALYSIS	4800 W SAN ANTONIO ST	STE 103	BROKEN ARROW	OK	74012-6127	9183071320	9182529032	In-Center Hemo	4	37-2607	Y
PAULS VALLEY DIALYSIS	2410 W GRANT AVE		PAULS VALLEY	OK	73075-9229	4052079274	4052079407	In-Center Hemo, PD Services	12	372605	Y
HERMISTON COMMUNITY DIALYSIS CENTER	1155 W LINDA AVE		HERMISTON	OR	97838-9601	5412891122	5412891150	In-Center Hemo, PD Services	12	38-2544	Y
FOUR RIVERS DIALYSIS CENTER	515 EAST LN		ONTARIO	OR	97914-3953	5418899557	5418894649	In-Center Hemo	13	38-2519	Y
FOUR RIVERS DIALYSIS CENTER PD	515 EAST LN		ONTARIO	OR	97914-3953	5418899557	5418894649	PD Services		38-2519	Y
KLAMATH FALLS DIALYSIS	2421 WASHBURN WAY	STE B	KLAMATH FALLS	OR	97603-4505	5418823401	5412737431	In-Center Hemo	17	38-2557	Y
GRANTS PASS II DIALYSIS	1055 REDWOOD AVE		GRANTS PASS	OR	97527-5525	5414790545	5414794271	In-Center Hemo	12	38-2565	Y
SHERWOOD DIALYSIS CENTER	21035 SW PACIFIC HWY		SHERWOOD	OR	97140-8062	5039250105	5039251734	In-Center Hemo, PD Services	13	38-2546	Y
HILLSBORO DIALYSIS CENTER	2500 NE CENTURY BLVD	BLDG E, STE 300	HILLSBORO	OR	97124-7516	5036819460	5036158453	In-Center Hemo, PD Services	13	38-2550	Y
MERIDIAN PARK DIALYSIS CENTER	19255 SW 65TH AVE	STE 100	TUALATIN	OR	97062-9712	5036928159	5036921896	In-Center Hemo, Nocturnal Hemo, PD Services	14	38-2549	Y
WEST LINN DIALYSIS CENTER	19056 WILLAMETTE DR		WEST LINN	OR	97068-1715	5036360244	5036364246	In-Center Hemo	13	38-2553	Y
BLUE MOUNTAIN KIDNEY CENTER	72556 COYOTE RD		PENDLETON	OR	97801-1002	5419668563	5419668573	In-Center Hemo, Home Hemo, PD Services	12	38-2554	Y
GRESHAM STATION DIALYSIS	878 NW BURNSIDE RD		GRESHAM	OR	97030-3718	5034651068	5034919229	In-Center Hemo, PD Services	17	38-2578	Y
ROSEBURG MERCY DIALYSIS	2410 NW EDENBOWER BLVD	STE 178	ROSEBURG	OR	97471-8830	5416724608	5416724817	In-Center Hemo, In-Center Hemo Self Care, PD Services	24	38-2514	Y
SALEM DIALYSIS	3550 LIBERTY RD S	STE 100	SALEM	OR	97302-5700	5033718047	5033717455	In-Center Hemo, In-Center Hemo Self Care, PD Services	25	38-2502	Y
SALEM NORTH DIALYSIS	1220 LIBERTY ST NE		SALEM	OR	97301-7330	5033152212	5033152199	In-Center Hemo	12	38-2530	Y
WOODBURN DIALYSIS	1840 NEWBERG HWY	STE 140	WOODBURN	OR	97071-3187	5039822005	5039822561	In-Center Hemo, In-Center Hemo Self Care	20	38-2516	Y
MCMINNVILLE DIALYSIS	200 NE NORTON LN		MCMINNVILLE	OR	97128-8470	5034350597	5034350862	In-Center Hemo, PD Services	12	38-2558	Y
PORTLAND GATEWAY DIALYSIS	9932 NE HALSEY ST		PORTLAND	OR	97220-4495	5032538170	5032538573	In-Center Hemo, PD Services	16	38-2571	Y
NE SALEM DIALYSIS	4792 PORTLAND RD NE		SALEM	OR	97305-3920	5033932142	5033932521	In-Center Hemo	13	38-2566	Y
ROGUE VALLEY DIALYSIS	760 GOLF VIEW DR	UNIT 100	MEDFORD	OR	97504-9685	5417764805	5417736016	In-Center Hemo, PD Services	39	38-2505	Y
REDWOOD DIALYSIS	201 SW L ST		GRANTS PASS	OR	97526-2913	5414740776	5414740122	In-Center Hemo	12	38-2513	Y
ROGUE VALLEY AT HOME	760 GOLF VIEW DR UNIT 100		MEDFORD	OR	97504-9685	5418429450	5418429486	Home Hemo		38-2505	Y
HILLSBORO AT HOME	2500 NE CENTURY BLVD	STE 300 BLDG E	HILLSBORO	OR	97124-7516	5036819460	5036158453	Home Hemo		38-2550	Y
SALEM AT HOME	3550 LIBERTY RD S	STE 100	SALEM	OR	97302-5700	5033718047	5033717455	Home Hemo		38-2502	Y
FOUR RIVERS AT HOME	515 EAST LN		ONTARIO	OR	97914-3953	5418899557	5418893251	Home Hemo	0	38-2519	Y
MERIDIAN PARK AT HOME	19255 SW 65TH AVE	STE 100	TUALATIN	OR	97062-9712	5036928159	5036921896	Home Hemo		38-2549	Y
HERMISTON COMMUNITY AT HOME	1155 W LINDA AVE		HERMISTON	OR	97838-9601	5412891122	5412891150	Home Hemo		38-2544	N
ROSEBURG MERCY AT HOME	2410 NW EDENBOWER BLVD	STE 178	ROSEBURG	OR	97471-8847	5416724608	5416724817	Home Hemo		38-2514	Y
NORTHEAST PORTLAND RENAL AT HOME	703 NE HANCOCK ST		PORTLAND	OR	97212-3955	5034933322	5032879434	Home Hemo		38-2540	Y
CORNELL ROAD DIALYSIS	1700 NW 167TH PL	STE 230	BEAVERTON	OR	97006-4872	5034398829	5034399942	In-Center Hemo	16	38-2559	Y
NORTHEAST PORTLAND RENAL CENTER	703 NE HANCOCK ST		PORTLAND	OR	97212-3955	5034933322	5032879434	In-Center Hemo, Nocturnal Hemo, PD Services	15	38-2540	Y
OREGON KIDNEY CENTER	3524 NE SANDY BLVD		PORTLAND	OR	97232-1961	5032367097	5032368110	In-Center Hemo	21	38-2500	Y
LAKE ROAD DIALYSIS	6902 SE LAKE RD	STE 100	MILWAUKIE	OR	97267-2148	5037941288	5037945916	In-Center Hemo, Nocturnal Hemo	21	38-2534	Y
WILLAMETTE VALLEY RENAL CENTER	1510 DIVISION ST	SUITE 90	OREGON CITY	OR	97045-1572	5035571373	5035571087	In-Center Hemo	13	38-2520	Y
MCMINNVILLE AT HOME	200 NE NORTON LN		MCMINNVILLE	OR	97128-8470	5034350597	5034350862	Home Hemo	1	38-2558	Y
PORTLAND MLK AT HOME	2737 NE MARTIN LUTHER KING JR BLVD		PORTLAND	OR	97212-3037	5032821253	5035288420	Home Hemo			Y
PORTLAND MLK DIALYSIS	2737 NE MARTIN LUTHER KING JR BLVD		PORTLAND	OR	97212-3037	5032821253	5035288420	In-Center Hemo, PD Services	20	38-2572	Y
LANCASTER DRIVE DIALYSIS	421 LANCASTER DR NE		SALEM	OR	97301-4729	5035816236	5033630490	In-Center Hemo, PD Services	25	38-2577	Y
LANCASTER DRIVE AT HOME	421 LANCASTER DR NE		SALEM	OR	97301-4729	5035816236	5033630490	Home Hemo		38-2577	Y
PALMER DIALYSIS CENTER	30 COMMUNITY DR		EASTON	PA	18045-2658	6102588855	6102583322	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care, PD Services	20	39-2619	Y
HONESDALE DIALYSIS CENTER	600 MAPLE AVE	STE 8	HONESDALE	PA	18431-1459	5702530952	5702530954	In-Center Hemo, In-Center Hemo Self Care	12	39-2582	Y

DELAWARE VALLEY DIALYSIS CENTER	102 DAVITA DR		MILFORD	PA	18337-9390	5704919210	5704919220	In-Center Hemo, In-Center Hemo Self Care, PD Services	16	39-2600	Y
FRANKLIN DIALYSIS CENTER	150 S INDEPENDENCE MALL W	STE 101	PHILADELPHIA	PA	19106-3400	2159222801	2159222817	In-Center Hemo, In-Center Hemo Self Care	28	39-2531	Y
NEWTOWN DIALYSIS CENTER	60 BLACKSMITH RD		NEWTOWN	PA	18940-1847	2677578060	2677578066	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care, PD Services	18	39-2616	Y
DIALYSIS CENTER AT OXFORD COURT	930 TOWN CENTER DR	STE G100	LANGHORNE	PA	19047-4260	2157509831	2157509837	In-Center Hemo, In-Center Hemo Self Care	14	39-2644	Y
NE PHILADELPHIA DIALYSIS CENTER	518 KNORR ST		PHILADELPHIA	PA	19111-4604	2157454859	2157459145	In-Center Hemo, In-Center Hemo Self Care	16	39-2555	Y
SOUTH PHILADELPHIA DIALYSIS CENTER	109 DICKINSON ST		PHILADELPHIA	PA	19147-6107	2154686616	2152711180	In-Center Hemo, In-Center Hemo Self Care	20	39-2556	Y
WEST SHORE DIALYSIS	550 N 12TH ST	STE 110	LEMOYNE	PA	17043-1242	7177373272	7177307139	In-Center Hemo, In-Center Hemo Self Care, PD Services	13	39-2534	Y
UPLAND DIALYSIS CENTER	1 MEDICAL CENTER BLVD	STE 120	CHESTER	PA	19013-3902	6104472825	6104900945	In-Center Hemo, In-Center Hemo Self Care	36	39-2508	Y
THORNDALE DIALYSIS	3243 LINCOLN HWY		THORNDALE	PA	19372-1012	6103843902	6103801246	In-Center Hemo, In-Center Hemo Self Care, PD Services	24	39-2522	Y
LEWISTOWN DIALYSIS CENTER	611 ELECTRIC AVE		LEWISTOWN	PA	17044-1128	7172482344	7172483240	In-Center Hemo, In-Center Hemo Self Care, Acute Hemo 1:1, Acute PD, PD Services	23	39-2598	Y
JENNERSVILLE DIALYSIS CENTER	1011 W BALTIMORE PIKE	STE 107	WEST GROVE	PA	19390-9446	6103450188	6103450245	In-Center Hemo, In-Center Hemo Self Care, Acute Hemo 1:1, Acute PD	18	39-2631	Y
PALMERTON DIALYSIS CENTER	185 DELAWARE AVE	STE C	PALMERTON	PA	18071-1716	6108265929	6108264552	In-Center Hemo, In-Center Hemo Self Care, PD Services	10	39-2584	Y
POCONO DIALYSIS CENTER	100 PLAZA CT	STE B	EAST STROUDSBURG	PA	18301-8258	5704765630	5704765634	In-Center Hemo, In-Center Hemo Self Care	16	39-2606	Y
MT POCONO DIALYSIS	100 COMMUNITY DR	STE 106	TOBYHANNA	PA	18466-8986	5708390900	5708391065	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care	12	39-2705	Y
PDI-JOHNSTOWN	344 BUDFIELD ST		JOHNSTOWN	PA	15904-3214	8142664949	8142664948	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care, PD Services	21	39-2687	Y
PDI-EBENSBURG	429 MANOR DR	STE 650	EBENSBURG	PA	15931-4917	8144722642	8144722138	In-Center Hemo, In-Center Hemo Self Care, PD Services	9	39-2686	Y
PDI-WALNUT TOWER	834 WALNUT ST		PHILADELPHIA	PA	19107-5109	2156291490	2156295728	In-Center Hemo, In-Center Hemo Self Care, PD Services	19	39-2702	Y
PDI-LANCASTER	1412 E KING ST		LANCASTER	PA	17602-3240	7173921552	7173924413	In-Center Hemo, In-Center Hemo Self Care	20	39-2609	Y
PDI-EPHRATA	67 W CHURCH ST		STEVENS	PA	17578-9203	7173357399	7173350488	In-Center Hemo, In-Center Hemo Self Care, PD Services	16	39-2706	Y
CHILDS DIALYSIS	101 MAIN ST		CHILDS	PA	18407-2614	5702819201	5702819185	In-Center Hemo, In-Center Hemo Self Care	8	39-2724	Y
DUNMORE DIALYSIS	1212 O'NEIL HWY		DUNMORE	PA	18512-1717	5705580190	5705580195	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care, PD Services	12	39-2723	Y
QUINCY AVE DIALYSIS	700 QUINCY AVE		SCRANTON	PA	18510-1724	5707705380	5707705394	In-Center Hemo	12	39-2819	N
OLD FORGE DIALYSIS	325 S MAIN ST		OLD FORGE	PA	18518-1677	5704573174	5704573313	In-Center Hemo, In-Center Hemo Self Care	12	39-2726	Y
SCRANTON DIALYSIS	475 MORGAN HWY		SCRANTON	PA	18508-2605	5703418270	5703418299	In-Center Hemo, In-Center Hemo Self Care, Acute Hemo 1:1, Acute PD	14	39-2729	Y
TUNKHANNOCK DIALYSIS	5950 SR 6		TUNKHANNOCK	PA	18657-7905	5708366139	5705870882	In-Center Hemo, In-Center Hemo Self Care	12	39-2725	Y
DIALYSIS CENTER OF ERIE	1641 SASSAFRAS ST		ERIE	PA	16502-1858	8144556455	8144561188	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care, PD Services	28	39-2528	Y
WARREN DIALYSIS	2 W CRESCENT PARK		WARREN	PA	16365-2111	8147285570	8147285574	In-Center Hemo, In-Center Hemo Self Care, PD Services	12	39-2666	Y
PITTSBURGH HOME MODALITY COE PD	5171 LIBERTY AVE	STE A	PITTSBURGH	PA	15224-2254	4126050415	4126050853	PD Services		39-2772	Y
RIDDLE DIALYSIS CENTER	100 GRANITE DR	STE 106	MEDIA	PA	19063-5134	6108924701	6108922769	In-Center Hemo, In-Center Hemo Self Care, PD Services	16	39-2739	Y
SOUTH BROAD STREET DIALYSIS	1172 S BROAD ST		PHILADELPHIA	PA	19146-3142	2158756720	2158756721	In-Center Hemo, In-Center Hemo Self Care	24	39-2753	Y
PITTSBURGH DIALYSIS	4312 PENN ST		PITTSBURGH	PA	15224-1310	4126818556	4126818537	In-Center Hemo, In-Center Hemo Self Care	12	39-2699	Y
ELIZABETH DIALYSIS	201 MCKEESPORT RD		ELIZABETH	PA	15037-1623	4123841822	4123841828	In-Center Hemo, In-Center Hemo Self Care	12	39-2710	Y
NORTHUMBERLAND DIALYSIS	103 W STATE ROUTE 61		MOUNT CARMEL	PA	17851-2539	5703395558	5703395997	In-Center Hemo, In-Center Hemo Self Care	13	39-2613	Y
ABINGTON DIALYSIS	3940A COMMERCE AVE		WILLOW GROVE	PA	19090-1705	2158301115	2156572674	In-Center Hemo, In-Center Hemo Self Care, PD Services	22	39-2614	Y
ROXBOROUGH DIALYSIS	5003 UMBRIA ST		PHILADELPHIA	PA	19128-4301	2154871869	2154871062	In-Center Hemo, In-Center Hemo Self Care	16	39-2516	Y
WAVERLY DIALYSIS	407 BALTIMORE PIKE		MORTON	PA	19070-1042	6106901100	6106903618	In-Center Hemo, PD Services, Nocturnal Hemo	20	39-2502	Y
MANHEIM PIKE DIALYSIS (PD ONLY)	1650 MANHEIM PIKE		LANCASTER	PA	17601-3056	7175196978	7175810924	PD Services	0	39-2785	Y
PHILADELPHIA PMC DIALYSIS	3823 MARKET ST		PHILADELPHIA	PA	19104-3145	2152220671	2158236949	In-Center Hemo, In-Center Hemo Self Care	27	39-2538	Y
PHILADELPHIA 42ND STREET DIALYSIS	4126 WALNUT ST		PHILADELPHIA	PA	19104-3511	2153870500	2153876414	In-Center Hemo, In-Center Hemo Self Care	36	39-2521	Y
RADNOR DIALYSIS	250 KING OF PRUSSIA RD		RADNOR	PA	19087-5235	6102540070	6102540077	In-Center Hemo, In-Center Hemo Self Care, PD Services	12	39-2630	Y
WYNCOTE DIALYSIS	1000 EASTON RD	STE 250	WYNCOTE	PA	19095-2934	2158843398	2158843424	In-Center Hemo, In-Center Hemo Self Care	24	39-2635	Y
HUNTINGDON VALLEY DIALYSIS	769 HUNTINGDON PIKE	STE 18	HUNTINGDON VALLEY	PA	19006-8362	2153791788	2153796779	In-Center Hemo	23	39-2682	Y
MCKEESPORT WEST DIALYSIS	101 9TH ST		MCKEESPORT	PA	15132-3953	4126723720	4126723724	In-Center Hemo, In-Center Hemo Self Care	16	39-2700	Y
CLEARFIELD DIALYSIS	8866 CLEARFIELD CURWENSVILLE HWY		CLEARFIELD	PA	16830-3519	8147652543	8147683594	In-Center Hemo, In-Center Hemo Self Care, PD Services	10	39-2704	Y
MARKET STREET DIALYSIS	3701 MARKET ST	STE 100	PHILADELPHIA	PA	19104-5503	2153872658	2153874134	In-Center Hemo, In-Center Hemo Self Care	16	39-2718	Y
PA TAX ALLOCATIONS	2476 SWEDESFORD RD	STE 150	MALVERN	PA	19355-1456			In-Center Hemo			N

ERIE DIALYSIS	350 E BAYFRONT PKWY	STE A	ERIE	PA	16507-2410	8144540480	8144540682	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care, Acute Hemo 1:1	30	39-2543	Y
HOMESTEAD DIALYSIS	207 W 7TH AVE		WEST HOMESTEAD	PA	15120-1002	4124768700	4124768805	In-Center Hemo, In-Center Hemo Self Care	16	39-2662	Y
MCKEESPORT DIALYSIS	2001 LINCOLN WAY		WHITE OAK	PA	15131-2419	4126780183	4126788417	In-Center Hemo, In-Center Hemo Self Care, PD Services, Nocturnal Hemo	13	39-2532	Y
PHILADELPHIA WEST DIALYSIS	7609 LINDBERGH BLVD		PHILADELPHIA	PA	19153-2301	2159371103	2159370770	In-Center Hemo, In-Center Hemo Self Care	24	39-2513	Y
JEFFERSON DIALYSIS	14 CLAIRTON BLVD		PITTSBURGH	PA	15236-3911	4126536007	4126535915	In-Center Hemo, In-Center Hemo Self Care, PD Services	17	39-2573	Y
PARIS DIALYSIS	32 STEUBENVILLE PIKE		PARIS	PA	15021-8529	7247293350	7247293353	In-Center Hemo, In-Center Hemo Self Care, PD Services	17	39-2595	Y
CORRY DIALYSIS	300 YORK ST		CORRY	PA	16407-1420	8146647520	8146630295	In-Center Hemo, In-Center Hemo Self Care, PD Services	12	39-2580	Y
ELIZABETHTOWN DIALYSIS	844 N HANOVER ST		ELIZABETHTOWN	PA	17022-1303	7173610151	7173618875	In-Center Hemo, In-Center Hemo Self Care	13	39-2604	Y
COBBS CREEK DIALYSIS	1700 S 60TH ST		PHILADELPHIA	PA	19142-1404	2157300500	2157300600	In-Center Hemo, In-Center Hemo Self Care	25	39-2536	Y
MEADVILLE DIALYSIS	19050 PARK AVENUE PLZ		MEADVILLE	PA	16335-4012	8143366044	8143372294	In-Center Hemo, In-Center Hemo Self Care, PD Services, Nocturnal Hemo	17	39-2537	Y
BRADFORD DIALYSIS	665 E MAIN ST		BRADFORD	PA	16701-1816	8143627417	8143626327	In-Center Hemo, Acute Hemo 1:1, Acute PD, PD Services	13	39-2523	Y
WAYNESBURG DIALYSIS	248 ELM DR		WAYNESBURG	PA	15370-8269	7246273997	7246275305	In-Center Hemo, In-Center Hemo Self Care, PD Services	13	39-2641	Y
SELINSGROVE DIALYSIS	1030 N SUSQUEHANNA TRAIL		SELINSGROVE	PA	17870-7767	5703741160	5703743439	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care, PD Services	13	39-2628	Y
LEBANON COUNTY DIALYSIS	440 OAK ST		LEBANON	PA	17042-6243	7172723050	7172723963	In-Center Hemo, PD Services	16	39-2557	Y
BUDFIELD STREET HOME DIALYSIS	350 BUDFIELD ST	STE 1	JOHNSTOWN	PA	15904-3214	8142544262	8142544323	PD Services		39-2775	Y
CALLOWHILL DIALYSIS CENTER	313 CALLOWHILL ST		PHILADELPHIA	PA	19123-4103	2156293580	2156293588	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care	20	39-2749	Y
BLOOMFIELD-PITTSBURGH DIALYSIS	5171 LIBERTY AVE	STE C	PITTSBURGH	PA	15224-2254	4126833212	4126833216	In-Center Hemo, In-Center Hemo Self Care	24	39-2751	Y
MONROEVILLE DIALYSIS	2690 MONROEVILLE BLVD		MONROEVILLE	PA	15146-2302	4128565950	4128565940	In-Center Hemo, In-Center Hemo Self Care, PD Services	20	39-2752	Y
EAST END-PITTSBURGH DIALYSIS	7714 PENN AVE		PITTSBURGH	PA	15221-2116	4122416790	4122416794	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care, PD Services	16	39-2748	Y
FRANKLIN DIALYSIS AT HOME	301 CALLOWHILL ST		PHILADELPHIA	PA	19123-4117	2158730711	2158730718	PD Services		39-2756	Y
PAXTON DIALYSIS	479 PORT VIEW DR	STE B21	HARRISBURG	PA	17111-1229	7175580290	7175615167	In-Center Hemo, PD Services, In-Center Hemo Self Care	17	39-2797	Y
FRACKVILLE DIALYSIS	801 SCHUYLKILL MALL		FRACKVILLE	PA	17931-2524	5708741238	5708741863	In-Center Hemo, PD Services	12	39-2776	Y
WILLOW GROVE DIALYSIS	1849 DAVISVILLE RD		WILLOW GROVE	PA	19090-4111	2156593426	2156593547	In-Center Hemo, Nocturnal Hemo	24	39-2764	Y
UNIVERSITY CITY DIALYSIS	3020 MARKET ST	STE 100	PHILADELPHIA	PA	19104-2999	2153822439	2153860307	In-Center Hemo, Nocturnal Hemo, PD Services	20	39-2787	Y
FRANKLIN COMMONS DIALYSIS	720 JOHNSVILLE BLVD	STE 800	WARMINSTER	PA	18974-3546	2156827691	2156827695	In-Center Hemo	16	39-2771	Y
COTTMAN KIDNEY CENTER	7198 CASTOR AVE		PHILADELPHIA	PA	19149-1105	2157454060	2157450139	In-Center Hemo, PD Services	24	39-2766	Y
BUTTONWOOD DIALYSIS	449 N BROAD ST		PHILADELPHIA	PA	19123-3628	2152381201	2155745065	In-Center Hemo, PD Services	24	39-2788	Y
COMMONWEALTH DIALYSIS	920 S WASHINGTON AVE		SCRANTON	PA	18505-3810	5703445267	5709632125	In-Center Hemo	13	39-2761	Y
STATE COLLEGE DIALYSIS	500 SCIENCE PRK DR	STE 2	STATE COLLEGE	PA	16803-2218	8142373082	8142373653	In-Center Hemo, PD Services	12	39-2789	Y
LAKE ERIE HOME DIALYSIS	2563 W 8TH ST		ERIE	PA	16505-4430	8148382849	8148381584	PD Services		39-2796	Y
PENN HILLS DIALYSIS	202 RODI RD		PENN HILLS	PA	15235-3337	4123711102	4122414705	In-Center Hemo, Nocturnal Hemo	25	39-2798	Y
GRANT ONE DIALYSIS	9475 ROOSEVELT BLVD	STE 9	PHILADELPHIA	PA	19114-2212	2156730490	2156773152	In-Center Hemo, Nocturnal Hemo	17	39-2792	Y
HARMARVILLE DIALYSIS	791 FREEPORT RD		CHESWICK	PA	15024-1201	7242749281	7242749412	In-Center Hemo, PD Services	13	39-2800	Y
CHELTENHAM DIALYSIS	133 CHELTENHAM AVE		CHELTENHAM	PA	19012-1301	2156351870	2156351857	In-Center Hemo, PD Services	21	39-2810	Y
CARLISLE REGIONAL DIALYSIS	419 VILLAGE DR	STE 10	CARLISLE	PA	17015-6943	7172185104	7172410019	In-Center Hemo, PD Services, In-Center Hemo Self Care	12	39-2801	Y
WESTTOWN DIALYSIS	105 WESTTOWN RD		WEST CHESTER	PA	19382-8902	6107012492	6104295478	In-Center Hemo, PD Services	24	39-2791	Y
POCONO HOME TRAINING	3361 RTE 611	STE 1	BARTONSVILLE	PA	18321-7821	5706291292	5706292482	PD Services		39-2804	Y
MANHEIM PIKE DIALYSIS	1650 MANHEIM PIKE		LANCASTER	PA	17601-3056	7175196978	7175810924	In-Center Hemo, In-Center Hemo Self Care	12	39-2785	Y
BETHEL PARK DIALYSIS	6000 ALICIA DR		BETHEL PARK	PA	15102-1806	4128332612	4128352527	In-Center Hemo, Home Hemo, PD Services	4	39-2808	Y
MILLCREEK DIALYSIS	2042 EDINBORO RD		ERIE	PA	16509-3409	8148661930	8148682693	In-Center Hemo	17	39-2822	Y
CITY LINE DIALYSIS	4508 CITY LINE AVE		PHILADELPHIA	PA	19131-1509	2154733071	2158798305	In-Center Hemo	17	39-2809	Y
WOODLYN DIALYSIS	1310 MACDADE BLVD		WOODLYN	PA	19094-1501	6108331713	6108335103	In-Center Hemo	16	39-2826	Y
ELLWOOD CITY DIALYSIS	807 LAWRENCE AVE		ELLWOOD CITY	PA	16117-1941	7247521081	7247529419	In-Center Hemo, PD Services	5	39-2855	Y
EAGLE VALLEY DIALYSIS	166 EAGLES GLEN PLZ		EAST STROUDSBURG	PA	18301-1349	5704245307	5704212561	In-Center Hemo	13	39-2821	Y
TYRONE DIALYSIS	175 HOSPITAL DR		TYRONE	PA	16686-1808	8146844390	8146842402	In-Center Hemo, PD Services	8	39-2825	Y
BROOMALL DIALYSIS	2835 W CHESTER PIKE	STE 2	BROOMALL	PA	19008-1833	6103562719	6103563647	In-Center Hemo	16	39-2794	Y
MONTAGE HOME DIALYSIS	3409 BIRNEY AVE		MOOSIC	PA	18507-1505	5703441745	5703441097	PD Services		39-2811	Y
PROVIDENCE SQUARE HOME TRAINING (PD)	831 PROVIDENCE RD	STE 1	SECANE	PA	19018-2921	6106261816	6106262174	PD Services		39-2813	Y
THORN RUN DIALYSIS	1136 THORN RUN RD	STE J1	MOON TOWNSHIP	PA	15108-4301	4122692304	4122692840	In-Center Hemo, PD Services	15	39-2779	Y

ALLEGHENY VALLEY DIALYSIS	1620 PACIFIC AVE	HEIGHTS PLAZA SHOPPING CENTER	NATRONA HEIGHTS	PA	15065-2101	7242244382	7242247298	In-Center Hemo, Acute Hemo 1:1, PD Services	11	39-2768	Y
NORTHSIDE DIALYSIS	930 MADISON AVE		PITTSBURGH	PA	15212-4937	4123222520	4123211283	In-Center Hemo, Acute Hemo 1:1, PD Services	21	39-2769	Y
SOMERSET COUNTY DIALYSIS	229 S KIMBERLY AVE	STE 100	SOMERSET	PA	15501-2022	8144456127	8144455627	In-Center Hemo, PD Services, In-Center Hemo Self Care	8	39-2778	Y
LINCOLN WAY DIALYSIS	1303 LINCOLN WAY STE A		WHITE OAK	PA	15131-1603	4126731191	4126781746	In-Center Hemo, Acute Hemo 1:1	14	39-2719	Y
OAK SPRINGS DIALYSIS	764 LOCUST AVE		WASHINGTON	PA	15301-2756	7242297377	7242250490	In-Center Hemo, PD Services	13	39-2692	Y
SUBURBAN CAMPUS DIALYSIS	2100 HARRISBURG PIKE	3RD FLR	LANCASTER	PA	17601-2644	7173974019	7173973758	In-Center Hemo, PD Services, Nocturnal Hemo, In-Center Hemo Self Care	30	39-2803	Y
MONROEVILLE AT HOME	2690 MONROEVILLE BLVD		MONROEVILLE	PA	15146-2302	4128565950	4128565940	Home Hemo		39-2752	Y
POCONO HT AT HOME	3361 RTE 611	STE 1	BARTONSVILLE	PA	18321-7821	5706291292	5706292482	Home Hemo		39-2804	Y
PAXTON AT HOME	479 PORT VIEW DR	STE B21	HARRISBURG	PA	17111-1229	7175615164	7175615168	Home Hemo		39-2797	Y
MANHEIM PIKE AT HOME	1650 MANHEIM PIKE		LANCASTER	PA	17601-3056	7175196978	7175810924	Home Hemo		39-2785	Y
STATE COLLEGE AT HOME	500 SCIENCE PARK DR	STE 2	STATE COLLEGE	PA	16803-2218	8142373082	8142373653	Home Hemo		39-2789	Y
BUTTONWOOD AT HOME	449 NORTH BROAD STREET		PHILADELPHIA	PA	19123-3628	2152381201	2155745065	Home Hemo		39-2788	Y
LAKE ERIE HOME AT HOME	2563 W 8TH ST		ERIE	PA	16505-4430	8148382849	8148381584	Home Hemo		39-2796	Y
OAK SPRINGS AT HOME	764 LOCUST AVE		WASHINGTON	PA	15301-2756	7242297377	7242250490	Home Hemo		39-2692	Y
COTTMAN KIDNEY AT HOME	7198 CASTOR AVE		PHILADELPHIA	PA	19149-1105	2157454060	2157450139	Home Hemo		39-2766	Y
UNIVERSITY CITY AT HOME	3020 MARKET ST	STE 103	PHILADELPHIA	PA	19104-2999	2153822439	2153860209	Home Hemo		39-2787	Y
ALLEGHENY VALLEY AT HOME	1620 PACIFIC AVE	HEIGHTS PLAZA SHOPPING CENTER	NATRONA HEIGHTS	PA	15065-2101	7242244382	7242247298	Home Hemo		39-2768	N
NORTHSIDE AT HOME	930 MADISON AVE		PITTSBURGH	PA	15212-4937	4123222520	4123211539	Home Hemo		39-2769	Y
FRANKLIN AT HOME	301 CALLOWHILL ST		PHILADELPHIA	PA	19123-4117	2158730711	2158730718	Home Hemo		39-2756	Y
PITTSBURGH HOME MODALITY COE AT HOME	5171 LIBERTY AVE	STE A	PITTSBURGH	PA	15224-2254	4126050415	4126050853	Home Hemo		39-2772	Y
DUNMORE AT HOME	1212 ONEILL HWY		DUNMORE	PA	18512-1717	5705580190	5705580195	Home Hemo		39-2723	Y
PALMERTON AT HOME	185 DELAWARE AVE	STE C	PALMERTON	PA	18071-1716	6108265929	6108264552	Home Hemo		39-2584	Y
BRADFORD AT HOME	665 E MAIN ST		BRADFORD	PA	16701-1816	8143627417	8143626327	Home Hemo		39-2523	Y
MEADVILLE AT HOME	19050 PARK AVENUE PLZ		MEADVILLE	PA	16335-4012	8143366044	8143372294	Home Hemo		39-2537	Y
NEWTOWN AT HOME	60 BLACKSMITH RD		NEWTOWN	PA	18940-1847	2677578060	2677578066	Home Hemo	0	39-2616	Y
PALMER AT HOME	30 COMMUNITY DRIVE		EASTON	PA	18045-2658	6102588855	6102583322	Home Hemo		39-2619	N
PDI - LANCASTER AT HOME	1412 E KING ST		LANCASTER	PA	17602-3240	7173921552	7173924413	Home Hemo	1	39-2609	N
PDI-JOHNSTOWN AT HOME	344 BUDFIELD ST		JOHNSTOWN	PA	15904-3214	8142664949	8142664948	Home Hemo		39-2687	Y
WEST SHORE AT HOME	550 N 12TH ST	STE 110	LEMOYNE	PA	17043-1242	7177373272	7177307139	Home Hemo		39-2534	Y
ELIZABETH AT HOME	201 MCKEESPORT RD		ELIZABETH	PA	15037-1623	4123841822	4123841828	Home Hemo		39-2710	Y
ABINGTON AT HOME	3940A COMMERCE AVE		WILLOW GROVE	PA	19090-1705	2158301115	2156593541	Home Hemo		39-2614	Y
RADNOR AT HOME	250 KING OF PRUSSIA RD		RADNOR	PA	19087-5220	6102540070	6102540077	Home Hemo		39-2630	Y
ERIE AT HOME	350 E BAYFRONT PKWY	STE A	ERIE	PA	16507-2410	8144540480	8144540682	Home Hemo		39-2543	N
SELINSGROVE AT HOME	1030 N SUSQUEHANNA TRL		SELINSGROVE	PA	17870-7767	5703741160	5703743439	Home Hemo		39-2628	Y
PARIS AT HOME	32 STEUBENVILLE PIKE		PARIS	PA	15021-8529	7247293350	7247293353	Home Hemo		39-2595	N
MONTAGE HOME AT HOME	3409 BIRNEY AVE		MOOSIC	PA	18507-1505	5703416728	5703441097	Home Hemo		39-2811	Y
BUDFIELD STREET HOME AT HOME	350 BUDFIELD ST	STE 1	JOHNSTOWN	PA	15904-3214	8142544262	8142544323	Home Hemo		39-2775	N
MEMPHIS STREET RENAL CENTER	3310 MEMPHIS ST		PHILADELPHIA	PA	19134-4510	2157399558	2157399586	In-Center Hemo	18	39-2601	Y
NORTHERN PHILADELPHIA DIALYSIS	5933 N BROAD ST		PHILADELPHIA	PA	19141-1801	2155495000	2155499558	In-Center Hemo	24	39-2509	Y
ST LUKE'S BETHLEHEM DIALYSIS	1425 8TH AVE		BETHLEHEM	PA	18018-2256	4844034304	6108661739	In-Center Hemo, PD Services	36	39-2817	Y
ST LUKE'S QUAKERTOWN DIALYSIS	1021 PARK AVE		QUAKERTOWN	PA	18951-1573	2155368184	2155382090	In-Center Hemo	12	39-2815	Y
ST LUKE'S ALLENTOWN DIALYSIS	1901 HAMILTON ST	STE 100	ALLENTOWN	PA	18104-6459	6104352590	6104331386	In-Center Hemo	13	39-2818	Y
FAYETTE COUNTY DIALYSIS	201 MARY HIGGINSON LN	STE A	UNIONTOWN	PA	15401-2658	7244379480	7244379646	In-Center Hemo, Nocturnal Hemo	17	39-2767	Y
PROVIDENCE SQUARE HT AT HOME	831 PROVIDENCE RD	STE 1	SECANE	PA	19018-2921	6106261816	6106262174	Home Hemo		39-2813	Y
WARREN AT HOME	2 W CRESCENT PARK		WARREN	PA	16365-2111	8147285570	8147285574	Home Hemo			Y
SAINT CHARLES WAY AT HOME	308 ST CHARLES WAY		YORK	PA	17402-4647	7174305454	7177413956	Home Hemo	1	39-2838	Y
ROBINSON HT AT HOME	5888 STEUBENVILLE PIKE	STE 4	MC KEES ROCKS	PA	15136-1347	4127870314	4127882089	Home Hemo		39-2824	Y
QUENTIN CIRCLE AT HOME	966 ISABEL DR		LEBANON	PA	17042-7482	7172731026	7172777204	Home Hemo		39-2834	Y
ST LUKES AT HOME	1901 HAMILTON ST	STE 200	ALLENTOWN	PA	18104-6459	6107761479	6104336306	Home Hemo		39-2840	Y
POINT BREEZE DIALYSIS	2501 REED ST	STE A	PHILADELPHIA	PA	19146-3900	2153340250	2152714584	In-Center Hemo, PD Services	16		Y
ROBINSON HOME TRAINING	5888 STEUBENVILLE PIKE	STE 4	MC KEES ROCKS	PA	15136-1347	4127870314	4127882089	PD Services		39-2824	Y

ST LUKE'S HOME TRAINING (PD)	1901 HAMILTON ST	STE 200	ALLENTOWN	PA	18104-6459	6107761479	6104336306	PD Services		39-2840	Y
EYNON DIALYSIS	260 SCRANTON CARBONDALE HWY		EYNON	PA	18403-1029	5708761874	5708766894	In-Center Hemo	13	39-2836	Y
QUENTIN CIRCLE DIALYSIS	966 ISABEL DR		LEBANON	PA	17042-7482	7172731026	7172777204	In-Center Hemo, PD Services	8	39-2834	Y
LEOLA DIALYSIS	345 WEST MAIN ST	STE 202	LEOLA	PA	17540-2108	7175560080	7175560085	In-Center Hemo	13	39-2833	Y
ST LUKE'S WHITEHALL DIALYSIS	1220 3RD ST		WHITEHALL	PA	18052-4905	6102661706	6102661574	In-Center Hemo	13	39-2845	Y
NEW KENSINGTON DIALYSIS	1 KENSINGTON SQ		NEW KENSINGTON	PA	15068-6451	7243352876	7243396916	In-Center Hemo	8	39-2852	Y
WISSAHICKON DIALYSIS	235 W CHELTEN AVE		PHILADELPHIA	PA	19144-3802	2158440637	2158445685	In-Center Hemo	26	39-2867	Y
CONCORD TOWNSHIP DIALYSIS	265 WILMINGTON W CHESTER PIKE		CHADDS FORD	PA	19317-9039	6105586965	6105587806	In-Center Hemo	13	39-2862	Y
PROGRESS AVENUE DIALYSIS	4390 STURBRIDGE DR		HARRISBURG	PA	17110-3668	7175452805	7175453987	In-Center Hemo		39-2858	Y
COATESVILLE DIALYSIS	1129 W LINCOLN HWY		COATESVILLE	PA	19320-1836	6103833866	6103845270	In-Center Hemo, PD Services	13	39-2859	Y
ROARING SPRINGS DIALYSIS	96 JUNE DR		ROARING SPRING	PA	16673-2316	8142246290	8142247525	In-Center Hemo	8	39-2864	Y
PENN TRAFFORD DIALYSIS	4044 ROUTE 130	STE 100	IRWIN	PA	15642-7830	7247440713	7247445004	In-Center Hemo, PD Services	8	39-2860	Y
HERITAGE LAKE DIALYSIS	20 EXPEDITION TRL	STE 202	GETTYSBURG	PA	17325-8598	7173371012	7173373834	In-Center Hemo	9		Y
NORTH WALES DIALYSIS	1551 S VALLEY FORGE RD		LANSDALE	PA	19446-5461	2153616192	2153612032	In-Center Hemo, Home Hemo, PD Services	13		Y
PAOLI PARK DIALYSIS	4 INDUSTRIAL BLVD	STE 155	PAOLI	PA	19301-1605	6106443084	6104072805	In-Center Hemo	9	39-2865	Y
SAINT CHARLES WAY DIALYSIS	308 SAINT CHARLES WAY		YORK	PA	17402-4647	7174305454	7177413956	In-Center Hemo, PD Services	47	39-2838	Y
HANOVER DIALYSIS	1155 CARLISLE ST	STE 610	HANOVER	PA	17331-1200	7176321681	7176320625	In-Center Hemo, PD Services	18	39-2839	Y
RENAL CENTER OF PHILADELPHIA	5630 CHESTNUT ST	2ND FLR	PHILADELPHIA	PA	19139-3232	2154768301	2154768393	In-Center Hemo	19	39-2665	Y
WESTTOWN AT HOME	105 WESTTOWN RD		WEST CHESTER	PA	19382-8902	6107012492	6104295478	Home Hemo	1		Y
NORTH PROVIDENCE RENAL CENTER	1635 MINERAL SPRING AVE		NORTH PROVIDENCE	RI	02904-4025	4013545340	4013537020	In-Center Hemo, Acute Hemo 1:1, PD Services	19	41-2506	Y
UPSTATE DIALYSIS CENTER	308 MILLS AVE		GREENVILLE	SC	29605-4022	8642713700	8642717929	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care, PD Services	34	42-2540	Y
GREER KIDNEY CENTER	14152 E WADE HAMPTON BLVD		GREER	SC	29651-1554	8648774432	8648774662	In-Center Hemo, In-Center Hemo Self Care	21	42-2539	Y
NORTH CHARLESTON DIALYSIS	5900 RIVERS AVE	STE E	NORTH CHARLESTON	SC	29406-6054	8437473447	8437473911	In-Center Hemo, In-Center Hemo Self Care, PD Services	17	42-2585	Y
FABER PLACE DIALYSIS	3801 FABER PLACE DR		NORTH CHARLESTON	SC	29405-8533	8433771566	8433771573	In-Center Hemo, In-Center Hemo Self Care	16	42-2598	Y
GOOSE CREEK DIALYSIS	109 GREENLAND DR		GOOSE CREEK	SC	29445-5354	8433771199	8433771262	In-Center Hemo, In-Center Hemo Self Care	17	42-2596	Y
PENDLETON DIALYSIS	7703 HIGHWAY 76		PENDLETON	SC	29670-1818	8646467715	8646467423	In-Center Hemo, In-Center Hemo Self Care	10	42-2597	Y
FORT MILL DIALYSIS	1975 CAROLINA PLACE DR		FORT MILL	SC	29708-6922	8038023027	8038020319	In-Center Hemo, In-Center Hemo Self Care	22	42-2609	Y
MYRTLE BEACH DIALYSIS	3919 MAYFAIR ST		MYRTLE BEACH	SC	29577-5773	8434484920	8434484930	In-Center Hemo, In-Center Hemo Self Care	16	42-2610	Y
JEDBURG DIALYSIS	2897 W 5TH NORTH ST		SUMMERVILLE	SC	29483-9674	8438733955	8438730266	In-Center Hemo, In-Center Hemo Self Care	18	42-2620	Y
LONGS DIALYSIS	90 CLOVERLEAF DR	STE 306	LONGS	SC	29568-9262	8433995275	8433995314	In-Center Hemo, In-Center Hemo Self Care	10	42-2622	Y
RIDGELAND DIALYSIS	112 WEATHERSBY ST		RIDGELAND	SC	29936-9514	8437179379	8437179384	In-Center Hemo	10	42-2626	Y
WALTERBORO DIALYSIS	302 RUBY ST		WALTERBORO	SC	29488-2758	8435496743	8435495228	In-Center Hemo, In-Center Hemo Self Care, PD Services	25	42-2528	Y
AIKEN DIALYSIS	775 MEDICAL PARK DR		AIKEN	SC	29801-6306	8036414222	8036414224	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care, PD Services	21	42-2512	Y
PAGELAND DIALYSIS	505A S PEARL ST		PAGELAND	SC	29728-2222	8436723491	8436723504	In-Center Hemo	16	42-2592	Y
SANTEE DIALYSIS	228 BRADFORD BLVD		SANTEE	SC	29142-8677	8038543133	8038543135	In-Center Hemo, In-Center Hemo Self Care	24	42-2547	Y
ALLENDALE COUNTY DIALYSIS	1241 BOUNDARY ST W		FAIRFAX	SC	29827-3611	8036321587	8036321611	In-Center Hemo, In-Center Hemo Self Care	21	42-2557	Y
NORTH ORANGEBURG DIALYSIS	124 FIRE TOWER RD		ORANGEBURG	SC	29118-1401	8035316202	8035345263	In-Center Hemo, In-Center Hemo Self Care, PD Services	27	42-2508	Y
SOUTH ORANGEBURG DIALYSIS	1080 SUMMERS AVE		ORANGEBURG	SC	29115-4920	8035390084	8035390097	In-Center Hemo, In-Center Hemo Self Care	16	42-2565	Y
GREENWOOD DIALYSIS	109 OVERLAND DR		GREENWOOD	SC	29646-4053	8642276011	8642272098	In-Center Hemo, In-Center Hemo Self Care, PD Services	41	42-2515	Y
LANCASTER SC DIALYSIS	1100 W MEETING ST		LANCASTER	SC	29720-2251	8033136600	8033136608	In-Center Hemo, In-Center Hemo Self Care, PD Services	29	42-2549	Y
CENTRAL BAMBERG DIALYSIS	67 SUNSET DR		BAMBERG	SC	29003-1181	8032455166	8032453315	In-Center Hemo, In-Center Hemo Self Care, Acute Hemo 1:1	20	42-2534	Y
ABBEVILLE DIALYSIS	904 W GREENWOOD ST		ABBEVILLE	SC	29620-5687	8644590347	8644595879	In-Center Hemo, PD Services	10	42-2628	Y
CHARLES TOWNE DIALYSIS	1964 ASHLEY RIVER RD	STE D-3	CHARLESTON	SC	29407-4737	8438523537	8438523241	In-Center Hemo	20	42-2632	Y
CHARLES TOWNE HOME PROGRAM	1964 ASHLEY RIVER RD	STE D2	CHARLESTON	SC	29407-4782	8435738767	8435732394	PD Services	4	42-2633	Y
CAROLINA COAST HOME TRAINING	25 HOSPITAL CTR BLVD	STE 104A	HILTON HEAD ISLAND	SC	29926-2735	8433427300	8433427311	PD Services	2	42-2643	Y
GASTON DIALYSIS	5224 HWY 321		GASTON	SC	29053-9194	8037967830	8037963458	In-Center Hemo	11	42-2641	Y
HARTS DIALYSIS	1015 S 4TH ST		HARTSVILLE	SC	29550-5791	8433325688	8433321039	In-Center Hemo, PD Services	22	42-2642	Y
BLUFFTON DIALYSIS	101 OKATIE CENTER BLVD S		BLUFFTON	SC	29909-7547	8437069900	8437069949	In-Center Hemo, PD Services	12	42-2647	Y
MARKET COMMONS DIALYSIS CENTER	1350 FARROW PKWY	STE 100	MYRTLE BEACH	SC	29577-1668	8438390966	8438390977	In-Center Hemo, PD Services	17	42-2649	Y
PAMPLICO DIALYSIS	1520 FLAG DR		FLORENCE	SC	29505-2854	8434130857	8434130864	In-Center Hemo, PD Services	20	42-2645	Y
GREER SOUTH HOME TRAINING (PD)	3254 BRUSHY CRK RD	STE A	GREER	SC	29650-1000	8648779157	8648012937	PD Services	3	42-2638	Y
MCCOLL DIALYSIS	3595 US HWY 15-401 E		MCCOLL	SC	29570-5918	8435236274	8435235418	In-Center Hemo, PD Services	16	42-2640	Y

PALMETTO DIALYSIS	317 PROFESSIONAL PARK RD		CLINTON	SC	29325-7625	8648330717	8648336020	In-Center Hemo	21	42-2578	Y
GREER SOUTH DIALYSIS	3254 BRUSHY CREEK RD		GREER	SC	29650-1000	8648012065	8648012742	In-Center Hemo	21	42-2611	Y
DOWNTOWN GREENVILLE DIALYSIS	297 PETE HOLLIS BLVD		GREENVILLE	SC	29601-1143	8642329456	8642988038	In-Center Hemo	21	42-2567	Y
FOUNTAIN INN DIALYSIS	298 CHAPMAN RD		FOUNTAIN INN	SC	29644-6129	8648622273	8648622465	In-Center Hemo	11	42-2616	Y
GREER SOUTH HT AT HOME	3254 BRUSHY CREEK RD	STE A	GREER	SC	29650-1000	8648779157	8648012937	Home Hemo		42-2638	Y
CHARLES TOWNE HOME AT HOME	1964 ASHLEY RIVER RD	STE D2	CHARLESTON	SC	29407-4737	8435738767	8435732394	Home Hemo	0	42-2633	Y
JEDBURG AT HOME	2897 W 5TH NORTH ST		SUMMERVILLE	SC	29483-9674	8438731638	8438730266	Home Hemo		42-2620	Y
AIKEN AT HOME	775 MEDICAL PARK DR		AIKEN	SC	29801-6306	8036414222	8036414224	Home Hemo	0	42-2512	Y
UPSTATE AT HOME	308 MILLS AVE		GREENVILLE	SC	29605-4022	8642713765	8642713528	Home Hemo		42-2540	Y
NORTH ORANGEBURG AT HOME	124 FIRE TOWER RD		ORANGEBURG	SC	29118-1401	8035337313	8035345263	Home Hemo		42-2508	Y
MCCOLL AT HOME	3595 US HWY 15-401		MCCOLL	SC	29570-5918	8435236274	8435235418	Home Hemo			Y
BLUFFTON AT HOME	101 OKATIE CENTER BLVD S		BLUFFTON	SC	29909-7547	8437069900	8437069949	Home Hemo		42-2647	Y
CYPRESS GARDENS HT AT HOME	526 BROAD ST		SUMTER	SC	29150-3306	8037735891	8037736464	Home Hemo		42-2648	Y
MARKET COMMONS AT HOME	1350 FARROW PKWY	STE 100	MYRTLE BEACH	SC	29577-1668	8438390966	8438390977	Home Hemo	3	42-2649	Y
WALTERBORO AT HOME	302 RUBY ST		WALTERBORO	SC	29488-2758	8435496743	8435495228	Home Hemo	2	42-2528	Y
WOFFORD AT HOME	8024 WHITE AVE		SPARTANBURG	SC	29303-2043	8645834798	8645838220	Home Hemo		42-2656	Y
CYPRESS GARDENS HOME TRAINING	526 BROAD ST		SUMTER	SC	29150-3306	8037735891	8037736464	PD Services	4	42-2648	Y
WOFFORD DIALYSIS	8024 WHITE AVE		SPARTANBURG	SC	29303-2043	8645834798	8645838220	In-Center Hemo, PD Services	14	42-2656	Y
CYPRESS GARDENS DIALYSIS	418 BROAD ST		SUMTER	SC	29150-4155	8034185129	8034180722	In-Center Hemo	20	42-2661	Y
FLOWER TOWN HOME TRAINING	2143 N MAIN ST		SUMMERVILLE	SC	29486-7800	8438751779	8438757461	PD Services	4	42-2665	Y
MARION TOWNE DIALYSIS	2529 E HIGHWAY 76		MARION	SC	29571-6347	8434238861	8434235334	In-Center Hemo	12	42-2667	Y
MITCHELL DIALYSIS	819 E SPRUCE ST	STE 100	MITCHELL	SD	57301-4800	6059960097	6059960679	In-Center Hemo, PD Services	12	43-2505	Y
ROSEBUD DIALYSIS	1 SOLDIER CREEK RD		ROSEBUD	SD	57570-0610	6057472916	6057472699	In-Center Hemo, Acute Hemo 1:1, Acute PD	12	43-2504	Y
SIOUX FALLS COMMUNITY DIALYSIS	2326 W 69TH ST		SIOUX FALLS	SD	57108-5600	6053321262	6053396183	In-Center Hemo, In-Center Hemo Self Care, PD Services	12	43-2503	Y
SIOUX FALLS AT HOME	2326 W 69TH ST		SIOUX FALLS	SD	57108-5600	6053396180	6053396189	Home Hemo		43-2503	Y
MOCCASIN CREEK DIALYSIS	3313 SE 6TH AVE		ABERDEEN	SD	57401-5504	6052257344	6052251698	In-Center Hemo	8	43-2515	Y
BOLIVAR DIALYSIS	515 PECAN DR		BOLIVAR	TN	38008-1611	7316583828	7316592840	In-Center Hemo	18	44-2601	Y
BROWNSVILLE DIALYSIS	380 N DUPREE AVE		BROWNSVILLE	TN	38012-2332	7317723735	7317729794	In-Center Hemo, In-Center Hemo Self Care	21	44-2599	Y
CAMDEN DIALYSIS	168 W MAIN ST	STE A	CAMDEN	TN	38320-1767	7315840447	7315845256	In-Center Hemo, In-Center Hemo Self Care	13	44-2607	Y
COLLIERVILLE DIALYSIS	791 W POPLAR AVE		COLLIERVILLE	TN	38017-2543	9018537809	9018533538	In-Center Hemo, In-Center Hemo Self Care	13	44-2648	Y
GALLERIA DIALYSIS	9160 HIGHWAY 64		LAKELAND	TN	38002-4766	9013801511	9013805624	In-Center Hemo, In-Center Hemo Self Care	16	44-2611	Y
HUMBOLDT DIALYSIS	2214 OSBORNE ST		HUMBOLDT	TN	38343-3044	7318242742	7318242743	In-Center Hemo, In-Center Hemo Self Care	25	44-2598	Y
NORTH JACKSON DIALYSIS	217 STERLING FARM DR		JACKSON	TN	38305-5727	7316647444	7316647470	In-Center Hemo, In-Center Hemo Self Care, PD Services	24	44-2600	Y
LEXINGTON DIALYSIS (TN)	390 S BROAD ST		LEXINGTON	TN	38351-2257	7319680350	7319680354	In-Center Hemo, In-Center Hemo Self Care	13	44-2622	Y
PICKWICK DIALYSIS	121 PICKWICK ST		SAVANNAH	TN	38372-1953	7319263188	7319258652	In-Center Hemo, In-Center Hemo Self Care	12	44-2632	Y
SELMER DIALYSIS	251 OAKGROVE RD		SELMER	TN	38375-1881	7316454939	7316453137	In-Center Hemo, In-Center Hemo Self Care	10	44-2592	Y
MEMPHIS DOWNTOWN DIALYSIS PD	2076 UNION AVE	FL 2	MEMPHIS	TN	38104-4138	9017256603	9017223037	PD Services		44-2682	Y
TENNESSEE VALLEY DIALYSIS CENTER	107 WOODLAWN DR	STE 2	JOHNSON CITY	TN	37604-6287	4239262976	4239261232	In-Center Hemo	16	44-2666	Y
CLARKSVILLE NORTH DIALYSIS	3071 CLAY LEWIS RD		CLARKSVILLE	TN	37040-5141	9315520644	9315526036	In-Center Hemo, Home Hemo, In-Center Hemo Self Care, PD Services	13	44-2672	Y
LIVINGSTON TN DIALYSIS	308 OAK ST		LIVINGSTON	TN	38570-1729	9314035255	9314035258	In-Center Hemo	8	44-2669	Y
SMYRNA DIALYSIS	537 STONECREST PKWY		SMYRNA	TN	37167-6884	6152203024	6152206238	In-Center Hemo, Home Hemo	8	44-2671	Y
MEMPHIS SOUTHEAST DIALYSIS	1805 MORIAH WOODS BLVD	STE 101	MEMPHIS	TN	38117-7119	9016853192	9016853645	In-Center Hemo, In-Center Hemo Self Care	24	44-2674	Y
SOMERVILLE DIALYSIS	12475 US HIGHWAY 64		SOMERVILLE	TN	38068-6029	9014661919	9014661930	In-Center Hemo, In-Center Hemo Self Care, PD Services	14	44-2683	Y
MEMPHIS DOWNTOWN DIALYSIS	2076 UNION AVE		MEMPHIS	TN	38104-4138	9017251169	9017252778	In-Center Hemo, In-Center Hemo Self Care	28	44-2682	Y
RIPLEY DIALYSIS CENTER	854 HWY 51 S		RIPLEY	TN	38063-5536	7312211883	7312218022	In-Center Hemo, PD Services	12	44-2696	Y
MEMPHIS SOUTH DIALYSIS	1205 MARLIN RD		MEMPHIS	TN	38116-5812	9013466637	9013467884	In-Center Hemo, In-Center Hemo Self Care	16	44-2649	Y
TEAM MUSIC CITY-BRENTWOOD CORPORATE OFFICE	5200 VIRGINIA WAY		BRENTWOOD	TN	37027-7569	8004674736		Support, PD Services		023850	Y
COOKEVILLE DIALYSIS	320 N WILLOW AVE		COOKEVILLE	TN	38501-2337	9315207763	9316464866	In-Center Hemo, In-Center Hemo Self Care, PD Services	17	44-2511	Y
MEMPHIS CENTRAL DIALYSIS	889 DR M L KING JR AVE		MEMPHIS	TN	38126-1928	9015251719	9015250341	In-Center Hemo, In-Center Hemo Self Care	26	44-2573	Y
MEMPHIS EAST DIALYSIS	6029 WALNUT GROVE RD	STE C003	MEMPHIS	TN	38120-2112	9017472316	9017470634	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care	28	44-2576	Y
CLARKSVILLE DIALYSIS	231 HILLCREST DR		CLARKSVILLE	TN	37043-5093	9316459694	9316475517	In-Center Hemo, In-Center Hemo Self Care, PD Services	14	44-2556	Y
WHITEBRIDGE DIALYSIS	103 WHITE BRIDGE PIKE	STE 6	NASHVILLE	TN	37209-4539	6153525535	6153525875	In-Center Hemo, In-Center Hemo Self Care	16	44-2540	Y
COLUMBIA DIALYSIS	1705 GROVE ST		COLUMBIA	TN	38401-3517	9313814445	9313819398	In-Center Hemo, In-Center Hemo Self Care, PD Services	15	44-2539	Y
MURFREESBORO DIALYSIS	1346 DOW ST STE B		MURFREESBORO	TN	37130-2470	6158907270	6158907337	In-Center Hemo, In-Center Hemo Self Care, PD Services	13	44-2549	Y
SUMNER DIALYSIS	300 STEAM PLANT RD	STE 130	GALLATIN	TN	37066-3056	6154525131	6154528970	In-Center Hemo, In-Center Hemo Self Care, PD Services	14	44-2623	Y
HERMITAGE DIALYSIS	5530 OLD HICKORY BLVD	STE 18	HERMITAGE	TN	37076-2576	6152322347	6152327150	In-Center Hemo, In-Center Hemo Self Care, PD Services	12	44-2617	Y

WILLIAMSON COUNTY DIALYSIS	3983 CAROTHERS PKWY	STE E-4	FRANKLIN	TN	37067-5936	6157944423	6157941672	In-Center Hemo, In-Center Hemo Self Care, PD Services	9	44-2587	Y
TIPTON COUNTY DIALYSIS	107 TENNESSEE AVE		COVINGTON	TN	38019-3902	9014750410	9014759040	In-Center Hemo, In-Center Hemo Self Care, Acute Hemo 1:1	13	44-2604	Y
DYERSBURG DIALYSIS	1575 PARR AVE		DYERSBURG	TN	38024-3151	7312865184	7312860174	In-Center Hemo, In-Center Hemo Self Care, PD Services	17	44-2533	Y
MEMPHIS EAST DIALYSIS PD	6029 WALNUT GROVE	STE 105	MEMPHIS	TN	38120-2112	9017470493	9017472845	PD Services		44-2576	Y
NASHVILLE HOME TRAINING DIALYSIS PD	1919 CHARLOTTE AVE	STE 200	NASHVILLE	TN	37203-2245	6153291162	6153291368	PD Services	7	44-2699	Y
KNOXVILLE CENTRAL DIALYSIS	9141 CROSS PARK DR	STE 102	KNOXVILLE	TN	37923-4557	8655314681	8656909943	In-Center Hemo, In-Center Hemo Self Care, PD Services	8	44-2681	Y
GALLERIA HOME TRAINING DIALYSIS PD	9045 HIGHWAY 64	STE 102	LAKELAND	TN	38002-8394	9012132955	9012131724	PD Services	0	44-2678	Y
CAPELVILLE DIALYSIS CENTER	7008 E SHELBY DR		MEMPHIS	TN	38125-3416	9017575001	9017575263	In-Center Hemo	24	44-2692	Y
STATE LINE DIALYSIS	2049 E SHELBY DR		MEMPHIS	TN	38116-7639	9013481931	9013488401	In-Center Hemo, PD Services	18	44-2710	Y
MEMPHIS MIDTOWN DIALYSIS	3430 SUMMER AVE		MEMPHIS	TN	38122-3610	9014540815	9014546437	In-Center Hemo	24	44-2704	Y
MILLINGTON DIALYSIS	8510 WILKINSVILLE RD	STE 121	MILLINGTON	TN	38053-1537	9018733302	9018733344	In-Center Hemo, PD Services	12	44-2689	Y
AIRWAYS DIALYSIS	5247 AIRWAYS BLVD		MEMPHIS	TN	38116-9401	9013450671	9013482068	In-Center Hemo	13	44-2740	Y
SPARTA DIALYSIS	150 SAM WALTON DR	STE 800	SPARTA	TN	38583-8818	9317393550	9317393553	In-Center Hemo, PD Services	8	44-2708	Y
WOLF RIVER DIALYSIS	7990 TRINITY PL	STE 101	CORDOVA	TN	38018-7731	9017513120	9017513223	In-Center Hemo	12	44-2709	Y
SOUTH JACKSON DIALYSIS	46 HARTS BRIDGE RD		JACKSON	TN	38301-7512	7314229568	7314229556	In-Center Hemo	16	44-2714	Y
GREENEVILLE DIALYSIS	110 HERITAGE CT		GREENEVILLE	TN	37743-2081	4236392110	4236392071	In-Center Hemo	12	44-2716	Y
CAMPBELL STATION DIALYSIS	111 S CAMPBELL STATION RD		FARRAGUT	TN	37934-2845	8657772750	8657772755	In-Center Hemo, PD Services	13	44-2721	Y
APPALACHIAN DIALYSIS	503 ELM ST		NEW TAZEWELL	TN	37825-7525	4236261242	4236266587	In-Center Hemo, Acute Hemo 1:1, Acute PD	14	44-2567	Y
MORRISTOWN DIALYSIS	120 PEARCE DR		MORRISTOWN	TN	37814-3649	4235873537	4235873538	In-Center Hemo	20	44-2517	Y
BLOUNT DIALYSIS	714 E HARPER AVE		MARYVILLE	TN	37804-4028	8653791070	8653791090	In-Center Hemo, PD Services	28	44-2639	Y
CLINCH RIVER DIALYSIS	702 N MAIN ST		CLINTON	TN	37716-3143	8654571114	8654575576	In-Center Hemo, PD Services	17	44-2686	Y
KNOXVILLE DIALYSIS	2909 E MAGNOLIA AVE		KNOXVILLE	TN	37914-4516	8655252232	8655242425	In-Center Hemo, PD Services	25	44-2670	Y
ROCKY TOP DIALYSIS	921 NEW HWY 68		SWEETWATER	TN	37874-2726	4233375770	4233379142	In-Center Hemo, PD Services	17	44-2676	Y
TN SMOKIE MOUNTAIN DIALYSIS PD	2320 KNOB CREEK	STE 408	JOHNSON CITY	TN	37604-2580	4232321969	4232620320	PD Services	2	44-2668	Y
ETOWAH DIALYSIS	109 GRADY RD		ETOWAH	TN	37331-1903	4232633666	4232633758	In-Center Hemo, Acute Hemo 1:1	16	44-2715	Y
STATE LINE AT HOME	2049 E. SHELBY DRIVE		MEMPHIS	TN	38116-7639	9013481931	9013488401	Home Hemo		44-2710	Y
NORTH JACKSON AT HOME	217 STERLING FARM DR		JACKSON	TN	38305-5727	7316687118	7316682497	Home Hemo		44-2600	Y
KNOXVILLE CENTRAL AT HOME	9141 CROSS PARK DR	STE 102	KNOXVILLE	TN	37923-4557	8655314681	8656909943	Home Hemo	0	44-2681	Y
MEMPHIS DOWNTOWN AT HOME	2076 UNION AVE	FL 2	MEMPHIS	TN	38104-4138	9017251169	9017252778	Home Hemo		44-2682	Y
GALLERIA HOME TRAINING AT HOME	9045 HIGHWAY 64	STE 102	LAKELAND	TN	38002-8394	9012132955	9012131724	Home Hemo	0	44-2678	Y
MEMPHIS EAST AT HOME	6029 WALNUT GROVE RD	STE 105	MEMPHIS	TN	38120-2110	9017470493	9017472845	Home Hemo	0	44-2576	Y
RIPLEY AT HOME	854 HWY 51 S		RIPLEY	TN	38063-5536	7312211883	7312218022	Home Hemo			Y
COOKEVILLE AT HOME	320 N WILLOW AVE		COOKEVILLE	TN	38501-2337	9315207763	9316464866	Home Hemo		44-2511	Y
NASHVILLE HOME TRAINING AT HOME	1919 CHARLOTTE AVE	STE 200	NASHVILLE	TN	37203-2245	6153291162	6153291368	Home Hemo		44-2699	Y
RENAL CARE OF CENTRAL MEMPHIS AT HOME	1331 UNION AVE	STE 101	MEMPHIS	TN	38104-7559	9012785400	9012785200	Home Hemo		44-2637	Y
RENAL CARE OF CENTRAL MEMPHIS	1331 UNION AVE	STE 101	MEMPHIS	TN	38104-7559	9012785400	9012785200	In-Center Hemo, PD Services	40	44-2637	Y
MEMPHIS GRACELAND RENAL CENTER	4180 AUBURN RD		MEMPHIS	TN	38116-6202	9013328699	9013328234	In-Center Hemo	16	44-2650	Y
RENAL CARE OF MIDTOWN MEMPHIS	1166 MONROE AVE		MEMPHIS	TN	38104-6614	9017222012	9017222919	In-Center Hemo	24	44-2646	Y
RENAL CARE OF MEMPHIS NORTH	4913 RALEIGH COMMON DR	STE 100	MEMPHIS	TN	38128-2485	9019370650	9013850740	In-Center Hemo	19	44-2640	Y
WHITEHAVEN RENAL CENTER	3420 ELVIS PRESLEY BLVD		MEMPHIS	TN	38116-3260	9013963794	9013969286	In-Center Hemo, PD Services	25	44-2655	Y
BARTLETT RENAL CENTER	2920 COVINGTON PIKE		MEMPHIS	TN	38128-6007	9012486020	9013770879	In-Center Hemo	12	44-2711	Y
TOP LEVEL DSI OPER	424 CHURCH ST	STE 1900	NASHVILLE	TN	37219-2387			In-Center Hemo			Y
DYERSBURG AT HOME	1575 PARR AVE		DYERSBURG	TN	38024-3154	7312865184	7312860174	Home Hemo	17	44-2533	Y
RIVER OAKS DIALYSIS	8000 WOLF RIVER BLVD	STE 106	GERMANTOWN	TN	38138-1754	9017574809	9017573627	In-Center Hemo, PD Services	17	44-2747	Y
MEDINA DIALYSIS	210 GRACE COVE		MEDINA	TN	38355-8738	7317830527	7317835420	In-Center Hemo, PD Services	12	44-2733	Y
FORT CAMPBELL DIALYSIS	1459 FORT CAMPBELL BLVD		CLARKSVILLE	TN	37042-3552	9315526491	9316487946	In-Center Hemo, PD Services	13	442742	Y
INTERSTATE DRIVE DIALYSIS	1843 FOREMAN DR	STE B	COOKEVILLE	TN	38501-5933	9313728853	9313721777	In-Center Hemo	12	44-2737	Y
WOODBINE DIALYSIS	5209 LINBAR DR	STE 605	NASHVILLE	TN	37211-1037	6153339765	6153339331	In-Center Hemo, PD Services	12	44-2743	Y
BRILEY PARKWAY DIALYSIS	1221 BRIARVILLE RD		MADISON	TN	37115-5145	6158659363	6158700906	In-Center Hemo	16	44-2744	Y
MT JULIET DIALYSIS	1050 HERSCHEL DR		MT JULIET	TN	37122-6338	6157581970	6157581974	In-Center Hemo		44-2738	Y
TN SMOKIE MOUNTAIN AT HOME	2320 KNOB CREEK	STE 408	JOHNSON CITY	TN	37604-2580	4232321969	4232620320	Home Hemo			Y
HENDERSON DIALYSIS CENTER	1002 US HWY 79 N		HENDERSON	TX	75652-6008	9036556922	9036551719	In-Center Hemo	13	45-2803	Y
LONE STAR DIALYSIS	8560 MONROE RD		HOUSTON	TX	77061-4815	7133786094	7133786398	In-Center Hemo,	48	45-2676	Y
Moncrief Dialysis Center	800 W 34TH ST	STE 101	AUSTIN	TX	78705-1144	5124857872	5124853992	In-Center Hemo, PD Services	26	45-2783	Y
Cyfair Dialysis Center	9110 JONES RD	STE 110	HOUSTON	TX	77065-4489	2815170527	2815170930	In-Center Hemo, Nocturnal Hemo,	16	45-2762	Y

KATY DIALYSIS GRAND PARKWAY	403 W GRAND PKWY S	STE T	KATY	TX	77494-8358	2813926063	2813924331	In-Center Hemo, In-Center Hemo Self Care,	20	45-2761	Y
MEMORIAL DIALYSIS CENTER	11621 KATY FWY		HOUSTON	TX	77079-1801	2815585702	2815978377	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care, PD Services,	26	45-2755	Y
BROOKRIVER DIALYSIS	8101 BROOKRIVER DR		DALLAS	TX	75247-4003	2149517789	2149519013	In-Center Hemo, PD Services,	20	45-2703	Y
Cielo Vista Dialysis	7200 GATEWAY BLVD E	STE B	EL PASO	TX	79915-1301	9157716893	9157716897	In-Center Hemo, PD Services	24	45-2707	Y
West Texas Dialysis	5595 ALAMEDA AVE	STE B	EL PASO	TX	79905-2915	9158810254	9157722823	In-Center Hemo	21	45-2720	Y
Mesa Vista Dialysis	1211 E CLIFF DR		EL PASO	TX	79902-4734	9155338147	9155338593	In-Center Hemo, PD Services	20	45-2758	Y
Houston Kidney Center Southwest	9980 W SAM HOUSTON PKWY S	STE 100	HOUSTON	TX	77099-5104	2815301905	2815301590	In-Center Hemo, In-Center Hemo Self Care,	24	45-2780	Y
Northwest Kidney Center	10985 NORTHWEST FWY		HOUSTON	TX	77092-7305	7138121217	7138121693	In-Center Hemo,	24	45-2642	Y
NorthStar Dialysis Center	380 W LITTLE YORK RD		HOUSTON	TX	77076-1303	2814484506	2814484376	In-Center Hemo,	49	45-2675	Y
Houston Kidney Center Cypress Station	72 CYPRESS CREEK PKWY		HOUSTON	TX	77090-3531	2815806157	2815806850	In-Center Hemo, PD Services,	32	45-2784	Y
OAK CLIFF DIALYSIS	2000 S LLEWELLYN AVE		DALLAS	TX	75224-1804	2149430011	2149430064	In-Center Hemo	16	45-2894	Y
Fourth Street Dialysis	3101 N 4TH ST	STE B	LONGVIEW	TX	75605-5146	9032340112	9032341341	In-Center Hemo	12	45-2776	Y
Pearland Dialysis	6516 BROADWAY ST	STE 122	PEARLAND	TX	77581-7879	2814127422	2814127791	In-Center Hemo, PD Services,	20	45-2845	Y
Central City Dialysis	1310 MURCHISON DR	STE 200	EL PASO	TX	79902-4821	9155338503	9155338379	In-Center Hemo	28	45-2651	Y
LOMA VISTA DIALYSIS CENTER	1382 LOMALAND DR	STE A	EL PASO	TX	79935-5204	9155910834	9155915029	In-Center Hemo, PD Services	53	45-2741	Y
WATERLOO DIALYSIS CENTER	5310 BURNET RD	UNIT 122	AUSTIN	TX	78756-2003	5124209403	5124209640	In-Center Hemo	24	45-2696	Y
LIVE OAK DIALYSIS	6700 RANDOLPH BLVD	STE 101	LIVE OAK	TX	78233-4222	2105900103	2105900813	In-Center Hemo, PD Services,	20	45-2570	Y
STONE OAK DIALYSIS	731 CARNOUSTIE DR	STE 101	SAN ANTONIO	TX	78258-4800	2104032162	2104990884	In-Center Hemo, In-Center Hemo Self Care	20	45-2623	Y
EL MILAGRO DIALYSIS UNIT	2800 S INTERSTATE HWY 35	STE 120	AUSTIN	TX	78704-5700	5124489750	5124484617	In-Center Hemo, In-Center Hemo Self Care, PD Services	24	45-2727	Y
MED CENTER DIALYSIS	5610 ALMEDA RD		HOUSTON	TX	77004-7515	7135206878	7135270575	In-Center Hemo, In-Center Hemo Self Care, PD Services,	72	45-2572	Y
SOUTH SAN ANTONIO DIALYSIS CENTER	1313 SE MILITARY DR	STE 111	SAN ANTONIO	TX	78214-2850	2109322434	2109320073	In-Center Hemo, PD Services	24	45-2747	Y
CLEVELAND DIALYSIS CENTER	202 E FORT WORTH ST		CLEVELAND	TX	77327-4917	2816599679	2816590026	In-Center Hemo, In-Center Hemo Self Care,	20	45-2731	Y
KINGWOOD DIALYSIS CENTER	2300 GREEN OAK DR	STE 500	KINGWOOD	TX	77339-2053	2813594433	2813595159	In-Center Hemo, In-Center Hemo Self Care,	12	45-2646	Y
LIVINGSTON DIALYSIS CENTER	209 W PARK		LIVINGSTON	TX	77351-7020	9363271108	9363271135	In-Center Hemo	12	45-2661	Y
LUFKIN DIALYSIS CENTER	700 S JOHN REDDITT DR		LUFKIN	TX	75904-3145	9366342224	9366320764	In-Center Hemo, PD Services	37	45-2639	Y
SHERMAN DIALYSIS CENTER	205 W LAMBERTH RD		SHERMAN	TX	75092-2659	9038682227	9038932559	In-Center Hemo	19	45-2774	Y
DENISON DIALYSIS CENTER	123 N US HIGHWAY 75		DENISON	TX	75020-1544	9033370731	9034651659	In-Center Hemo, PD Services	21	45-2665	Y
VICTORIA DIALYSIS CENTER	1405 VICTORIA STATION DR		VICTORIA	TX	77901-3092	3615769907	3615763979	In-Center Hemo, In-Center Hemo Self Care, PD Services,	29	45-2658	Y
OMNI DIALYSIS CENTER	9350 KIRBY DR	STE 110	HOUSTON	TX	77054-2528	7136654747	7136653570	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care,	48	45-2667	Y
GONZALES DIALYSIS CENTER	1406 N SARAH DEWITT DR		GONZALES	TX	78629-2702	8306724377	8306724469	In-Center Hemo,	16	45-2734	Y
HILL COUNTRY DIALYSIS	1250 DACY LN		KYLE	TX	78640-4921	5122682523	5122681542	In-Center Hemo, PD Services	12	45-2769	Y
SOUTHWEST SAN ANTONIO DIALYSIS CENTER	7515 BARLITE BLVD		SAN ANTONIO	TX	78224-1311	2109234566	2109226256	In-Center Hemo, PD Services,	24	45-2571	Y
NORTH HOUSTON DIALYSIS CENTER	8621 FULTON ST		HOUSTON	TX	77022-2021	7136993748	7136993558	In-Center Hemo, PD Services,	24	45-2678	Y
TOMBALL DIALYSIS CENTER	27720A TOMBALL PKWY		TOMBALL	TX	77375-6472	2813516802	2813516805	In-Center Hemo, In-Center Hemo Self Care,	25	45-2743	Y
CONROE DIALYSIS CENTER	233 I-45 N		CONROE	TX	77304-2307	9367602240	9367602238	In-Center Hemo, In-Center Hemo Self Care,	16	45-2708	Y
LONGVIEW DIALYSIS CENTER	425 N FREDONIA ST		LONGVIEW	TX	75601-6464	9032341452	9037586379	In-Center Hemo, PD Services	35	45-2744	Y
MARSHALL DIALYSIS CENTER	1301 S WASHINGTON AVE		MARSHALL	TX	75670-6215	9039351158	9039386341	In-Center Hemo	15	45-2624	Y
HEB DIALYSIS CENTER	1809 FOREST RIDGE DR		BEDFORD	TX	76022-7961	8175454509	8175457392	In-Center Hemo, In-Center Hemo Self Care	17	45-2583	Y
Pin Oak Dialysis	24968 KATY RANCH RD	STE 500	KATY	TX	77494-3404	2815744387	2815744349	In-Center Hemo,	12	45-2847	Y
SPRING BRANCH DIALYSIS	1425 BLALOCK RD	STE 100	HOUSTON	TX	77055-4446	7139327795	7139327644	In-Center Hemo,	18	45-2728	Y
PDI-NORTH HOUSTON	7115 NORTH LOOP E		HOUSTON	TX	77028-5948	7136754794	7136754126	In-Center Hemo,	20	45-2875	Y
PDI-SOUTH HOUSTON	5989 SOUTH LOOP E		HOUSTON	TX	77033-1017	7136416130	7136416056	In-Center Hemo, In-Center Hemo Self Care, PD Services,	24	45-2886	Y
SOUTH AUSTIN DIALYSIS CENTER	6114 S 1ST ST		AUSTIN	TX	78745-4008	5124478500	5124478512	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care	20	45-2892	Y
Spring Dialysis	607 TIMBERDALE LN	STE 100	HOUSTON	TX	77090-3043	2818807066	2818808287	In-Center Hemo, PD Services,	18	45-2787	Y
CUERO LAKEVIEW DIALYSIS	1105 E BROADWAY ST		CUERO	TX	77954-2108	3612758648	3612758691	In-Center Hemo,	16	45-2889	Y
NEW BRAUNFELS DIALYSIS	798 GENERATIONS DR		NEW BRAUNFELS	TX	78130-0005	8306292848	8306292779	In-Center Hemo, In-Center Hemo Self Care, PD Services	24	45-2798	Y
PORT LAVACA DIALYSIS	1300 N VIRGINIA ST	STE 102	PORT LAVACA	TX	77979-2512	3615523800	3615528703	In-Center Hemo,	10	67-2595	Y
Mission Hills Dialysis	2700 N STANTON ST		EL PASO	TX	79902-2500	9153510722	9153512528	In-Center Hemo, PD Services	24	45-2858	Y
Brookhollow Dialysis	4918 W 34TH ST		HOUSTON	TX	77092-6606	7136813043	7136836456	In-Center Hemo, PD Services,	12	45-2868	Y
DALLAS NORTH DIALYSIS CENTER	11886 GREENVILLE AVE	STE 100B	DALLAS	TX	75243-0584	9729180100	9729180110	In-Center Hemo, Nocturnal Hemo	12	45-2884	Y
DOWNTOWN HOUSTON DIALYSIS CENTER	2207 CRAWFORD ST		HOUSTON	TX	77002-8915	7136550900	7136550909	In-Center Hemo,	16	45-2899	Y
JACINTO DIALYSIS CENTER	11515 MARKET STREET RD		HOUSTON	TX	77029-2305	7134530505	7134530599	In-Center Hemo,	16	67-2503	Y
Sun City Dialysis Center	600 NEWMAN ST		EL PASO	TX	79902-5543	9153512010	9153512018	In-Center Hemo, PD Services	20	67-2508	Y
KILGORE DIALYSIS CENTER	2403 STATE HIGHWAY 42		KILGORE	TX	75662-5554	9039888200	9039888208	In-Center Hemo	16	45-2885	Y
River Park Dialysis	2010 S LOOP 336 W	STE 200	CONROE	TX	77304-3313	9367603333	9364413330	In-Center Hemo, In-Center Hemo Self Care, PD Services,	12	45-2898	Y

PINECREST DIALYSIS CENTER	913 E PINECREST DR		MARSHALL	TX	75670-7309	9039349660	9039348474	In-Center Hemo	20	45-2893	Y
TRANSMOUNTAIN DIALYSIS	5800 WOODROW BEAN		EL PASO	TX	79924-5060	9157596532	9157596534	In-Center Hemo, PD Services	36	67-2501	Y
SUMMIT DIALYSIS CENTER	3150 POLK ST		HOUSTON	TX	77003-4631	7132283500	7132282136	In-Center Hemo,	12	67-2537	Y
MERIDIAN DIALYSIS CENTER	201 W FAIRMONT PKWY	STE A	LA PORTE	TX	77571-6303	2814710172	2814710591	In-Center Hemo,	12	67-2511	Y
WILLOWBROOK DIALYSIS	12120 JONES RD	STE G	HOUSTON	TX	77070-5280	2818907288	2818907248	In-Center Hemo, PD Services,	12	67-2538	Y
SOUTH SHORE DIALYSIS CENTER	212 GULF FWY S	STE G3	LEAGUE CITY	TX	77573-3956	2815546050	2813161385	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care, PD Services,	12	67-2522	Y
Bayou City Dialysis	10655 EASTEX FWY		HOUSTON	TX	77093-4323	7136958986	7136955647	In-Center Hemo,	16	67-2535	Y
BONHAM DIALYSIS	201 W 5TH ST		BONHAM	TX	75418-4302	9035834700	9035834772	In-Center Hemo	12	67-2513	Y
GILMER DIALYSIS	510 US HIGHWAY 271 N		GILMER	TX	75644-5569	9038439886	9038439665	In-Center Hemo	12	45-2897	Y
THE WOODLANDS DIALYSIS CENTER	9301 PINECROFT DR	STE 130	SHENANDOAH	TX	77380-3178	2812926788	2812925950	In-Center Hemo, In-Center Hemo Self Care, PD Services,	16	67-2581	Y
ARLINGTON DIALYSIS	1250 E PIONEER PKWY	STE 700	ARLINGTON	TX	76010-6423	8174696100	8174691930	In-Center Hemo	12	67-2525	Y
GRAPEVINE DIALYSIS	1651 W NORTHWEST HWY		GRAPEVINE	TX	76051-3100	8172510675	8174210417	In-Center Hemo, Nocturnal Hemo, PD Services	25	67-2531	Y
Lancaster Dialysis	2424 W PLEASANT RUN RD		LANCASTER	TX	75146-4005	9722239292	9722232027	In-Center Hemo	12	67-2520	Y
DAVITA EAST DIALYSIS CLINIC	11989 PELLICANO DR		EL PASO	TX	79936-6287	9158566363	9158569777	In-Center Hemo, PD Services	24	67-2558	Y
RIVERCENTER DIALYSIS	1123 N MAIN AVE	STE 150	SAN ANTONIO	TX	78212-4738	2102707887	2102707892	In-Center Hemo, In-Center Hemo Self Care	22	67-2516	Y
MARYMONT DIALYSIS CENTER	2391 NE LOOP 410	STE 211	SAN ANTONIO	TX	78217-5675	2106468788	2106466583	In-Center Hemo	26	67-2523	Y
NORTHWEST MEDICAL CENTER DIALYSIS	5284 MEDICAL DR	STE 100	SAN ANTONIO	TX	78229-4849	2106169699	2106169504	In-Center Hemo, In-Center Hemo Self Care, PD Services	24	67-2515	Y
SOUTHCROSS DIALYSIS CENTER	4602 E SOUTHCROSS BLVD		SAN ANTONIO	TX	78222-4911	2106485988	2106489929	In-Center Hemo	24	67-2519	Y
LAS PALMAS DIALYSIS CENTER	803 CASTROVILLE RD	STE 415	SAN ANTONIO	TX	78237-3148	2104389290	2104389289	In-Center Hemo, In-Center Hemo Self Care	24	67-2521	Y
CEDAR PARK DIALYSIS CENTER	1720 E WHITESTONE BLVD		CEDAR PARK	TX	78613-7640	5125288478	5125288504	In-Center Hemo, PD Services	12	67-2591	Y
BEAR CREEK DIALYSIS	4978 HIGHWAY 6 N	STE I	HOUSTON	TX	77084-2764	2818595020	2818594969	In-Center Hemo,	12	67-2549	Y
CARROLLTON DIALYSIS	1544 VALWOOD PKWY	STE 114	CARROLLTON	TX	75006-8425	9722437001	9722438865	In-Center Hemo	12	67-2548	Y
UPPER VALLEY DIALYSIS	7933 N MESA ST	STE H	EL PASO	TX	79932-1699	9158320555	9158320554	In-Center Hemo, PD Services	24	67-2536	Y
BENBROOK DIALYSIS	6260 SOUTHWEST BLVD		BENBROOK	TX	76109-6906	8177313652	8177314655	In-Center Hemo	13	67-2661	Y
NORTH CONROE DIALYSIS	3211 INTERSTATE 45 N	STE 500	CONROE	TX	77304-2180	9367569400	9367569450	In-Center Hemo, PD Services,	16	67-2717	Y
DEERBROOK DIALYSIS	9660 FM 1960 BYPASS RD W		HUMBLE	TX	77338-4039	2813126362	2813126370	In-Center Hemo, PD Services,	24	67-2560	Y
FIRST COLONY DIALYSIS CENTER	1447 HIGHWAY 6	STE 140	SUGAR LAND	TX	77478-5094	2814941465	2814941484	In-Center Hemo,	13	67-2592	Y
DAVITA DOWNTOWN DALLAS DIALYSIS	3515 SWISS AVE	STE A	DALLAS	TX	75204-6223	2148282280	2148277204	In-Center Hemo, In-Center Hemo Self Care	16	67-2553	Y
DOWNTOWN SAN ANTONIO DIALYSIS	615 E QUINCY ST		SAN ANTONIO	TX	78215-1600	2102221260	2102221499	In-Center Hemo, In-Center Hemo Self Care, PD Services	20	67-2556	Y
LAKE CLIFF DIALYSIS CENTER	805 N BECKLEY AVE		DALLAS	TX	75203-1612	2149427727	2149427774	In-Center Hemo	20	67-2580	Y
MANSFIELD DIALYSIS CENTER	352 MATLOCK RD	STE 120	MANSFIELD	TX	76063-8016	8174538167	8174732610	In-Center Hemo, PD Services	25	67-2550	Y
PLANO DIALYSIS CENTER	481 SHILOH RD	STE 100	PLANO	TX	75074-7231	9728813270	9728815086	In-Center Hemo	12	67-2636	Y
GARLAND DIALYSIS	776 E CENTERVILLE RD		GARLAND	TX	75041-4640	9722782757	9722782675	In-Center Hemo, In-Center Hemo Self Care	20	67-2555	Y
SEALY DIALYSIS	2242 CHAMPIONSHIP DR		SEALY	TX	77474-8122	9796270300	9796270318	In-Center Hemo,	12	67-2606	Y
BOERNE DIALYSIS CENTER	1369 S MAIN ST	STE 101	BOERNE	TX	78006-2860	8302491491	8302491508	In-Center Hemo	12	67-2578	Y
MID CITIES DIALYSIS CENTER	117 E HARWOOD RD		HURST	TX	76054-3043	8176562843	8176562040	In-Center Hemo	16	67-2579	Y
NORTH HILLS DIALYSIS	7927 BOULEVARD 26		NORTH RICHLAND HILLS	TX	76180-7103	8176059861	8176059862	In-Center Hemo	15	67-2620	Y
MISSION VALLEY DIALYSIS	1203 ST CLAIRE BLVD 9B		MISSION	TX	78572-6601	9565833760	9565838252	In-Center Hemo, Home Hemo, Nocturnal Hemo, PD Services	15	67-2646	Y
RIDGECREST DIALYSIS	12249 ROJAS DR		EL PASO	TX	79936-7750	9157900839	9158581063	In-Center Hemo	20	67-2691	Y
TC JESTER DIALYSIS	1800 W 26TH ST	STE 101	HOUSTON	TX	77008-1451	7138630463	7138638272	In-Center Hemo, PD Services,	16	67-2675	Y
LA CENTRAL DIALYSIS	902 HOUSTON ST		LAREDO	TX	78040-8015	9565238652	9565230598	In-Center Hemo, PD Services	13	67-2759	Y
TAYLOR DIALYSIS	3100 W 2ND ST		TAYLOR	TX	76574-4647	5123522549	5123522535	In-Center Hemo, In-Center Hemo Self Care, PD Services	12	67-2617	Y
HEARNE DIALYSIS CENTER	106 CEDAR ST		HEARNE	TX	77859-2523	9792799632	9792799621	In-Center Hemo, In-Center Hemo Self Care	12	67-2599	Y
MAGNOLIA DIALYSIS CENTER	17649 FM 1488 RD		MAGNOLIA	TX	77354-5235	2812590397	2812590425	In-Center Hemo, PD Services,	12	67-2625	Y
CYPRESS WOODS NORTHWEST DIALYSIS	20320 NORTHWEST FWY	STE 100	JERSEY VILLAGE	TX	77065-5643	2818902540	2818905376	In-Center Hemo,	13	67-2669	Y
SAN ANGELO DIALYSIS	3518 KNICKERBOCKER RD		SAN ANGELO	TX	76904-7611	3259496035	3259496791	In-Center Hemo, PD Services	12	67-2719	Y
DAVITA CENTRAL DALLAS DIALYSIS	9500 N CENTRAL EXPY	STE 102	DALLAS	TX	75231-5139	2147393004	2147393002	In-Center Hemo, In-Center Hemo Self Care, PD Services	16	67-2632	Y
CHANNELVIEW DIALYSIS	777 SHELDON RD	STE C	CHANNELVIEW	TX	77530-3509	2818600600	2818609608	In-Center Hemo,	20	45-2647	Y
SAGEMONT DIALYSIS	10851 SCARSDALE BLVD	STE 200	HOUSTON	TX	77089-5738	2814814577	2814810938	In-Center Hemo,	12	45-2612	Y
SAN JACINTO DIALYSIS	11430 EAST FWY	STE 330	HOUSTON	TX	77029-1959	7134504991	7134504994	In-Center Hemo,	17	45-2530	Y
CENTRAL HOUSTON DIALYSIS	610 S WAYSIDE DR	UNIT B	HOUSTON	TX	77011-4605	7139288188	7139289059	In-Center Hemo,	20	45-2677	Y
KERRVILLE DIALYSIS	515 GRANADA PL		KERRVILLE	TX	78028-5992	8302578734	8302578775	In-Center Hemo, PD Services	18	45-2546	Y
FLORESVILLE DIALYSIS	543 10TH ST		FLORESVILLE	TX	78114-3107	8303934010	8303933056	In-Center Hemo	12	45-2733	Y
PEARSALL DIALYSIS	1305 N OAK ST		PEARSALL	TX	78061-3414	8303344690	8303343380	In-Center Hemo, In-Center Hemo Self Care	12	45-2740	Y

SAN ANTONIO WEST DIALYSIS	4530 CALLAGHAN RD		SAN ANTONIO	TX	78228-2617	2104319048	2104318934	In-Center Hemo, Home Hemo, In-Center Hemo Self Care, PD Services	24	45-2587	Y
HOUSTON DIALYSIS	900 S LOOP W	STE 100	HOUSTON	TX	77054-4632	7137480942	7137417357	In-Center Hemo, PD Services,	20	45-2584	Y
RELIANT DIALYSIS	1335 LA CONCHA LN		HOUSTON	TX	77054-1809	7137940600	7137940999	In-Center Hemo, In-Center Hemo Self Care, PD Services,	24	45-2705	Y
SOUTHWEST SAN ANTONIO DIALYSIS	1620 SOMERSET RD		SAN ANTONIO	TX	78211-3021	2109246684	2109248332	In-Center Hemo, In-Center Hemo Self Care	16	45-2605	Y
NORTH LOOP EAST DIALYSIS	7139 NORTH LOOP E		HOUSTON	TX	77028-5903	7136758499	7136753510	In-Center Hemo,	16	45-2706	Y
KATY CINCO RANCH DIALYSIS	1265 ROCK CANYON DR		KATY	TX	77450-3831	2813921616	2813922544	In-Center Hemo, In-Center Hemo Self Care, PD Services,	12	45-2833	Y
UT SOUTHWESTERN-DALLAS DIALYSIS	204 E AIRPORT FWY		IRVING	TX	75062-6305	9724387375	9725541489	In-Center Hemo, PD Services	36	45-2736	Y
UT SOUTHWESTERN-OAKCLIFF DIALYSIS	610 WYNNEWOOD DR		DALLAS	TX	75224	2149417807	2149417813	In-Center Hemo, In-Center Hemo Self Care	36	45-2773	Y
COLLEGE STATION DIALYSIS	1640 BRIARCREST DR	STE 100	BRYAN	TX	77802-2709	9792604908	9792685890	In-Center Hemo, Acute Hemo 1:1, Acute PD, PD Services,	25	45-2550	Y
BRENHAM DIALYSIS	2815 HIGHWAY 36 S		BRENHAM	TX	77833-8143	9792517287	9798362276	In-Center Hemo, In-Center Hemo Self Care, PD Services	16	45-2641	Y
HUNTSVILLE DIALYSIS	521 IH 45 S	STE 20	HUNTSVILLE	TX	77340-5651	9362955500	9362955889	In-Center Hemo, PD Services,	26	45-2663	Y
DALLAS EAST DIALYSIS	3402 N BUCKNER BLVD	STE 308	DALLAS	TX	75228-5646	2146609413	2146609465	In-Center Hemo	32	45-2822	Y
MAINLAND DIALYSIS	4201 GULF FWY		LA MARQUE	TX	77568-3516	4099381678	4099381679	In-Center Hemo, In-Center Hemo Self Care,	24	45-2635	Y
ISLAND DIALYSIS	5920 BROADWAY ST		GALVESTON	TX	77551-4305	4097401109	4097401464	In-Center Hemo, In-Center Hemo Self Care,	27	45-2520	Y
ROCK PRAIRIE ROAD DIALYSIS	1724 BIRMINGHAM RD		COLLEGE STATION	TX	77845-4063	9797046903	9797046906	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care	20	67-2504	Y
DIALYSIS COTTAGE	1902 HOSPITAL BLVD	STE D	GAINESVILLE	TX	76240-2008	9406121642	9406122360	In-Center Hemo	12	67-2585	Y
WOODFOREST DIALYSIS	12626 WOODFOREST BLVD	STE C	HOUSTON	TX	77015-3425	7134553370	7134553387	In-Center Hemo,	15	67-2679	Y
LAKE JACKSON DIALYSIS	450 THIS WAY ST	STE A	LAKE JACKSON	TX	77566-5152	9792996565	9792996568	In-Center Hemo, Acute Hemo 1:1, Acute PD,	24	67-2500	Y
ANGLETON DIALYSIS	102 E HOSPITAL DR		ANGLETON	TX	77515-4146	9798644330	9798644339	In-Center Hemo, Acute Hemo 1:1, Acute PD,	20	67-2524	Y
NORTH SHEPHERD DIALYSIS	7272 N SHEPHERD DR	BLDG B	HOUSTON	TX	77091-2435	7136971115	7136971116	In-Center Hemo,	30	67-2518	Y
ROMANO WOODS DIALYSIS	16910 MATHIS CHURCH RD		HOUSTON	TX	77090-3710	2818936300	2818936366	In-Center Hemo,	30	67-2655	Y
JENSEN DIALYSIS	9716 JENSEN DR		HOUSTON	TX	77093-6302	7136924600	7136924607	In-Center Hemo, PD Services,	22	67-2721	Y
WHARTON DIALYSIS	103 W AHLDAG ST		WHARTON	TX	77488-2407	9792828484	9792828489	In-Center Hemo, PD Services,	25	67-2572	Y
EL CAMPO DIALYSIS	307 SANDY CORNER RD		EL CAMPO	TX	77437-9535	9795438200	9795438214	In-Center Hemo,	18	67-2645	Y
KAUFMAN DIALYSIS	2851 MILLENNIUM DR		KAUFMAN	TX	75142-8865	9729329091	9729329098	In-Center Hemo	12	67-2619	Y
ROCKWALL DIALYSIS CENTER	2455 RIDGE RD	STE 101	ROCKWALL	TX	75087-5530	9727224060	9727227491	In-Center Hemo	8	67-2638	Y
DUNCANVILLE DIALYSIS	270 E HIGHWAY 67	STE 100	DUNCANVILLE	TX	75137-4428	9722964911	9722964429	In-Center Hemo, Nocturnal Hemo	12	67-2635	Y
PINE PARK DIALYSIS	3333 BAYSHORE BLVD		PASADENA	TX	77504-1952	7139431463	7139431481	In-Center Hemo, PD Services,	24	672767	Y
WEST PLANO DIALYSIS	5036 TENNYSON PKWY		PLANO	TX	75024-3002	9726081089	9726081096	In-Center Hemo	12	67-2658	Y
WEST ARLINGTON DIALYSIS	1001 W ARBROOK BLVD	STE 101 AND 111	ARLINGTON	TX	76015-4222	8174667403	8174667408	In-Center Hemo	21	67-2810	Y
FLOYD CURL DIALYSIS	9238 FLOYD CURL DR	STE 102	SAN ANTONIO	TX	78240-1691	2105614373	2105619415	In-Center Hemo, PD Services	20	67-2653	Y
CHAMPIONS DIALYSIS	4427 FM 1960 RD W		HOUSTON	TX	77068-3409	2814448439	2815378250	In-Center Hemo,	20	67-2676	Y
BAYTOWN DIALYSIS	4665 GARTH RD	STE 900	BAYTOWN	TX	77521-2261	2814220820	2814220961	In-Center Hemo, PD Services,	12	67-2641	Y
WEST OAKS DIALYSIS	14800 WESTHEIMER RD	STE A	HOUSTON	TX	77082-1675	2817525469	2817529929	In-Center Hemo,	12	67-2686	Y
BINZ HOME TRAINING	1213 HERMANN DR	STE 180	HOUSTON	TX	77004-7070	7135295155	7135295135	PD Services,	5	67-2664	Y
SAGEMEADOW DIALYSIS	10923 SCARSDALE BLVD		HOUSTON	TX	77089-6024	2819226130	2819226145	In-Center Hemo,	20	67-2670	Y
MCKINNEY DIALYSIS	4717 MEDICAL CENTER DR		MCKINNEY	TX	75069-1870	9725420495	9725429676	In-Center Hemo, PD Services	18	67-2671	Y
AMERICAS DIALYSIS	715 N AMERICAS AVE		EL PASO	TX	79907-7004	9158728185	9158728921	In-Center Hemo	20	67-2692	Y
DENTON DIALYSIS	3305 UNICORN LAKE BLVD		DENTON	TX	76210-0102	9403874592	9403832324	In-Center Hemo	13	67-2776	Y
WEST POINT DIALYSIS	12051 WESTPARK DR	STE 100	HOUSTON	TX	77082-6604	2819204892	2819204879	In-Center Hemo, PD Services,	16	67-2693	Y
VILLAGE DIALYSIS	6952 INDUSTRIAL PKWY		ROSENBERG	TX	77471-5656	2812323116	2812325821	In-Center Hemo,	12	67-2715	Y
GEORGETOWN DIALYSIS	201 FM 971		GEORGETOWN	TX	78626-4631	5128199636	5128638173	In-Center Hemo, PD Services	12	67-2687	Y
WESTOVER DIALYSIS	9846 WESTOVER HILLS BLVD	STE 103	SAN ANTONIO	TX	78251-4125	2106819180	2106819745	In-Center Hemo, PD Services	18	67-2708	Y
SPRING CREEK DIALYSIS	301 E AIRLINE RD		VICTORIA	TX	77901-3901	3615723343	3615723380	In-Center Hemo,	16	67-2696	Y
SEGUIN DIALYSIS	618 E COURT ST		SEGUIN	TX	78155-5714	8303722521	8303721384	In-Center Hemo, PD Services	16	67-2707	Y
SUGAR LAND HOME TRAINING-PD	1447 HWY 6	STE 130	SUGAR LAND	TX	77478-5094	2812770692	2815650923	PD Services,	4	67-2690	Y
HORIZON DIALYSIS	2222 GREENHOUSE RD		HOUSTON	TX	77084-7287	2818295941	2818291304	In-Center Hemo, PD Services,	16	67-2734	Y
ROUND ROCK DIALYSIS	1800 ROUND ROCK AVE	STE 200	ROUND ROCK	TX	78681-4016	5123108797	5122460030	In-Center Hemo	12	67-2780	Y
BALCH SPRINGS DIALYSIS	12001 ELAM RD		BALCH SPRINGS	TX	75180-2822	9729138767	9722864095	In-Center Hemo, PD Services	13	67-2726	Y
TEXAS CITY PD	13003 DELANEY ST		LA MARQUE	TX	77568-2506	4099353026	4099353320	PD Services,		67-2727	Y
EL PASO PERITONEAL DIALYSIS	1310 MURCHISON DR	STE C	EL PASO	TX	79902-4821	9153510893	9155338516	PD Services		67-2768	Y
WYLIE DIALYSIS	941 S WESTGATE WAY		WYLIE	TX	75098-4947	9724294315	9724298954	In-Center Hemo, PD Services	15	67-2702	Y
CENTRAL FORT WORTH DIALYSIS	1000 SAINT LOUIS AVE	STE 101	FORT WORTH	TX	76104-3377	8178100379	8178709767	In-Center Hemo, PD Services	24	67-2723	Y
NORTH FORT WORTH DIALYSIS	3812 E BELKNAP ST		FORT WORTH	TX	76111-6012	6826470013	6826471494	In-Center Hemo, PD Services	13	67-2731	Y
NORTH ARLINGTON DIALYSIS	642 LINCOLN SQUARE		ARLINGTON	TX	76011-4896	8175420529	8175420419	In-Center Hemo, PD Services	17	67-2725	Y

SOUTHEAST FORT WORTH DIALYSIS	3845 E LOOP 820 S		FORT WORTH	TX	76119-4337	8174969035	8174460012	In-Center Hemo	25	672790	Y
GRANBURY DIALYSIS	1200 PALUXY MEDICAL CIR	STE 100	GRANBURY	TX	76048-5696	8175791417	8175799605	In-Center Hemo, PD Services	12	67-2729	Y
HOUSTON GALLERIA DIALYSIS	5923 WESTHEIMER ROAD		HOUSTON	TX	77057-7603	7139771278	7139771429	In-Center Hemo, PD Services,	12	67-2730	Y
FORT BROWN DIALYSIS	2000 BOCA CHICA BLVD		BROWNSVILLE	TX	78521-2226	9565410130	9565410160	In-Center Hemo	13	67-2777	Y
TREASURE HILLS DIALYSIS	1629 TREASURE HILLS BLVD	STE 8	HARLINGEN	TX	78550-8907	9563642120	9564408747	In-Center Hemo	13	67-2771	Y
BLUEBONNET DIALYSIS	3601 MANOR RD		AUSTIN	TX	78723-5816	5129267378	5129267364	In-Center Hemo, PD Services	24	67-2704	Y
CROSSTIMBERS DIALYSIS	4400A NORTH FWY	STE 100	HOUSTON	TX	77022-3604	7136954413	7136954518	In-Center Hemo, PD Services,	12	67-2739	Y
HIGHLAND VILLAGE DIALYSIS	2700 VILLAGE PKWY		HIGHLAND VILLAGE	TX	75077-3286	9723175609	9723175723	In-Center Hemo, PD Services	13	67-2720	Y
WEST BELLFORT DIALYSIS	21026 W BELLFORT ST		RICHMOND	TX	77406-1685	8325950187	8325950637	In-Center Hemo, PD Services,	12	67-2733	Y
RIVERSTONE DIALYSIS	5672 HIGHWAY 6		MISSOURI CITY	TX	77459-4188	2814998950	2814993805	In-Center Hemo, PD Services,	12	67-2769	Y
VICTORY LAKES DIALYSIS	3290 GULF FWY S	STE H	DICKINSON	TX	77539-4542	2813372175	2813372386	In-Center Hemo,	12	67-2754	Y
DENVER HARBOR DIALYSIS	7065 EAST FWY		HOUSTON	TX	77020-5328	7136703173	7136700876	In-Center Hemo,	20	67-2782	Y
ALLEN DIALYSIS	201 S JUPITER RD		ALLEN	TX	75002-3035	4693426709	4693426398	In-Center Hemo	21	67-2728	Y
COLLEGE PARK DIALYSIS	17191 ST LUKES WAY	STE 100	THE WOODLANDS	TX	77384-8042	9362733350	9362734539	In-Center Hemo, PD Services,	24	67-2745	Y
ACE DIALYSIS	14512 LEE RD		HUMBLE	TX	77396-3425	2814415016	2814415099	In-Center Hemo, PD Services,	12	67-2756	Y
FORT WORTH SAGINAW DIALYSIS	900 N BLUE MOUND RD	STE 192	SAGINAW	TX	76131-8828	8172321502	8172321652	In-Center Hemo	13	67-2761	Y
VIVIFY DIALYSIS	800 N TEXAS AVE		ODESSA	TX	79761-4012	4323321974	4323324183	PD Services, In-Center Hemo	12	67-2822	Y
VALLEY BAPTIST-HARLINGEN DIALYSIS	2220 HAINE DR STE 40		HARLINGEN	TX	78550-8584	9563642789	9564233395	In-Center Hemo, PD Services	48	67-2665	Y
VALLEY BAPTIST-RAYMONDVILLE DIALYSIS	894 FM 3168		RAYMONDVILLE	TX	78580-4519	9566899084	9566891951	In-Center Hemo, PD Services	16	67-2674	Y
AMARILLO DIALYSIS	8604 S COULTER ST		AMARILLO	TX	79119-7379	8063580051	8063550410	In-Center Hemo, PD Services	36	45-2866	Y
MIDLAND DIALYSIS	705 W WADLEY AVE		MIDLAND	TX	79705-5351	4326861806	4326867439	In-Center Hemo, Acute Hemo 1:1, Acute PD, PD Services	20	45-2622	Y
ODESSA DIALYSIS	6005 EASTRIDGE RD		ODESSA	TX	79762-5019	4323623008	4323623302	In-Center Hemo	12	45-2873	Y
TEXARKANA REGIONAL DIALYSIS	5502 MEDICAL PARKWAY DR		TEXARKANA	TX	75503-4623	9038329771	9037911774	In-Center Hemo, PD Services	38	45-2552	Y
NORTHEAST TEXAS DIALYSIS	413B LOOP 59		ATLANTA	TX	75551-2015	9037995843	9037961137	In-Center Hemo	13	45-2710	Y
BROWNFIELD DIALYSIS	710 E FELT ST		BROWNFIELD	TX	79316-3440	8066376373	8066376371	In-Center Hemo, Acute Hemo 1:1	8	67-2596	Y
COLORADO CITY DIALYSIS	1546 CHESTNUT ST		COLORADO CITY	TX	79512-3925	3257288348	3257289228	In-Center Hemo	8	67-2628	N
FORT STOCKTON DIALYSIS	387 INTERSTATE 10 W	STE C	FORT STOCKTON	TX	79735-2700	4323368041	4323368205	In-Center Hemo	11	67-2639	Y
DUMAS DIALYSIS	109 BINKLEY AVE		DUMAS	TX	79029-3825	8069352273	8069342273	In-Center Hemo	8	67-2682	Y
WEST PARK DIALYSIS	5920 RENWICK DR	STE A	HOUSTON	TX	77081-0004	7136600073	7136600259	In-Center Hemo,	20	67-2621	Y
GRACIAS DIALYSIS	2506 W MOUNT HOUSTON RD	STE A	HOUSTON	TX	77038-3536	2818204880	2818207062	In-Center Hemo, PD Services,	16	67-2529	Y
NORTH PARK DIALYSIS	324 FM 1960 RD	STE 104	HOUSTON	TX	77073-1887	2814432209	2814431983	In-Center Hemo,	30	67-2640	Y
CENTRAL FORT WORTH AT HOME	1000 ST LOUIS AVE	STE 101	FORT WORTH	TX	76104-3366	8178100379	8178709767	Home Hemo		67-2723	Y
TEXARKANA REGIONAL AT HOME	5502 MEDICAL PARKWAY DR		TEXARKANA	TX	75503-4623	9038329771	9039711774	Home Hemo		45-2552	Y
MISSION VALLEY AT HOME	1203 ST CLAIRE BLVD 9B		MISSION	TX	78572-6601	9565833760	9565838252	Home Hemo		67-2646	Y
PLANO AT HOME	481 SHILOH RD	STE 100	PLANO	TX	75074-7231	9728813270	9728815086	Home Hemo		67-2636	Y
BINZ HOME TRAINING AT HOME	1213 HERMANN DR STE 180		HOUSTON	TX	77004-7070	7135295155	7135295135	Home Hemo		67-2664	Y
FLOYD CURL AT HOME	9238 FLOYD CURL DR	STE 102	SAN ANTONIO	TX	78240-1691	2105614373	2105619415	Home Hemo		67-2653	N
MED-CENTER AT HOME	7580 FANNIN ST	STE 230	HOUSTON	TX	77054-1939	7137900150	7137900740	Home Hemo,	4	67-2583	Y
GRAPEVINE AT HOME	1651 W NORTHWEST HWY		GRAPEVINE	TX	76051-3100	8172510675	8174210417	Home Hemo	0	67-2531	Y
NORTHWEST MEDICAL CENTER AT HOME	5284 MEDICAL DR	STE 100	SAN ANTONIO	TX	78229-4849	2106169699	2106169504	Home Hemo		67-2515	Y
LONGVIEW AT HOME	425 N FREDONIA ST		LONGVIEW	TX	75601-6464	9037588860	9037533694	Home Hemo	0	45-2744	Y
DENISON AT HOME	1220 REBA MACENTIRE LN		DENISON	TX	75020-9057	9034654111	9034636830	Home Hemo	0	45-2665	N
EL MILAGRO AT HOME	2800 S INTERSTATE HWY 35	STE 120	AUSTIN	TX	78704-5700	5124489750	5124484617	Home Hemo	0	45-2727	Y
SOUTH SHORE AT HOME	212 GULF FWY S	STE G3	LEAGUE CITY	TX	77573-3957	2815546050	2813161385	Home Hemo,	0	67-2522	Y
BROOKRIVER AT HOME	8101 BROOKRIVER DR		DALLAS	TX	75247-4003	2149517789	2149519013	Home Hemo	0	45-2703	Y
SOUTHWEST SAN ANTONIO AT HOME	7515 BARLITE BLVD		SAN ANTONIO	TX	78224-1311	2109234566	2109211565	Home Hemo	0	45-2571	Y
DOWNTOWN SAN ANTONIO AT HOME	615 E QUINCY ST		SAN ANTONIO	TX	78215-1600	2102221260	2102221499	Home Hemo	0	67-2556	Y
CEDAR PARK AT HOME	1720 E WHITESTONE BLVD		CEDAR PARK	TX	78613-7640	5125288478	5125288504	Home Hemo		67-2591	Y
THE WOODLANDS AT HOME	9301 PINECROFT DR		SHENANDOAH	TX	77380-3179	2812926788	2812925950	Home Hemo		67-2581	Y
VICTORIA AT HOME	1405 VICTORIA STATION DR		VICTORIA	TX	77901-3092	3615769907	3615763979	Home Hemo	0	45-2658	N
COLLEGE STATION AT HOME	1640 BRIARCREST DR	STE 100	BRYAN	TX	77802-2709	9792604908	9792685890	Home Hemo	0	45-2550	N
KERRVILLE AT HOME	515 GRANADA PL		KERRVILLE	TX	78028-5992	8302578734	8302578775	Home Hemo	0	45-2546	Y
COASTAL AT HOME	4300 S PADRE ISLAND DR		CORPUS CHRISTI	TX	78411-4433	3618559449	3618559398	Home Hemo		45-2715	Y
EDINBURG RENAL CENTER	3902 S JACKSON RD		EDINBURG	TX	78539-6676	9566312401	9566312664	In-Center Hemo, PD Services	24	45-2764	Y
DIALYSIS CARE OF MCALLEN	411 LINDBERG AVE		MCALLEN	TX	78501-2921	9566876701	9566831901	In-Center Hemo, PD Services	32	45-2654	Y

WESLACO RENAL CENTER	910 SOUTH UTAH		WESLACO	TX	78596-4270	9569681895	9569684886	In-Center Hemo	20	45-2672	Y
ALICE RENAL CENTER	2345 ALICE REGIONAL BLVD		ALICE	TX	78332-7291	3616641723	3616641763	In-Center Hemo,	24	45-2537	Y
BEEVILLE RENAL CENTER	1905 N FRONTAGE RD		BEEVILLE	TX	78102-2954	3613584175	3613584733	In-Center Hemo, PD Services,	21	45-2742	Y
BROWNSVILLE RENAL CENTER	2945 CENTRAL BLVD		BROWNSVILLE	TX	78520-8958	9565428094	9565420742	In-Center Hemo, PD Services	20	45-2737	Y
CORPUS CHRISTI DIALYSIS	2733 SWANTNER DR		CORPUS CHRISTI	TX	78404-2832	3618554911	3618554914	In-Center Hemo,	26	45-2514	Y
RIVERSIDE RENAL CENTER	13434 LEOPARD ST	STE A17	CORPUS CHRISTI	TX	78410-4466	3612414873	3612415544	In-Center Hemo,	17	45-2751	Y
COASTAL DIALYSIS	4300 S PADRE ISLAND DR	STE 2-2	CORPUS CHRISTI	TX	78411-4433	3618559449	3618559398	In-Center Hemo, PD Services,	20	45-2715	Y
MORGAN AVENUE DIALYSIS	2222 S MORGAN AVE	STE 104	CORPUS CHRISTI	TX	78405-1992	3618841113	3618841623	In-Center Hemo,	20	45-2800	Y
DIALYSIS CARE OF GREENVILLE	7215 INTERSTATE HWY 30	STE N	GREENVILLE	TX	75402-7110	9034550041	9034550220	In-Center Hemo	20	45-2694	Y
GREENWOOD HOLLY RENAL CENTER	1533 HOLLY RD		CORPUS CHRISTI	TX	78417-2010	3618507300	3618507305	In-Center Hemo,	24	67-2630	Y
GREATWOOD DIALYSIS	20333 SOUTHWEST FREEWAY	STE 105	SUGAR LAND	TX	77479-6183	2815451470	2815451839	In-Center Hemo,	17	67-2758	Y
HOME FOR TEXAS (HOUSTON SAHHD)	7580 FANNIN ST	STE 200	HOUSTON	TX	77054-1919	7137901983	7137955931	Home Hemo, Staff Assisted Home Hemo,	0		Y
PINE PARK AT HOME	3333 BAYSHORE BLVD		PASADENA	TX	77504-1952	7139431463	7139431481	Home Hemo			Y
MCKINNEY ON 380 AT HOME	5329 W UNIVERSITY DR		MCKINNEY	TX	75071-8186	2144914263	2144914984	Home Hemo		67-2805	Y
WEST HOUSTON HOME AT HOME	1319 W SAM HOUSTON PKWY N	STE 130	HOUSTON	TX	77043-4010	7134650005	7134650028	Home Hemo		672787	Y
JERSEY VILLAGE DIALYSIS	8787 FALLBROOK DR		HOUSTON	TX	77064-3318	2814777878	2819550015	In-Center Hemo, PD Services,	12	67-2781	Y
MCKINNEY ON 380 DIALYSIS	5329 W UNIVERSITY DR		MCKINNEY	TX	75071-8186	2144914263	2144914984	In-Center Hemo, PD Services	13	67-2805	Y
BALCONES DIALYSIS	11150 RESEARCH BLVD	STE 201	AUSTIN	TX	78759-5242	5123421097	5123421967	In-Center Hemo, PD Services	12	67-2824	Y
CORYELL DIALYSIS	224 MEMORIAL DR		GATESVILLE	TX	76528-1071	2544042090	2544042479	In-Center Hemo, PD Services	14	67-2796	Y
MAY STREET DIALYSIS	712 S MAY ST		MADISONVILLE	TX	77864-2564	9363490326	9363490447	In-Center Hemo, PD Services	12	67-2813	Y
GREEN OAK DIALYSIS	1426 KINGWOOD DR		KINGWOOD	TX	77339-3040	2813121301	2813581472	In-Center Hemo, PD Services,	23	67-2764	Y
CLOVERLEAF DIALYSIS	13525 EAST FWY	STE A	HOUSTON	TX	77015-5902	7134500874	7134515377	In-Center Hemo, PD Services,	12	67-2773	Y
SOUTH SHORE ANNEX DIALYSIS	16750 HIGHWAY 3		WEBSTER	TX	77598-2000	2813324719	2813323720	In-Center Hemo, PD Services	12	672779	Y
SOUTHSIDE DIALYSIS	6018 PARKWAY DR		CORPUS CHRISTI	TX	78414-2488	3619945262	3619945232	In-Center Hemo, PD Services	20	45-2947	Y
WEST HOUSTON HOME DIALYSIS (PD)	1319 W SAM HOUSTON PKWY N	STE 130	HOUSTON	TX	77043-4010	7134650005	7134650028	PD Services,	0	67-2787	Y
KELLER DIALYSIS	11000 OLD DENTON RD		FORT WORTH	TX	76244-5407	8173375483	8174319475	In-Center Hemo, PD Services	17	67-2788	Y
DIALYSIS CARE OF GRAND PRAIRIE	402 N CARRIER PKWY	STE 102	GRAND PRAIRIE	TX	75050-5426	9722642660	9722642687	In-Center Hemo, Home Hemo, PD Services	13	672789	Y
CYPRESS FAIRFIELD DIALYSIS	15103 MASON RD	STE D-5	CYPRESS	TX	77433-6458	2817581380	2817581470	In-Center Hemo, PD Services,	24	672786	Y
VINTAGE DIALYSIS	20025 CHASEWOOD PARK DR		HOUSTON	TX	77070-1465	2812510966	2812574706	In-Center Hemo, PD Services,	17	67-2801	Y
CLEAR CREEK DIALYSIS	220 COTTONWOOD DR		HEMPSTEAD	TX	77445-9226	9798260477	9798269183	In-Center Hemo,	12	67-2808	Y
SPRINGWOODS DIALYSIS	2950 FM 2920 RD	STE 100	SPRING	TX	77388-3427	2819076269	2819076852	In-Center Hemo, PD Services,	20	67-2803	Y
TANNER DIALYSIS	5655 W SAM HOUSTON PKWY N	STE A	HOUSTON	TX	77041-5148	7139838616	7138569294	In-Center Hemo,	16	67-2802	Y
COWTOWN WEST DIALYSIS	2400 LANDS END BLVD	STE 131	FORT WORTH	TX	76116-2170	8175700916	8173770279	In-Center Hemo, PD Services	17	672783	Y
HULEN DIALYSIS	5832 S HULEN ST		FORT WORTH	TX	76132-2684	8173707642	8173707774	In-Center Hemo	17	672797	Y
HEIGHTS DIALYSIS	739 E 20TH ST		HOUSTON	TX	77008-4471	7138020542	7138020762	In-Center Hemo, PD Services,	16	67-2804	Y
BAYMONT DIALYSIS	10424 INTERSTATE 10 E	STE 100	BAYTOWN	TX	77523-0816	2815732539	2815733289	In-Center Hemo, PD Services,	12	67-2826	Y
PLANO ON CUSTER DIALYSIS	1301 CUSTER RD	STE 524	PLANO	TX	75075-9400	9725787047	9724247204	In-Center Hemo, PD Services	17	67-2816	Y
PLANO TOLLWAY DIALYSIS	6101 WINDHAVEN PKWY	STE 165	PLANO	TX	75093-8197	9724737891	9724730150	In-Center Hemo, PD Services	17	67-2827	Y
LOCKHART DIALYSIS	1806 S COLORADO ST		LOCKHART	TX	78644-3947	5123986419	5123986471	In-Center Hemo, PD Services	13	67-2819	Y
SOUTHFIELD DIALYSIS	11600 BROADWAY ST		PEARLAND	TX	77584-3780	7134360263	7134360948	In-Center Hemo, PD Services,	14	67-2833	Y
MONTANA VISTA DIALYSIS	2204 JOE BATTLE BLVD	STE A	EL PASO	TX	79938-4660	9158498374	9158498301	In-Center Hemo	24	67-2817	Y
DIALYSIS CARE OF WEATHERFORD	2107 FT WORTH HWY		WEATHERFORD	TX	76086-4808	8175996954	8175993526	In-Center Hemo, PD Services, Nocturnal Hemo	13	67-2770	Y
CEDAR HILL DIALYSIS	439 E FM 1382		CEDAR HILL	TX	75104-6006	9722915817	9722915875	In-Center Hemo	21	45-2938	Y
GARLAND SHILOH DIALYSIS	800 N SHILOH RD		GARLAND	TX	75042-5716	9722767961	9722050191	In-Center Hemo	21	45-2942	Y
CITY CENTER DIALYSIS	10405 KATY FWY	STE 140	HOUSTON	TX	77024-1165	7136470641	7136470620	In-Center Hemo,	24	45-2946	Y
DAIRY ASHFORD DIALYSIS	12606 WESTPARK DR		HOUSTON	TX	77082-5526	2816791848	2814962093	In-Center Hemo, PD Services,	20	45-2934	Y
AVIAN DIALYSIS	8486 BELLAIRE BLVD		HOUSTON	TX	77036-4702	7137740253	7137740315	In-Center Hemo,	12	67-2841	Y
INWOOD DIALYSIS	6626 ANTOINE DR		HOUSTON	TX	77091-1206	7136810481	7136810913	In-Center Hemo,	16	45-2941	Y
RENAL CENTER OF BEAUMONT	3050 LIBERTY AVE		BEAUMONT	TX	77702-1846	4098386602	4098389052	In-Center Hemo, PD Services,	16	45-2577	Y
RENAL CENTER OF NEDERLAND	8797 9TH AVE		PORT ARTHUR	TX	77642-8011	4097292212	4097292656	In-Center Hemo,	16	45-2856	Y
RENAL CENTER OF ORANGE	280 STRICKLAND DR		ORANGE	TX	77630-4750	4098834001	4098834330	In-Center Hemo,	13	45-2802	Y
RENAL CENTER OF PORT ARTHUR	3730 DRYDEN RD		PORT ARTHUR	TX	77642-2764	4099834110	4099834118	In-Center Hemo, PD Services,	25	45-2763	Y
GOLDEN TRIANGLE DIALYSIS	1020 N 14TH ST		BEAUMONT	TX	77702-1103	4098328423	4098328431	In-Center Hemo, PD Services,	30	45-2524	Y
RENAL CENTER OF CARROLLTON	4240 INTERNATIONAL PKWY	STE 158	CARROLLTON	TX	75007-1974	9723068410	9723068109	In-Center Hemo	16	45-2887	Y
DALLAS HOME TRAINING (PD)	6200 LBJ FREEWAY	STE 100	DALLAS	TX	75240-6355	2144667233	2143934738	PD Services		45-2857	Y
RENAL CENTER OF FORT WORTH	251 UNIVERSITY DRIVE	STE 101	FORT WORTH	TX	76107-1955	8178705002	8178700044	In-Center Hemo, PD Services	16	45-2819	Y
RENAL CENTER OF THE HILLS	6331 BLVD 26	STE 200	N RICHLAND HILLS	TX	76180-1590	8172843343	8172843448	In-Center Hemo, PD Services	25	67-2649	Y
RENAL CENTER OF FRISCO	10850 FRISCO ST	STE 300	FRISCO	TX	75033-3586	2148722421	2148722426	In-Center Hemo	21	67-2654	Y
RENAL CENTER OF KELLER	10708 VICTORIA ASH DR		FORT WORTH	TX	76244-6392	8174316533	8174316543	In-Center Hemo	21	67-2741	Y

RENAL CENTER OF LEWISVILLE	1600 WATERS RIDGE DR	STE B	LEWISVILLE	TX	75057-6039	9724367211	9724364138	In-Center Hemo	30	45-2648	Y
RENAL CENTER OF NORTH DENTON	4309 MESA DRIVE		DENTON	TX	76207-3438	9405662701	9404838251	In-Center Hemo, PD Services	20	45-2528	Y
RENAL CENTER OF NORTH DALLAS	6190 LBJ FREEWAY	BLDG 2 STE 701	DALLAS	TX	75240-6383	9727890192	9727890198	In-Center Hemo	16	67-2732	Y
RENAL CENTER OF PLANO	4112 W SPRING CREEK PARKWAY	STE D200	PLANO	TX	75024-5231	9726087831	9726087837	In-Center Hemo	17	67-2694	Y
RENAL CENTER OF TYLER	510 SSW LOOP 323	STE 580	TYLER	TX	75702-7693	9035960102	9035969704	In-Center Hemo, PD Services	16	45-2867	Y
RENAL CENTER OF WATERTON	2895 SHILOH RD		TYLER	TX	75703-2936	9035610292	9035611896	In-Center Hemo	20	67-2647	Y
RENAL CENTER OF FLOWER MOUND	4941 LONG PRAIRIE RD		FLOWER MOUND	TX	75028-2782	9725375572	4694644357	In-Center Hemo, PD Services	13	67-2807	Y
DALLAS HT AT HOME	6200 LBJ FREEWAY	STE 100	DALLAS	TX	75240-6355	2144667233		Home Hemo		45-2857	Y
MESA VISTA AT HOME	1211 E CLIFF DR		EL PASO	TX	79902-4734	9155338147	9155333693	Home Hemo			Y
WEST BOUNTIFUL DIALYSIS	724 W 500 S	STE 300	WEST BOUNTIFUL	UT	84087-1471	8012969091	8012969094	In-Center Hemo, In-Center Hemo Self Care, PD Services	12	46-2520	Y
TIMPANOGOS DIALYSIS	1055 N 500 W	STE 222	PROVO	UT	84604-3329	8013568907	8013562481	PD Services	1	46-2524	Y
UTAH VALLEY DIALYSIS CENTER	1055 N 500 W	STE 221	PROVO	UT	84604-3305	8013735400	8013736400	In-Center Hemo	25	46-2525	Y
LONE PEAK DIALYSIS	1175 E 50 S	STE 111	AMERICAN FORK	UT	84003-2845	8017631304	8017631305	In-Center Hemo	12	46-2535	Y
MT NEBO DIALYSIS	555 W STATE ROAD 164	STE 101	SALEM	UT	84653-5732	8017987903	8017987237	In-Center Hemo	12		Y
WEBER VALLEY DIALYSIS	1920 W 250TH N		MARRIOTT-SLATERVILLE	UT	84404-9233	8017314178	8017311286	In-Center Hemo, In-Center Hemo Self Care	13	46-2539	Y
WEBER VALLEY AT HOME	1920 W 250TH N		MARRIOTT-SLATERVILLE	UT	84404-9233	8017314178	8017311286	Home Hemo		46-2539	Y
WEST BOUNTIFUL AT HOME	724 W 500 S	STE 300	WEST BOUNTIFUL	UT	84087-1471	8012969091	8012969094	Home Hemo	0	46-2520	Y
UTAH VALLEY AT HOME	1055 N 500 W	STE 221	PROVO	UT	84604-3305	8013735400	8013736400	Home Hemo		46-2525	Y
PETERSBURG DIALYSIS	20 MEDICAL PARK BLVD		PETERSBURG	VA	23805-9280	8048610967	8048610796	In-Center Hemo, In-Center Hemo Self Care, PD Services, Nocturnal Hemo	20	49-2594	Y
MEHERRIN DIALYSIS CENTER	201A WEAVER AVE		EMPORIA	VA	23847-1248	4343483882	4343489317	In-Center Hemo, In-Center Hemo Self Care	24	49-2551	Y
FAIRFAX DIALYSIS CENTER	8501 ARLINGTON BLVD	STE 100	FAIRFAX	VA	22031-4625	7038768445	7038766786	In-Center Hemo, PD Services	24	49-2591	Y
RICHMOND COMMUNITY HOSPITAL DIALYSIS	913 N 25TH ST		RICHMOND	VA	23223-6562	8046430506	8046480462	In-Center Hemo, Home Hemo, In-Center Hemo Self Care, PD Services	28	49-2599	Y
GREAT BRIDGE DIALYSIS CENTER	745 BATTLEFIELD BLVD N	STE 100	CHESAPEAKE	VA	23320-0305	7573128346	7573827844	In-Center Hemo, In-Center Hemo Self Care, PD Services	26	49-2604	Y
CDC OF WOODBRIDGE	2751 KILLARNEY DR		WOODBRIDGE	VA	22192-4119	7038977027	7038971328	In-Center Hemo, PD Services, Nocturnal Hemo	24	49-2521	Y
CDC MANASSAS DIALYSIS	10655 LOMOND DR	STE 101	MANASSAS	VA	20109-2877	7032575445	7032571050	In-Center Hemo, In-Center Hemo Self Care	20	49-2549	Y
CDC OF SPRINGFIELD	8003 FORBES PL	STE 110	SPRINGFIELD	VA	22151-2215	7033217207	7033218658	In-Center Hemo	21	49-2535	Y
CDC STERLING DIALYSIS	46396 BENEDICT DR	STE 100	STERLING	VA	20164-6626	7034448932	7034449060	In-Center Hemo	15	49-2541	Y
CDC OF ALEXANDRIA	5999 STEVENSON AVE	STE 100	ALEXANDRIA	VA	22304-3302	7037516115	7037513892	In-Center Hemo	14	49-2562	Y
EAST END DIALYSIS CENTER	2201 E MAIN ST	STE 100	RICHMOND	VA	23223-7071	8046433050	8046433059	In-Center Hemo, PD Services	16	49-2534	Y
NORFOLK DIALYSIS CENTER	962 NORFOLK SQ		NORFOLK	VA	23502-3235	7574610501	7574555011	In-Center Hemo, In-Center Hemo Self Care, PD Services	40	49-2537	Y
CHESAPEAKE DIALYSIS CENTER	1400 CROSSWAYS BLVD	CROSSWAYS II STE 106	CHESAPEAKE	VA	23320-0207	7575230666	7575234545	In-Center Hemo, In-Center Hemo Self Care	24	49-2545	Y
VIRGINIA BEACH DIALYSIS CENTER	740 INDEPENDENCE CIR		VIRGINIA BEACH	VA	23455-6438	7574991301	7574992499	In-Center Hemo, In-Center Hemo Self Care	20	49-2575	Y
NEWPORT NEWS DIALYSIS CENTER	711 79TH ST		NEWPORT NEWS	VA	23605-2767	7572458090	7572458176	In-Center Hemo, In-Center Hemo Self Care	32	49-2574	Y
HOPEWELL DIALYSIS CENTER	301 W BROADWAY AVE		HOPEWELL	VA	23860-2645	8044522494	8044521204	In-Center Hemo, In-Center Hemo Self Care, PD Services	16	49-2563	Y
GREATER PORTSMOUTH DIALYSIS	3516 QUEEN ST		PORTSMOUTH	VA	23707-3238	7573972806	7573977006	In-Center Hemo	19	49-2618	Y
PENINSULA DIALYSIS CENTER	716 DENBIGH BLVD	STE D1 AND D2	NEWPORT NEWS	VA	23608-4414	7578751125	7578751105	In-Center Hemo, In-Center Hemo Self Care, PD Services	16	49-2617	Y
FRONT ROYAL DIALYSIS	1360 N SHENANDOAH AVE		FRONT ROYAL	VA	22630-3636	5406222413	5406310326	In-Center Hemo, PD Services	16	49-2573	Y
WINCHESTER DIALYSIS	2301 VALOR DR		WINCHESTER	VA	22601-6111	5406670227	5405351605	In-Center Hemo, PD Services	25	49-2523	Y
CAMELOT DIALYSIS CENTER	1800 CAMELOT DR	STE 100	VIRGINIA BEACH	VA	23454-2440	7574816879	7574960187	In-Center Hemo, In-Center Hemo Self Care, PD Services	25	49-2517	Y
PORTSMOUTH DIALYSIS	2000 HIGH ST		PORTSMOUTH	VA	23704-3012	7573974300	7573976151	In-Center Hemo	15	49-2616	Y
FAIR OAKS DIALYSIS	3955 PENDER DR	STE 110	FAIRFAX	VA	22030-6091	7033855315	7033856731	In-Center Hemo	13	49-2626	Y
FRANCONIA DIALYSIS CENTER	5695 KING CENTRE DR	STE 105	ALEXANDRIA	VA	22315-5746	7039219506	7039219564	In-Center Hemo, In-Center Hemo Self Care	14	49-2623	Y
RESTON DIALYSIS CENTER	530 HUNTMAR PARK DR	STE D	HERNDON	VA	20170-5144	7034370414	7034370498	In-Center Hemo, PD Services	17	49-2625	Y
HARBOUR VIEW DIALYSIS	1039 CHAMPIONS WAY	STE 500	SUFFOLK	VA	23435-3771	7574842814	7574846087	In-Center Hemo, PD Services	16	49-2659	Y
LEIGH DIALYSIS CENTER	420 N CENTER DR	BLDG 11-STE 128	NORFOLK	VA	23502-4019	7574550060	7574550065	In-Center Hemo, Home Hemo, In-Center Hemo Self Care, PD Services	24	49-2629	Y
WILLIAMSBURG DIALYSIS	500 SENTARA CIR	STE 103	WILLIAMSBURG	VA	23188-5727	7572061408	7572061418	In-Center Hemo, In-Center Hemo Self Care, PD Services	16	49-2651	Y
MIDTOWNE NORFOLK DIALYSIS	2201 COLONIAL AVE		NORFOLK	VA	23517-1928	7576263111	7576263341	In-Center Hemo, In-Center Hemo Self Care	28	49-2658	Y
GARRISONVILLE DIALYSIS CENTER	70 DOC STONE RD	STE 101	STAFFORD	VA	22556-4628	5406581135	5406581288	In-Center Hemo, In-Center Hemo Self Care, PD Services	13	49-2637	Y
HAYMARKET DIALYSIS	14664 GAP WAY		GAINESVILLE	VA	20155-1683	7037533520	7037533528	In-Center Hemo, PD Services	13	49-2652	Y
CHARTER COLONY DIALYSIS CENTER	2312 COLONY CROSSING PL		MIDLOTHIAN	VA	23112-4280	8047396383	8047396083	In-Center Hemo, In-Center Hemo Self Care, PD Services	20	49-2650	Y
BUTLER FARM DIALYSIS	501 BUTLER FARM RD	STE A	HAMPTON	VA	23666-1777	7577661921	7577666073	In-Center Hemo, In-Center Hemo Self Care, PD Services	30	49-2653	Y

CHARLOTTESVILLE DIALYSIS	1460 PANTOPS MOUNTAIN PL		CHARLOTTESVILLE	VA	22911-4600	4349795997	4349799409	In-Center Hemo, PD Services	24	49-2564	Y
ALEXANDRIA DIALYSIS	5150 DUKE ST		ALEXANDRIA	VA	22304-2906	7038237940	7038237945	In-Center Hemo	20	49-2589	Y
HENRICO COUNTY DIALYSIS	5270 CHAMBERLAYNE RD		RICHMOND	VA	23227-2950	8042628077	8042629125	In-Center Hemo, In-Center Hemo Self Care, PD Services	26	49-2598	Y
MIDLOTHIAN	14281 MIDLOTHIAN TPKE	BLDG B	MIDLOTHIAN	VA	23113-6560	8045943520	8045943531	In-Center Hemo, In-Center Hemo Self Care, Nocturnal Hemo	17	49-2608	Y
MECHANICSVILLE DIALYSIS	8191 ATLEE RD		MECHANICSVILLE	VA	23116-1807	8047303149	8047304187	In-Center Hemo, In-Center Hemo Self Care	22	49-2605	Y
RADFORD DIALYSIS	600 E MAIN ST	STE F	RADFORD	VA	24141-1826	5406399561	5406399567	In-Center Hemo, PD Services	17	49-2619	Y
CHARLOTTESVILLE NORTH DIALYSIS	1800 TIMBERWOOD BLVD	STE C	CHARLOTTESVILLE	VA	22911-7544	4349738555	4349731088	In-Center Hemo, In-Center Hemo Self Care	13	49-2636	Y
TYSON'S CORNER DIALYSIS	8391 OLD COURTHOUSE RD	STE 160	VIENNA	VA	22182-3819	7038278644	7038270657	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care, PD Services	15	49-2580	Y
AMELIA DIALYSIS	15151 PATRICK HENRY HWY		AMELIA COURT HOUSE	VA	23002-4700	8045616667	8045616738	In-Center Hemo, Home Hemo, PD Services	15	49-2583	Y
CHESTER DIALYSIS	10360 IRON BRIDGE RD		CHESTER	VA	23831-1426	8047686770	8047686775	In-Center Hemo, In-Center Hemo Self Care	24	49-2607	Y
THREE CHOPT DIALYSIS	8813 THREE CHOPT RD		RICHMOND	VA	23229-4774	8042826791	8042824937	In-Center Hemo, In-Center Hemo Self Care, PD Services	16	49-2506	Y
HIOAKS DIALYSIS	671 HIOAKS RD	STE A	RICHMOND	VA	23225-4072	8042720179	8043201550	In-Center Hemo	20	49-2556	Y
HIOAKS DIALYSIS PD	681 HIOAKS RD	STE B	RICHMOND	VA	23225-4043	8043272440	8043272447	PD Services		49-2556	Y
ARLINGTON DIALYSIS	4805 1st ST N		ARLINGTON	VA	22203-2603	7035270652	7035270956	In-Center Hemo, Nocturnal Hemo	20	49-2559	Y
STAUNTON DIALYSIS	29 IDLEWOOD BLVD		STAUNTON	VA	24401-9355	5408858906	5408850824	In-Center Hemo, PD Services	17	49-2528	Y
COVINGTON DIALYSIS	2504 VALLEY RIDGE RD		COVINGTON	VA	24426-6339	5408624419	5408625768	In-Center Hemo, In-Center Hemo Self Care, PD Services	13	49-2522	Y
CULPEPER DIALYSIS	430 SOUTHRIDGE PARKWAY		CULPEPER	VA	22701-3791	5408259332	5408259356	In-Center Hemo, In-Center Hemo Self Care, PD Services	17	49-2543	Y
HARRISONBURG DIALYSIS	871 MARTIN LUTHER KING JR WAY	STE 100	HARRISONBURG	VA	22801-4323	5404341033	5404341192	In-Center Hemo, In-Center Hemo Self Care, PD Services	35	49-2507	Y
LEXINGTON DIALYSIS (VA)	756 N LEE HWY		LEXINGTON	VA	24450-3724	5404631121	5404646302	In-Center Hemo, In-Center Hemo Self Care, PD Services	20	49-2539	Y
MARTINSVILLE DIALYSIS	33 BRIDGE ST S		MARTINSVILLE	VA	24112-6214	2766323743	2766382716	In-Center Hemo, PD Services	20	49-2560	Y
LEESBURG VIRGINIA DIALYSIS	224D CORNWALL ST NW	STE 100	LEESBURG	VA	20176-2700	5712581362	5712581342	In-Center Hemo, PD Services	12	49-2654	Y
PARK HILL DIALYSIS	1151 HOSPITAL DR		FREDERICKSBURG	VA	22401-3361	5403732470	5403745252	In-Center Hemo, PD Services, Nocturnal Hemo	21	49-2692	Y
JEFFERSON AVENUE DIALYSIS	11234 JEFFERSON AVE		NEWPORT NEWS	VA	23601-2207	7575956167	7575956210	In-Center Hemo, PD Services	12	49-2660	Y
PRINCESS ANNE DIALYSIS	3973 HOLLAND RD		VIRGINIA BEACH	VA	23452-2804	7573403526	7573404916	In-Center Hemo	17	49-2675	Y
LITTLE CREEK DIALYSIS	1817 E LITTLE CREEK RD	STE A	NORFOLK	VA	23518-4203	7574803780	7574803783	In-Center Hemo	12	49-2665	Y
FOREST HILL AVENUE DIALYSIS	4900 FOREST HILL AVE		RICHMOND	VA	23225-3146	8042303594	8042303971	In-Center Hemo	16	49-2663	Y
GILES COUNTY DIALYSIS	377 BOXWOOD LN		PEARISBURG	VA	24134-1166	5409211384	5409211864	In-Center Hemo, PD Services	13	49-2671	Y
TWO RIVERS DIALYSIS	100 WINTERS ST	STE 12B	WEST POINT	VA	23181-9534	8048432516	8048432318	In-Center Hemo, PD Services	13	49-2686	Y
ROYAL OAKS DIALYSIS	1587 N MAIN ST		MARION	VA	24354-4317	2767810461	2767810527	In-Center Hemo, PD Services	13	49-2668	Y
PORT WARWICK DIALYSIS	445 ORIANA RD	STE 18	NEWPORT NEWS	VA	23608-3742	7578989212	7578989216	In-Center Hemo, PD Services	17	492706	Y
NANSEMOND DIALYSIS	3009 CORPORATE LN	STE 130	SUFFOLK	VA	23434-8478	7575390618	7579254530	In-Center Hemo, PD Services	13	49-2695	Y
MEHERRIN HOME TRAINING (PD)	201B WEAVER AVE		EMPORIA	VA	23847-1248	4346343084	4346340671	PD Services		49-2708	Y
TIDEWATER HOME DIALYSIS	230 CLEARFIELD AVE	STE 106	VIRGINIA BEACH	VA	23462-1832	7575189439	7575199519	PD Services	8	49-2669	Y
LYNCHBURG HOME TRAINING (PD)	2091 LANGHORNE RD		LYNCHBURG	VA	24501-1443	4348472085	4348461972	PD Services	6	49-2667	Y
LANSDOWNE DIALYSIS	44084 RIVERSIDE PKWY	STE 100	LEESBURG	VA	20176-5102	7037243941	7037249387	In-Center Hemo, Nocturnal Hemo	17	49-2672	Y
NEWINGTON HOME TRAINING	8520 CINDER BED RD	STE 200	LORTON	VA	22079-1471	7033396050	7033396371	PD Services	4	49-2691	Y
HAMPTON ROADS HOME TRAINING	11234 JEFFERSON AVE	STE B	NEWPORT NEWS	VA	23601-2207	7575955469	7575955985	PD Services	8	49-2678	Y
HARBOUR VIEW AT HOME	1039 CHAMPIONS WAY	STE 500	SUFFOLK	VA	23435-3761	7574842814	7574846087	Home Hemo		49-2659	Y
TIDEWATER HOME AT HOME	230 CLEARFIELD AVE	STE 106	VIRGINIA BEACH	VA	23462-1832	7575189439	7575199519	Home Hemo	0	49-2669	Y
LYNCHBURG HT AT HOME (HHD ONLY)	2091 LANGHORNE RD		LYNCHBURG	VA	24501-1443	4348472085	4348461972	Home Hemo	0	49-2667	Y
WINCHESTER AT HOME	2301 VALOR DR		WINCHESTER	VA	22601-6111	5406670227	5406676139	Home Hemo		49-2523	Y
TYSON'S CORNER AT HOME	8391 OLD COURTHOUSE RD	STE 160	VIENNA	VA	22182-3819	7038272956	7038270657	Home Hemo		49-2580	Y
FAIRFAX AT HOME	8501 ARLINGTON BLVD	STE 100	FAIRFAX	VA	22031-4625	7038768445	7038766786	Home Hemo	4	49-2591	Y
PETERSBURG AT HOME	20 MEDICAL PARK BLVD		PETERSBURG	VA	23805-9280	8047220672	8048610824	Home Hemo		49-2594	Y
BUTLER FARM AT HOME	501 BUTLER FARM RD	STE A	HAMPTON	VA	23666-1777	7577661921	7577666073	Home Hemo		49-2653	Y
WILLIAMSBURG AT HOME	500 SENTARA CIR	STE 103	WILLIAMSBURG	VA	23188-5727	7572061408	7572061418	Home Hemo		49-2651	Y
HIOAKS AT HOME	681 HIOAKS RD	STE B	RICHMOND	VA	23225-4043	8043272440	8043272447	Home Hemo		49-2556	Y
CHARLOTTESVILLE NORTH AT HOME	1800 TIMBERWOOD BLVD	STE C	CHARLOTTESVILLE	VA	22911-7544	4349738555	4349731088	Home Hemo		49-2636	Y
RADFORD AT HOME	600 E MAIN ST	STE F	RADFORD	VA	24141-1826	5406333072	5406333983	Home Hemo		49-2619	Y
HARRISONBURG AT HOME	871 MARTIN LUTHER KING JR WAY	STE 100	HARRISONBURG	VA	22801-4323	5404341033	5404341192	Home Hemo		49-2507	Y
AMELIA AT HOME	15151 PATRICK HENRY HWY		AMELIA COURT HOUSE	VA	23002-4700	8045616667	8045616738	Home Hemo		49-2583	Y
HENRICO COUNTY AT HOME	5270 CHAMBERLAYNE RD		RICHMOND	VA	23227-2950	8042628077	8042629125	Home Hemo		49-2598	Y
MARTINSVILLE AT HOME	33 BRIDGE ST S		MARTINSVILLE	VA	24112-6214	2766323743	2766382716	Home Hemo		49-2560	Y

LANSDOWNE AT HOME	44084 RIVERSIDE PKWY	STE 250	LEESBURG	VA	20176-5102	7037249791	7037297516	Home Hemo	0	49-2672	Y
ROYAL OAKS AT HOME	1587 N MAIN ST		MARION	VA	24354-4317	2767810461	2737810527	Home Hemo	1	49-2668	N
HAMPTON ROADS AT HOME	11234 JEFFERSON AVE	STE B	NEWPORT NEWS	VA	23601-2207	7575955469	7575955985	Home Hemo		49-2678	Y
TWO RIVERS AT HOME	100 WINTERS ST	STE 12B	WEST POINT	VA	23181-9534	8048432516	8048432318	Home Hemo		49-2686	Y
DALE CITY AT HOME	2920 DALE BLVD		DALE CITY	VA	22193-1120	7036805837	7037307462	Home Hemo	4	49-2689	Y
SOCO AT HOME	1384 ARMORY DR		FRANKLIN	VA	23851-2421	7575622137	7575622085	Home Hemo			Y
PARK HILL AT HOME	1151 HOSPITAL DR		FREDERICKSBURG	VA	22401-3361	5403732470	5403745252	Home Hemo		492692	Y
GILES COUNTY AT HOME	377 BOXWOOD LN		PEARISBURG	VA	24134-1166	5409211384	5409211864	Home Hemo		49-2671	Y
MEHERRIN HT AT HOME	201B WEAVER AVE		EMPORIA	VA	23847-1248	4346343084	4346340671	Home Hemo		49-2708	Y
LANSDOWNE DIALYSIS (PD)	44084 RIVERSIDE PKWY	STE 250	LEESBURG	VA	20176-5102	7037249791	7037297516	PD Services	17	49-2672	Y
CUMBERLAND DIALYSIS	1131 PLAZA DR	STE D	GRUNDY	VA	24614-6780	2769355481	2769352726	In-Center Hemo	9	49-2685	N
GLENSIDE DIALYSIS	7001 W BROAD ST		RICHMOND	VA	23294-3701	8047552368	8046727612	In-Center Hemo, PD Services, Nocturnal Hemo	21	49-2701	Y
NEWINGTON DIALYSIS (ICHD Only)	8520 CINDER BED RD	STE 100	LORTON	VA	22079-1471	7033396050	7033396371	In-Center Hemo	17	49-2690	Y
SOCO DIALYSIS	1384 ARMORY DR		FRANKLIN	VA	23851-2421	7575622137	7575622085	In-Center Hemo, PD Services	13	49-2688	Y
DALE CITY DIALYSIS	2920 DALE BLVD		DALE CITY	VA	22193-1120	7036805837	7037307461	In-Center Hemo, PD Services, Nocturnal Hemo	17	49-2689	Y
LANGLEY DIALYSIS	5 W MERCURY BLVD		HAMPTON	VA	23669-2508	7577234620	7577283566	In-Center Hemo	20	49-2703	Y
BULL RUN DIALYSIS	9420 FORESTWOOD LN	STE 100	MANASSAS	VA	20110-4757	7032571749	7033679136	In-Center Hemo, PD Services, Nocturnal Hemo	21	49-2693	Y
LABURNUM DIALYSIS	4352 S LABURNUM AVE		HENRICO	VA	23231-2418	8042364699	8042369235	In-Center Hemo, PD Services	17	49-2710	Y
OCEANA DIALYSIS	1375 OCEANA BLVD	STE 114	VIRGINIA BEACH	VA	23454-5579	7579616239	7579616665	In-Center Hemo	17	49-2698	Y
RUTHERFORD CROSSING DIALYSIS	141 MARKET ST		WINCHESTER	VA	22603-4750	5406655169	5406671805	In-Center Hemo, PD Services	13	492704	Y
HOPKINS ROAD DIALYSIS	5750 HOPKINS RD		NORTH CHESTERFIELD	VA	23234-6614	8042758631	8042758705	In-Center Hemo	17	49-2712	Y
GLENVAR DIALYSIS	3737 W MAIN ST	STE 103	SALEM	VA	24153-2072	5403803130	5403803784	In-Center Hemo, PD Services	13	49-2709	Y
LEE'S HILL DIALYSIS	4701 SPOTSYLVANIA PKWY	STE 109	FREDERICKSBURG	VA	22407-9435	5408988004	5407109584	In-Center Hemo, PD Services	15	49-2714	Y
GLENVAR AT HOME	3737 W MAIN ST	STE 103	SALEM	VA	24153-2072	5403803130	5403803784	Home Hemo		49-2709	Y
LEE'S HILL AT HOME	4701 SPOTSYLVANIA PKWY	STE 109	FREDERICKSBURG	VA	22407-9435	5408988004	5407109584	Home Hemo		49-2714	Y
MID COLUMBIA KIDNEY CENTER	6825 BURDEN BLVD	STE A	PASCO	WA	99301-9584	5095450205	5095450212	In-Center Hemo, In-Center Hemo Self Care, PD Services	21	50-2504	Y
MT ADAMS KIDNEY CENTER	3220 PICARD PL		SUNNYSIDE	WA	98944-8400	5098372013	5098375270	In-Center Hemo, In-Center Hemo Self Care, PD Services	15	50-2514	Y
KENT DIALYSIS CENTER	21851 84TH AVE S		KENT	WA	98032-1958	2538725474	2538726968	In-Center Hemo, PD Services	19	50-2526	Y
PUYALLUP DIALYSIS	716 SOUTH HILL PARK DR	STE C	PUYALLUP	WA	98373-1445	2538452127	2538452241	In-Center Hemo, PD Services	19	50-2534	Y
WESTWOOD DIALYSIS CENTER	2615 SW TRENTON ST		SEATTLE	WA	98126-3745	2069386738	2069385217	In-Center Hemo, In-Center Hemo Self Care, PD Services	7	50-2544	Y
OLYMPIC VIEW DIALYSIS CENTER	125 16TH AVE E CSB	5TH FL	SEATTLE	WA	98112-5211	2063238900	2063238899	In-Center Hemo, PD Services	20	50-2525	Y
LAKEWOOD COMMUNITY DIALYSIS CENTER	5919 LAKEWOOD TOWNE CENTER BLVD SW	STE A	LAKEWOOD	WA	98499-6513	2535122400	2535120196	In-Center Hemo, PD Services	26	50-2519	Y
FEDERAL WAY COMMUNITY DIALYSIS CENTER	1015 S 348TH ST		FEDERAL WAY	WA	98003-7078	2536619055	2536619093	In-Center Hemo, PD Services	16	50-2513	Y
YAKIMA DIALYSIS CENTER	1221 N 16TH AVE		YAKIMA	WA	98902-1347	5094578333	5094578334	In-Center Hemo, In-Center Hemo Self Care	21	50-2541	Y
UNION GAP DIALYSIS	1236 AHTANUM RIDGE DR	AHTANUM RIDGE BUSINESS PARK	UNION GAP	WA	98903-1813	5094696292	5094696299	In-Center Hemo, In-Center Hemo Self Care, PD Services	12	50-2543	Y
BELLEVUE DIALYSIS CENTER	3535 FACTORIA BLVD SE	STE 150	BELLEVUE	WA	98006-1293	4256416514	4256416518	In-Center Hemo, PD Services	10	50-2542	Y
TACOMA DIALYSIS CENTER	3401 S 19TH ST		TACOMA	WA	98405-1909	2535731600	2535731601	In-Center Hemo, PD Services	18	50-2551	Y
GRAHAM DIALYSIS CENTER	10219 196TH ST CT E	STE C	GRAHAM	WA	98338-7792	2538755382	2538752616	In-Center Hemo, In-Center Hemo Self Care, PD Services	8	50-2554	Y
VANCOUVER DIALYSIS CENTER	9120 NE VANCOUVER MALL DR	STE 160	VANCOUVER	WA	98662-9401	3608915777	3608911085	In-Center Hemo, PD Services, Nocturnal Hemo	12	50-2550	Y
ELLENSBURG DIALYSIS CENTER	2101 W DOLARWAY RD	STE 1	ELLENSBURG	WA	98926-7846	5099252333	5099252334	In-Center Hemo, In-Center Hemo Self Care, PD Services	7	50-2552	Y
KENNEWICK DIALYSIS	3208 W 19TH AVE	STE 101	KENNEWICK	WA	99337-2318	5095821677	5095855535	In-Center Hemo, PD Services	10	50-2572	Y
CHINOOK KIDNEY CENTER	1315 AARON DR	BLDG C1	RICHLAND	WA	99352-4678	5099434598	5099438563	In-Center Hemo, Nocturnal Hemo	19	50-2559	Y
ZILLAH DIALYSIS	823 ZILLAH WEST RD	STE 300	ZILLAH	WA	98953-9548	5098290209	5098293052	In-Center Hemo	8	50-2571	Y
PARKLAND DIALYSIS	311 140TH ST S		PARKLAND	WA	98444-4526	2535365961	2535365967	In-Center Hemo, PD Services	21	50-2566	Y
EAST WENATCHEE DIALYSIS	300 COLORADO AVE		EAST WENATCHEE	WA	98802-3800	5098864950	5098864957	In-Center Hemo, PD Services	8	50-2569	Y
SEAVIEW DIALYSIS CENTER	101 18TH ST SE		LONG BEACH	WA	98631-2500	3606423442	3606423460	In-Center Hemo, Home Hemo, PD Services	10	50-2562	Y
ECHO VALLEY DIALYSIS	198 PONDEROSA RD		COLVILLE	WA	99114-2003	5096842285	5096843799	In-Center Hemo, PD Services	6	50-2582	Y
OLYMPIA DIALYSIS CENTER	335 COOPER POINT RD NW	STE 105	OLYMPIA	WA	98502-4436	3603576198	3603576303	In-Center Hemo, PD Services	6	50-2555	Y
MILL CREEK DIALYSIS CENTER	18001 BOTHELL EVERETT HWY	STE 112	BOTHELL	WA	98012-1661	4254815258	4254813438	In-Center Hemo, PD Services	9	50-2561	Y
WHIDBEY ISLAND DIALYSIS CENTER	32650 STATE RD 20	BLDG D STE 101	OAK HARBOR	WA	98277-2641	3602401596	3602401730	In-Center Hemo, PD Services	5	50-2564	Y
EVERETT DIALYSIS CENTER	8130 EVERGREEN WAY		EVERETT	WA	98203-6419	4253536036	4253531210	In-Center Hemo, PD Services, Nocturnal Hemo	13	50-2560	Y

WENATCHEE VALLEY DIALYSIS	116 OLDS STATION RD		WENATCHEE	WA	98801-5936	5096620385	5096620656	In-Center Hemo	20	50-2568	Y
EAST WENATCHEE AT HOME	300 N COLORADO AVE		EAST WENATCHEE	WA	98802-3800	5098864950	5098864957	Home Hemo		50-2569	Y
CHINOOK KIDNEY AT HOME	1315 AARON DR BLDG C1		RICHLAND	WA	99352-4678	5099434598	5099438563	Home Hemo		50-2559	N
EVERETT AT HOME	8130 EVERGREEN WAY STE C		EVERETT	WA	98203-6419	4253536036	4253531210	Home Hemo		50-2560	Y
OLYMPIA AT HOME	335 COOPER POINT ROAD NW	SUITE 105	OLYMPIA	WA	98502-4436	3603576198	3603576303	Home Hemo		50-2555	Y
WESTWOOD AT HOME	2615 SW TRENTON ST		SEATTLE	WA	98126-3745	2069355423	2069355469	Home Hemo		50-2544	Y
LAKEWOOD COMMUNITY AT HOME	5919 LAKEWOOD TOWNE CENTER BLVD SW	STE A	LAKEWOOD	WA	98499-6513	2535122400	2535120196	Home Hemo		50-2519	Y
FEDERAL WAY COMMUNITY AT HOME	1015 S 348TH ST		FEDERAL WAY	WA	98003-7078	2536619055	2536619093	Home Hemo		50-2513	Y
YAKIMA AT HOME	1221 N 16TH AVE		YAKIMA	WA	98902-1347	5094578333	5094578334	Home Hemo		50-2541	Y
MID COLUMBIA AT HOME	6825 BURDEN BLVD	STE A	PASCO	WA	99301-9584	5095450205	5095450212	Home Hemo		50-2504	Y
OLYMPIC VIEW AT HOME	125 16TH AVE E CSB	FL 5	SEATTLE	WA	98112-5211	2063238900	2063238899	Home Hemo	0	50-2525	Y
VANCOUVER AT HOME	9120 NE VANCOUVER MALL DRIVE		VANCOUVER	WA	98662-9401	3608915777	3608911085	Home Hemo		50-2550	N
TACOMA AT HOME	3401 S 19TH ST		TACOMA	WA	98405-1909	2535731600	8557094489	Home Hemo		50-2551	Y
NORTH SPOKANE RENAL AT HOME	7701 N DIVISION ST		SPOKANE	WA	99208-5689	5094653161	5094651812	Home Hemo		50-2538	Y
DOWNTOWN SPOKANE RENAL CENTER	601 W 5TH AVE	STE 101	SPOKANE	WA	99204-2708	5093630070	5093630073	In-Center Hemo, PD Services	12	50-2547	Y
NORTH SPOKANE RENAL CENTER	7701 N DIVISION ST		SPOKANE	WA	99208-5615	5094651729	5094651812	In-Center Hemo, Nocturnal Hemo, PD Services	12	50-2538	Y
SPOKANE VALLEY RENAL CENTER	12610 E MIRABEAU PKWY	STE 100	SPOKANE	WA	99216-1450	5092289933	5092289399	In-Center Hemo, Nocturnal Hemo, PD Services	10	50-2537	Y
SPOKANE VALLEY RENAL AT HOME	12610 E MIRABEAU PKWY	STE 100	SPOKANE	WA	99216-1450	5092289933	5092289399	Home Hemo	1	50-2537	Y
DAVITA-MOUNT BAKER KIDNEY AT HOME	410 BIRCHWOOD AVE	STE 100	BELLINGHAM	WA	98225-1783	3607344243	3607159858	Home Hemo		50-2501	Y
PILCHUCK DIALYSIS	1250 STATE AVE		MARYSVILLE	WA	98270-3659	3606510780	3606510680	In-Center Hemo, PD Services	8	50-2577	Y
RAINIER VIEW DIALYSIS	1822 112TH STREET EAST	STE A	TACOMA	WA	98445-3724	2535395659	2535395950	In-Center Hemo	10	50-2579	Y
REDONDO HEIGHTS DIALYSIS	27320 PACIFIC HWY S		FEDERAL WAY	WA	98003-2413	2535297825	2535280851	In-Center Hemo	12	50-2585	Y
BELFAIR DIALYSIS	23961 NE STATE ROUTE 3		BELFAIR	WA	98528-9698	3602750141	3602756348	In-Center Hemo, PD Services	4	50-2583	Y
TUMWATER DIALYSIS	855 TROSPER RD SW	STE 110	TUMWATER	WA	98512-8108	3603527522	3603527542	In-Center Hemo, PD Services	10	50-2578	Y
CASCADE DIALYSIS	145 CASCADE PL	STE 100	BURLINGTON	WA	98233-3156	3607075373	3607072503	In-Center Hemo, PD Services	3	50-2581	Y
BATTLE GROUND DIALYSIS	720 W MAIN ST	STE 112	BATTLE GROUND	WA	98604-4474	3606874677	3606666623	In-Center Hemo, PD Services	10	50-2584	Y
RENTON DIALYSIS	4110 NE 4TH ST	STE E	RENTON	WA	98059-5045	4252262408	4252262372	In-Center Hemo, PD Services	7	50-2586	Y
COOKS HILL DIALYSIS	1815 COOKS HILL RD		CENTRALIA	WA	98531-9170	3607361188	3608070824	In-Center Hemo, PD Services	6	50-2592	Y
DAVITA-MOUNT BAKER KIDNEY CENTER	410 BIRCHWOOD AVE	STE 100	BELLINGHAM	WA	98225-1783	3607344243	3607159858	In-Center Hemo, PD Services	26	50-2501	Y
CASCADE AT HOME	145 CASCADE PL	STE 100	BURLINGTON	WA	98233-3156	3607075373	3607072503	Home Hemo	1	50-2581	Y
PARKLAND AT HOME	311 140TH ST S		TACOMA	WA	98444-4526	2535365961	2535365967	Home Hemo			Y
ST CROIX FALLS DIALYSIS CENTER	744 E LOUISIANA ST		SAINT CROIX FALLS	WI	54024-9501	7154831555	7154839639	In-Center Hemo, In-Center Hemo Self Care	9	52-2519	Y
FOX RIVER DIALYSIS	1910 RIVERSIDE DR		GREEN BAY	WI	54301-2319	9204364910	9204371718	In-Center Hemo, In-Center Hemo Self Care, PD Services	28	52-2501	Y
TITLETOWN DIALYSIS	120 SIEGLER ST		GREEN BAY	WI	54303-2636	9203272120	9203272150	In-Center Hemo, In-Center Hemo Self Care	17	52-2558	Y
GREEN BAY NORTHWOOD DIALYSIS	W 7305 ELM AVE		SHAWANO	WI	54166	7155264310	7155266010	In-Center Hemo, In-Center Hemo Self Care	15	52-2511	Y
AMERY DIALYSIS PD	970 ELDEN AVE		AMERY	WI	54001-1448	7152684288	7152684689	PD Services		52-2575	Y
OAK CREEK DIALYSIS	8201 S HOWELL AVE	STE 600	OAK CREEK	WI	53154-8336	4147623784	4147624012	In-Center Hemo, In-Center Hemo Self Care	12	52-2578	Y
LOOMIS ROAD DIALYSIS	4120 W LOOMIS RD		GREENFIELD	WI	53221-2052	4147614920	4147614926	In-Center Hemo, In-Center Hemo Self Care	21	52-2507	Y
WISCONSIN AVENUE DIALYSIS	3801 W WISCONSIN AVE		MILWAUKEE	WI	53208-3155	4149378240	4149378248	In-Center Hemo, In-Center Hemo Self Care	24	52-2502	Y
RIVER CENTER DIALYSIS	117 N JEFFERSON ST		MILWAUKEE	WI	53202-6160	4142253740	4142253744	In-Center Hemo, Nocturnal Hemo, In-Center Hemo Self Care	20	52-2509	Y
FOND DU LAC DIALYSIS	210 WISCONSIN AMERICAN DR	ATTN DAVITA DIALYSIS (WEST END OF BLDG)	FOND DU LAC	WI	54937-2999	9209070689	9209070760	In-Center Hemo	9	52-2526	Y
SHEBOYGAN DIALYSIS	1338 N TAYLOR DR		SHEBOYGAN	WI	53081-3042	9204581724	9204581763	In-Center Hemo, PD Services	14	52-2527	Y
LAKE GENEVA DIALYSIS	650 N EDWARDS BLVD		LAKE GENEVA	WI	53147-4595	2622482502	2622480316	In-Center Hemo, PD Services	16	52-2537	Y
CEDARBURG DIALYSIS	N54 W 6135 MILL ST		CEDARBURG	WI	53012-2021	2623768011	2623769369	In-Center Hemo, In-Center Hemo Self Care	10	52-2529	Y
BROOKFIELD DIALYSIS	19395 W CAPITOL DR	BLDG C	BROOKFIELD	WI	53045-2736	2627810273	2627810305	In-Center Hemo, In-Center Hemo Self Care, PD Services	12	52-2532	Y
MARINETTE DIALYSIS	2706 CAHILL RD	STE A	MARINETTE	WI	54143-3886	7157322372	7157322269	In-Center Hemo, PD Services, Acute Hemo 1:1, Acute PD	16	52-2551	Y
GREEN BAY DIALYSIS	1751 DECKNER AVE		GREEN BAY	WI	54302-2630	9204650430	9204651311	In-Center Hemo, PD Services	10	52-2552	Y
STURGEON BAY DIALYSIS	108 S 10TH AVE		STURGEON BAY	WI	54235-1802	9207467955	9207467974	In-Center Hemo, PD Services	6	52-2556	Y
JANESVILLE DIALYSIS	1305 WOODMAN RD		JANESVILLE	WI	53545-1068	6087414181	6087412369	In-Center Hemo, In-Center Hemo Self Care, PD Services	12	52-2503	Y

OSHKOSH WEST DIALYSIS	855 N WESTHAVEN DR		OSHKOSH	WI	54904-7668	9203030650	9203030645	In-Center Hemo	10	52-2560	Y
MANITOWOC DIALYSIS	3303 DEWEY ST		MANITOWOC	WI	54220-5987	9206520593	9206860550	In-Center Hemo, PD Services	9	52-2562	Y
WAUTOMA DIALYSIS	900 EAST DIVISION ST		WAUTOMA	WI	54982-6944	9207871031	9207871055	In-Center Hemo	8	52-2563	Y
AMERY DIALYSIS	970 ELDEN AVE		AMERY	WI	54001-1448	7152684288	7152684689	In-Center Hemo, In-Center Hemo Self Care	14	52-2575	Y
LAKE HALLIE DIALYSIS	3636 EAST MELBY ST		LAKE HALLIE	WI	54729-8392	7158338512	7158338534	In-Center Hemo, PD Services	12	52-2596	Y
MILL STREET HOME TRAINING (PD)	N54 W6135 MILL ST	STE 500	CEDARBURG	WI	53012-2067	2623772158	2623772191	PD Services	0	52-2595	Y
CAPITOL COURT DIALYSIS	4176 N 56TH ST		MILWAUKEE	WI	53216-1276	4144452119	4144453794	In-Center Hemo	16	52-2598	Y
CHILTON DIALYSIS	425 M-B LN		CHILTON	WI	53014-1604	9208493390	9208493432	In-Center Hemo, PD Services	12	52-2601	Y
SUN PRAIRIE DIALYSIS	719 BUNNY TRL		SUN PRAIRIE	WI	53590-8507	6088256556	6088252886	In-Center Hemo, PD Services	12	52-2607	Y
HUMBOLDT RIDGE DIALYSIS	2211 N HUMBOLDT BLVD		MILWAUKEE	WI	53212-3507	4143367200	4143367210	In-Center Hemo	24	52-2577	Y
WEST APPLETON DIALYSIS	10130 W APPLETON AVE	STE 500	MILWAUKEE	WI	53225-2579	4143930600	4143930910	In-Center Hemo	26	52-2548	Y
BAY SHORE DIALYSIS	5650 N GREEN BAY AVE	STE 150	GLENDALE	WI	53209-4449	4143511290	4143511244	In-Center Hemo	28	52-2554	Y
SOUTH RIDGE DIALYSIS	7740 W LAYTON AVE		GREENFIELD	WI	53220-3707	4142811313	4142811722	In-Center Hemo	22	52-2543	Y
BLUEMOUND DIALYSIS	601 N 99TH ST	STE 100	WAUWATOSA	WI	53226-4362	4147556300	4147556310	In-Center Hemo	23	52-2566	Y
BLUEMOUND DIALYSIS PD	601 N 99TH ST STE 300		MILWAUKEE	WI	53226-4362	4147781623	4147781631	PD Services	5	52-2536	Y
PRAIRIE RIVER DIALYSIS	601 S CENTER AVE		MERRILL	WI	54452-3404	7155390613	7155393948	In-Center Hemo	6	52-2585	Y
STEVENS POINT DIALYSIS	1100 MERIDIAN DR		PLOVER	WI	54467-2385	7153431266	7153444179	In-Center Hemo	12	52-2587	Y
WAUPACA DIALYSIS	930 FURMAN DR		WAUPACA	WI	54981-2200	7152580934	7152580926	In-Center Hemo	10	52-2592	Y
WAUSAU DIALYSIS	2600 STEWART AVE	STE 144	WAUSAU	WI	54401-1403	7158411708	7158456353	In-Center Hemo, PD Services	26	52-2593	Y
RHINELANDER DIALYSIS	1306 LINCOLN ST		RHINELANDER	WI	54501-3664	7153623718	7153623765	In-Center Hemo	9	52-2591	Y
WISCONSIN RAPIDS DIALYSIS	1041B HILL ST		WISCONSIN RAPIDS	WI	54494-5221	7154220550	7154220555	In-Center Hemo	18	52-2589	Y
MARSHFIELD DIALYSIS	123 NORTHRIDGE ST		MARSHFIELD	WI	54449-8341	7153843478	7153874690	In-Center Hemo, PD Services	17	52-2588	Y
NORTHERN STAR DIALYSIS	311 ELM ST		WOODRUFF	WI	54568-9149	7153560132	7153566392	In-Center Hemo, PD Services	24	52-2586	Y
WILLOW CREEK DIALYSIS	1139 WARWICK WAY		RACINE	WI	53406-5661	2628842730	2628842802	In-Center Hemo	12	52-2584	Y
HARBOR VIEW DIALYSIS	3113 WASHINGTON AVE		RACINE	WI	53405-3001	2626320120	2626371441	In-Center Hemo, PD Services	20	52-2583	Y
LAKE GENEVA AT HOME	650 N EDWARDS BLVD		LAKE GENEVA	WI	53147-4595	2622482502	2622480316	Home Hemo		52-2537	Y
LAKE HALLIE AT HOME	3636 E MELBY ST		LAKE HALLIE	WI	54729-8392	7158338512	7158338534	Home Hemo		52-2596	Y
MILL STREET HT AT HOME	N54 W6135 MILL ST	STE 500	CEDARBURG	WI	53012-2021	2623772158	2623772191	Home Hemo		52-2595	Y
MARSHFIELD AT HOME	123 NORTHRIDGE ST		MARSHFIELD	WI	54449-8341	7153843478	7153874690	Home Hemo		52-2588	Y
BLUEMOUND AT HOME	601 N 99TH ST	STE 110	WAUWATOSA	WI	53226-4362	4147556330	4147556320	Home Hemo		52-2566	Y
FOX RIVER AT HOME	1910 RIVERSIDE DR		GREEN BAY	WI	54301-2319	9204364910	9204364905	Home Hemo	0	52-2501	Y
JANESVILLE AT HOME	1305 WOODMAN RD		JANESVILLE	WI	53545-1068	6087414181	6087412369	Home Hemo		52-2503	Y
BROOKFIELD AT HOME	19395 W CAPITOL DR		BROOKFIELD	WI	53045-2736	2627810273	2627810305	Home Hemo		52-2532	Y
LOOMIS ROAD AT HOME	4120 W LOOMIS RD		GREENFIELD	WI	53221-2052	4147614920	4147614926	Home Hemo		52-2507	Y
SIREN AT HOME	24670 STATE RD 35 70	STE 100	SIREN	WI	54872-4419	7153494220	7153494224	Home Hemo			Y
CHILTON AT HOME	425 M-B LN		CHILTON	WI	53014-1604	9208493390	9208493432	Home Hemo		52-2601	Y
HUDSON AT HOME	421 STAGELINE RD		HUDSON	WI	54016-7848	7153818240	7153818454	Home Hemo	1	52-2606	Y
HARBOR VIEW AT HOME	3113 WASHINGTON AVE		RACINE	WI	53405-3001	2626320120	2626371441	Home Hemo			Y
HUDSON DIALYSIS	421 STAGELINE RD		HUDSON	WI	54016-7848	7153818240	7153818454	In-Center Hemo, PD Services	12	52-2606	Y
LAKE DELTON DIALYSIS	14 COUNTY ROAD P		WISCONSIN DELLS	WI	53965-9764	6082533597	6082533948	In-Center Hemo, PD Services	12	52-2608	Y
SIREN DIALYSIS	24670 STATE RD 35 70	STE 100	SIREN	WI	54872-4419	7153494220	7153494224	In-Center Hemo, PD Services	8	52-2600	Y
GREEN LAKE COUNTY DIALYSIS	432 OAK ST		BERLIN	WI	54923-1204	9203611177	9203611435	In-Center Hemo, PD Services	12	52-2605	Y
LAKE COUNTRY DIALYSIS (PD)	2301 SUN VALLEY DR	STE 101	DELAFIELD	WI	53018-2318	2626463080	2626463084	PD Services		52-2597	Y
FOX BROOK DIALYSIS	18740 W BLUE MOUND RD		BROOKFIELD	WI	53045-2936	2627829856	2627829984	In-Center Hemo	8	52-2513	Y
FORT ATKINSON DIALYSIS	525 HANDEYSIDE LN		FORT ATKINSON	WI	53538-1281	9205638665	9205638643	In-Center Hemo	15	52-2533	Y
MEQUON ROAD DIALYSIS	W175 N11056 STONEWOOD DR		GERMANTOWN	WI	53022-4799	2622514047	2622514171	In-Center Hemo	12	52-2579	Y
MENOMONEE FALLS DIALYSIS	N87W17301 MAIN ST		MENOMONEE FALLS	WI	53051-2760	2622539768	2622539870	In-Center Hemo	11	52-2523	Y
MUKWONAGO DIALYSIS	400 BAY VIEW RD	STE F	MUKWONAGO	WI	53149-1770	2623633561	2623633564	In-Center Hemo	10	52-2521	Y
OCONOMOWOC DIALYSIS	1253 CORPORATE CENTER DR		OCONOMOWOC	WI	53066-4891	2625600371	2625600399	In-Center Hemo	15	52-2517	Y
WATERTOWN DIALYSIS	123 HOSPITAL DR	STE 1004	WATERTOWN	WI	53098-3390	9202060666	9202060688	In-Center Hemo	11	52-2525	Y
WAUKESHA DIALYSIS	721 AMERICAN AVE	STE 204	WAUKESHA	WI	53188-5071	2625490754	2625490782	In-Center Hemo	12	52-2504	Y
SPRING CITY DIALYSIS	1260 SENTRY DR		WAUKESHA	WI	53186-5974	2624465100	2624465199	In-Center Hemo	12	52-2535	Y
SUN PRAIRIE AT HOME	719 BUNNY TRL		SUN PRAIRIE	WI	53590-8507	6088256556	6088252886	Home Hemo	1	52-2607	Y
WEST VIRGINIA DIALYSIS	300 PROSPERITY LN	STE 150	LOGAN	WV	25601-3494	3047522700	3047525656	In-Center Hemo, In-Center Hemo Self Care, PD Services	13	51-2518	Y
GRAND CENTRAL DIALYSIS	800 GRAND CENTRAL MALL	STE 8	VIENNA	WV	26105-4100	3049174124	3049174136	In-Center Hemo, In-Center Hemo Self Care, PD Services	18	51-2519	Y
GREENBRIER DIALYSIS	9745 SENECA TRL S		LEWISBURG	WV	24901-1580	3046454806	3046473941	In-Center Hemo, PD Services	16	51-2509	Y

WOOD COUNTY DIALYSIS	214 GIHON VLG		PARKERSBURG	WV	26101-7163	3044223687	3044225455	In-Center Hemo, PD Services	12	51-2547	Y
MOUNTAINEER DIALYSIS	2958 ROBERT C BYRD DR		BECKLEY	WV	25801-4448	3042529183	3042529194	In-Center Hemo, PD Services	17	51-2538	Y
POINT PLEASANT DIALYSIS	3683 OHIO RIVER DR		POINT PLEASANT	WV	25550-9244	3046751500	3046751505	In-Center Hemo, PD Services	12	51-2530	Y
GREENBRIER AT HOME	9745 SENECA TRL S		LEWISBURG	WV	24901-1580	3046454806	3046473941	Home Hemo		51-2509	N
GRAND CENTRAL AT HOME	800 GRAND CENTRAL MALL	STE 8	VIENNA	WV	26105-4100	3049174124	3049174136	Home Hemo		51-2519	N
GREATER CHARLESTON DIALYSIS	24 MACCORKLE AVE SW		SOUTH CHARLESTON	WV	25303-1476	3047202222	3047202322	In-Center Hemo, PD Services	23	51-2520	Y
GREATER BOONE DIALYSIS	300 4TH ST		DANVILLE	WV	25053	3043076201	3043076210	In-Center Hemo	16	51-2531	Y
GREATER CHARLESTON AT HOME	24 MACCORKLE AVE SW		SOUTH CHARLESTON	WV	25303-1476	3047202222	3047202322	Home Hemo	1	51-2520	Y
HARRISON COUNTY DIALYSIS	95 ROSEBUD PLZ	STE 101	CLARKSBURG	WV	26301-9823	3046240478	3046240640	In-Center Hemo, PD Services	9	51-2540	Y
BEECH FORK DIALYSIS	600 MCGINNIS DR		WAYNE	WV	25570-9696	3042723703	3042723476	In-Center Hemo, PD Services	12	51-2545	Y
WHEELING DIALYSIS	500 MEDICAL PARK	STE 100	WHEELING	WV	26003-7600	3042429135	3042426097	In-Center Hemo, PD Services	17	51-2513	Y
NEW MARTINSVILLE DIALYSIS	1 EAST BENJAMIN DR		NEW MARTINSVILLE	WV	26155-2705	3044552700	3044554151	In-Center Hemo, PD Services	10	51-2514	Y
RENAL CENTER OF KEYSER	1080 NEW CREEK HIGHWAY		KEYSER	WV	26726-9508	3047885057	3047885059	In-Center Hemo, PD Services	12	51-2537	Y
RENAL CENTER OF MOOREFIELD	8 LEE ST	2ND FLR	MOOREFIELD	WV	26836-1068	3045301200	3045301212	In-Center Hemo	14	51-2522	Y
MOUNTAINEER AT HOME	2958 ROBERT C BYRD DR		BECKLEY	WV	25801-4448	3042529183	3042529194	Home Hemo		51-2538	Y
BISHAN KIDNEY DIALYSIS FOUNDATION	BLK 197 BISHAN CENTRE BLK 197 BISHAN ST. 13	#01-575	SINGAPORE		570197	65-62592744	65-62562687	In-Center Hemo			Y
MVZ SALZGITTER	HINTER DEM SALZE 33		SALZGITTER-BAD		38259			In-Center Hemo			Y
MVZ SEESEN	LAUTENTHALER STRASSE 99		SEESEN		38723	0049 (0) 5381 94171-0	0049 (0) 5381 94171-	In-Center Hemo			Y
NHRZ DRESDEN	CASPAR-DAVID-FRIEDRICH-STR. 10A		DRESDEN		1217	0049 (0) 351 87698-0	0049 (0) 351 87698-5	In-Center Hemo			Y
SHANTINAGAR-FLAGSHIP (BANGALORE)	NO. 38/5, 1ST FLOOR, BERLIE STREET	SHANTINA GAR	BANGALORE		560027	91 80 4912 9900		In-Center Hemo			Y
EXCEL CARE-SHOP IN SHOP (BLR)	3/2, 27TH CROSS, BANASHANKARI II STAGE		BANGALORE		560070	91 77609 68336		In-Center Hemo			Y
ANANYA-SHOP-IN-SHOP (BANGALORE)	389/44, 19TH MN RD, 1ST BLK,	RAJAJINAG AR,	BANGALORE		560010	91 80 41110233		In-Center Hemo			Y
CHALLA-SHOP-IN-SHOP-HYDERABAD	7-1-71/A/1, DHARAM KARAM ROAD,	AMEERPET	HYDERABAD		500016	91 40 40165733		In-Center Hemo			Y
BRS (CHENNAI)	28, CATHEDRAL GARDENS ROAD,	NUNGAMBA KKAM	CHENNAI		600034	91 44 4212 5325		In-Center Hemo			Y
KUMARAN	214, E.V.R PERIYAR SALAI, PH ROAD,	KILPAUK	CHENNAI		600010	91 44 4203 5324		In-Center Hemo			Y
PMM-SHOP-IN-SHOP	1 SAPTAGIRI GARDEN, SOLAI NAGAR MAIN ROAD,	MUTHIALPE T	PONDICHERRY		600503	91 413 2235734		In-Center Hemo			Y
SATELLITE 1 (HOSUR)	120/2, OPP. CSI CHURCH, DENKANI KOTA ROAD	SHANTINA GAR	HOSUR		560027			In-Center Hemo			Y
LIVE 100-SHOP-IN-SHOP (BANGALORE)	NO 2, SETLUR STREET	SHANTINA GAR	BANGALORE		560027			In-Center Hemo			Y
TUMKUR-SHOP-IN-SHOP (BANGALORE)	BEHIND KRISHNA THEATER, MG ROAD		TUMKUR		572101	0816 227 3990		In-Center Hemo			Y
KILPAUK-FLAGSHIP (CHENNAI)	80, ALAGAPPA NAGAR, NEW AVADI ROAD,	KILPAUK	CHENNAI		600010	91 44 4908 7272		In-Center Hemo			Y
KtDOQI			RIYADH			1234567890		In-Center Hemo			Y
ABANAMY			RIYADH			1234567890		In-Center Hemo			Y
SMCH			RIYADH			1234567890		In-Center Hemo			Y
POULUMI-SHOP IN SHOP-HYDERABAD	A-2 & B-17, DR. A.S. RAO NAGAR, ECIL MAIN ROAD	SECUNDER ABAD	HYDERABAD		500062	91 77027 75960		In-Center Hemo			Y
PIMUS-SHOP IN SHOP-DELHI	NO. 2, 4TH FLOOR, CHANDRAGUPTA MARG. CHANAKYAPURI		NEW DELHI		11002121	91 98100 15306		In-Center Hemo			Y
BDH-SATELITE-BANGALORE	THIMMAIAH ROAD, VASANTH NAGAR		BANGALORE		560052	91 80 2237 2980		In-Center Hemo			Y
PUNE-NOBLE HOSPITAL-SHOP IN SHOP	153, MAGARPATTA CITY ROAD,	HADAPSAR	PUNE		411013	91 20 6000 6200		In-Center Hemo			Y
FRONTIER LIFELINE (FLL) CHENNAI	R-30C, AMBATTUR INDUSTRIAL ESTATE RD		CHENNAI		600058			In-Center Hemo			Y

YINGKOU CENTER	NO. 11, 33 BUILDING XUEFU ROAD 33-11	STATION DISTRICT	YINGKOU			0417-2603333		In-Center Hemo			Y
BENXI CENTER	NO. 31 BUILDING WEN HUA STREET	MING SHAN DISTRICT	BENXI			0414-4820522		In-Center Hemo			Y
KDF - GHIM MOH CENTRE	KDF-GHIM MOH CENTRE BLK 6	#01-188 GHIM MOH ROAD	SINGAPORE		27006	65-64637032		In-Center Hemo			Y
TULIPS DIALYSIS CENTER	65, JALAN CECAWI 6/33	SEKSYEN 6, KOTA DAMANSARA	PETALING JAYA		47810	60361423301		In-Center Hemo			Y
KOLOBRZEG II	JEDNOSCI NARODOWEJ 86/88		KOLOBRZEG		78-100	48 94 3545430		In-Center Hemo			Y
PILA	WOJSKA POLSKIEGO 43		PILA		64-920	48 67 2122223		In-Center Hemo			Y
POZNAN	UL.GRUNWALDZKA 16/18, 60-780		POZNAN					In-Center Hemo			Y
KOLO	PONIATOWSKIEGO 52		KOLO		62-600	48 63 2627740		In-Center Hemo			Y
KOLOBRZEG	LOPUSKIEGO 31		KOLOBRZEG		78-100	48 94 3511548		In-Center Hemo			Y
PORTO	RUA PEREIRA REIS 405/413		PORTO		4200-448			In-Center Hemo			Y
GONDOMAR	RUA DR. AFONSO COSTA 137/147		GONDOMAR		4420-125			In-Center Hemo			Y
LEIRIA	RUA DA CARRASQUEIRA, 19		PARCEIROS-LEIRIA		2400-441			In-Center Hemo			Y
OBIDOS	CASAIS DO ALVITO 2510-702		GAEIRAS - OBIDOS		2510-702			In-Center Hemo			Y
HONG REN CLINIC	2F.,NO. 297, LINSEN RD	NORTH DISTRICT	HSINCHU		300			In-Center Hemo			Y
AN SHU CLINIC	8F, NO. 59, WANHUA ROAD	SANSIAN DISTRICT	NEW TAIPEI CITY		238	886-286723525	886-286723676	In-Center Hemo			Y
AN REN CLINIC	6F., NO 29, SEC.1, ANHE RD	DA'AN DIST	TAIPEI CITY		106			In-Center Hemo			Y
XIANG YOU CLINIC	3F., NO 7, ZHONG'AN ST	XINZHUANG DIST	NEW TAIPEI CITY		242			In-Center Hemo			Y
DIALIZA GROJEC	PIOTRA SKARGI 10		GROJEC		05-600	48 48 6643147		In-Center Hemo			Y
ANSHAB 3SBIO HOSPITAL	NO. 265 BUILDING PEOPLE RD	TIE XI DISTRICT	AN SHAN					In-Center Hemo			Y
CHANGCHUN GUOHUL HOSPITAL	NO. 77736 LIN HE STREET	JINGYUE ECONOMIC DEVELOPMENT ZONE	CHANGCHUN					In-Center Hemo			Y
RUBY HALL CENTRE	GRANT MEDICAL FOUNDATION NO 59/6, NEAR JHULELAL MANDIR,	KROOT MEMORIAL HIGH SCHOOL, AZAD NAGAR, WANOWRIE	PUNE		411040			In-Center Hemo			Y
UNIDAD SANTA MARGARITA PD	CRA 45 A NO. 103B-16	BARRIO SANTA MARGARITA	BOGOTA					PD Services			Y
SANTA MARIA DEL LAGO	CALLE 74 NO. 76-83	BARRIO TABORA	BOGOTA					In-Center Hemo			Y
UNIDAD RENAL MEDELLIN	CALLE 9C SUR NO. 50FF-116	BARRIO GUAYABAL	MEDELLIN					In-Center Hemo, PD Services			Y

UNIDAD RENAL BARRANQUILLIA	CRA 47 NO. 84-150	BARRIO SAN VICENTE PRADO	BARRANQUILLA					In-Center Hemo, Acute Hemo 1:1, PD Services			Y
UNIDAD RENAL CALLE 26	CALLE 26 A NO 33A-28	BARRIO ACEVEDO TEJADA	BOGOTA					In-Center Hemo, Acute Hemo 1:1			Y
UNIDAD RENAL AUTOPISTA NORTE	AUTOPISTA NORTE NO 103-35	BARRIO SANTA MARGARITA	BOGOTA					In-Center Hemo, Acute Hemo 1:1			Y
UNIDAD RENAL CALI	CRA 44 NO 9C-58 (PISO 4)	BARRIO TEQUENDAMA	CALI					In-Center Hemo, Acute Hemo 1:1			Y
QDC-BANGI	NO. 13, JALAN REKO SENTRAL 2,	REKO, SENTRAL	KAJANG, SELANGOR		43300	603-87416422	016-2612816	In-Center Hemo			Y
QDC-CHERAS	NO. 29, GROUND FLOOR,	JALAN MIDAH 5,	TAMAN MIDAH, KUALA LUMPUR		56000	016-2612836		In-Center Hemo			Y
QDC-PENDANG	NO. 11, KAWASAN PERNIAGAAN TIARA MAS,	JALAN TANAH MERAH,	PENDANG, KEDAH		6700	604-7593495	016-2612817	In-Center Hemo			Y
QDC-JERANTUT	NO. 6, JALAN ALAMANDA 1,	TAMAN ALAMANDA	JERANTUT, PEHANG		27000	609-2666089	016-2267681	In-Center Hemo			Y
QDC-TANJUNG KARANG	NO. 20, LORONG BAHAGIAN 2,	JALAN SUNGAI KAJANG	TANJUNG KARANG, SELANGOR		45500	603-32694028	016-2267687	In-Center Hemo			Y
QDC-BATANG BERJUNTAI	NO. 24, JALAN SATU,	TAMAN SRI CAHAYA,	BATANG BERJUNTAI, SELANGOR		45600	603-32717082	016-2267683	In-Center Hemo			Y
QDC-SG. PETANI SELATAN	NO. 17, GROUND FLOOR,	LORONG 13, TAMAN PETANI JAYA,	SUNGAI PETANI, KEDAH		8000	604-4255572	016-2267975	In-Center Hemo			Y
QDC-SABAK BERNAM	PT1277, TAMAN FERI,	JALAN FERI,	SABAR BERNAM, SELANGOR		45200	603-32164311	162267672	In-Center Hemo			Y
QDC-SANDAKAN	LOT 3 & 4, GROUND FLOOR,	BANGUNAN YUAN LI, JALAN UTARA, BATU 1 1/2	SANDAKAN, SABAH		90000	6089-213064	016-2267678	In-Center Hemo			Y
QDC-KANGAR	NO. 15, JALAN KANGAR-ALOR SETAR,	SERIAB	KANGAR, PERLIS		1000	604-9763651	016-2267662	In-Center Hemo			Y
QDC-SG. BESAR	NO. 4, JALAN GEMILANG 1,	TAMAN GEMILANG,	SUNGAI BESAR, SELANGOR		45300	603-32247995	016-2267671	In-Center Hemo			Y
QDC-SG. SIPUT	NO. 45, JALAN BESAR		SG. SIPUT (U), PERAK		31100	605-5971284	016-2267675	In-Center Hemo			Y
QDC-SG. PETANI UTARA	NO. 270 & 271, GROUND FLOOR,	JALAN LEGENDA 11, LEGENDA HEIGHTS	SUNGAI PETANI,KEDAH DARUL AMAN		8000	604-4254886	016-2267689	In-Center Hemo			Y
QDC-WANGSA MAJU	NO. 63, JALAN WANGSA DELIMA 5,	SECTION 5,	WANGSA MAJU, KUALA LUMPUR		53300	603-41421730	016-2267972	In-Center Hemo			Y
QDC-GURUN	NO. 49, GROUND FLOOR,	PEKAN GURUN,	GURUN, KEDAH		8300	604-4688425	016-2267686	In-Center Hemo			Y
QDC-MERU	NO. 4 & 6, JALAN SEJAHTERA 8/KU 8,	TAMAN MERU SEJAHTERA	KLANG, SELANGOR		41050	603-33931559	016-2267685	In-Center Hemo			Y
QDC-KLANG	NO. 61, PERSIARAN TENGKU AMPUAN	RAHIMAH, TAMAN SRI ANDALAS,	KLANG, SELANGOR		41200	603-33193622	016-2267659	In-Center Hemo			Y

QDC-KOTA KINABALU	LOT 3, GROUND FLOOR,	BANGUNAN DAYA, JALAN KEBAJIKAN	KOTA KINABALU, SABAH		88300	6088-213216	016-2267679	In-Center Hemo			Y
GOSTYN	MARCINKOWSKIEGO 8/9		GOSTYN		63-800	48 65 5758020		In-Center Hemo			Y
ADIVA HOSPITALS PRIVATE LIMITED	C/1/C, GREEN PARK EXTENSION, 4TH FLOOR		NEW DEHLI		110016	TBD	TBD	In-Center Hemo	0		Y
BIALA PODLASKA	UL. TEREBELASKA 57-65		BIALA PODLASKA		21-500			In-Center Hemo			Y
ANTU HOSPITAL	33 HUAYUANSHIQIAO RD	ROOM 2369 LEVEL 23 CITIGROUP TOWER	PUDONG					In-Center Hemo			Y
RATINGEN	WERDENER STRASSE 3		RATINGEN		40878			In-Center Hemo			Y
HEERDT	AM HEERDTER KRANKENHAUS 2		DUSSENDORF		40549			In-Center Hemo			Y
SUED	BAHLENSTRASSE 178-180		DUSSELDORF		40589			In-Center Hemo			Y
AUGUSTERKRANKENHAUS	AMALIENSTRASSE 9		DUSSELDORF		40472			In-Center Hemo			Y
KARLSTRASSE	BISMARCKSTRASSE 101		DUSSELDORF		40210			In-Center Hemo			Y
GERRESHEIM	GRAULINGER STRASSE 120		DUSSELDORF		40625			In-Center Hemo			Y
RUBY HALL MAIN	NO 40 SASSON ROAD		PUNE		411001			In-Center Hemo			Y
REMBAU	PT. NO. 386, TAMAM SRI REMBAU	PEKAN REMBAU	REMBAU		71300			In-Center Hemo			Y
SEREMBAN	C-02-1&2, JALAN DATARAN SENTRAL 3	DATARAN SENTRAL	SEREMBAN		70200			In-Center Hemo			Y
TAMAN TASIK JAYA	NO. 38&40, JALAN BUNGA RAYA 9	TAMAN TASIK JAYA	SEREMBAN		70400			In-Center Hemo			Y
DIALYSE GERA	FELDBRUNNENSTRASSE 57		HAMBURG		20148			In-Center Hemo			Y
EMDEN	FELDBRUNNENSTRASSE 57		HAMBURG		20148			In-Center Hemo			Y
DIALYSE ESSEN	AM LICHTBOGEN 43		ESSEN		45141			In-Center Hemo			Y
BEJA	RUA DR COVAS DE LIMA		BEJA		7800-309			In-Center Hemo			Y
AMPANG DIALYSIS CENTRE	STE 7.01 MEDICAL OFFICE BUILDING	GLENEAGLES HOSPITAL, JALAN AMPANG	KUALA LUMPUR		50450			In-Center Hemo	0		Y
DIALYSE NORDEN	JUISTER STRABE 9		NORDEN		26506			In-Center Hemo			Y
ALZEY DIALYSIS	AM DAMM 17		ALZEY		55232			In-Center Hemo			Y
MING DER CLINIC	NO 663, SEC 1, NORTH MINGDE RD		DOULIU CITY		640			In-Center Hemo			Y
TIANQIAO DISTRICT RENAL HOSPITAL	COURTYARD 108, DIKOU RD	TIANQIAO DISTRICT	JINAN CITY					In-Center Hemo			Y
CHANGQING DISTRICT RENAL HOSPITAL	14388 JINGSHI RD W		JINAN CITY					In-Center Hemo			Y
BAD MUNDER	DEISTERRALLEE 36		BAD MUNDER		31848			In-Center Hemo			Y
HANNOVER LINDEN	FALKENSTR 27		HANNOVER LINDEN		30449			In-Center Hemo			Y
STADTHAGEN	AM KANTENHAUS 1		STADTHAGEN		31655			In-Center Hemo			Y
HANN MUNDEN	VOGELSANG 105		HANN MUNDEN		34346			In-Center Hemo			Y
DVAM (NUSG) ALOR SETAR DIALYSIS CENTRE	NO 17, JALAN BESTARI 1, TAMAN BESTARI	LEBUHRAYA SULTAN ABDUL HALIM	ALOR SETAR		5400	6047714644		In-Center Hemo			Y
DVAM (NUSG) BANDAR BARU UDA DIALYSIS CENTRE	NO 74, GROUND FLR JALAN PADI 1	BANDAR BARU UDA,	JOHOR BAHRU		82100			In-Center Hemo	0		Y
DVAM (NUSG) BANGSAR DIALYSIS CENTRE	NO 14, JALAN KEMUJA OFF	JALAN BANGSAR UTAMA, BANGSAR	KUALA LUMPUR		59100			In-Center Hemo	0		Y

DVAM (NUSG) BATU BERENDAM DIALYSIS CENTRE	NO 26, JALAN MJ 1	TAMAN MERDEKA JAYA	BATU BERENDAM		75350	6063176942	6063173202	In-Center Hemo	0		Y
DVAM (NUSG) BENUT DIALYSIS CENTRE	NO 1, GROUND & 1ST FLR	JALAN BENUT UTAMA, TAMAN BENUT UTAMA, BENUT	PONTIAN		82200	6076901042		In-Center Hemo	0		Y
DVAM (NUSG) KAJANG DIALYSIS CENTRE	NO 2 GROUND FLR JALAN KP 1/6	KAJANG PRIMA	KAJANG		43000	60387399667	60387399667	In-Center Hemo	0		Y
DVAM (NUSG) KOTA TINGGI DIALYSIS CENTRE	NO 20 & 22, JALAN SS/1	TAMAN SRI SAUJANA	KOTA TINGGI		81900	6078830811	6078830811	In-Center Hemo	0		Y
DVAM (NUSG) KUALA PILAH DIALYSIS CENTRE	NO 4, JALAN 1, TAMAN DAMAI	JALAN MELANG	KUALA PILAH		72000	6064814142	6064814142	In-Center Hemo	0		Y
DVAM (NUSG) KUALA SUNGAI BARU DIALYSIS CENTRE	KS 1092, JALAN KUALA JAYA 2	TAMAN KUALA JAYA	KUALA SUNGAI BARU		78200			In-Center Hemo	0		Y
DVAM (NUSG) MASJID TANAH DIALYSIS CENTRE	SU 949 & SU 950, JALAN BANDAR BARU 6		MASJID TANAH		78300	6063847122	6063847122	In-Center Hemo	0		Y
DVAM (NUSG) PONTIAN DIALYSIS CENTRE	NO 31 & 32, JALAN DELIMA 2	PUSAT PERDAGANGAN PONTIAN	PONTIAN		82000	6076883613	6076883613	In-Center Hemo	0		Y
DVAM (NUSG) PUCHONG DIALYSIS CENTRE	NO 20 & 22G, JALAN OP 1/5	PUSAT PERDAGANGAN ONE PUCHONG	PUCHONG		47160	60380769909	60380769808	In-Center Hemo	0		Y
DVAM (NUSG) SEBERANG PERAI DIALYSIS CENTRE	NO 3 & 5, GROUND FLR	LORONG DESA PAUH 1, TAMAN DESA PAUH	SEBERANG PERAI TENGAH		13700	6043988421	6043978421	In-Center Hemo	0		Y
DVAM (NUSG) SRI RAMPAI DIALYSIS CENTRE	NO 2 & 2A, JALAN MEGAN SETAPAK	MEGAN SETAPAK	KUALA LUMPUR		53000	60341430421	60341490421	In-Center Hemo	0		Y
PATEL HOSPITAL-SHOP-IN-SHOP	1ST FLR, PATEL HOSPITAL	CIVIL LINES	JALANDHAR		144001			In-Center Hemo	0		Y
Neuss	AM HASENBERG 44		NEUSS		41462			In-Center Hemo	0		Y
SEDE TELEMEDICINA	CARRERA 45 NO 103-02	BARRIO SANTA MARGARITA	BOGOTA CUNDINAMARCA					In-Center Hemo	0		Y
RIO HACHA	CR. 11A NO. 13-70		RIO HACHA			(5)7289559		In-Center Hemo, PD Services	0		Y
SOLEDAD ATLANTICO	CL. 47 NO. 6C-7		SOLEDAD					In-Center Hemo, Acute Hemo 1:1	0		Y
PESMSR-HOSPITAL SHOP-IN-SHOP	NATIONAL HIGHWAY 219		KUPPAM		517425			In-Center Hemo			Y
PRAYAS SHOP-IN-SHOP	36-C, ECC APARTMENTS	NORTH BOAG RD	CHENNAI		600017			In-Center Hemo	0		Y
JACOBISTRASSE	JACOBISTRASSE 3-5		DUSSELDORF		40211			In-Center Hemo	0		Y
DAVITA UBERLANDIA	AV GETULIO VARGAS	961-CENTRO	UBERLANDIA		38400-299			In-Center Hemo			Y
LUDHIANA-FLAGSHIP	PLOT NO. 28, SHAHEED BHAGAT SINGH NAGAR	LODHI CLUB RD (BRS BYPASS)	LUDHIANA		141013			In-Center Hemo	0		Y
DORMAGEN	ELSA-BRNDSTROEM-STR 17		DORMAGEN		41540			In-Center Hemo	0		Y
ELSTERLAND	FRNAKFURTER STE 16B		HERZBERG		4916			In-Center Hemo	0		Y
WEDAU	ZU DEN REHWIESEN 5		DUISBURG		47055			In-Center Hemo	0		Y
WALSUM	WILLY BARTOCK ST 101		DUISBURG		47179			In-Center Hemo	0		Y
MEIDERICH	VON DER MARKTSTR 34		DUISBURG		47137			In-Center Hemo	0		Y

DAVITA SP2	R PROF ENEAS DE SIQUERIA NETO	549-JARDIM DAS IMBUIAS	SAO PAULO		04829-300			In-Center Hemo	0		Y
DAVITA SP3	R BRAGANCA PAULISTA	718-SANTO AMARO	SAO PAULO		04727-001			In-Center Hemo	0		Y
WHITEFIELD-BANGALORE	NO 3, HOODI VILLAGE	K.R. PURAM HODLI	BANGALORE		560036			In-Center Hemo			Y
DAVITA PENHA	AV MAJOR ANGELO ZANCHI 725		SAO PAULO		03633-000			In-Center Hemo			Y
PSRI HOSPITAL-DELHI	PRESS ENCLAVE MARG	SHEIKFH SARAI-II	NEW DEHLI		110017			In-Center Hemo	0		Y
AURICH	WALLINGHAUSENER STR 14		AURICH		26603			In-Center Hemo	0		Y
DIALYSE KRANKENHAUS BETHESDA	LUDWIG-WEBER-STRASSE 14A		MONCHENGLADBACH		41061			In-Center Hemo			Y
DIALYSE RHEYDT	FRIEDRICH-EBERT-STRASSE 148		MONCHENGLADBACH		41236			In-Center Hemo			Y
HOSPITAL ZUM HEILIGEN GEIST	VON-BROICHHAUSEN-ALLEE 1		KEMPEN		47906			In-Center Hemo			Y
DIALYSE WILLICH	BAHNSTRASSE 28		WILLICH		47877			In-Center Hemo			Y
DIALYSE KEMPEN	ARNOLDSTRASSE 13B		KEMPEN		47906			In-Center Hemo			Y
BERLIN DIALYSE	BRITZER DAMN 185		BERLIN		12346			In-Center Hemo	0		Y
DAVITA LONDRINA	AV DUQUE DE CAXIAS	1371-JARDIM PETROPOLIS	LONDRINA		86015-000			In-Center Hemo			Y
DAVITA ARARAQUARA	AVENIDA PAPA BENTO XV - NUMERO 30	ARARAQUARA	SAO PAULO		14.807-240	5.51633E+11		In-Center Hemo			Y
UNIDAD RENAL SAN CARLOS	CARRERA 13 NO 32-44	SUR PISO 3	BOGATA					In-Center Hemo			Y
MALLIGE MEDICAL CENTRE	MUNICIPAL NO. 32, WARD NO. 77	CRESCENT RD, MADHAVANAGAR	BANGALORE		560001			In-Center Hemo	0		Y
AMAR HOSPITAL	8, INCOME TAX RD	BANK COLONY	PATIALA		147001			In-Center Hemo	0		Y
TORGAU	DOMMITZSCHER STRASSE 30A		TORGAU		4860			In-Center Hemo	0		Y
BAD DUBEN	BITTERFELDER STRASSE 24 A-C		BAD DUBEN		4849			In-Center Hemo	0		Y
RECIFE	AVENIDA CRUZ CABUGA - 1563	SANTO AMARO	RECIFE		55040-000			In-Center Hemo	0		Y
LIN HSIU-CHE CLINIC	NO. 69 ZHONGHUA RD		PINGTUNG CITY		900			In-Center Hemo			Y
DIACARE CRUISE SHIPS	MITTELWEG 110B		HAMBURG		20149			In-Center Hemo	0		Y
V S HOSPITALS INDIA PVT LTD	NO 7 EAST SPUR TANK RD	CHETPET	CHENNAI		600031			In-Center Hemo			Y
BOL-BOLESTAWIEC DC	4 JELENIOGORSKA		BOLESTAWIEC		59700	757811462		In-Center Hemo	0		Y
BRZ-BRZEG-DC	1 MOSSORA		BRZEG		49301	774163684		In-Center Hemo	0		Y
BRS-BRZESKO-DC	33 KOSCIUSZKI		BRZESKO		32800	146635215		In-Center Hemo	0		Y
CHO-CHORZOW-DC	11 STRZELCOW BYTOMSKICH		CHORZOW		41500	322417101		In-Center Hemo	0		Y
GLO-GTOGOW-DC	15 KOSCIUSZKI A		GTOGOW		67200	768341131		In-Center Hemo	0		Y
GRA-GRAJEWO-DC	34 KONSTYTUCJI 3 MAJA		GRAJEWO		18200	862726018		In-Center Hemo	0		Y
HRU-HRUBIESZOW-DC	11 PITSUDSKIEGO		HRUBIESZOW		22500	846972321		In-Center Hemo	0		Y
KAT-KATOWICE-DC	65 PANEWICKA		KATOWICE		40752	322525698		In-Center Hemo	0		Y
KAO-KATOWICE ON-NW	65 PANEWICKA		KATOWICE ON		40760			In-Center Hemo	0		Y
KED-KEDZIERZYNKOZLE-DC	11 KOZIELSKA		KEDZIERZYN KOZLE		40760	774837578		In-Center Hemo	0		Y
KLU-KLUCZBORK-DC	23 SKTODOWSKIEJ-CURIE		KLUCZBORK		46200	774008266		In-Center Hemo	0		Y
KOZ-KOZIENICE-DC	5 ALEJA SOLIDARNOSCI		KOZIENICE		26900	486856121		In-Center Hemo	0		Y
KRA-KRAKOW-DC	7 KIELECKA A		KRAKOW		31526			In-Center Hemo	0		Y
KRS-KRASNYSTAW-DC	4 SOBIESKIEGO B		KRASNYSTAW		22300	825763922		In-Center Hemo	0		Y
KRY-KRYNICA-DC	9 NOWOTARSKIEGO 5		KRYNICA		33380			In-Center Hemo	0		Y
LEB-LEBORK-DC	13 WEGRZYNOWICZA		LEBORK		84300	598413497		In-Center Hemo	0		Y
LUB-LUBLINIEC-DC	64 GRUNWALDZKA		LUBLINIEC		42700	343561180		In-Center Hemo	0		Y
MAL-MALBORK-DC	105 ARMII KRAJOWEJ 106		MALBORK		82200	556123144		In-Center Hemo	0		Y

OLE-OLECKO-DC	1 GOTDAPSKA		OLECKO		19400	875203232		In-Center Hemo	0		Y
OLS-OLESNICA-DC	1 ARMII KRAJOWEJ		OLESNICA		56400	713985201		In-Center Hemo	0		Y
OLK-OLKUSZ-DC	15 BUCHOWIECKIEGO A		OLKUSZ		32300	326454902		In-Center Hemo	0		Y
OPO-OPOLE-DC	31 BIASA		OPOLE		45748			In-Center Hemo	0		Y
PIS-PISZ-DC	8 KLEMENTOWSKIEGO		PISZ		12200	874232241		In-Center Hemo	0		Y
PRU-PRUSZKOW-DC	1 WARSZTATOWA		PRUSZKOW		5800	227588319		In-Center Hemo	0		Y
PSZ-PSZCZYNA-DC	11 ANTESA		PSZCZYNA		43200	324471707		In-Center Hemo	0		Y
RAD-RADOMSKO-DC	36 JAGIELLONSKA		RADOMSKO		97500	446822930		In-Center Hemo	0		Y
RAZ-RADZYNPODLASKI-DC	111 WISZNICKA		RADZYN PODLASKI		21300	833521344		In-Center Hemo	0		Y
SIE-SIEDLCE-DC	26 PONIATOWSKIEGO		SIEDLCE		8110	256403266		In-Center Hemo	0		Y
SID-SIEDLCE ON-NW	26 PONIATOWSKIEGO		SIEDLCE ON		8110	256403266		In-Center Hemo	0		Y
SKA-SKARZYSKOKAMIENNA-DC	1 SZPITALNA		SKARZYSKO KAMIENNA		26110	412629145		In-Center Hemo	0		Y
SOP-SOPOT-DC	1 GRUNWALDZKA 3		SOPOT		81759	583422382		In-Center Hemo	0		Y
SOS-SOSNOWIEC-DC	27 JABTONIOWA		SOSNOWIEC		41200	322906968		In-Center Hemo	0		Y
STA-STASZOW-DC	78 11 LISTOPADA		STASZOW		28200	158645095		In-Center Hemo	0		Y
STR-STRZELNO-DC	8 POWSTANIA WIELKOPOLSKIEGO		STRZELNO		88320	523182075		In-Center Hemo	0		Y
TOM-TOMASZOWMAZOWIECKI-DC	35 JANA PAWTA II		TOMASZOW MAZOWIECKI		97200	447241256		In-Center Hemo	0		Y
TUR-TUREK-DC	4 TAKOWA A		TUREK		62700	632891516		In-Center Hemo	0		Y
TYC-TYCHY-DC	24 NARCYZOW		TYCHY		43100	323276341		In-Center Hemo	0		Y
UST-USTRON-DC	7 SANATORYJNA		USTRON		40450	338565000		In-Center Hemo	0		Y
WAD-WADOWICE-DC	9 STOWACKIEGO		WADOWICE		34100	338232271		In-Center Hemo	0		Y
WAL-WATCZ-DC	9 12 LUTEGO		WATCZ		78600	673505323		In-Center Hemo	0		Y
WAR-WARSAWAKASPRZAKA-DC	17 KASPRZAKA		WARSZAWA		1211	226230233		In-Center Hemo	0		Y
WAS-WARSAWAMANGALIA-DC	4 MANGALIA		WARSZAWA		2758	226421589		In-Center Hemo	0		Y
WOD-WODZISTAWSL.-DC	10 LESZKA		WODZISTAW SL.		44307	324555135		In-Center Hemo	0		Y
ZAK-ZAKOPANE-DC	15 OSWALDA BALZERA		ZAKOPANE		34500	182001462		In-Center Hemo	0		Y
ZAW-ZAWIERCIE-DC	2 11 LISTOPADA 4		ZAWIERCIE		42400	326724915		In-Center Hemo	0		Y
ZOR-ZORY-DC	20 DABROWSKIEO		ZORY		44241	324351114		In-Center Hemo	0		Y
ZYR-ZYRARDOW-DC	30 LIMANOWSKIEGO		ZYRARDOW		96300	468589198		In-Center Hemo	0		Y
NETTETAL	SASSENFELDER KIRCHWEG 1		NETTETAL		41334			In-Center Hemo			Y
VIERSEN-DULKEN	KAMPWEG 21		VIERSEN-DULKEN		41751			In-Center Hemo			Y
HOSPITAL VIERSEN	HOSERKIRCHWEG 63		VIERSEN		41747			In-Center Hemo			Y
ISERLOHN	HOCHSTRASSE 54		ISERLOHN		58638			In-Center Hemo			Y
GEILENKIRCHEN	HERZOG-WILHELM-SR 105		GEILENKIRCHEN		52511			In-Center Hemo			Y
DAVITA CIRURGIA VASCULAR	RUA CASTRO ALVES - 581	20 FLR - ACLIMACAO	SAO PAULO		01.532-001	+55 11 6218 2290		In-Center Hemo			Y
DAVITA SANTOS	AV BERNARDINO DE CAMPOS, 47 - VILA BELMIRO		SANTOS		11 065-001	+55 13 3224 1256		In-Center Hemo			Y
DAVITA NITEROI	RUA DR MARTINS TORRES, 214 - SANTA ROSA		NITEROI		24240-705	+55 21 2422 5780		In-Center Hemo			Y
SHANTI MUKAND HOSPITAL	NO 2 TRANS YAMUNA - INSTITUTIONAL AREA	VIKAS MARG EXTN - KARKARDOOMA	DELHI		110092			In-Center Hemo	0		Y
SANTA MARTA	CALLE 14 NO 15-24		SANTA MARTA MAGDALENA		470001			In-Center Hemo	0		Y
CHEN MIN CHENG CLINIC	NO 3 ZHENGZHOU ST		TAITUNG CITY		950			In-Center Hemo	0		Y
DAVITA AMR	RUA DONA MARIANA	166 BOTAFOGO	RIO DE JANEIRO		22280-020			In-Center Hemo	0		Y
DAVITA BOTAFOGO	RUA DONA MARIANA	166-BOTAFOGO	RIO DE JANEIRO		22280-020			In-Center Hemo	0		Y
DAVITA MEIRELES	RUA DR CASTRO MEDEIROS	62 - MEIRELES	FORTALEZA		60160-100			In-Center Hemo	0		Y
DAVITA MONDUBIM	RUA WENEFRIDO MELO	150 - MONDUBIM	FORTALEZA		60762-410			In-Center Hemo	0		Y

DAVITA SAO GERARDO	AV BEZERRA DE MENEZES	1330 SAO GERARDO	FORTALEZA		60325-000			In-Center Hemo	0		Y
ANGEL AND EVE HOSPITAL PVT LTD.	51B GF - BLOCK-D	EAST OF KAILASH	NEW DELHI		110065			In-Center Hemo	0		Y
RAM RAGHU HEALTHCARE PVT LTD	3,4 and 5 , SURESH PLAZA, M.G RD	OPP SANJAY PLACE	AGRA		282002			In-Center Hemo	0		Y
DAVITA PERDIZES	AV FRANCISCO MATARAZZO989 AGUA BRANCA		SAO PAULO		05001-350			In-Center Hemo			Y
ADENAU	HAUPTSTRASSE 19		ADENAU		53518			In-Center Hemo			Y
REMAGEN	AM ANGER 1		REMAGEN		53424			In-Center Hemo			Y
AHRWEILER	WALPORZHEIMER STRASSE 30		BAD NEUENAHR-AHRWEILER		53474			In-Center Hemo			Y
FORTIS HOSPITALS LIMITED	OKHLA RD	ESCORTS HEART INSTITUTE AND RESEARCH CENTRE	NEW DELHI, DELHI		110025			In-Center Hemo	0		Y
LANDMARK CENTER	UNIT 02-02 AND 02-03, LEVEL 2,	MENARA LANDMARK , NO 12 JALAN NGEE HENG	JOHOR BAHRU		80000	6072212128		In-Center Hemo	0		Y
TAMAN SRI SETIA TSS CENTER	NO 117 JALAN DAMAI	TAMAN SRI SETIA	JOHOR BAHRU		80300	6072235137		In-Center Hemo	0		Y
FRITZLAR	AM HOSPITAL 11		FRITZLAR		34560			In-Center Hemo	0		Y
HOMBERG	OBERTORSTRABE 9		HOMBERG EFZE		34576			In-Center Hemo	0		Y
SCHWALMSTADT	KRANKENHAUSSTR 27		SCHWALMSTADT		34613			In-Center Hemo	0		Y
PASEWALK	PRENZLAUER CHAUSSEE 30		PASEWALK		17309			In-Center Hemo	0		Y
PRENZLAU	KARL MARX STRABE 2A		PRENZLAU		17291			In-Center Hemo	0		Y
TEMPLIN	FRIEDRICH ENGELS STRABE 15		TEMPLIN		17628			In-Center Hemo	0		Y
DAVITA SANTANA	RUA CARLOS CAMARGO ARANHA, 10	VILA RABELO	JARDIM SAO PAULO		02039-090			In-Center Hemo	0		Y

Appendix 3

Medical Director Agreement

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MEDICAL DIRECTOR AGREEMENT
SCHEDULE 1: SELECTED KEY TERMS

This Schedule 1 is attached to and a part of this Medical Director Agreement

1. **Parties and Notice:**

Party	Name	Notice Address	Address for Additional Required Copy of Notice
Contractor	Pacific Nephrology Associates, P.S.	1901 S. Union Avenue Suite B7011 Tacoma, WA 98493	
Company	Total Renal Care, Inc.	c/o Chief Operating Officer 2000 16th Street Denver, CO 80202	c/o Group General Counsel 2000 16th Street Denver, CO 80202

2. **Center:**

Facility Name	Facility Number	Address
King 11 (Auburn) Dialysis	TBD	1700 O Street Auburn, WA 98001

3. **Date of Last Signature:** The date of last signature shown via DocuSign or, if DocuSign is not used by one or more of the parties, the date of last signature of all parties to this Agreement.

4. **Initial Term**:

The Initial Term of this Agreement will commence on the date on which Center dialyzes and/or trains its first patient, whichever first occurs (the "Commencement Date") and will continue thereafter for a period of ten (10) years, unless earlier terminated pursuant to the terms of this Agreement. Company will submit notice to Contractor confirming the Commencement Date, which notice will be attached to, and incorporated by this reference in, this Agreement.

5. **Renewal Term**: At the expiration of the Initial Term and each successive Renewal Term, the term of this Agreement is extended automatically for additional one year periods (each, a "Renewal Term") unless Contractor or Company gives at least 180 days' prior written notice of the non-extension of the Initial Term or Renewal Term then in effect to the other, in which case, the Term expires and terminates on the last day of the Initial Term or Renewal Term then in effect.

6. **Medical Director**:

Medical Director Name
Di Zhao, M.D.

7. **Preapproved Physicians:** Zheng Ge, M.D., Yajuan He, M.D., Ho Won Lee, M.D., Di Zhao, M.D., and Young Ho Kim, M.D.

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8. Compensation and Modalities:

Pre-Medicare Certification Compensation

Facility Name	Facility Number	Hemo Monthly	Annual Compensation Hemo
King 11 (Auburn) Dialysis	TBD	$2,916.66	$35,000

Post-Medicare Certification Compensation

Facility Name	Facility Number	Hemo Monthly	Annual Compensation Hemo
King 11 (Auburn) Dialysis	TBD	$5,833.33	$70,000

9. Non-Competition:

Modality	Restricted Area (radius from Center)	Restricted Period
In-Center Hemodialysis and all other Dialysis Services except for Peritoneal Dialysis and Home Hemodialysis which has the Restricted Area defined below	20 miles	Date of Last Signature through Termination Date + 2 years
Peritoneal Dialysis and Home Hemodialysis	30 miles	Date of Last Signature through Termination Date + 2 years

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MEDICAL DIRECTOR AGREEMENT

This **Medical Director Agreement** ("Agreement") is by and between **Total Renal Care, Inc.**, a California corporation ("Company") and **Pacific Nephrology Associates, P.S.**, a Washington professional service corporation ("Contractor").

RECITALS

A. Company is in the business of owning and operating dialysis centers including the center to be known as "King 11 (Auburn) Dialysis" as more particularly described in Schedule 1. Contractor is in the business of rendering professional medical services.

B. During the Term, Company will provide Medical Director with equipment, materials, facilities, and valuable Confidential Information for the purpose of assisting Medical Director in the performance of Medical Director's obligations and responsibilities under this Agreement.

C. This Agreement contains the respective rights and obligations of the parties hereto and in connection with Medical Director's appointment and role in performing the Services hereunder.

D. Capitalized terms not otherwise defined have the meanings set forth in **Exhibit A**, which is attached to and incorporated in this Agreement.

In consideration of the Recitals, which are incorporated herein, the mutual promises herein, and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree as follows:

1. **Initial Term and Renewals**. The Term of and ability to renew this Agreement are in Schedule 1.

2. **Appointment**.

2.1 Current Appointment. The physician listed as Medical Director in Schedule 1 is duly appointed and agrees to serve as the Medical Director of the Center. Without limiting Contractor's obligations under this Agreement, Medical Director hereby represents and warrants that he or she meets the Medical Director Qualifications and will perform the Services under this Agreement and will comply with all other requirements specifically applicable to Medical Directors hereunder. Subject to the conditions of Section 2.2, the Preapproved Physicians set forth in Schedule 1 are preapproved by Company to serve as the Medical Director of the Center. During the Term, the Services will be provided only through the named Medical Director, except as otherwise expressly set forth herein. At Company's discretion, and pursuant to a written amendment executed by all parties hereto if appropriate, additional physicians may provide Services as associate medical directors; however, Medical Director or any successor Medical Director is at all times the lead Medical Director and is responsible for oversight of any other physicians providing Services.

2.2 New Appointments. Contractor may appoint any Preapproved Physician to serve as a successor Medical Director for Center, provided that such Preapproved Physician meets the Medical Director Qualifications and, pursuant to Company's then-current compliance standards, such Preapproved Physician has the practice capacity to provide the Services at the Center at the time of his or her appointment as successor Medical Director. Notwithstanding the foregoing, Contractor may not make multiple appointments of Preapproved Physicians to serve as a successor Medical Director for Center in any 12 month period without written consent from Company. If Contractor wishes to appoint a physician not listed

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in Schedule 1 as Medical Director or add or remove a Preapproved Physician, Contractor must obtain Company's consent and the compensation set forth in Schedule 1 is subject to modification (see Section 3.2). Contractor will provide Company and the Division Vice President for the division of Company in which Center is located with reasonable advance notice of its intent to appoint a successor Medical Director or add/remove a Preapproved Physician. If such successor is a Preapproved Physician, Company will memorialize its acceptance in a written notification to Contractor. Any appointment (and acceptance) of a successor Medical Director who is not a Preapproved Physician will be memorialized in an amendment duly executed by the parties.

3. Compensation.

3.1 Compensation Structure. Beginning on the Commencement Date, Company will pay Contractor for the performance of the Services the sums set forth in Schedule 1. In the event of any temporary closure of the Center, including an Interruption Event, no payment will be owed for Services from the date the Center closes until it reopens, other than Interruption Services in accordance with Section 13, if any. On or after the fifth (5th) anniversary of the Commencement Date, the compensation paid under this Section 3.1 will be reviewed and prospectively adjusted in a written amendment, if appropriate, to ensure that such compensation continues to reflect the fair market value of the Services provided and continues to be consistent with DaVita's then current policies and procedures for medical director compensation. For purposes of this section, fair market value will be determined by DaVita's compliance policies and procedures. Notification of any necessary adjustments to compensation will be provided to Contractor prior to the fifth (5th) anniversary of the Commencement Date. Adjustments to compensation made in accordance with this provision will become effective on the earlier of date of last signature to the Amendment, which will occur as promptly as possible after notice of adjustment is received, or the one (1) year anniversary of notification to the Contractor of such needed adjustment. If such amendment is not executed within one (1) year of the notification and Company determines that the amount then being paid is above fair market value that can be justified by Company, Company is entitled to unilaterally reduce compensation to the maximum amount allowable under its then-current compensation structure of medical director agreements in accordance with Company's compliance policies and procedures. Company is only obligated to compensate Contractor for Services rendered through the Termination Date. Company is only obligated to begin paying compensation for the Post-Medicare Certification Period for Services rendered with respect to a particular modality on the later of the Medicare Certification Date for such modality or the date on which the Center begins providing treatment or training services under such modality. Company will provide notice to Contractor confirming the Medicare Certification Date with respect to each modality.

3.2 Adjustment. In the event that Company consents to an appointment of a successor Medical Director, who is not a Preapproved Physician pursuant to Section 2 of this Agreement, a removal of a Preapproved Physician from the Agreement, or any change described in Section 4.1.2, the compensation set forth in Schedule 1 is subject to modification based on Company's assessment of the successor Medical Director's qualifications or remaining Preapproved Physicians, as appropriate, and DaVita's then current policies and procedures for fair market value medical director compensation. One hundred eighty (180) days prior to the first day of each Renewal Term, the parties will begin negotiation of any compensation adjustment to be effective at the commencement of the Renewal Term; however, if no such agreement can be reached during such 180-day period, and negotiation extends beyond the commencement of the Renewal Term, then any such compensation adjustment, if applicable, will not be effective until such time as the agreement or amendment documenting the revised compensation is fully executed, or the commencement date of such agreement, or amendment, whichever is later, and will only be paid prospectively for services rendered after that date.

3.3 Payment. Contractor will utilize Company forms and adhere to policies and procedures regarding invoicing and attestation including, but not limited to, submitting an itemized invoice (dated no

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earlier than the first day of the month following the month in which the Services being invoiced were rendered). The invoice must be accompanied by an attestation (signed by the Medical Director or Covering Medical Director), in a form provided by Company, that clearly states the Services were performed and the terms and conditions of this Agreement were fully satisfied by the Medical Director (or a Covering Medical Director) during such month. Subject to Section 5.1 herein, Company will review the invoice and pay any amounts not disputed in good faith within 30 days of receipt of such invoice. If any disputed item cannot be resolved by the parties within 15 days after payment of the undisputed amount, the parties will submit to the dispute resolution process set forth in Section 14.2 below. Other than an invoice for Interruption Services, Contractor will not submit an invoice during an Interruption Period from the date Center closes until it reopens. Company may deduct from the amount due the fair market value of any Services set forth in **Exhibit B** not performed by Contractor in any given month and any other unpaid amounts owed to Company by Contractor under this Agreement or any other written agreement among such parties; provided, however, that Company will first provide notice to Contractor of its intention to deduct such amounts and gives Contractor an opportunity to provide evidence of entitlement to full payment.

3.4 Fair Market Value. The parties agree that the compensation provided under this Agreement has been determined based on arm's-length bargaining between the parties and reflects fair market value for the Services. Furthermore, the compensation is not and has not been determined in a manner that takes into account the volume or value of any referrals or business otherwise generated for or with respect to Center or between the parties for which payment may be made in whole or in part under Medicare, Medicaid, or any federal or state health care program or under any other third party payor program. Upon any amendment of this Agreement, the Company will ensure that the compensation paid hereunder continues to reflect Company's internal compliance policies regarding fair market value of the Services being provided and may adjust compensation as necessary.

4. Duties, Responsibilities, and Conditions; Exclusive Use of Center Resources.

4.1 Duties, Responsibilities, and Conditions.

4.1.1 Services. Medical Director will provide the Services set forth in **Exhibit B**. The Governing Body of Center retains ultimate authority and responsibility for the standards of, and procedures and practices for, the care provided by Center. Medical Director must maintain unrestricted privileges at Center and will be a voting member of the Governing Body. Copies of the Governing Body Bylaws and the Medical Staff Bylaws (together, the "Bylaws") have been or will be made available to Medical Director prior to the Center opening. In the event of a governmental survey, Medical Director must be present and participate, or arrange for a Covering Medical Director to be present and participate, in assisting and providing the government agent with any requested information. In addition, Medical Director is expected to attend DaVita sponsored educational meetings from time to time. DaVita will reimburse expenses associated with attending these educational meetings in accordance with applicable DaVita policies and the terms of this Agreement.

4.1.2 Covering Medical Directors. In the event of any temporary absences that would prevent Medical Director from meeting the requirements of **Exhibit B**, Contractor must notify the Center administrator in writing in advance of such absences (except for emergency situations, in which Contractor will notify Company as soon as practicable), and Contractor must arrange for a Covering Medical Director to perform the Services. Any absence in excess of 21 consecutive days or 30 days within any 60 day period requires Company's prior written consent, which will not be unreasonably withheld. If a Covering Medical Director is appointed by Contractor for a period of more than sixty (60) consecutive days the compensation paid under Section 3.1 will be reviewed and prospectively adjusted in a written amendment, if appropriate, to ensure that such compensation continues to reflect the fair market value of the Services provided by the Covering Medical Director and continues to be consistent with DaVita's then current policies and

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procedures for medical director compensation. Each Covering Medical Director is be deemed to be an agent of Contractor. In accordance with this Agreement, Company will pay Contractor for the Services provided by the Covering Medical Director and Contractor will pay the Covering Medical Director for such services. Company has no responsibility for compensating the Covering Medical Director or supervising the Covering Medical Director, other than that responsibility retained by the Governing Body of Center under **Exhibit B**. Each Covering Medical Director must: (a) meet the Medical Director Qualifications, (b) meet all Company criteria for membership on the Center's medical staff, and (c) be duly approved by the Governing Body of the Center prior to performing Services pursuant to this Agreement. Contractor will ensure that Covering Medical Director complies with the terms of this Agreement, including but not limited to the obligations set forth in Section 5 hereof. Once approved, a Covering Medical Director also can provide routine or emergency, unplanned coverage for Medical Director; provided, however, that Covering Medical Director gives the Center administrator his/her necessary contact information and provides notice if/when the Covering Medical Director is covering for Medical Director, when possible. Center Administrator may use the assigned Covering Medical Director as a backup if Medical Director is unavailable for any reason.

4.2 Exclusive Use of Center Resources. Contractor will use the Center and its supplies, equipment, and non-physician employees solely and exclusively for providing the Services. Contractor or any Related Physician will use no portion of the Center, its supplies or equipment, or the time of any Company employee or contractor for the general practice of medicine, invoice preparation, or for any other purpose not expressly set forth in this Agreement except as otherwise agreed in advance in a written agreement setting forth the applicable terms and conditions, which complies with applicable regulatory requirements, and which is duly executed by both parties. Company may deduct from the compensation payable under this Agreement the fair market value of Company space, facilities, supplies, equipment, time of non-physician staff, or any other item or service actually utilized by Contractor or any Related Physician for the general practice of medicine or for any other purpose not expressly set forth in this Agreement, provided that Company first provides notice to Contractor of its intention to deduct such amounts and gives Contractor an opportunity to provide evidence of entitlement to full payment. Nothing in this Section 4.2 restricts Contractor from generally using the physical plant of the Center for purposes of rounding on its patients.

5. Compliance.

5.1 Compliance. The parties enter into this Agreement with the intent of conducting their relationship in full compliance with applicable federal, state, and local law, including without limitation the Anti-Kickback Statute, and certify that no party will violate the Anti-Kickback Statute with respect to the performance of this Agreement. Notwithstanding any unanticipated effect of any of the provisions of this Agreement, neither party will intentionally conduct itself under the terms of this Agreement in a manner that would violate any such law. Contractor, Medical Director and each Covering Medical Director will comply with and ensure that the Center is operated in accordance with:

(i) the Bylaws and all of Company's and DaVita's Policies and Procedures (as defined below) and the Company's and DaVita's Code of Conduct; Contractor will be provided copies and/or access to the foregoing electronically;

(ii) Company's written and the community's accepted standards of care, (Contractor will be provided copies and/or access to the written standards electronically);

(iii) the requirements of a medical director imposed by the Conditions for Coverage Section 42 C.F.R. §494.150 et. seq. as may be amended from time to time;

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(iv) all clinical initiatives of Company and DaVita and initiatives by DaVita's Office of Chief Medical Officer, provided that Contractor is made aware of each of the foregoing;

(v) all Company and DaVita compliance initiatives and initiatives by DaVita's Chief Compliance Officer, including audits, internal reviews, investigations, protocol monitoring documentation programs, education, and other related initiatives that Contractor is made aware of or provided access to;

(vi) all applicable laws, regulations and governmental standards relating to licensing, certification, and operation, including without limitation any federal and state ESRD programs, the disclosure requirements and self-referral prohibitions of the Federal Ethics in Patient Referrals Act, 42 U.S.C. §1395nn (known as the "Stark Law") and any applicable state self-referral laws, the anti-fraud and abuse statute, 42 U.S.C. §1320a-7b(b) (known as the "Anti-Kickback Statute") and any applicable state anti-kickback laws;

(vii) HIPAA, including Privacy and Security Standards;

(viii) any other applicable federal and state laws; and

(ix) Company's and DaVita's corporate compliance program (including, but not limited to, its HIPAA Policies, Code of Conduct, and Policies and Procedures) provided that Contractor will be provided copies and/or access to the foregoing electronically.

Medical Director and each Covering Medical Director will participate in and complete on an annual basis compliance training (online and otherwise) that Company provides to such parties on an annual basis. The compliance training includes training on Company policies and procedures designed to ensure compliance with relevant Federal health care program requirements that are applicable to the activities of such parties as required by this Agreement ("Policies and Procedures"), DaVita's/the Center's compliance program, and DaVita's/Center's Code of Conduct. At least one hour of compliance training discusses the Anti-Kickback Statute and provide examples of arrangements that potentially implicate the Anti-Kickback Statute. Company will provide copies of the Policies and Procedures and the Code of Conduct in electronic or hardcopy form as part of the compliance training or in advance of the training.

Contractor, Medical Director and each Covering Medical Director must certify in writing or electronic form that each party has received, read, understood and will abide by the Company Code of Conduct and must complete and return such certification to Company.

Contractor, Medical Director and each Covering Medical Director will provide access to billing documentation, participate in contract and claims audits, and other aspects of Company's and DaVita's compliance program, and, upon request, cooperate and assist during any internal compliance review, investigation, monitoring protocol and/or audit. In addition, Contractor will comply with the obligations set forth in the BAA. Contractor and Medical Director will ensure that all persons who perform Services under this Agreement adhere to the terms of this Section 5 throughout the Term.

5.1.1 Timeliness. The required persons listed above must complete the above training (a) within 30 days after the Commencement Date and any approved appointment of a successor Medical Director, and then (b) annually by April 15th of each subsequent year of the Term (each, a "Training Deadline"). Contractor and Medical Director will ensure that any Covering Medical Director who is appointed to serve for greater than 60 consecutive days during the Term completes such training within 30 days of his or her appointment, or in the event of a Covering Medical Director whose appointment was anticipated to be less than 60 days and who serves for 60 consecutive days or longer, such training completed within 30 days of that Medical Director exceeding 60 days of consecutive coverage. Company

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will send a courtesy reminder, via electronic mail, to Contractor prior to the Training Deadline to notify Contractor of the outstanding training requirement. Notwithstanding the foregoing, if a required person fails to complete the required training by the Training Deadline, Company will send written notice to Contractor and may thereafter, in addition to all other rights and remedies available to Company under this Agreement, withhold compensation for Services until such training has been completed. The withholding contemplated under this Section, and any invoice not paid as a result thereof, is not considered a disputed invoice under Section 3.3 or a breach of Section 12.1.1. If such training is not completed within a reasonable time thereafter, it is considered a breach of this Agreement subject to the remedies contained in Section 12 and the notice required under 12.2.5 does not apply.

5.1.2 Notification. Contractor will immediately notify DaVita's Chief Compliance Officer of any violation of any applicable law, regulation, third party payor requirement, or breach of Company's or DaVita's compliance program, Code of Conduct, or Policies and Procedures of which Contractor or its employees or agents become aware of during the Term. Contractor will instruct its employees and agents working in or with Center of this obligation.

5.1.3 Cooperation. Contractor will cooperate with Company in responding to or resolving any complaint, investigation, inquiry, or review initiated by a governmental agency, Company, or otherwise. Contractor will also cooperate with any insurance company providing coverage to Company in connection with the foregoing. Nothing herein will be deemed to require a waiver of the attorney-client privilege by any party.

5.2 Non-Exclusion. Contractor represents and warrants to Company that neither Contractor, Medical Director, nor any of their employees, officers, directors, equity owners, or Affiliates engaged to provide Services under this Agreement: (i) is or has been excluded from participation in any federal health care program, as defined under 42 U.S.C. §1320a-7b(f), for the provision of items or services for which payment may be made under such federal health care programs and is not currently excluded, debarred, suspended, or otherwise ineligible to participate in Federal procurement or nonprocurement programs; (ii) has arranged or contracted (by employment or otherwise) with any employee, contractor, or agent that such party or its Affiliates know or should know is excluded from participation in any federal health care program to provide items or services hereunder; or (iii) has been convicted of a criminal offense that falls within the scope of 42 U.S.C. § 1320a-7(a), but has not yet been excluded, debarred, suspended, or otherwise declared ineligible.

In the event that any of (i)-(iii) above has occurred, this Agreement will, as of the effective date of such exclusion or breach, automatically terminate.

5.2.1 Contractor and Medical Director further represent and warrant to Company that during the 6 years preceding the Date of Last Signature, no Final Adverse Action has occurred, is pending or, to Contractor's knowledge, is threatened against Contractor or a Related Physician, or any of their Affiliates or, to their knowledge, against any employee, contractor, or agent engaged to provide items or services under this Agreement. "Final Adverse Action" means any of the following involving Contractor or any Related Physician: (a) any final civil judgments in federal or state court related to the delivery of a health care item or service; (b) any federal or state criminal convictions related to the delivery of a health care item or service; (c) any final actions by federal or state agencies responsible for the licensing and certification of health care providers, suppliers, and licensed health care practitioners, including: (1) formal or official actions, such as revocation or suspension of a license (and the length of any such suspension), reprimand, censure, or probation; (2) any other temporary or final loss of license or the right to apply for, or renew, a license of the provider, supplier, or practitioner, whether by operation of law, voluntary surrender, non-renewability, or otherwise; (3) any other negative action or finding by such federal or state agency; or (d) exclusion from participation in any federal or state health care programs, being listed as an

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excluded provider or banned contractor by the United States Department of Health and Human Services Office of Inspector General or United States General Services Administration, or being listed in the Office of Foreign Assets Control's "Specially Designated Nationals and Blocked Persons" list. The term "Final Adverse Action" does not include any action or judgment solely with respect to a professional malpractice claim.

5.2.2 During the Term and for a period of 6 years following the Term, Contractor will notify Company of (a) any Final Adverse Action or basis for a Final Adverse Action that relates to or arises from actions occurring during the periods prior to and during the Term or relating to the Services, or (b) any complaint, investigation, inquiry, or review by any governmental agency or third party payor relating to or arising from actions occurring during the periods prior to and during the Term or relating to the Services. Such notice must be provided within 2 business days of learning of the event giving rise to such notice and must include a description of the matters at issue.

6. Indemnification and Insurance.

6.1 Indemnification.

6.1.1. Company Indemnity for Acts within Scope of Medical Director Duties. Company will indemnify Contractor, Medical Director and Covering Medical Director for any liability arising from the provision of Services which are provided in accordance with the terms of this Agreement except in circumstances of gross negligence or intentional actions by the Medical Director or Covering Medical Director.

6.1.2. Contractor Indemnity for Acts of Medical Director Outside Scope of Medical Director Duties. Contractor hereby agrees to indemnify and defend Company for any liability arising from the actions, acts, or omissions of the Medical Director and any Covering Medical Director in providing professional medical services to patients other than in the capacity as Medical Director or Covering Medical Director.

6.1.3. Other Indemnity between the Parties. Each party hereby covenants and agrees to indemnify, defend, and hold harmless ("Indemnifying Party") any other party ("Indemnified Party") to this Agreement from any and all liability, losses, costs, obligations, and expenses, including reasonable attorneys' fees, which the Indemnified Party may incur as a result of the negligence, fraud, or other misconduct of the Indemnifying Party to this Agreement, or its respective agents or employees, including, but not limited to, such acts and claims against the Indemnifying Party as assault, battery, intentional infliction of emotional distress, negligence while operating motor vehicles to or from Center or in the parking lot of Center, libel, slander, and other acts not associated with the provision of the Services. Additionally, each party agrees to indemnify, defend, and hold harmless the other party for the breach by the Indemnifying Party of its respective obligations under this Agreement, including but not limited to, breaches of Sections 5, 7, 8, 9, 10, 11, and 14.5.

6.1.4. Rights and Duties of Indemnifying Party. The Indemnifying Party will not settle any such claim or alleged claim hereunder without first obtaining the Indemnified Party's prior written consent in all instances where the settlement concerned might adversely affect the Indemnified Party's rights (under this Agreement or otherwise); and such consent will not be unreasonably withheld. If the Indemnifying Party assumes the defense and settlement of the claims it is responsible for as set forth above, then the Indemnifying Party's only obligation is to satisfy the claim, judgment or approved settlement, and provide reasonable costs and fees as detailed herein. Under no circumstances will an Indemnifying Party be responsible for an Indemnified Party's consequential damages, liquidated damages, lost profits, or otherwise, except as part of a judgment or settlement with a third party.

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6.1.5. Notice. In the event of any such claim as described in this Section 6, the Indemnified Party will (a) promptly notify the Indemnifying Party of the claim; (b) allow the Indemnifying Party to direct the defense and settlement of such claim with counsel of the Indemnifying Party's choosing (subject to Section 6.1.4); and (c) provide the Indemnifying Party, at the Indemnifying Party's expense, with information and assistance that is reasonably necessary for the defense and settlement of the claim. The Indemnified Party reserves the right to retain its own counsel, at the Indemnified Party's sole expense, and to participate with Indemnifying Party in the defense of any such claim.

6.2 Insurance.

6.2.1 Company's Coverage. At its expense, Company will maintain general and professional liability insurance, during the Term, with a minimum annual coverage limitation of $250,000 per occurrence and $750,000 in the aggregate, or such higher coverage as may be required by law through policies obtained from third party insurance carriers or through a program of self-insurance. Within 30 days of a written request from Contractor, Company will produce documentation substantiating the existence of such insurance. The parties acknowledge and agree that the insurance coverage maintained by Company in accordance with this Section 6.2.1 will cover Medical Director or Covering Medical Director for the Services that Medical Director or Covering Medical Director is providing pursuant to this Agreement, but will not extend to any claims of professional malpractice against Contractor, Medical Director or Covering Medical Director not arising from the Services, or any private practice of medicine by any Related Physician. Company will maintain workers' compensation insurance in accordance with statutory limits for Company employees.

6.2.2 Contractor's Coverage. At its expense, Contractor will maintain policies of professional and general liability insurance, during the Term, covering Contractor, Medical Director, Preapproved Physicians, and Contractor's employees and agents. Such insurance will insure against liability for damages caused by the acts or omissions of Contractor, Medical Director, Preapproved Physicians, and employees and agents in the performance of their respective professional practices of medicine. Such coverage will include, but not be limited to, professional liability insurance with a minimum annual coverage limitation of $250,000 per occurrence and $750,000 in the annual aggregate, or such higher coverage as may be required by law. In addition, Contractor will ensure that each Covering Medical Director maintains the professional and general liability insurance coverage described in this Section 6.2.2. Such policy or policies will specifically cover Contractor, Medical Director, Preapproved Physicians, or Covering Medical Director, as applicable. Within 30 days of request by Company, Contractor will provide Company with documentation substantiating the existence of such insurance and the rating of the insurance carrier. Contractor will maintain workers' compensation insurance in accordance with statutory limits for Contractor employees. Contractor's coverage will be with an insurance carrier that maintains an A.M. Best rating of "A-" or higher unless otherwise approved by DaVita's Corporate Risk Department.

7. Limitations on Use and Disclosure of Confidential Information. Contractor and Related Physicians acknowledge and agree as follows:

(a) Restricted Persons will use Confidential Information only as necessary to provide Services and will not disclose, Directly or Indirectly, any Confidential Information in any manner whatsoever, in whole or in part, without the prior written consent of Company. Contractor will ensure that each Restricted Person is aware of and agrees to the limitations on the use and disclosure of Confidential Information set forth in this Section 7. Contractor and each other Restricted Person will promptly notify Company of any breach of this Section 7 which becomes known. For the avoidance of doubt, this Section 7 prohibits disclosure of Confidential Information to any third party (other than to Contractors' agents and attorneys,

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who must be made aware of, and agree to abide by, the confidentiality provisions of this Agreement) whether or not permitted by applicable law, regardless of whether the Restricted Person is compensated by such third party. In addition to the foregoing, under no circumstances will any Restricted Person relay any Confidential Information, whether orally or in any form of writing or electronic submission, to (i) any physician affiliated with Contractor or any employee of Contractor who is not providing Services or who has not signed this Agreement or a joinder hereto and (ii) any individual or entity in connection with any ESCO, managed care, outcome based or shared savings arrangement that such Restricted Person is involved in. This includes any Covering Medical Director, who must return any and all Confidential Information in his/her possession upon completion of his/her covering period and such Covering Medical Director may not use the Confidential Information for any other purposes than the covering medical directors services hereunder

(b) If a Restricted Person is requested or required, in connection with any proceeding, to disclose any Confidential Information, such Restricted Person will give Company prompt notice of such request or requirement so that Company may seek an appropriate protective order or other remedy and/or waive compliance with the provisions of this Section 7, and the Restricted Person will cooperate with Company to obtain such protective order. In the event that such protective order or other remedy is not obtained or Company grants a waiver, the Restricted Person will furnish only that portion of the Confidential Information which, in the written opinion of Company's counsel, is legally required to be disclosed and the Restricted Person will use best efforts to obtain assurances that the information will be treated as confidential. The confidentiality provisions of this Agreement will be effective as of the Date of Last Signature.

8. Records.

8.1 Removal of Records or Charts. Medical Director, Covering Medical Director, or any of Contractor's other agents or employees may not remove patient records or charts from Center premises at any time. Unauthorized removal of said records or failure to immediately return said records after notice is a material breach of this Agreement and, in addition to all other legal and/or equitable remedies available to Company, constitute grounds for immediate termination of this Agreement by Company.

8.2 Record Review and Retention.

8.2.1 Each party permits, and will ensure that any subcontractor permits, the United States Department of Health and Human Services and General Accounting Office to review appropriate books and records relating to the performance of this Agreement to the extent required under Section 1861(v)(1)(I) of the Social Security Act, 42 U.S.C. Section 1395x(v)(1)(I), or any successor law or regulation for a period of 4 years following the Termination Date. The access will be provided in accordance with the provisions of 42 C.F.R. Part 420, Subpart D.

8.2.2 If Contractor carries out any of the duties of this Agreement through a subcontract, with a value or cost of $10,000 or more over a 12 month period, with a related organization, such subcontract must contain a clause to the effect that until the expiration of 4 years after the furnishing of such services pursuant to such subcontract, the related organization will make available, upon written request to the Secretary of the United States Department of Health and Human Services or upon request to the Comptroller General of the United States, or any of their duly authorized representatives, the subcontract, and books, documents, and records of such organization that are necessary to verify the nature and extent of the costs incurred pursuant to such subcontract. In addition, the subcontract will require the related organization to comply with and be bound by Company's privacy, compliance, and record retention policies.

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8.2.3 Contractor will notify Company immediately of the nature and scope of any request for access to books and records described above and will provide copies of any books, records, or documents to Company prior to the provision of same to any governmental agent to give Company an opportunity to lawfully oppose such production of documents. In addition, Contractor will indemnify and hold Company harmless from any liability arising out of any refusal by Contractor or any Related Physician or any subcontractors of the foregoing to grant access to books and records as required above. Nothing herein will be deemed to be a waiver of the attorney-client privilege) by any party.

9. No Conflicts. Contractor (on its own behalf and on behalf of any Related Physicians) represents, warrants, and covenants to Company that, as of the Date of Last Signature and throughout the Term, Contractor, Medical Director and any Related Physician: (a) is not a party to, and will not become a party to, any other medical director agreement, consulting agreement, or other agreement that would be prohibited under Section 10; (b) is and will remain under no obligation or commitment, contractual or otherwise, that would prohibit or prevent it, him, or her from entering into or performing under this Agreement; (c) has no Financial Relationships with any vendors or suppliers of goods or services or providers of Dialysis Services which would cause a conflict of interest with regard to the Services provided under this Agreement; and (d) is and will remain free to enter into and perform all of its, his, or her respective duties and obligations under this Agreement. Without limiting the foregoing, or any of the provisions of Section 11, during the Term, Contractor will not join any medical practice, or permit any other physician to join Contractor's medical practice if such affiliation would result in a breach of any representation, warranty, or covenant contained in this Agreement. Company is entering into this Agreement based upon the representations and warranties in this Section and throughout the Agreement. For purposes of this Section 9, "Financial Relationship" is defined as any relationship which causes a medical director to recommend or use any product or service through any third party which benefits the medical director financially. If any such Financial Relationship exists or comes into existence during the Term of this Agreement, Contractor will inform Company of such interest as soon as Contractor becomes aware of any such interest.

10. Non-Competition and Non-Solicitation.

10.1 Non-Competition.

10.1.1 Contractor and each Related Physician acknowledge and agree (a) that each will be exposed to valuable Confidential Information of Company and will participate at Company's expense in building and maintaining its goodwill with employees, vendors, and others, and (b) that Company and Center will suffer serious, irreparable, competitive injury if Contractor or any Related Physician were to engage in any business or activities in competition with Company or Center.

10.1.2 Contractor and each Related Physician covenant and agree that each will not, during the Restricted Period, Directly or Indirectly take, prepare to take, or permit to be taken any action that results in or may reasonably be expected to result in owning (other than as a passive shareholder of less than a 2% interest in a public company), operating, managing, leasing, extending credit to, engaging in or preparing to engage in, being employed by, or otherwise participating in (including, without limitation, as a medical director, contractor, consultant, or employee) the business of any Competitor, in the Restricted Area other than in connection with rendering Services under this Agreement or any other agreement with Company or its Affiliates**.**

"**Dialysis Services**" means all dialysis and renal care services and related services, including but not limited to, hemodialysis, acute dialysis, apheresis services, peritoneal dialysis of any type, staff assisted hemodialysis, dialysis related laboratory and pharmacy services, the provision of home dialysis services and supplies, administration of dialysis-related pharmaceuticals (including, without limitation, EPO, Aranesp, iron supplements, vitamin D supplements, or other products related to the

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treatment of anemia and secondary hyperparathyroidism) to ESRD patients or to patients treated in an acute care hospital due to temporary kidney failure. The Restricted Period and the Restricted Area are set forth in Schedule 1.

10.1.3 Section 10.1.2 does not prevent Contractor or any Related Physician from earning a living by engaging in the professional practice of medicine or nephrology or prevent any licensed physician from exercising sound, professional medical judgment, including with respect to a patient's right to choose where he or she desires to receive dialysis.

10.1.4 Contractor or any Related Physician is not prohibited from engaging in managed care contracting, including an ESCO, as a participating provider of professional services or otherwise under this Section 10, so long as such relationship does not: (a) provide such party with remuneration related or attributable, Directly or Indirectly, to Dialysis Services, or (b) involve such party contracting with any person or entity that, Directly or Indirectly, is owned, managed, operated or controlled by, or affiliated with any person or entity (other than Company) that provides Dialysis Services.

10.2 Non-Solicitation. Contractor and each Related Physician agree that each will not, during the Restricted Period, Directly or Indirectly, take any action that constitutes, results, or may reasonably be expected to result in:

10.2.1 Soliciting the termination of, diverting, or interfering with any relationship that Company has with any person or entity who is an independent contractor, supplier, or provider to Company; or

10.2.2 Soliciting, inducing, or encouraging any person (who is presently, or within the most recent 12 month period, affiliated with or employed by Company or an Affiliate of Company) to curtail or terminate such person's affiliation or employment with Company or at a Center.

10.3 Interpretation.

10.3.1 For the avoidance of doubt, no party to this Agreement is required to treat patients at or refer any patients to, Center or any Affiliate of Company, whether during or after the Term.

10.4 Modification. If any restriction contained in this Section 10 is held by any court to be unenforceable or unreasonable as a matter of law as to time, geographic area, or business limitation, the parties agree that such restriction will be and hereby is reformed to the maximum time, geographic area, or business limitation permitted by applicable laws and that any court of proper jurisdiction may issue all orders necessary to accomplish such reformation.

10.5 Necessary and Reasonable. The parties acknowledge that the restrictions set forth in this Section 10 are reasonable and necessary to protect the legitimate business interests of Company, including but not limited to Company's interest in protecting its Confidential Information and its investment in the development of goodwill at Center, and that Company would not have entered into this Agreement in the absence of such restrictions.

10.6 Joinder. Contractor is responsible for and will ensure that each person who is a Related Physician as of the Date of Last Signature has executed this Agreement or a Joinder as of the Date of Last Signature. Contractor will also be responsible for and ensure that each person who becomes a Related Physician during the Restricted Period executes the Joinder upon becoming a Related Physician. Contractor will notify Company promptly of new Related Physicians so that compliance with the joinder process may be monitored.

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11. Assignment and Subcontracting.

11.1 No Assignment by Contractor. Contractor will not, Directly or Indirectly, assign or otherwise transfer this Agreement, or any rights, obligations, or interest in this Agreement without the prior written consent of Company, which may be withheld in Company's sole discretion. Upon any assignment, Contractor and Related Physicians will continue to be bound by those provisions which survive termination, including but not limited to Sections 5, 6, 7, 8, 10, 11, 14.2, and 14.3, after such assignment is completed and upon the agreement by the transferee, in writing, to assume all of the transferring party's obligations under this Agreement.

11.2 No Series of Transactions. In the event that more than 50% of the equity in (or other ownership interests) OR Assets of the medical practice of Contractor is to be sold, transferred, or issued, whether in a single transaction or series of related transactions, Contractor will provide Company with notice at least 180 days prior to such sale, transfer, or issuance. Company may, in its sole discretion, terminate this Agreement at any time within such 180 day period. In the event that Contractor fails to provide Company with such 180 days' notice, Company has the right to terminate this Agreement upon learning of such transfer or proposed transfer, and to seek such other remedies as may be available in law or equity.

11.3 No Subcontracting. Contractor will not subcontract to provide Services under this Agreement without the prior written consent of Company, which may be withheld in Company's sole discretion.

11.4 Company's Right to Assign. Company will be permitted, without the consent of Contractor to assign or otherwise transfer this Agreement or any of its rights hereunder.

12. Termination. This Agreement will terminate upon the expiration of the Term or as provided in this Section 12.

12.1 Termination by Contractor. Contractor may terminate this Agreement prior to expiration of the Initial Term or any Renewal Term upon notice to Company specifying the Termination Date, for any of the following reasons:

12.1.1 A failure by Company to pay any undisputed compensation due under this Agreement within 30 days of Company's receipt of notice from Contractor.

12.1.2 Upon the revocation of Center's Medicare certification, unless Company is actively attempting to cure such revocation, in which case Company will have six (6) months to cure such revocation or such longer period as Contractor may determine in its sole, reasonable discretion is appropriate, or unless such revocation is materially due in whole or in part to acts or omissions of Contractor, a Related Physician, or any of their agents, subcontractors, or employees.

12.1.3 Any other material breach of this Agreement by Company, provided that Contractor provides Company 30 days' advance notice detailing such breach and such breach is not cured within such 30 day period or, if Company is actively engaged in attempting to cure such breach and such breach cannot reasonably be cured in 30 days, then Company has such longer period as is reasonably required to cure the breach.

12.1.4 Upon the filing of a case by or against Company under the Bankruptcy Code which is not stayed or terminated within 30 days.

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12.1.5 Immediately upon the final, non-appealable exclusion of Company from any federal healthcare program, as defined under 42 U.S.C. §1320a-7b(f).

12.2 Termination by Company. Company may terminate this Agreement prior to expiration of the Term upon notice to Contractor specifying the Termination Date, for any of the following reasons:

12.2.1 For Misconduct. "Misconduct" means the occurrence of any of the following (except subsections (a) through (d) below will be considered cured if Contractor immediately removes such physician and appoints another Preapproved Physician or other qualified replacement in accordance with Section 2.2 or 4.1.2):

(a) Misconduct of either a personal or professional nature, including, without limitation, violation of the Bylaws or any applicable laws or regulations, or Company's or DaVita's policies or procedures, by Medical Director or a Covering Medical Director, which in Company's reasonable opinion interferes with Medical Director's or Contractor's ability to fulfill their obligations under this Agreement directly or through said Medical Director or Covering Medical Director;

(b) the revocation or suspension of any medical license of Medical Director or a Covering Medical Director, or the restriction or elimination of practice privileges of Medical Director or a Covering Medical Director at the Center for any reason set forth in the Bylaws and other rules for practice privileges at the Center, or the restriction or elimination of privileges of Medical Director or a Covering Medical Director at any hospital for any reason related to the quality of the patient care provided by Medical Director or said Covering Medical Director;

(c) any felony charge, indictment, or conviction of Medical Director or a Covering Medical Director, or any charge, indictment, or conviction involving moral turpitude of Medical Director or a Covering Medical Director;

(d) any failure by Medical Director or a Covering Medical Director to correct other acts or omissions which, in Company's reasonable opinion, materially interfere with the normal conduct of Center's operations in accordance with Company's or DaVita's policies and procedures, including endangering patient care or interfering with teammate welfare;

(e) as contemplated in Section 8, the unauthorized removal of records from Center by Medical Director, Covering Medical Director, or any of Contractor's other agents or employees or other noncompliance with Section 8;

(f) the unlawful alteration or falsification of the Center's records by Contractor or any Related Physician;

(g) the failure of Contractor or a Covering Medical Director to secure or maintain the insurance required under Section 6;

(h) upon the breach of Section 10;

(i) upon an unauthorized assignment of this Agreement, including subcontracting of Services, by Contractor or Medical Director in violation of Section 11; or

(j) upon the occurrence of a Final Adverse Action.

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12.2.2 Upon the death or disability of the physician serving as Medical Director and Contractor's failure to immediately appoint a Covering Medical Director and thereafter permanently name another Preapproved Physician within 60 days after the Medical Director's death**;** or upon the occurrence of a disability of a permanent nature which, in the reasonable opinion of a physician appointed by Company, would interfere with Medical Director's ability to serve in the capacity of Medical Director, unless Contractor immediately removes such disabled Medical Director and appoints a Covering Medical Director, and thereafter designates a Preapproved Physician within 60 days after determination of disability. Contractor or the disabled Medical Director will notify Company at the onset of any such disability, provided, however, that a failure to do so does not deprive Company of its rights under this Section 12.2.2.

12.2.3 Upon Contractor's failure to cause a Covering Medical Director to cease performing duties as permitted under this Agreement within 15 days of notice from Company detailing Company's concerns with Covering Medical Director's performance unless Contractor and Medical Director address such concerns to Company's satisfaction before the end of such 15 day period.

12.2.4 Upon the dissolution of Contractor's medical practice or upon appointment of a receiver or custodian to take possession of all or any material part of the assets of Contractor, a general assignment by Contractor for the benefit of Contractor's creditors, or the filing of a case by or against Contractor which is not stayed or terminated within 30 days.

12.2.5 In the event of any other material breach of this Agreement by Contractor, a Related Physician or Covering Medical Director, provided that Company provides Contractor 30 days' advance notice detailing such breach and such breach is not cured to the satisfaction of Company, in its sole discretion, within such 30 day period or, if Contractor is actively attempting to cure such breach and such cure cannot reasonably be accomplished within said 30 day period, then such longer period as Company may determine in its sole discretion is appropriate.

12.2.6 In the event that Medical Director is absent from Center for any reason for more than 21 consecutive days or for more than 30 days within any 60 day period without the prior written approval of Company; or, (to ensure Medical Director maintains availability and access to Center employees, patients and clinical needs) the Medical Director's residence or clinical office is not within a reasonable proximity of Center as reasonably determined by Company.

12.2.7 In the event that Medical Director fails to comply with Section 13.2.

12.2.8 Upon the termination of Center's business or Company's decision not to open Center.

12.2.9 In the event that Company does not reopen or relocate Center following an Interruption Event, Company will terminate this Agreement upon 30 days' prior notice to Contractor and Medical Director, and the compensation to be paid for Services provided hereunder will be reduced accordingly.

12.2.10 If the Certificate of Need ("CON") from the applicable governmental agency required for Center is not obtained by Company, or if obtained by Company but subsequently withdrawn by such governmental agency, then this Agreement is null and void and of no effect.

12.3 Remedies. Upon termination by Contractor pursuant to Section 12.1.1 or 12.1.3, Contractor is entitled to pursue such legal or equitable remedies as may be available to it to collect its actual and consequential damages suffered as a result thereof. Upon termination by Company pursuant to Sections 12.2.1 through 12.2.7 Company is entitled to pursue such legal or equitable remedies as may be available

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to it to collect its actual and consequential damages suffered as a result thereof.

12.4 Relocation of Center. A Relocation of Center during the Term of this Agreement will not result in termination of this Agreement.

12.5 Termination Due to a Regulatory Event. Notwithstanding any other provision in this Agreement, Company or Contractor may terminate this Agreement upon the occurrence of a Regulatory Event if such Regulatory Event cannot be corrected after each party has made a good faith effort to do so within 10 days after notice thereof by a party. Termination under this Section 12 will be effective immediately upon the expiration of such 10 day period.

12.6 Consequences of Termination/Expiration, and Termination of Relationship with Contractor. Upon any termination of this Agreement, the appointment terminates and all obligations of Company to Contractor and all Related Physicians immediately terminates, including without limitation all obligations to compensate Contractor or Medical Director for Services after the Termination Date, except for the obligation to pay for Services performed prior to the termination date. Upon any such termination or expiration of this Agreement, Contractor's and Related Physicians' obligations which are intended to survive the termination of this Agreement, including but not limited to those in Sections 5, 6, 7, 8, 10, 11, 14.2, and 14.3, survive. Notwithstanding the above, if Contractor's employment of, or affiliation with (as applicable), a Related Physician terminates (regardless of the reason for such termination) at any time during the Term, such Related Physician's obligations which are intended to survive the termination of this Agreement, including but not limited to those in Sections 5, 6, 7, 8, 10, 11, 14.2, and 14.3, survive until the end of his/her Restricted Period.

12.7 Termination within First Year. If this Agreement is terminated for any reason within 1 year of the Commencement Date, the parties will not enter into any agreement with each other for the same or similar Services at Center until after the expiration of the 1 year anniversary of the Commencement Date, if ever.

13. Force Majeure; Interruption Event.

13.1 Force Majeure. In the event that any party is prevented from performing or is unable to perform any of its obligations under this Agreement due to any Force Majeure, and if such party has used commercially reasonable efforts to mitigate its effects, such party will give prompt notice to the other party, its performance will be excused, and the time for the performance will be extended for the period of delay or inability to perform due to such occurrences.

13.2 Interruption Event Services. Notwithstanding Section 13.1, in the event of an Interruption Event during the Term, Company may reasonably require that Medical Director provide services during the Interruption Period that Company deems necessary or helpful for Center's reopening or relocation and for Center patients and teammates.

13.3 Compensation Adjustment and Time Sheets. The hourly compensation to be paid to Contractor during the Interruption Period will be $220 per hour. During the Interruption Period, Contractor must submit a time sheet on the first day of each month with the invoice described in Section 3. The time sheet must include a description of services provided and the specific days and hours worked by Medical Director during the previous month. Company will reimburse Contractor for the hours worked by Medical Director under this Section and any reasonable, pre-authorized/pre-approved out-of-pocket expenses incurred by Contractor in the course of performing services during the Interruption Period if in compliance with the requirements of Company's then-current applicable policies.

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14. Miscellaneous

14.1 Governing Law. This Agreement is governed by the laws of the State of Washington, without regard to the conflict of laws principles thereof.

14.2 Dispute Resolution. Except for alleged breaches of Sections 7, 8, 9, and 10, any dispute between or among the parties will be resolved as provided in this Section 14.2. Nothing in this section limits or delays a party's termination rights.

14.2.1 Informal Resolution. Notice of the dispute will be delivered from one party to the other parties and, thereafter, the parties' business representatives will meet in person and attempt to resolve the dispute in face-to-face negotiations. This meeting will occur within 30 days of the time the notice of such dispute is received by the other party.

14.2.2 Resolution Through Mediation. If a dispute is not resolved pursuant to Section 14.2.1, the parties will, within 45 days of the meeting referred to in Section 14.2.1, attempt to settle such dispute by formal mediation. If the parties cannot otherwise agree upon a mediator and the place of the mediation within such 45 day period, the American Health Lawyers' Association will administer the mediation in the State of Washington. In the event that the mediation does not resolve the dispute, the parties are entitled to seek any and all available legal remedies.

14.3 Injunctive Relief. The parties acknowledge that the breach or threatened breach of this Agreement, including, without limitation, Sections 6 through 11 and Section 13, would cause irreparable injury to the injured party that could not be adequately compensated by money damages. Accordingly, the injured party will be entitled to obtain from any court of competent jurisdiction a restraining order and/or injunction prohibiting a breach or threatened breach of the provisions of this Agreement, in addition to any other legal or equitable remedies that may be available. In the event a party seeks such injunctive or other relief with respect to a violation of this Agreement by another party, the injured party will be entitled to recover the costs of such action, including but not limited to reasonable attorney's fees. Notwithstanding the above, Company agrees and acknowledges it will not enforce any injunctive relief or restraining orders with regard to Sections 11.1 and 11.2 that would prevent the transfer of ownership in the Contractor, including the assignment of an MDA as a result of such transfer of ownership.

14.4 Notice. All notices must be in writing and must be addressed to each receiving party at the addresses set forth in Schedule 1 and must be (i) delivered by hand (ii) sent by recognized overnight courier, or (iii) sent by certified mail, return receipt requested, postage prepaid. Notices are deemed effective as follows: (1) if by hand, when delivered; (2) if by overnight courier, on the next business day; and (3) if by certified mail, on the fifth business day. Each party may change its notice address provided in Schedule 1 by providing written notice of its new address to the other party.

14.5 Independent Contractor. During the performance of any Services hereunder, Medical Director is acting and discharging Medical Director's duties and responsibilities as the Contractor or an employee or equity owner of Contractor, and Contractor during the Term will be acting and discharging its duties as an independent contractor of Company. Company will provide all applicable tax documents to Contractor and will not withhold any local, state, or federal employment taxes on Contractor's behalf. Contractor is responsible for paying all taxes due on all amounts paid to it under this Agreement, and for paying all local, state, and federal employment taxes, including unemployment insurance, social security taxes, and local, state, and federal withholding taxes for all employees of Contractor. If any taxing authority asserts that Contractor is not an independent contractor under this Agreement, the parties will cooperate in addressing such assertion. Except as expressly set forth in this Agreement or as may be required by applicable law, Company neither has nor will exercise any control or direction over the methods by which

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any Medical Director performs the Services hereunder.

14.6 Waivers; Severable Provisions; Headings. The failure of any party to insist in any one or more instances upon performance of any terms or conditions of this Agreement will not be construed as a waiver of future performance of any such term, covenant, or condition, and the obligations of such party with respect thereto continue in full force and effect. The provisions of this Agreement are severable. The invalidity or unenforceability of any term or provisions hereto in any jurisdiction in no way affects the validity or enforceability of any other terms or provisions in that jurisdiction, or of this entire Agreement in that jurisdiction. The headings in this Agreement are for convenience and reference only and are not intended to, and do not, define or limit the scope of the provisions to which they relate.

14.7 Agreement Collectively Prepared by Parties. Each party to this Agreement (i) has participated in the preparation of this Agreement, (ii) has read and understands this Agreement, and (iii) has been represented by counsel of its own choice (if such party so selects) in the negotiation and preparation of this Agreement. Each party represents that this Agreement is executed voluntarily and should not be construed against any party hereto solely because it drafted all or a portion hereof.

14.8 Entire Agreement; Binding Effect. This Agreement, including Exhibits hereto and the BAA, incorporated herein by reference, constitutes the entire agreement among the parties with respect to the subject matter hereof and supersedes all other agreements, either written or oral, among the parties including, without limitation, any prior agreement among Contractor, Medical Director, and Company or any of its subsidiaries or affiliates with respect to the subject matter hereof. This Agreement may be amended only by a writing that is executed by all of the parties. Subject to Section 11, this Agreement is binding upon and inure to the benefit of the parties and their respective successors, assigns, heirs, executors and legal representatives. Contractor has full power and authority to execute and deliver this Agreement and the related documents, if any, and to perform its obligations under this Agreement and related documents, if any, and such action has been duly authorized by all requisite action on the part of Contractor.

14.9 Counterparts; Approval by DaVita as to Form. This Agreement may be executed in one or more counterparts, each of which is deemed to be an original, but all of which together constitute one and the same instrument. Facsimile or electronic signature are permitted, except where prohibited by law. The parties acknowledge and agree that this Agreement is legally binding upon the parties only upon full execution hereof by the parties and by DaVita as to the form hereof, however, DaVita's signature as to form will not be considered when calculating the Date of Last Signature as it is not a party hereto.

14.10 Incorporation of Exhibits and Schedules; Priority in Event of a Conflict. The Exhibits and Schedules attached to this Agreement and the BAA are incorporated into the Agreement by reference. In the event of a conflict between the BAA and this Agreement, this Agreement controls unless applicable law requires that the BAA control.

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IN WITNESS WHEREOF, the parties have caused this Medical Director Agreement to be executed and delivered as of the Date of Last Signature.

COMPANY:

TOTAL RENAL CARE, INC., a California corporation

DocuSigned by:

By: Jennifer Funk
Its: Division Vice President
Dated: June 1, 2018

CONTRACTOR:

PACIFIC NEPHROLOGY ASSOCIATES, P.S., a Washington professional service corporation

DocuSigned by:

By: Zheng Ge, M.D.
Its: President
Dated: May 31, 2018

APPROVED AS TO FORM:
DAVITA INC.

DocuSigned by:
Doyna V. Ballew

By: Doyna V. Ballew
Its: Assistant General Counsel

DocuSign Envelope ID: 91FE9B3B-9336-44B7-B72E-C955C051CA4B

EXHIBIT A

DEFINITIONS

The terms below have the meanings below for the purposes of the Agreement:

TERM	DEFINITION
Affiliate	A person or entity that directly, or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with a person or entity, or who has the power to direct or cause the direction of the management of a person or entity, whether through voting rights, ownership, by contract, or otherwise. Affiliate also includes any combination of persons or entities that meet the definition of a "Controlled Group of Corporations," as defined in 26 U.S.C. § 1563(a), "two or more trades or business under common control," as defined in 26 CFR 1.414(c), or an "Affiliated Service Group," as defined in 26 U.S.C. § 414(m).
Agreement	This Medical Director Agreement, including all incorporated schedules and exhibits.
Assets	For the purposes of this Section 11.2, "**Assets**" means those Contractor assets that relate to professional nephrology, and include, but are not limited to, physician agreements, accounts receivable, goodwill, and services offered in-office and in hospitals to patients, but specifically excludes any assets that are used by the Contractor or its Affiliates that are related to the Direct or Indirect ownership in dialysis units/facilities (such as joint ventures with Company), and that include, but are not limited to, assets of vascular centers, ambulatory surgery centers, labs and research.
BAA	The Business Associate Agreement executed by Company and Contractor effective as of the effective date contained therein.
Bylaws	The Governing Body Bylaws and the Medical Staff Bylaws.
Center	The facility identified as such in Schedule 1. Center also includes the applicable programs identified in Schedule 1.
CMS	The Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services.
Commencement Date	The date identified as such in Schedule 1.
Company	The entity identified as such in Schedule 1.
Competitor	Any person, clinic, corporation, partnership, management services organization, proprietorship, independent practice association, firm, entity, or association which engages in or derives any economic benefit from, or is preparing to engage in or derive any economic benefit from, the business of providing, offering, arranging, or subcontracting Dialysis Services.
Conditions for Coverage	The Medicare Conditions for Coverage for End-Stage Renal Disease Facilities at 42 C.F.R. Part 494, as amended from time to time.
Confidential Information	Confidential or proprietary information or trade secrets including (a) any information, in whatever form, relating directly or indirectly to the business of Center, Company or any Affiliate of Company, whether prepared by Company or by any other person, that is, has been, or will be made available to Restricted Persons; (b) the medical and other identifying information, in whatever form, of any patient currently receiving treatment or having previously received treatment at Center, which is compiled by, obtained by, or furnished to any of the Restricted Persons in the course of performing services hereunder; (c) specialized training materials and information to assist Medical Director in the performance of the Services including, but not limited to, information and training in Company's pricing structures and guidelines for the services it provides, Company's cost structure (including, without limitation, profits and margins) for the services it provides, Company's methods of operating, Company's methods, strategies, and specific operating techniques related to integrated kidney care, managed care, or related areas, and Company's products and marketing techniques and strategies, Internet strategies, plans, and business models; (d) shift patterns; (e) commercial insurance information; and (f) any of the terms of this Agreement, including without limitation the compensation payable under the Agreement.

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	Confidential Information does not include (a) any information that is or becomes generally available to the public other than as a direct or indirect result of the disclosure of any of such information by any Restricted Person; (b) any information that becomes available to a Restricted Person from a source other than Company, provided that such source is not bound by any contractual or other obligation of confidentiality to Company or any other person with respect to any of such information; or (c) any information previously known to Medical Director, provided such information was not subject to protection by a separate agreement with Company or any Affiliate of Company, and subject to Medical Director's patient privacy and security obligations under Section 5 of this Agreement, and as set forth in the BAA.
Contractor	The party or parties listed in Schedule 1.
Covering Medical Director	A physician who performs Services pursuant to Section 4.1.2 in the event of a temporary absence of Medical Director.
DaVita	DaVita Inc., Company's parent company.
Dialysis Services	"Dialysis Services" is defined in Section 10.1.2.
Directly or Indirectly	Any and all activities undertaken by, through or on behalf of Contractor or any Related Physicians, and/or any of their Affiliates, and any and all entities with respect to which Contractor or any Related Physician, and/or any of their Affiliates serves as a contractor, agent, employee, or representative or has a direct or indirect financial interest.
ESCO	An abbreviation for End Stage Renal Disease Seamless Care Organization.
ESRD	An abbreviation for End Stage Renal Disease that means the stage of renal impairment that appears irreversible and permanent, and requires a regular course of dialysis or kidney transplantation to maintain life, which definition is set forth in 42 C.F.R. Section 405.2102. To the extent such regulation is changed or amended, ESRD has the meaning set forth in the amended regulation or any successor regulation.
Final Adverse Action	"Final Adverse Action" is defined in Section 5.2.2.
Force Majeure	An act of God, fire, casualty, flood, earthquake, war, strike, lockout, epidemic, destruction of Center, riot, insurrection, material unavailability, or any other cause beyond the reasonable control of the party invoking Section 13 of the Agreement.
Governing Body	The governing body of Center as set forth in Center's Medical Staff Bylaws.
HIPAA	The Health Insurance Portability and Accountability Act of 1996, and its related regulations, as amended by the federal Health Information Technology for Economic and Clinical Health Act and its implementing regulations, all as may be amended from time to time, including by the future issuance of regulations and guidance by the United States Department of Health and Human Services.
HIPAA Policies	DaVita's health information privacy and security policies and procedures, as currently in effect and as updated from time to time.
ICHD Program	The in-center staff-assisted hemodialysis program at Center.
Initial Term	The period identified as such in Schedule 1.
Interruption Event	The temporary closure of Center **or** destruction of Center or a reduction or interruption in Center services due to any force majeure described in Section 13.
Interruption Period	The time period following such Interruption Event until such time as Center is reopened or relocated.
Joinder	The Joinder to the Medical Director Agreement, the form of which is set forth at **Exhibit C**.
Medical Director	A physician duly appointed by Contractor and approved by Company in accordance with this Agreement to serve as the Medical Director for Center.
Medical Director Qualifications	The following qualifications: (a) be qualified and licensed to practice medicine in the state in which the Center is located; (b) be board-certified by either the American Board of Internal Medicine ("ABIM"), the American Osteopathic Association ("AOA"), or such other board-certification entities as approved by Company in writing, in one or more of nephrology, pediatrics, or internal medicine, or to have received a waiver that the certification is not needed and such waiver is approved by Company; (c) have completed a board-approved training

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	program in nephrology; (d) specialize in the treatment of individuals with ESRD; (e) have at least 12 consecutive months of experience or training in the care of patients at ESRD facilities immediately preceding the Commencement Date; and (f) be experienced in the medical administration of ESRD facilities.
Medicare Certification Date	The date on which Company receives written notice of Medicare certification for Center.
Misconduct	"Misconduct" is defined in Section 12.2.1.
PHI	Protected Health Information, including but not limited to electronic Protected Health Information as defined in HIPAA.
Policies and Procedures	"Policies and Procedures" is defined in Section 5.1.
Preapproved Physicians	The specific physicians, including the Medical Director, named on Schedule 1, as may be updated from time to time in an amendment signed by the parties.
Pre-Medicare Certification	The time period from first date of treatment for each modality program until the date that Center receives written notice of Medicare certification.
Post-Medicare Certification Period	The time period after the date on which Center receives written notice of Medicare certification.
Regulatory Event	The occurrence of any of the following: (a) the performance by a party hereto of any term, covenant, condition, or provision of this Agreement that (1) jeopardizes the certification of Center by or under any federal or state ESRD program, or by or under any other regulatory program; (2) is or, in the reasonable opinion of a party's counsel will become, illegal or in violation of any statute, regulation, or ordinance; or (3) does or, in the reasonable opinion of either party's counsel will, result in a reduction in or elimination of the amount or the rate of reimbursement paid to Company from the Medicare program, any Medicaid program, or any other third party payor program, whether governmental or non-governmental; or (b) the enactment of legislation or issuance of regulations or interpretations thereof, by the federal government or the state government in which Center is located, or the issuance of judicial orders or decrees or governmental ruling or opinion, or any change in the rules and regulations of any third party payment program, or any other similar event which in the reasonable judgment of either party's counsel adversely impacts the operations of the Center or requires Company to divest itself of interests in investments such as the Center or which would result in a reduction in or elimination of the amount of or rate of reimbursement to Company from the Medicare program or any state Medicaid program or any other third-party payor program, whether governmental or non-governmental.
Related Physician	Any physician who is employed by or engaged in medical practice with Contractor (including Medical Director and each Preapproved Physician), Medical Director, a Preapproved Physician or any Affiliate thereof, or who is a shareholder, partner, member, or other equity holder of Contractor, Medical Director, Preapproved Physician, such medical practice, or Affiliate of any of the foregoing.
Relocation	The closure of Center and the physical relocation of substantially all staff of Center to another center that is not a then-existing center operated under the same Medicare provider number as the closed Center.
Renewal Term	The period identified as such in Schedule 1.
Restricted Area	The area set forth as such in Schedule 1.
Restricted Period	The period from the Date of Last Signature through the time period set forth in Schedule 1; provided, however, that with respect to any physician who ceases to be a Related Physician during the Term, the Restricted Period ends on the second anniversary of the date on which such physician ceases to be a Related Physician.
Restricted Person	Contractor, Related Physicians, any Covering Medical Director, any Affiliate of Contractor or a Related Physician, and any of their respective agents, independent contractors, or employees.
Services	The duties and responsibilities set forth in **Exhibit B**, together with all other services to be provided by Medical Director under this Agreement.

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Term	The period during which this Agreement is in effect, and which consists of the Initial Term and any and all Renewal Terms through the date on which the Agreement expires due to non-renewal or is terminated in accordance with the terms of the Agreement.
Termination Date	The date on which this Agreement terminates, whether such termination occurs as a result of the expiration of the Term due to non-renewal or otherwise under the terms of the Agreement.

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EXHIBIT B
SUMMARY OF DUTIES FOR A MEDICAL DIRECTOR OF AN IN-CENTER DAVITA DIALYSIS FACILITY

Training, Certification, Credentialing & Privileges

- ☐ Completed board approved training in nephrology (unless specific waiver received)
- ☐ Completed 12 months of experience or training in end stage renal disease (ESRD)
- ☐ Licensed to practice in the state where Center is located
- ☐ Maintain CMS-recognized Board certification in nephrology, pediatric nephrology, or internal medicine
- ☐ Maintain current credentials and privileges at Center and unrestricted staff privileges at a healthcare provider (e.g. hospital) providing acute hospitalization and back-up to patients of Center

Availability

- ☐ Be "on call" 24/7 to respond to emergencies
- ☐ Arrange for a Covering Medical Director when unavailable

Company Meetings and Committees

- ☐ Actively participate in meetings, education sessions and events as required by Company.
- ☐ Attend administrative meetings with Facility Administrator, ROD or DVP.

Center Clinical & Professional Leadership

- ☐ Promote DaVita's Medical Staff Bylaws, safe working environment, compliance with laws, regulations, and DaVita policies & procedures
- ☐ Be accountable for Associate Medical Directors, if any
- ☐ Assure attendance by all attending physician at monthly patient care meetings (Interdisciplinary Team meetings)
- ☐ Attend and serve as a member and clinical leader of all planned and *ad hoc* Governing Body ("GB") meetings
- ☐ Be accountable to GB for quality and safety of medical care provided

Policies and Procedures

- ☐ Participate in development, implementation, review and approval of (and adherence by Center providers to) all Center policies and procedures including, but not limited to, those addressing:

– Patient admission, discharge and transfer, rights and confidentiality, and care
– Quality assessment and performance improvement
– Infection control and safety
– Documentation maintenance and retention
– Center staff education, training and performance

Patient Admission

- ☐ Review patient summaries for new patient admissions in a timely fashion
- ☐ Confirm patients have initial dialysis prescriptions, orders, baseline physical and nursing assessments
- ☐ Confirm patients can be safely treated at Center prior to dialysis treatment

Patient Discharge and Transfers

- ☐ Direct interdisciplinary team ("IDT") in management of patients with disruptive behavior
- ☐ Address issues of non-compliance with patient's attending physician
- ☐ Review, approve, and sign each involuntary patient discharge or transfer

Patient Rights and Confidentiality and Patient Care

- ☐ Confirm Center maintains an internal grievance mechanism that is communicated to patients
- ☐ Review all patient grievances during FHM
- ☐ Provide general oversight and responsibility of all patient care, outcomes and safety including that the water system will produce AAMI quality water

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Quality Assessment and Performance Improvement (QAPI)

- ☐ Actively oversee, lead and participate in the Center's monthly Facility Health Meeting ("FHM")
- ☐ Lead quality and process improvement activities at Center

Oversight of Integrated Care Initiatives

- ☐ Actively oversee, lead and participate in the Company's Integrated Care initiatives, protocol, policies and procedures including, but not limited, to:
  - Cost of Care Reduction
  - Re-hospitalization avoidance
  - Managed Care Initiatives

Infection Control

- ☐ Review infectious disease data monthly (e.g. during FHM)
- ☐ Review and sign water culture and *Limulus amebocyte lysate* test results monthly (e.g. during FHM)
- ☐ Conduct and document investigations into infectious disease outbreaks and drug resistant organisms

Safety

- ☐ Provide general oversight for safety activities at Center
- ☐ Work with Center staff to monitor potential safety issues at Center

Physical Environment

- ☐ Work with Center staff to maintain a safe treatment environment (including emergency equipment, dialysis machines and equipment, the water treatment system and dialyzer reprocessing equipment)
- ☐ Assure there is a process for the general oversight of maintenance

Documentation Maintenance and Retention

- ☐ Direct Center staff to document thoroughly and accurately every incident of non-compliance
- ☐ Assure all patient medical records are current and maintained in accordance with Center's policies and procedures, Medical Staff Bylaws and applicable regulations

Center Staff Education, Training and Performance

- ☐ Assure Center staff members receive the appropriate education and training to competently perform their job responsibilities
- ☐ Review and attest to Center staff competency files at least quarterly for existing staff and upon completion of training for new hires.
- ☐ Participate in Center's and Company's education and in-service programs.
- ☐ Oversee appropriate orientation of medical staff (e.g. attending physicians) and other providers, to Center policies and procedures, clinical benchmarks, guidelines, protocols, and quality processes
- ☐ Review privilege requests and credentialing files and assure maintenance of privileges at local hospitals by medical staff.
- ☐ Counsel in-person or in-writing any member of the medical staff not complying with Medical Staff Bylaws or meeting Company and DaVita performance standards and requirements
- ☐ Act in coordination with Company, the Physician Council, the Credentialing and Peer Review Committee, DaVita's Office of Chief Medical Officer ("OCMO"), Facility Administrator and GB in matters of concern to Center, and participate in the medical staff peer review process as provided for in the Medical Staff Bylaws

Protection of Confidential Information and Goodwill

- ☐ Assure that the Confidential Information and the goodwill associated with Center's and Company's relationships with patients, employees, vendors, consultants and others, are protected and preserved to the maximum extent possible.

Compliance with Conditions for Coverage, Laws, and DaVita's Compliance Programs

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- ☐ Perform any duties required to be in compliance with *42 C.F.R. Part 494 Medicare Conditions for Coverage for End-Stage Renal Disease Facilities*, other applicable laws and regulations, DaVita's Code of Conduct, Medical Staff Bylaws, Company's and DaVita's compliance program, initiatives, policies, training, and Privacy & Security Standards
- ☐ Participate in interviews with Medicare Surveyors to clarify any issues regarding Center and staff's practices related, but not limited, to infection control, water and dialysate, dialyzer reprocessing of hemodialyzers and bloodlines, and governance.
- ☐ Review survey reports, both internal and external, and participate as needed in Plans of Correction.

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EXHIBIT C

Sample only – Do Not Sign

SAMPLE JOINDER

JOINDER TO MEDICAL DIRECTOR AGREEMENT

This joinder ("Joinder") is made as of the last date of signature by a party hereto (the "Effective Date"), by and among the undersigned. Reference is made to the Medical Director Agreement dated June 1, 2018, 20__ (the "Agreement"), by and between **Total Renal Care, Inc.**, a California corporation ("Company") and **Pacific Nephrology Associates, P.S.**, a Washington professional service corporation ("Contractor") relating to the free-standing dialysis center to be known as "King 11 (Auburn) Dialysis" and to be located at 1700 O Street, Auburn, WA 98001 ("Center"). All terms not otherwise defined herein have the meaning given to them in the Agreement.

The undersigned acknowledges that [he/she] is a Related Physician (as defined in the Agreement) and receives and will receive compensation and benefits from Contractor based on such employment or equity ownership. Therefore, and as a condition of [his/her] status as a Related Physician, the undersigned agrees with and guarantees to Contractor that the undersigned will abide by the terms and conditions of the Agreement, as such may be amended over time, including, without limitation, the non-competition and non-solicitation covenants contained in Section 10 and the compliance representations, warranties and covenants contained in Section 5 of the Agreement.

The undersigned further acknowledges that Company has entered into the Agreement in reliance on the assurance, as reflected in Section 10.6 of the Agreement that the undersigned will execute this Joinder.

In the event the undersigned ceases to be a Related Physician during the Term of the Agreement, the Restricted Period called for in the Agreement ends on the second year anniversary of the date on which such physician ceases to be a Related Physician. The non-compete restrictions do not extend beyond the second year anniversary of the undersigned leaving the Contractor, or affiliation therewith, if such event occurs prior to the termination of the Agreement.

The undersigned agrees that Company will be a direct third party beneficiary of the covenants made in this Joinder and entitled to enforce the provisions of this Joinder.

The undersigned further acknowledges that the Agreement, including Exhibit B, may from time to time be amended by the Company and Contractor and agrees that [he/she] is bound by any such amendment in the same manner and to the same extent as if [he/she] had signed such amendment.

[SIGNATURES FOLLOW]

DocuSign Envelope ID: 91FE9B3B-9336-44B7-B72E-C955C051CA4B

Sample only – Do Not Sign

IN WITNESS WHEREOF, the undersigned has executed this Joinder as of the Effective Date, defined above.

SPECIMEN - DO NOT SIGN

_____, M.D.

SAMPLE

By:_____
Dated_____

CONTRACTOR:

PACIFIC NEPHROLOGY ASSOCIATES, P.S.,
a Washington professional service corporation

SPECIMEN - DO NOT SIGN
By:_____
Name: Zheng Ge, M.D.
Title: President
Dated_____

SAMPLE

Acknowledged:

COMPANY:

TOTAL RENAL CARE, INC., a
California corporation

SPECIMEN - DO NOT SIGN
_____

SAMPLE

By: Jennie Funk
Its: Division Vice President
Dated_____

DocuSign Envelope ID: 91FE9B3B-9336-44B7-B72E-C955C051CA4B

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[SIGNATURES FOLLOW]

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IN WITNESS WHEREOF, the undersigned has executed this Joinder as of the Effective Date, defined above.

DocuSigned by:
_____, M.D.
By: Zheng Ge, M.D.
Dated May 31, 2018

CONTRACTOR:

PACIFIC NEPHROLOGY ASSOCIATES, P.S.,
a Washington professional service corporation

DocuSigned by:
By: _____
Name: Zheng Ge, M.D.
Title: President
Dated May 31, 2018

Acknowledged:
COMPANY:

TOTAL RENAL CARE, INC., a
California corporation

DocuSigned by:
_____
By: Jennie Frank
Its: Division Vice President
Dated June 1, 2018

DocuSign Envelope ID: 91FE9B3B-9336-44B7-B72E-C955C051CA4B

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[SIGNATURES FOLLOW]

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IN WITNESS WHEREOF, the undersigned has executed this Joinder as of the Effective Date, defined above.

DocuSigned by:

_____, M.D.

By: Yaijuan He, M.D.

Dated June 1, 2018

CONTRACTOR:

PACIFIC NEPHROLOGY ASSOCIATES, P.S.,
a Washington professional service corporation

DocuSigned by:

By: _____

Name: Zheng He, M.D.

Title: President

Dated May 31, 2018

Acknowledged:
COMPANY:

TOTAL RENAL CARE, INC., a
California corporation

DocuSigned by:

_____

By: Jennie Funk

Its: Division Vice President

Dated June 1, 2018

DocuSign Envelope ID: 91FE9B3B-9336-44B7-B72E-C955C051CA4B

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[SIGNATURES FOLLOW]

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IN WITNESS WHEREOF, the undersigned has executed this Joinder as of the Effective Date, defined above.

DocuSigned by:
Ho Won Lee, M.D.
By: Ho Won Lee, M.D.
Dated May 31, 2018

CONTRACTOR:

PACIFIC NEPHROLOGY ASSOCIATES, P.S.,
a Washington professional service corporation

DocuSigned by:
By:
Name: Zheng Cui, M.D.
Title: President
Dated May 31, 2018

Acknowledged:
COMPANY:

TOTAL RENAL CARE, INC., a
California corporation

DocuSigned by:
By: Jennie Funk
Its: Division Vice President
Dated June 1, 2018

DocuSign Envelope ID: 91FE9B3B-9336-44B7-B72E-C955C051CA4B

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[SIGNATURES FOLLOW]

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IN WITNESS WHEREOF, the undersigned has executed this Joinder as of the Effective Date, defined above.

DocuSigned by:
Dr Zhao, M.D.
By: Dr Zhao, M.D.
Its: Dr Zhao, M.D.
Dated May 31, 2018

CONTRACTOR:

PACIFIC NEPHROLOGY ASSOCIATES, P.S.,
a Washington professional service corporation

DocuSigned by:
By: _____
Name: Zheng Ge, M.D.
Title: President
Dated May 31, 2018

Acknowledged:
COMPANY:

TOTAL RENAL CARE, INC., a
California corporation

DocuSigned by:
_____
By: Jennie Funk
Its: Division Vice President
Dated June 1, 2018

DocuSign Envelope ID: 91FE9B3B-9336-44B7-B72E-C955C051CA4B

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[SIGNATURES FOLLOW]

IN WITNESS WHEREOF, the undersigned has executed this Joinder as of the Effective Date, defined above.

DocuSigned by:
Young Ho Kim, M.D.
_____, M.D.
By: Young Ho Kim, M.D.
Dated May 31, 2018

CONTRACTOR:

PACIFIC NEPHROLOGY ASSOCIATES, P.S.,
a Washington professional service corporation

DocuSigned by:
By: _____
Name: Zhong Ge, M.D.
Title: President
Dated May 31, 2018

Acknowledged:
COMPANY:

TOTAL RENAL CARE, INC., a
California corporation

DocuSigned by:
_____
By: Jennie Funk
Its: Division Vice President
Dated June 1, 2018

Certificate Of Completion

Envelope Id: 91FE9B3B933644B7B72EC955C051CA4B
Status: Completed
Subject: Please DocuSign: 00149142.0-CON MDA King 11-Auburn-Pacific Neph Associates.pdf-URGENT
Source Envelope:
Document Pages: 39
Signatures: 18
Envelope Originator:
Certificate Pages: 6
Initials: 0
Kathy Hill
AutoNav: Enabled
2000 16th Street
EnvelopeId Stamping: Enabled
Denver, CO 80202
Time Zone: (UTC-07:00) Mountain Time (US & Canada)
kathy.hill@davita.com
IP Address: 24.11.232.46

Record Tracking

Status: Original
5/31/2018 9:10:20 AM
Holder: Kathy Hill
kathy.hill@davita.com
Location: DocuSign

Signer Events	Signature	Timestamp
Di Zhao, M.D. dizhao2000@yahoo.com Security Level: Email, Account Authentication (None)	DocuSigned by: Di Zhao, M.D. DB7DCCC9C8014A5...	Sent: 5/31/2018 9:25:11 AM Viewed: 5/31/2018 1:28:05 PM Signed: 5/31/2018 1:30:22 PM
	Using IP Address: 65.122.177.202	
Electronic Record and Signature Disclosure: Accepted: 10/28/2016 10:57:21 PM ID: da1e3bb7-208a-4f82-ba11-09687683bdc0		
Ho Won Lee, M.D. howonlee@gmail.com Security Level: Email, Account Authentication (None)	DocuSigned by: Ho Won Lee, M.D. D1D1C5DC8FF94A1...	Sent: 5/31/2018 9:25:11 AM Viewed: 5/31/2018 3:47:51 PM Signed: 5/31/2018 3:50:11 PM
	Using IP Address: 76.121.225.170 Signed using mobile	
Electronic Record and Signature Disclosure: Accepted: 5/31/2018 3:47:51 PM ID: dd830df2-7152-4a26-9bf8-7be000821c61		
Yajuan He, M.D. drjunehe@gmail.com Md Security Level: Email, Account Authentication (None)	DocuSigned by: D1E848F10A8C40F...	Sent: 5/31/2018 9:25:11 AM Viewed: 6/1/2018 12:15:23 AM Signed: 6/1/2018 12:18:51 AM
	Using IP Address: 67.183.198.129	
Electronic Record and Signature Disclosure: Accepted: 4/8/2017 6:01:19 PM ID: 02539757-f42c-4c6a-bf99-b6055813c716		
Young Ho Kim, M.D. ablapia@gmail.com Security Level: Email, Account Authentication (None)	DocuSigned by: Young Ho Kim, M.D. C6C9CD7F74F34F5...	Sent: 5/31/2018 9:25:12 AM Viewed: 5/31/2018 12:30:19 PM Signed: 5/31/2018 12:31:08 PM
	Using IP Address: 65.122.177.202	
Electronic Record and Signature Disclosure: Accepted: 5/31/2018 12:30:19 PM ID: 527dce48-6708-42e0-85dd-06e83b489956		

Signer Events	Signature	Timestamp
Zheng Ge, M.D. drzhengge@yahoo.com President Security Level: Email, Account Authentication (None) **Electronic Record and Signature Disclosure:** Accepted: 5/31/2018 11:58:29 AM ID: f2ef3ad7-db6a-48c5-8ad9-bf9bdaa6292f	DocuSigned by: D6AC31124578476...	Sent: 5/31/2018 9:25:12 AM Viewed: 5/31/2018 11:49:30 AM Signed: 5/31/2018 11:58:52 AM
	Using IP Address: 174.216.7.105 Signed using mobile	
Jennie Funk jennie.funk@davita.com DVP Security Level: Email, Account Authentication (None) **Electronic Record and Signature Disclosure:** Accepted: 6/1/2018 7:10:12 AM ID: 7d9dbb02-9d00-4d8b-9c97-e53997e9c1ae	DocuSigned by: 923E8DF6860847B...	Sent: 6/1/2018 12:18:53 AM Viewed: 6/1/2018 7:10:12 AM Signed: 6/1/2018 7:11:47 AM
	Using IP Address: 73.221.3.99 Signed using mobile	
Doyna V. Ballew doyna.ballew@davita.com Assistant General Counsel DaVita Security Level: Email, Account Authentication (None) **Electronic Record and Signature Disclosure:** Not Offered via DocuSign	DocuSigned by: Doyna V. Ballew F953732A721A434...	Sent: 6/1/2018 7:11:49 AM Viewed: 6/1/2018 7:13:23 AM Signed: 6/1/2018 7:13:28 AM
	Using IP Address: 76.171.98.18 Signed using mobile	

In Person Signer Events	Signature	Timestamp

Editor Delivery Events	Status	Timestamp

Agent Delivery Events	Status	Timestamp

Intermediary Delivery Events	Status	Timestamp

Certified Delivery Events	Status	Timestamp

Carbon Copy Events	Status	Timestamp
Jesse Jenson jesse.jenson@davita.com Security Level: Email, Account Authentication (None) **Electronic Record and Signature Disclosure:** Not Offered via DocuSign	COPIED	Sent: 5/31/2018 9:25:12 AM
Compliance Training Compliance.training@davita.com Security Level: Email, Account Authentication (None) **Electronic Record and Signature Disclosure:** Accepted: 11/25/2015 1:19:29 PM ID: bea3cc2a-45e4-4db3-b0cd-27371f4838cd	COPIED	Sent: 6/1/2018 7:13:30 AM Viewed: 6/1/2018 7:48:56 AM
TQQC TQQC@davita.com Security Level: Email, Account Authentication (None) **Electronic Record and Signature Disclosure:**	COPIED	Sent: 6/1/2018 7:13:30 AM

Carbon Copy Events	Status	Timestamp
Accepted: 8/9/2016 7:20:26 AM ID: c5bdce90-3465-4836-9574-1316003a5917		

Notary Events	Signature	Timestamp

Envelope Summary Events	Status	Timestamps
Envelope Sent	Hashed/Encrypted	6/1/2018 7:13:31 AM
Certified Delivered	Security Checked	6/1/2018 7:13:31 AM
Signing Complete	Security Checked	6/1/2018 7:13:31 AM
Completed	Security Checked	6/1/2018 7:13:31 AM

Payment Events	Status	Timestamps

Electronic Record and Signature Disclosure

ELECTRONIC RECORD AND SIGNATURE DISCLOSURE

From time to time, DaVita (we, us or Company) may be required by law to provide to you certain written notices or disclosures. Described below are the terms and conditions for providing to you such notices and disclosures electronically through your DocuSign, Inc. (DocuSign) Express user account. Please read the information below carefully and thoroughly, and if you can access this information electronically to your satisfaction and agree to these terms and conditions, please confirm your agreement by clicking the 'I agree' button at the bottom of this document.

Getting paper copies

At any time, you may request from us a paper copy of any record provided or made available electronically to you by us. For such copies, as long as you are an authorized user of the DocuSign system you will have the ability to download and print any documents we send to you through your DocuSign user account for a limited period of time (usually 30 days) after such documents are first sent to you. After such time, if you wish for us to send you paper copies of any such documents from our office to you, you will be charged a $0.00 per-page fee. You may request delivery of such paper copies from us by following the procedure described below.

Withdrawing your consent

If you decide to receive notices and disclosures from us electronically, you may at any time change your mind and tell us that thereafter you want to receive required notices and disclosures only in paper format. How you must inform us of your decision to receive future notices and disclosure in paper format and withdraw your consent to receive notices and disclosures electronically is described below.

Consequences of changing your mind

If you elect to receive required notices and disclosures only in paper format, it will slow the speed at which we can complete certain steps in transactions with you and delivering services to you because we will need first to send the required notices or disclosures to you in paper format, and then wait until we receive back from you your acknowledgment of your receipt of such paper notices or disclosures. To indicate to us that you are changing your mind, you must withdraw your consent using the DocuSign 'Withdraw Consent' form on the signing page of your DocuSign account. This will indicate to us that you have withdrawn your consent to receive required notices and disclosures electronically from us and you will no longer be able to use your DocuSign Express user account to receive required notices and consents electronically from us or to sign electronically documents from us.

All notices and disclosures will be sent to you electronically

Unless you tell us otherwise in accordance with the procedures described herein, we will provide electronically to you through your DocuSign user account all required notices, disclosures, authorizations, acknowledgements, and other documents that are required to be provided or made available to you during the course of our relationship with you. To reduce the chance of you inadvertently not receiving any notice or disclosure, we prefer to provide all of the required notices and disclosures to you by the same method and to the same address that you have given us. Thus, you can receive all the disclosures and notices electronically or in paper format through the paper mail delivery system. If you do not agree with this process, please let us know as described below. Please also see the paragraph immediately above that describes the consequences of your electing not to receive delivery of the notices and disclosures electronically from us.

How to contact DaVita:
You may contact us to let us know of your changes as to how we may contact you electronically, to request paper copies of certain information from us, and to withdraw your prior consent to receive notices and disclosures electronically as follows:
To contact us by email send messages to: emily.briggs@davita.com

To advise DaVita of your new e-mail address
To let us know of a change in your e-mail address where we should send notices and disclosures electronically to you, you must send an email message to us at jennifer.vanhyning@davita.com and in the body of such request you must state: your previous e-mail address, your new e-mail address. We do not require any other information from you to change your email address..
In addition, you must notify DocuSign, Inc to arrange for your new email address to be reflected in your DocuSign account by following the process for changing e-mail in DocuSign.

To request paper copies from DaVita
To request delivery from us of paper copies of the notices and disclosures previously provided by us to you electronically, you must send us an e-mail to emily.briggs@davita.com and in the body of such request you must state your e-mail address, full name, US Postal address, and telephone number. We will bill you for any fees at that time, if any.

To withdraw your consent with DaVita
To inform us that you no longer want to receive future notices and disclosures in electronic format you may:

i. decline to sign a document from within your DocuSign account, and on the subsequent page, select the check-box indicating you wish to withdraw your consent, or you may;
ii. send us an e-mail to emily.briggs@davita.com and in the body of such request you must state your e-mail, full name, IS Postal Address, telephone number, and account number. We do not need any other information from you to withdraw consent.. The consequences of your withdrawing consent for online documents will be that transactions may take a longer time to process..

Required hardware and software

Operating Systems:	Windows2000? or WindowsXP?
Browsers (for SENDERS):	Internet Explorer 6.0? or above
Browsers (for SIGNERS):	Internet Explorer 6.0?, Mozilla FireFox 1.0, NetScape 7.2 (or above)
Email:	Access to a valid email account
Screen Resolution:	800 x 600 minimum
Enabled Security Settings:	•Allow per session cookies •Users accessing the internet behind a Proxy Server must enable HTTP 1.1 settings via proxy connection

** These minimum requirements are subject to change. If these requirements change, we will provide you with an email message at the email address we have on file for you at that time providing you with the revised hardware and software requirements, at which time you will have the right to withdraw your consent.

Acknowledging your access and consent to receive materials electronically
To confirm to us that you can access this information electronically, which will be similar to other electronic notices and disclosures that we will provide to you, please verify that you were able to read this electronic disclosure and that you also were able to print on paper or electronically save this page for your future reference and access or that you were able to e-mail this disclosure and consent to an address where you will be able to print on paper or save it for your future reference and access. Further, if you consent to receiving notices and disclosures exclusively in electronic format on the terms and conditions described above, please let us know by clicking the 'I agree' button below.
By checking the 'I Agree' box, I confirm that:

- I can access and read this Electronic CONSENT TO ELECTRONIC RECEIPT OF ELECTRONIC RECORD AND SIGNATURE DISCLOSURES document; and

- I can print on paper the disclosure or save or send the disclosure to a place where I can print it, for future reference and access; and

- Until or unless I notify DaVita as described above, I consent to receive from exclusively through electronic means all notices, disclosures, authorizations, acknowledgements, and other documents that are required to be provided or made available to me by DaVita during the course of my relationship with you.

Appendix 4

Patients by Zip Code

Not Applicable to this Application

Appendix 5

Letter of Intent

DaVita

May 1, 2018

Janis Sigman, Manager
Certificate of Need Program
Washington State Department of Health
111 Israel Road SE
Tumwater, WA 98501

Dear Ms. Sigman:

Total Renal Care, Inc., a subsidiary of DaVita Inc. (hereafter "DaVita"), hereby submits a letter of intent for Nonspecial Circumstances Cycle 1 to apply for a Certificate of Need to establish a new twenty-two (22) station facility in the King County ESRD Planning Area, Subsection 11 (hereafter "King County 11"). In accordance with WAC 246-310-080 and 246-310-806, the following information is provided:

A Description of the Services Proposed:

DaVita proposes to establish a new twenty-two (22) station facility that will provide and support in-center hemodialysis. Although it may not be necessary to provide this additional information in the LOI, in an abundance of caution we also note that this project will include creating the capability to offer home modalities in the future at this facility.

Estimated Cost of the Proposed Project:

The capital expenditure associated with this project is estimated to be **$3,557,747**.

Description of the Service Area:

The service area will be the King County 11 ESRD Planning Area.

We look forward to continuing to serve dialysis patients in Washington.

Sincerely,

Evan Moore
Director – Special Projects
DaVita, Inc.

Appendix 6

Operational and Financial Commitment Letter

DaVita™

April 4, 2018

Ms. Janis Sigman
Program Manager
Certificate of Need Program
Office of Certification and Enforcement
State of Washington Department of Health
111 Israel Rd. SE
Tumwater, WA 98501

Dear Ms. Sigman:

DaVita, Inc. is planning new projects for the Washington State area. The DaVita, Inc. Board of Directors has authorized management to make strategic investments in operations throughout the United States. The estimated capital expenditure for each project is outlined in a project specific proforma submitted with each Certificate of Need application. Each project will be funded with cash on hand that has been generated through operations. The capital expenditure is not an advance or loan and none of the parent company's debt will be assigned to the facility at any point after the project is complete.

As the Chief Operating Officer - Kidney Care for DaVita, Inc., I have the authority to both authorize individual Certificate of Need applications and commit DaVita to long-term lease agreements, consistent with the investment policies and financial controls that have been established for the corporation. DaVita has authorized its Special Projects Director responsible for Washington State to submit Certificate of Need applications in that state.

Sincerely,



Michael Staffieri
Chief Operating Officer – Kidney Care
Davita, Inc.

1-303-876-6007 office
1-866-309-3548 fax

Appendix 7

Credentialed Staff

Not Applicable to this Application

Appendix 8

Historical & Current Financials

Not Applicable to this Application

Appendix 9

Detailed Projected Operating Statement (Pro Forma)

Appendix 9
DaVita Auburn Valley Dialysis Center
Detailed Projected Operating Statement (Pro Forma)

Pro-Forma Operating Statement

DaVita Auburn Valley (King 11) Denovo

	5	6	7
	Full Year 2022	**Full Year 2023**	**Full Year 2024**
Years			
Total Stations	22	22	22
Total Shifts	6	6	6
Total Chronic Capacity	132	132	132
Total Chronic Patients (end of the year)	48	80	117
% of Capacity	*36.2%*	*60.3%*	*88.5%*
Total Chronic Treatments	5,030	9,435	14,553
Total Home Patients (end of the year)	0	0	0
Total Home Treatments	0	0	0
Total Patients	48	80	117
Total Treatments	5,030	9,435	14,553
Revenue			
Dialysis Revenue	$ 2,129,773	$ 3,994,958	$ 6,161,857
EPO	$ 88,946	$ 166,843	$ 257,339
Other	$ 96,309	$ 180,654	$ 278,642
Total Gross Revenue	**$ 2,315,028**	**$ 4,342,454**	**$ 6,697,838**
Charitable Care	$ 30,095	$ 56,452	$ 87,072
Total Net Revenue	**$ 2,284,933**	**$ 4,286,003**	**$ 6,610,766**
Expenses			
Salaries & Wages	$ 458,979	$ 720,875	$ 1,034,760
Employee Benefits & Taxes	$ 275,188	$ 432,211	$ 620,405
Total Salaries, Wages & Benefits	**$ 734,167**	**$ 1,153,086**	**$ 1,655,165**
Professional Dues	$ 765	$ 1,464	$ 2,304
Medical Director	$ 70,000	$ 70,000	$ 70,000
Medical Supplies	$ 111,343	$ 213,031	$ 335,152
Pharmacy (Other Drugs)	$ 32,069	$ 61,357	$ 96,531
EPO	$ 146,235	$ 279,789	$ 440,180
Non-Medical Supplies	$ 11,192	$ 21,414	$ 33,690
Utilities	$ 34,692	$ 66,376	$ 104,426
Lab Tests	$ 68,112	$ 130,318	$ 205,023
Repairs & Maintenance	$ 38,927	$ 74,478	$ 117,173
Water Service	$ 11,804	$ 22,585	$ 35,532
Other Purchased Services	$ 7,308	$ 13,982	$ 21,998
Other Direct Expenses	$ 12,020	$ 22,997	$ 36,180
Depreciation	$ 315,327	$ 315,327	$ 315,327
Lease Expenses	$ 456,297	$ 457,539	$ 458,805
Bad Debt	$ 120,203	$ 229,983	$ 361,822
Taxes and Licenses	$ 45,677	$ 87,393	$ 137,491
Total Other Operaing Expenses	**$ 1,481,972**	**$ 2,068,032**	**$ 2,771,633**
Total Direct Expenses	**$ 2,216,139**	**$ 3,221,118**	**$ 4,426,799**
Pre-G&A EBIT	**$ 68,794**	**$ 1,064,884**	**$ 2,183,968**
G&A Allocation	$ 248,038	$ 474,567	$ 746,616
EBIT	$ (179,244)	$ 590,317	$ 1,437,352

Assumptions:

First Full Year: 2022, based on a first patient date in May 2021.

Total Stations: CON Approved stations.

Total Chronic Capacity: 6 shift capacity is assumed to be 100% utilization.

Patient Census Projections: Census projections are based on a 5-year projection of planning area patients using a regression of 5 years historical data and DaVita's own experience and expertise.

Total Treatments: Total Treatment Volume is assumed to be based on average yearly census, a 5% missed treatment rate consistent with DaVita's own experience and expertise, and three treatments weekly for 52 weeks per year.

Revenue per treatment: No inflation is applied to revenue per treatment, which is based on the last full year of operation, 2017 and its payor mix, as an average of comparable facilities.

Expenses: Based on an average of comparable facilities for the last full calendar year (2017).

Cost inflation: DaVita's experience and expertise leads to an assumption that non-medical director or lease costs (which are previously contracted and based on actual contract costs) are likely to inflate at ~2% per year, and each category is assumed as such.

Medical Director Expense: based on contracted, known expenses in latest medical director agreements that run through the extent of the three year projection window. This includes post-certification ICHD compensation.

Lease Expense: base rent is directly pulled from the lease contract for each calendar year, per clause 3 of the Development Agreement, with the payment term projected to start in April 2021. Tax and CAM are calculated based average cost per square foot of comparable facilities in 2017, inflated at 2% annually.

Labor Assumptions: Based on safe, fair, and efficient staffing ratios for projected census and required staff type. Benefits are assumed at a rate of 60% of wages based on historical precedent. Salaries and wages are projected to inflate at 2% annually.

Appendix 10

Audited Financial Statement

SEC 10k – 2015, 2016, 2017

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-K

For the Fiscal Year Ended December 31, 2015

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

Commission File Number: 1-14106

DAVITA HEALTHCARE PARTNERS INC.

2000 16th Street
Denver, Colorado 80202
Telephone number (303) 405-2100

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

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

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

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ 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, 2015, the number of shares of the Registrant's common stock outstanding was approximately 215.5 million shares and the aggregate market value of the common stock outstanding held by non-affiliates based upon the closing price of these shares on the New York Stock Exchange was approximately $17.1 billion.

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

Documents incorporated by reference

Portions of the Registrant's proxy statement for its 2016 annual meeting of stockholders are incorporated by reference in Part III of this Form 10-K.

PART I

Item 1. Business

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

Overview of DaVita HealthCare Partners Inc.

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

For financial information about our reportable segments please read "Note 25 Segment Reporting" to the consolidated financial statements included in this report.

Kidney Care Division

U.S. dialysis and related lab services business overview

Our U.S. dialysis and related lab services business is a leading provider of kidney dialysis services for patients suffering from ESRD. As of December 31, 2015, we provided dialysis and administrative services in the U.S. through a network of 2,251 outpatient dialysis centers in 46 states and the District of Columbia, serving a total of approximately 180,000 patients. We also provide acute inpatient dialysis services in approximately 900 hospitals and related laboratory services throughout the U.S. Our U.S. dialysis and related lab services business accounted for approximately 62% of our 2015 consolidated net revenues. All references in this document to dialysis and related lab services refer only to our U.S. dialysis and related lab services business.

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

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

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

Although Medicare reimbursement limits the allowable charge per treatment, it provides industry participants with a relatively predictable and recurring revenue stream for dialysis services provided to patients without commercial insurance. For the year ended December 31, 2015, approximately 89% of our total dialysis patients were covered under some form of government-based programs, with approximately 76% of our dialysis patients covered under Medicare and Medicare-assigned plans.

Treatment options for ESRD

Treatment options for ESRD are dialysis and kidney transplantation.

Dialysis options

- *Hemodialysis*

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

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

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

- *Peritoneal dialysis*

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

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

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

Kidney transplantation

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

Dialysis and related lab services we provide

Outpatient hemodialysis services

As of December 31, 2015, we operated or provided administrative services through a network of 2,251 outpatient dialysis centers in the U.S. that are designed specifically for outpatient hemodialysis. In 2015, our overall network of U.S. outpatient dialysis centers increased by 72 primarily as a result of the opening of new dialysis centers, net of center closures and divestitures, and acquisitions, representing a total increase of approximately 3.3% from 2014.

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

Under Medicare regulations, we cannot promote, develop or maintain any kind of contractual relationship with our patients that would directly or indirectly obligate a patient to use or continue to use our dialysis services, or that would give us any preferential rights other than those related to collecting payments for our dialysis services. Our total patient turnover, which is based upon all causes, averaged approximately 25% in both 2015 and 2014. However, in 2015, the overall number of patients to whom we provided services in the U.S. increased by approximately 4.1% from 2014, primarily from the opening of new dialysis centers and acquisitions, and continued growth within the industry.

Hospital inpatient hemodialysis services

As of December 31, 2015, we provided hospital inpatient hemodialysis services, excluding physician services, to patients in approximately 900 hospitals throughout the U.S. We render these services based on a contracted per-treatment fee that is individually negotiated with each hospital. When a hospital requests our services, we typically administer the dialysis treatment at the patient's bedside or in a dedicated treatment room in the hospital, as needed. In 2015, hospital inpatient hemodialysis services accounted for approximately 4.2% of our total U.S. dialysis treatments.

Home-based hemodialysis services

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

ESRD laboratory services

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

Management services

We currently operate or provide management and administrative services pursuant to management and administrative services agreements to 31 outpatient dialysis centers located in the U.S. in which we either own a minority equity investment or are wholly-owned by third parties. Management fees are established by contract and are recognized as earned typically based on a percentage of revenues or cash collections generated by the outpatient dialysis centers.

Quality care

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

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

Sources of revenue—concentrations and risks

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

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

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

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

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

Medicare revenue

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

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

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

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

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

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

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

Medicaid revenue

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

Commercial revenue

Before a patient becomes eligible to have Medicare as their primary payor for dialysis services, a patient's commercial insurance plan, if any, is responsible for payment of such dialysis services for the first 33 months, as discussed above. Although commercial payment rates vary, average commercial payment rates established under commercial contracts are generally significantly higher than Medicare rates. The payments we receive from commercial payors generate nearly all of our profits. Payment methods from commercial payors can include a single lump-sum per treatment, referred to as bundled rates, or in other cases separate payments for dialysis treatments and pharmaceuticals, if used as part of the treatment, referred to as Fee-for-Service (FFS) rates. Commercial payment rates are the result of negotiations between us and insurers or third-party administrators. Our out-of-network payment rates are on average higher than in-network commercial contract payment rates. In 2015, we continued to enter into some commercial contracts, covering certain patients that will primarily pay us under a single bundled payment rate for all dialysis services provided to these patients. However, some of the contracts will pay us for certain other services and pharmaceuticals in addition to the bundled payment. These contracts typically contain annual price escalator provisions. We are continuously in the process of negotiating agreements with our commercial payors and if our negotiations result in overall commercial contract payment rate reductions in excess of our commercial contract payment rate increases, our revenues and operating results could be negatively impacted. In addition, if there is an increase in job losses in the U.S., or depending upon changes to the healthcare regulatory system by CMS and/or the impact of healthcare insurance exchanges, we could experience a decrease in the number of patients covered under traditional commercial insurance plans. Patients with commercial insurance who cannot otherwise maintain coverage frequently rely on financial assistance from charitable organizations, such as the American Kidney Fund. If these patients are unable to obtain or continue to receive such financial assistance, our revenues, earnings, and cash flow could be substantially reduced.

Approximately 34% of our dialysis services revenues and approximately 11% of our dialysis patients were associated with commercial payors for the year ended December 31, 2015. Commercial patients as a percentage of our total dialysis patients increased by approximately 1% in 2015 as compared to 2014. Less than 1% of our dialysis and related lab services revenues are due directly from patients. There is no single commercial payor that accounted for more than 10% of total dialysis and related lab services revenues for the year ended December 31, 2015.

The healthcare reform legislation enacted in 2010 introduced healthcare insurance exchanges which provide a marketplace for eligible individuals and small employers to purchase healthcare insurance. Although we cannot predict the long term effects of these exchanges, we believe the healthcare insurance exchanges could ultimately result in a reduction in patients covered by traditional commercial insurance or an increase of patients covered through the exchanges under more restrictive commercial plans with lower reimbursement rates. Approximately 11 million individuals were enrolled in the exchanges in 2015, as compared to approximately eight million in 2014. To the extent that the ongoing implementation of such exchanges results in a reduction in reimbursement rates for our services from commercial and/or government payors, our operating results could be adversely affected.

Revenue from other pharmaceuticals and EPO

The impact of physician-prescribed pharmaceuticals on our overall revenues that are separately billable has significantly decreased since Medicare's single bundled payment system went into effect beginning in January 2011, as well as some additional commercial contracts that pay us a single bundled payment rate. Approximately 2% of our total dialysis and related lab services revenues for the year ended December 31, 2015, as compared to 3% in 2014, are associated with the administration of separately-billable physician-prescribed pharmaceuticals. Of this, the administration of EPO that was separately billable, accounted for approximately half of our separately billable pharmaceuticals of our dialysis and related lab services revenues for the year ended December 31, 2015. EPO is produced by a single manufacturer, Amgen USA Inc. (Amgen). Any interruption of supply or product cost increases could impact our operations.

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

Physician relationships

An ESRD patient generally seeks treatment at an outpatient dialysis center near his or her home where his or her treating nephrologist has practice privileges. Our relationships with local nephrologists and our ability to meet their needs and the needs of their patients are key factors in the success of our dialysis operations. Approximately 4,900 nephrologists currently refer patients to our outpatient dialysis centers. As is typical in the dialysis industry, one or a few physicians, including the outpatient dialysis center's medical director, usually account for all or a significant portion of an outpatient dialysis center's patient base.

Participation in the Medicare ESRD program requires that dialysis services at an outpatient dialysis center be under the general supervision of a medical director who is a licensed physician. We have engaged physicians or groups of physicians to serve as medical directors for each of our outpatient dialysis centers. At some outpatient dialysis centers, we also separately contract with one or more other physicians to serve as assistant or associate medical directors or to direct specific programs, such as home dialysis training programs. We have approximately 950 individual physicians and physician groups under contract to provide medical director services.

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

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

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

Government regulation

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

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

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

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

Licensure and certification

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

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

Federal Anti-Kickback Statute

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

Federal criminal penalties for the violation of the federal Anti-Kickback Statute include imprisonment, fines and exclusion of the provider from future participation in the federal healthcare programs, including Medicare and Medicaid. Violations of the federal Anti-Kickback Statute are punishable by imprisonment for up to five years and fines of up to $25,000 or both. Larger fines can be imposed upon corporations under the provisions of the U.S. Sentencing Guidelines and the Alternate Fines Statute. Individuals and entities convicted of violating the federal Anti-Kickback Statute are subject to mandatory exclusion from participation in Medicare, Medicaid and other federal healthcare programs for a minimum of five years. Civil penalties for violation of this law include up to $50,000 in monetary penalties per violation, repayments of up to three times the total payments between the parties and suspension

from future participation in Medicare and Medicaid. Court decisions have held that the statute may be violated even if only one purpose of remuneration is to induce referrals. The Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 (Health Reform Acts) amended the federal Anti-Kickback Statute to clarify the intent that is required to prove a violation. Under the statute as amended, the defendant need not have known of the existence of the federal Anti-Kickback Statute or had the specific intent to violate it. In addition, the Health Reform Acts amended the federal Anti-Kickback Statute to provide that any claims submitted from an arrangement that violates the federal Anti-Kickback Statute are false for purposes of the FCA.

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

We enter into several arrangements with physicians that potentially implicate the Anti-Kickback Statute. These arrangements include:

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

Joint Ventures. We own a controlling interest in numerous U.S. dialysis related joint ventures. For the year ended December 31, 2015, these joint ventures represented approximately 23% of our dialysis and related lab services revenues. We may continue to increase the number of our joint ventures. Our relationships with physicians and other referral sources relating to these joint ventures do not fully satisfy the safe harbor for investments in small entities. Although failure to comply with a safe harbor does not render an arrangement illegal under the federal Anti-Kickback Statute, an arrangement that does not operate within a safe harbor may be subject to scrutiny and the Department of Health and Human Services' Office of Inspector General (OIG) has warned in the past that certain joint venture relationships have a potential for abuse. Based upon the foregoing, physician joint ventures that fall outside the safe harbors are not, by definition, prohibited by law. Instead, such joint ventures require case-by-case evaluation under the federal Anti-Kickback Statute.

In this regard, we have structured our joint ventures to satisfy as many elements of the safe harbor for investments in small entities as we believe are commercially reasonable. For example, we believe that these investments are offered and made by us on a fair market value basis and provide returns to the investors in proportion to their actual investment in the venture. We believe that our joint venture arrangements do not violate the federal Anti-Kickback Statute; however, since the arrangements do not satisfy all of the requirements of an applicable safe harbor, these arrangements could be subject to challenge on the ground that they are intended to induce patient referrals. In that regard, we were subject to investigation by the United States Attorney's Office for the District of Colorado, the Civil Division of the United States Department of Justice (DOJ) and the OIG related to our relationships with physicians, including our joint ventures, and whether those relationships and joint ventures comply with the federal Anti-Kickback Statute and the FCA. In October 2014, we entered into a Settlement Agreement with the United States and relator David Barbetta to resolve the then pending 2010 and 2011 U.S. Attorney physician relationship investigations. In connection with the resolution of this matter, and in exchange for the OIG's agreement not to exclude us from participating in the federal healthcare programs, we have entered into a five-year CIA with the OIG.

Lease Arrangements. We lease space for numerous dialysis centers from entities in which physicians, hospitals or medical groups hold ownership interests, and we sublease space to referring physicians at approximately 270 of our dialysis centers as of December 31, 2015. These arrangements comply with the federal Anti-Kickback Statute safe harbor for space rentals in all material respects. Therefore, we believe that these lease arrangements should not be subject to challenge under the federal Anti-Kickback Statute.

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

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

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

Stark Law

The federal Physician Self-Referral law, known as the Stark Law, prohibits a physician who has a financial relationship, or who has an immediate family member who has a financial relationship, with entities providing Designated Health Services (DHS), from referring Medicare patients to such entities for the furnishing DHS, unless an exception applies. DHS includes enumerated items and services, including home health services, outpatient prescription drugs, inpatient and outpatient hospital services and clinical laboratory services. The Stark Law also prohibits the DHS entity receiving a prohibited referral from filing a claim or billing for the services arising out of the prohibited referral. The prohibition applies regardless of the reasons for the financial relationship and the referral; unlike the federal Anti-Kickback Statute, intent to induce referrals is not required. Sanctions for violation of the Stark Law include denial of payment for claims for services provided in violation of the prohibition, refunds of amounts collected in violation of the prohibition, a civil penalty of up to $15,000 for each service arising out of the prohibited referral, exclusion from the federal healthcare programs, including Medicare and Medicaid, and a civil penalty of up to $100,000 against parties that enter into a scheme to circumvent the Stark Law prohibition. Furthermore, Stark Law violations can form the basis for FCA liability as discussed below. The types of financial arrangements between a physician and a DHS entity that trigger the self-referral prohibitions of the Stark Law are broad and include direct and indirect ownership and investment interests and compensation arrangements.

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

In addition, although prescription drugs are DHS, there is an exception in the Stark Law for EPO and other specifically enumerated dialysis drugs when furnished in or by an ESRD facility, in compliance with the federal Anti-Kickback Statute and applicable billing requirements. The exception is available only for drugs included on a list of CPT/HCPCS codes published by CMS, and in the case of home dialysis, the exception applies only to EPO, Aranesp® and equivalent drugs dispensed by the facility for use at home. While we believe that most drugs furnished by our dialysis centers are covered by the exception, dialysis centers may administer drugs that are not on the list of CPT/HCPCS codes and therefore do not meet this exception. In order for a physician who has a financial relationship with a dialysis center to order one of these drugs from the center and for the center to obtain Medicare reimbursement, another exception must apply.

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

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

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

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

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

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

Fraud and abuse under state law

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

The False Claims Act

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

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

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

The penalties for a violation of the FCA range from $5,500 to $11,000 (adjusted for inflation) for each false claim, plus up to three times the amount of damages caused by each false claim, which is generally equal to the amounts received directly or indirectly

from the government for each such false claim. The federal government has used the FCA to prosecute a wide variety of alleged false claims and fraud allegedly perpetrated against Medicare and state healthcare programs, including coding errors, billing for services not rendered, the submission of false cost reports, billing for services at a higher payment rate than appropriate, billing under a comprehensive code as well as under one or more component codes included in the comprehensive code and billing for care that is not considered medically necessary. The Health Reform Acts provide that claims tainted by a violation of the federal Anti-Kickback Statute are false for purposes of the FCA. Some courts have held that filing claims or failing to refund amounts collected in violation of the Stark Law can form the basis for liability under the FCA. In addition to the provisions of the FCA, which provide for civil enforcement, the federal government can use several criminal statutes to prosecute persons who are alleged to have submitted false or fraudulent claims for payment to the federal government.

Privacy and Security

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

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

Covered entities must report breaches of unsecured PHI to affected individuals without unreasonable delay but not to exceed 60 days of discovery of the breach by a covered entity or its agents. Notification must also be made to the U.S. Department of Health and Human Services (HHS), and, in certain situations involving large breaches, to the media. HHS is required to publish on its website a list of all covered entities that report a breach involving more than 500 individuals. All non-permitted uses or disclosures of unsecured PHI are presumed to be breaches unless the covered entity or business associate establishes that there is a low probability the information has been compromised. Various state laws and regulations may also require us to notify affected individuals in the event of a data breach involving individually identifiable information without regard to whether there is a low probability of the information being compromised.

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

Healthcare reform

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

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

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

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

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

Other regulations

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

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

Capacity and location of our U.S. dialysis centers

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

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

	2015	2014	2013	2012	2011	
Number of centers at beginning of year	2,179	2,074	1,954	1,809	1,612	
Acquired centers	6	18	26	93	170	(1)
Developed centers	72	105	98	70	65	
Net change in centers with management and administrative services agreements*	2	—	4	(8)	1	
Sold and closed centers**	(3)	(2)	(5)	(1)	(32)	(1)
Closed centers***	(5)	(16)	(3)	(9)	(7)	
Number of centers at end of year	2,251	2,179	2,074	1,954	1,809	

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

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

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

*** Represents dialysis centers that were closed for which the majority of patients were retained and transferred to one of our other existing outpatient dialysis centers.

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

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

Ancillary services and strategic initiatives businesses, including our international operations

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

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

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

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

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

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

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

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

International dialysis operations

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

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

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

Malaysia	38
Germany	20
Colombia	15
India	13
Saudi Arabia	10
Poland	8
Portugal	5
Taiwan	5
China	3
Singapore	1
	118

Corporate Administrative Support

Corporate administrative support consists primarily of labor, benefits and long-term incentive compensation costs for departments which provide support to all of our different operating lines of business. Corporate administrative support costs were approximately $19 million, $13 million and $53 million in 2015, 2014 and 2013, respectively. These expenses are included in our consolidated general and administrative expenses and are offset by the allocation of management fees. The increase in corporate administrative support costs in 2015 as compared to 2014 was due to an increase in professional fees.

HealthCare Partners Division

HealthCare Partners business overview

HCP is a patient- and physician-focused integrated healthcare delivery and management company with over two decades of experience providing coordinated, outcomes-based medical care in a cost-effective manner. As of December 31, 2015, HCP had approximately 807,400 members under its care in southern California, Colorado, central and south Florida, southern Nevada, central New Mexico and central Arizona through capitation contracts with some of the nation's leading health plans. Of these members, approximately 317,400 individuals were patients enrolled in Medicare Advantage, and the remaining approximately 490,000 individuals were managed care members whose health coverage is provided through their employer or who have individually acquired health coverage directly from a health plan or as a result of their eligibility for Medicaid benefits.

HCP patients as well as the patients of HCP's associated physicians, physician groups and IPAs benefit from an integrated approach to medical care that places the physician at the center of patient care. As of December 31, 2015, HCP delivered services to its members via a network of 547 associated group full-time primary care physicians, over 2,900 associated group and other network primary care physicians, 240 network hospitals, and several thousand associated group and network specialists. Together with hundreds of case managers, registered nurses and other care coordinators, these medical professionals utilize a comprehensive information technology system, sophisticated risk management techniques and clinical protocols to provide high-quality, cost-effective care to HCP's members.

U.S. healthcare spending has increased steadily over the past twenty years. These increases have been driven, in part, by the aging of the baby boomer generation, lack of healthy lifestyle both in terms of exercise and diet, rapidly increasing costs in medical technology and pharmaceutical research, and provider reimbursement structures that may promote volume over quality in a FFS environment. These factors, as well as the steady growth of the U.S. population, have made the healthcare industry a growing market. In 2014, CMS reported that healthcare accounted for 17.5% of the U.S. economy and healthcare spending increased 5.3% to reach $3.0 trillion. Medicare spending grew 5.5% to $620 billion in 2014 or 20% of National Health Expenditures, according to CMS. Medicare outlays accounted for 14% of the Federal Budget in 2014 according to the Congressional Budget Office (CBO). Medicare is frequently the focus of discussions on how to moderate the growth of both federal spending and healthcare spending in the U.S.

Growth in Medicare spending is expected to continue due to population demographics. According to the U.S. Census Bureau, the overall U.S. population grew 57% from 1970 through 2015, while the number of Medicare enrollees grew by 157% from 1970 to 2013 based on the latest publicly available CMS data. As an increasing number of the baby boomers become eligible for Medicare, the senior market is expected to be 20% of the total U.S. population by 2030 according to the U.S. Census Bureau.

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

Managed care health plans were developed, primarily during the 1980s, in an attempt to mitigate the rising cost of providing healthcare benefits to populations covered by traditional health insurance. These managed care health plans enroll members through their employers. As a result of the prevalence of these health plans, many seniors now becoming eligible for Medicare have been interacting with managed care companies through their employers for the last 30 years. Individuals turning 65 now are likely to be far more familiar with the managed care setting than previous Medicare populations. According to Kaiser Family Foundation, in 2014, Medicare Advantage represents only 31% of total Medicare members, creating a significant opportunity for additional Medicare Advantage penetration of newly eligible seniors.

In an effort to reduce the number of uninsured and to begin to control healthcare expenditures, President Obama signed the Health Reform Acts into law in March 2010, which were affirmed, in substantial part, by the U.S. Supreme Court in June 2012. The Health Reform Acts provide for a reduction of up to 27 million uninsured individuals by 2019, while potentially increasing Medicaid coverage by up to 15 million individuals. CMS projects that the total number of uninsured Americans will fall to 23 million in 2023 from 45 million in 2012. These previously uninsured Americans and potentially newly eligible Medicaid beneficiaries represent a significant new market opportunity for health plans. We believe that health plans looking to cover these newly eligible individuals under fixed premium arrangements will seek provider arrangements that can effectively manage the cost and quality of the care being provided to these newly eligible individuals.

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

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

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

Despite the fact that the plan bids average less than FFS spending, payments for enrollees in these plans usually exceed FFS spending because the benchmarks are high relative to FFS spending. For example, health maintenance organizations (HMOs) as a group bid an average of 90% of FFS spending, yet 2015 payments for HMO enrollees are estimated to average 101% of FFS spending because the benchmarks, including the quality bonuses, average 106% of FFS spending.

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

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

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

Healthcare reform

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

The Health Reform Acts reflect sweeping legislation that, once fully implemented, may have a significant impact on the U.S. healthcare system generally and the operations of HCP's business. There are numerous steps required to implement the Health Reform Acts, and implementation remains ongoing. Congress also has enacted, and may continue to seek, legislative changes that alter, delay, or eliminate some of their provisions. For example, under the 2016 Omnibus budget agreement, Congress voted to delay certain new

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

One provision of the Health Reform Acts required CMS to establish a Medicare Shared Savings Program (MSSP) that promotes accountability and coordination of care through the creation of ACOs. The program allows certain providers and suppliers (including hospitals, physicians and other designated professionals) to voluntarily form ACOs and work together along with other ACO participants to invest in infrastructure and redesign delivery processes to achieve high quality and efficient delivery of services. In 2014, HCP entered into an agreement with CMS to participate in the MSSP in California, Florida and Nevada. Under this program, HCP is striving to attain improved clinical outcomes to its Medicare FFS patients in a more cost-effective manner, and will have the opportunity to share with CMS in any financial savings created.

Payor environment

Government programs

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

Medicare. The Medicare program was established in 1965 and became effective in 1967 as a federally funded U.S. health insurance program for persons aged 65 and older, and it was later expanded to include individuals with ESRD and certain disabled persons, regardless of income or age. Since its formation, Medicare has grown to an approximately $620 billion program in 2014, covering approximately 55 million Americans and, based on the growing number of eligible beneficiaries and increases in the cost of healthcare, CBO projects that net Medicare spending will increase from $527 billion in 2015 to $866 billion in 2024.

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

FFS Medicare pays for physician services according to a physician fee schedule (PFS) set each year by CMS in accordance with formulas mandated by Congress. Historically, CMS annually adjusted the Medicare Physician Fee Schedule (Medicare PFS) payment rates based on an updated formula that included application of the Sustainable Growth Rate (SGR). On April 1, 2014, President Obama signed into law the Protecting Access to Medicare Act of 2014, which provided for a 0% update to the 2015 Medicare PFS through March 31, 2015. Subsequently, on April 16, 2015, President Obama signed and enacted into law H.R. 2, the Medicare Access and CHIP Reauthorization Act of 2015, which, among other things, repealed the SGR and instituted a 0% update to the single conversion factor under the Medicare PFS from January 1 through June 30, 2015, a 0.5% update for July 2015 through the end of 2019, and a 0% update for 2020 through 2025. For 2026 and subsequent years, the update will be either 0.75% or 0.25%, depending on which Alternate Payment Model (APM) the physician participates. Given that the payment updates for APMs have yet to take effect, we cannot determine the impact of such payment models on our business at this time.

In addition, in recent years, Congress has enacted various laws seeking to reduce the federal debt level and contain healthcare expenditures. For example, the BCA called for the establishment of a Joint Select Committee (the Committee) on Deficit Reduction, tasked with reducing the federal debt level. However, because the Committee did not draft a proposal by the BCA's deadline, President Obama issued an initial sequestration order on March 1, 2013 that imposed automatic spending cuts on various federal programs. Under the Bipartisan Budget Act of 2013 and a bill signed by the President on February 15, 2014, sequestration has been extended through fiscal year 2024. Medicare payments to providers are subject to such cuts, although the BCA generally limited the Medicare cuts to two percent. For fiscal year 2024, however, Medicare sequestration amounts will be realigned such that there will be a 4.0 percent sequester for the first six months and a zero percent sequester for the second six months.

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

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

or, most often in Medicare Advantage plans, the absence of any monthly premium. In certain parts of the country, many health plans that provide Medicare Advantage benefits subcontract with integrated medical systems such as HCP to transfer the responsibility for managing patient care.

In 2004, CMS adopted a risk adjustment payment system for Medicare Advantage health plans in which the participating health plans' premiums are adjusted based on the actual illness burden of the members that enroll. The model bases a portion of the total CMS reimbursement payments on various clinical and demographic factors, including hospital inpatient diagnoses, additional diagnosis data from ambulatory treatment settings, hospital outpatient department and physician visits, gender, age and Medicaid eligibility. CMS requires that all managed care companies capture, collect and submit the necessary diagnosis code information to CMS twice a year for reconciliation with CMS's internal database. Medical providers, such as HCP, provide this diagnosis code information to health plan customers for submission to CMS. Under this system, the risk-adjusted portion of the total CMS payment to the Medicare Advantage plans will equal the local rate set forth in the traditional demographic rate book, adjusted to reflect the plan members' gender, age and morbidity.

Most Medicare beneficiaries have the option to enroll in private health insurance plans that contract with Medicare under the Medicare Advantage program. According to the Kaiser Family Foundation, the share of Medicare beneficiaries in such plans has risen rapidly in recent years; it reached approximately 31% in 2015 from approximately 13% in 2004. Plan costs for the standard benefit package can be significantly lower or higher than the corresponding cost for beneficiaries in the traditional Medicare FFS payment program, but prior to the Health Reform Acts, private plans were generally paid a higher average amount, and they used the additional payments to reduce enrollee cost-sharing requirements, provide extra benefits, and/or reduce Medicare premiums. These enhancements were valuable to enrollees, but also resulted in higher Medicare costs overall and higher premiums for all Medicare Part B beneficiaries and not just those enrolled in Medicare Advantage plans. The Health Reform Acts require that future payments to plans be based on benchmarks in a range of 95% to 115% of local FFS Medicare costs, with bonus amounts payable to plans meeting high quality-of-care standards. In addition, health plans offering Medicare Advantage are required to spend at least 85% of their premium dollars on medical care, the so-called medical loss ratio (MLR). Since HCP is not a health plan, except for DaVita HealthCare Partners Plan (DHPP) it is not subject to the 85% MLR requirement (see "HealthCare Partners Division —Knox-Keene" below). However, payments that health plans make to HCP will apply in full towards the health plans' 85% MLR requirement. If a health plan does not meet the 85% MLR requirement, it must provide a rebate to its customers. Any such shortfalls will not impact amounts paid by health plans to HCP.

Medicaid. Medicaid is a federal entitlement program administered by the states that provides healthcare and long-term care services and support to low-income Americans. Medicaid is funded jointly by the states and the federal government. The federal government guarantees matching funds to states for qualifying Medicaid expenditures based on each state's federal medical assistance percentage, which is calculated annually and varies inversely with average personal income in the state. Subject to federal rules, each state establishes its own eligibility standards, benefit packages, payment rates and program administration within broad federal statutory and regulatory guidelines. Every state Medicaid program must balance a number of potentially competing demands, including the need for quality care, adequate provider access, and cost-effectiveness. In an effort to improve quality and provide more uniform and cost-effective care, many states have implemented Medicaid managed care programs to improve access to coordinated healthcare services, including preventative care, and to control healthcare costs. Under Medicaid managed care programs, a health plan receives capitation payments from the state. The health plan, in turn, arranges for the provision of healthcare services by contracting with a network of medical providers, such as HCP. HCP has entered into capitation agreements with health plans to manage approximately 122,600 Medicaid managed care members in its southern California and Florida markets.

Commercial payors

According to a survey conducted from January through June 2015 by the Kaiser Family Foundation and the Health Research and Education Trust, approximately 63% of non-elderly U.S. citizens received their healthcare benefits through their employers, which contracted with health plans to administer these healthcare benefits. Patients enrolled in health plans offered through an employment setting are generally referred to as commercial members. Commercial employer-sponsored health plan enrollment was approximately 147 million in 2015, according to the survey conducted by the Kaiser Family Foundation and the percentage of workers covered increased by approximately 1% from 62% in 2014. Under the Health Reform Acts, many uninsured individuals and many individuals who receive their health insurance benefits through small employers may purchase their healthcare benefits through insurance exchanges in which health plans compete directly for individual or small group members' enrollment. HCP derives a significant amount of its enrollment from commercial members; however, these members represent a disproportionately small share of HCP's operating profits.

Whether in the Medicare Advantage, commercial or Medicaid market, managed care health plans seek to provide a coordinated and efficient approach to managing the healthcare needs of their enrolled populations. By negotiating with providers, such as pharmacies, hospitals and physicians, and indirectly trying to influence physicians' behavior through various incentive and penalty schemes, managed care companies attempt to enhance their profitability by limiting their medical costs. These health plans have shown success in mitigating certain components of medical cost, but we believe they are limited by their indirect relationship with

physicians, who in the aggregate direct most of their patients' healthcare costs. We believe that physician-led and professionally-managed integrated medical systems such as HCP's have a greater opportunity to influence cost and improve quality due to the close coordination of care at the most effective point of contact with the patient—the primary care physician.

Capitation and FFS revenue

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

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

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

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

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

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

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

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

Risk-sharing model. In California, HCP currently utilizes a capitation model in several different forms. While there are variations specific to each arrangement, HealthCare Partners Affiliates Medical Group and HealthCare Partners Associates Medical Group, Inc. (collectively HCPAMG), which are medical groups that have entered into management services agreements with HCP, have historically contracted with health plans to receive a PMPM or percentage of premium (POP) capitation payment for professional (physician) services and assumed the financial responsibility for professional services. In some cases, the health plans separately enter into capitation contracts with third parties (typically hospitals) who directly receive a capitation payment and assume contractual financial responsibility for institutional (hospital) services. In other cases, the health plan does not pay a capitation payment to the

hospital, but rather administers and pays fee-for-service claims for hospital expenses. In both cases, HCPAMG has been responsible under its health plan agreements for managing the care dollars associated with both the professional and institutional services provided for in the HCPAMG capitation payment. In the case of institutional services and as a result of its managed care-related administrative services agreements with hospitals, HCPAMG has recognized a percentage of the surplus of institutional revenues less institutional expense as HCPAMG net revenues and has also been responsible for some percentage of any short-fall in the event that institutional expenses exceed institutional revenues. In connection with HCP's obtaining a restricted Knox-Keene license in California, substantially all of the California health plan contracts, along with the revenues received under such contracts, have been assigned from HCPAMG to DHPP. In addition, HCP now has the legal authority to transition these health plan contracts to global capitation arrangements in which HCP is responsible for arranging professional and institutional services in exchange for a single capitation payment. HCP is in the process of evaluating and identifying which risk-sharing arrangements, if any, will be converted to global capitation arrangements, subject to HCP's and the applicable health plan's satisfactory negotiation and approval, as well as approval from the Department of Managed Healthcare. Completion of such evaluation and possible conversion is expected to occur over time.

Government regulation

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

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

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

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

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

Professional licensing requirements. HCP's clinical personnel, including physicians, must satisfy and maintain their professional licensing in the states where they practice medicine. Activities that qualify as professional misconduct under state law may subject them to sanctions, including the loss of their licenses and could subject HCP to sanctions as well. Many state boards of medicine impose reciprocal discipline, that is, if a physician is disciplined for having committed professional misconduct in one state where he or she is licensed, another state where he or she is also licensed may impose the same discipline even though the conduct did not occur in that state. Therefore, if an HCP-associated physician is licensed in multiple states, sanctions or loss of licensure in one state may result in sanction or the loss of licensure in other states. Professional licensing sanctions may also result in exclusion from participation in governmental healthcare programs, such as Medicare and Medicaid, as well as other third-party programs.

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

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

In California, Nevada and Arizona, where the corporate practice of medicine is prohibited, HCP has historically operated by maintaining long-term management contracts with multiple associated professional organizations which, in turn, employ or contract with physicians to provide those professional medical services required by the enrollees of the payors with which the professional organizations contract. Under these management agreements, HCP performs only non-medical administrative services, does not represent that it offers medical services, and does not exercise influence or control over the practice of medicine by the physicians or the associated physician groups with which it contracts. For example, in California, HCP has full-service management contracts with HCPAMG. The HCPAMG entities are owned by California-licensed physicians and professional medical corporations and contract with physicians to provide professional medical services. In Nevada, HCP's Nevada subsidiaries have similar management agreements with Nevada professional corporations that employ and contract with physicians to provide professional medical services.

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

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

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

Knox-Keene. The California Department of Managed Health Care (DMHC) licenses and regulates Health Care Service Plans (HCSPs) pursuant to Knox-Keene. In addition to administering Knox-Keene's various patient's rights protections for HCSP-enrolled individuals, the DMHC is responsible for ensuring the financial sustainability over time of HCSPs and other regulated entities. As such, the DMHC is charged with continually monitoring the financial health of regulated entities. The DMHC's Division of Financial Oversight conducts examinations of the fiscal and administrative affairs of licensed HCSPs to protect consumers and providers from potential insolvencies. Financial examination reviews include examinations of cash flow, premium receivables, intercompany transactions and medical liabilities. The examination also ensures that there is adequate tangible net equity (TNE), as determined according to calculations included in Knox-Keene. The TNE regulations for organizations holding a Knox-Keene license, like HCP, vary depending on circumstances, but generally require any licensee to have on hand in cash or cash equivalents a minimum of the greater of (i) $1 million, (ii) the sum of 2% of the first $150 million of annualized premium revenues plus 1% of annualized premium revenues in excess of $150 million, or (iii) the sum of 8% of the first $150 million of annualized healthcare expenditures (except those paid on a capitated basis or managed hospital payment basis) plus 4% of the annualized healthcare expenditures, except those paid on a capitated basis or managed hospital payment basis, which are in excess of $150 million. In its sole discretion, DMHC may require, as a condition to obtaining or maintaining an HCSP license, that a licensee accept certain contractual undertakings such that the licensee is obligated to maintain TNE in amounts greater than the minimum amount described above. Such contractual undertakings may require 130% or more of TNE to be maintained by a licensee.

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

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

HCP services

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

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

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

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

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

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

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

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

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

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

- HCP's clinical leadership and associated group and network physicians devote significant efforts to ensure that HCP's members receive the most appropriate care in the most appropriate manner.
- HCP is committed to maximizing its patients' satisfaction levels.
- HCP has the scale which, combined with its strong reputation and high quality patient care, makes it an attractive partner for health plans, compared to smaller provider groups that may have a higher risk of default and may not have the same resources to devote and develop the same level of patient care.
- HCP has over two decades of experience in managing complex disease cases for its population of patients. As a result, HCP has developed a rich dataset of patient care experiences and outcomes which permits HCP to proactively monitor and intervene in improving the care of its members.
- HCP's senior management team possesses substantial experience with the healthcare industry with average experience of nearly 20 years, as of December 31, 2015.

Locations of HCP clinics

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

Competition

U.S. and International dialysis competition

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

The two largest dialysis companies, Fresenius Medical Care (FMC) and our Company, account for approximately 72% of outpatient dialysis patients in the U.S. with our Company serving approximately 36% of the total outpatient dialysis patients. Approximately 45% of the centers not owned by us or FMC are owned or controlled by hospitals or non-profit organizations. Hospital-based and non-profit dialysis units typically are more difficult to acquire than physician-owned dialysis centers.

FMC also manufactures a full line of dialysis supplies and equipment in addition to owning and operating outpatient dialysis centers worldwide. This may give FMC cost advantages over us because of its ability to manufacture its own products. Additionally, FMC has been one of our largest suppliers of dialysis products and equipment over the last several years. In January 2010, we entered into and subsequently extended an agreement with FMC to purchase a certain amount of dialysis equipment, parts and supplies from FMC through February 29, 2016. We are currently renegotiating this agreement to extend the period of the agreement and to finalize the costs of our dialysis products. In addition, we entered in to a product supply agreement with Baxter Healthcare Corporation (Baxter) that commits us to purchase a certain amount of dialysis supplies through 2018. Our purchases of products in these categories generally offered by both FMC and Baxter represent approximately 4% of our total U.S. dialysis operating expenses. In 2015, we purchased hemodialysis products and supplies from both FMC and Baxter that each represented approximately 2% of our total U.S.

dialysis operating expenses. The amount of purchases in future years from FMC will depend upon a number of factors, including the operating requirements of our centers, the number of centers we acquire, and growth of our existing centers.

HCP's competition

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

Corporate compliance program

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

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

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

- requires that we maintain certain elements of our compliance programs;
- imposes certain expanded compliance-related requirements during the term of the CIA, including increased training for teammates, physician partners and board members, implementing a series of procedures prior to entering into arrangements with referrals sources, execution of annual certifications by senior executives that evidence compliance with federal healthcare laws and regulations, internal compliance policies and the CIA, imposition of an executive recoupment program and quarterly and annual reports to the OIG;
- requires the formal allocation of certain oversight responsibility to the Board Compliance Committee and a resolution from that committee that it has made reasonable inquiry into the operations of the compliance program and the retention of an independent compliance advisor in year three of the CIA;
- contains certain business restrictions related to a subset of our joint venture arrangements, including our agreeing to:
    1. unwind 11 joint venture transactions, all of which have been completed,
    2. not enter into certain types of partial divestiture joint venture transactions with nephrologists during the term of the CIA, and
    3. certain other restrictions;
- requires that we engage an Independent Monitor who will provide additional oversight and reporting to the OIG for the term of the CIA.

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

Insurance

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

Teammates

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

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

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

Item 1A. Risk Factors.

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

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

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

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

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

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

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

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

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

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

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

- Risk that our rates are reduced by CMS. Uncertainty about future payment rates remains a material risk to our business. In December 2013, CMS published the 2014 final rule for the ESRD PPS, which phases in the payment reductions mandated by the American Taxpayer Relief Act of 2012 as modified by the Protecting Access to Medicare Act of 2014, which will reduce our market basket inflation adjustment by 1.25% in 2016 and 2017, and 1% in 2018. In November 2014, CMS published the 2015 final rule for the ESRD PPS, which increased payments to dialysis facilities in 2015 by 0.3% to 0.5%, although rural facilities received a decrease of 0.5%. CMS also recently issued the 2016 final rule for the ESRD PPS, which cuts dialysis facilities' bundled payment rate for 2016 as compared to 2015 and includes adjustments for certain co-morbidities and other patient health factors and rural facilities. CMS believes its 2016 final rule for the ESRD PPS will (i) increase overall payments to both hospital-based and freestanding dialysis facilities by approximately 0.20%, and (ii) decrease overall payments to rural dialysis facilities by approximately 0.10%.

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

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

- Risk that, if our clinical systems fail to accurately capture the data we report to CMS in connection with claims for which at least part of the government's payments to us is based on clinical performance or patient outcomes or co-morbidities, we might be over-reimbursed by the government which could subject us to certain liability. For example, we are required to return overpayments including, federal funds, within sixty days of identification or claims associated with those overpayments are subject to FCA penalties.

For additional details regarding the risks we face for failing to adhere to our Medicare and Medicaid regulatory compliance obligations, see the risk factor below under the heading "If we fail to adhere to all of the complex government regulations that apply to our business, we could suffer severe consequences that would substantially reduce our revenues, earnings, cash flows and stock price."

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

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

The healthcare reform legislation, enacted in 2010, introduced healthcare insurance exchanges which provide a marketplace for eligible individuals and small employers to purchase healthcare insurance. While patients have begun receiving insurance coverage through these exchanges, the business and regulatory environment for these exchanges continues to evolve as the exchanges mature. Additionally, there is uncertainty about how the applicable state and federal agencies will enforce regulations relating to the exchanges. Although we cannot predict the short- or long-term effects of these factors, we believe the healthcare insurance exchanges could result in a reduction in ESRD patients covered by traditional commercial insurance policies and an increase in the number of patients covered through the exchanges under more restrictive commercial plans with lower reimbursement rates or higher deductibles and co-payments that patients may not be able to pay. Approximately eight million individuals were enrolled in the exchanges in 2014, with that number increasing to approximately 11 million in 2015. To the extent that the ongoing implementation of such exchanges or changes in regulations or enforcement of regulations regarding the exchanges results in a reduction in reimbursement rates for our services from commercial and/or government payors, our revenues, earnings and cash flows could be adversely affected.

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

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

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

CMS instituted new screening procedures which we expect will delay the Medicare contractor approval process, potentially causing a delay in reimbursement. We anticipate the new screening and enrollment requirements will require additional personnel and financial resources and will potentially delay the enrollment and revalidation of our centers which in turn will delay payment. These delays may negatively impact our revenues, earnings and cash flows.

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

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

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

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

The VA adopted Medicare's bundled PPS pricing methodology for any veterans receiving treatment from non-VA providers under a national contracting initiative. Since we are a non-VA provider, these reimbursements are tied to a percentage of Medicare reimbursement, and we have exposure to any dialysis reimbursement changes made by CMS. Approximately 2% of our dialysis services revenues for the year ended December 31, 2015 was generated by the VA.

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

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

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

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

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

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

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

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

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

In October 2014, we entered into a Settlement Agreement with the United States and relator David Barbetta to resolve the then pending 2010 and 2011 U.S. Attorney physician relationship investigations and paid $406 million in settlement amounts, civil forfeiture, and interest to the United States and certain states. In connection with the resolution of these matters, and in exchange for the OIG's agreement not to exclude us from participating in the federal healthcare programs, we have entered into a five-year CIA with the OIG. The CIA (i) requires that we maintain certain elements of our compliance programs, (ii) imposes certain expanded compliance-related requirements during the term of the CIA, (iii) requires ongoing monitoring and reporting by an independent monitor, imposes certain reporting, certification, records retention and training obligations, allocates certain oversight responsibility to the Board's Compliance Committee, necessitates the creation of a Management Compliance Committee and the retention of an independent compliance advisor to the Board, and (iv) contains certain business restrictions related to a subset of our joint venture arrangements, including our agreeing to (i) unwind 11 joint venture transactions that were created through partial divestitures to, or partial acquisitions from, nephrologists and that cover 26 of our 2,119 clinics that existed at the time we entered into the Settlement Agreement, all of which have been completed, (ii) not enter into certain types of partial divestiture joint venture transactions with nephrologists during the term of the CIA, (iii) non-enforcement of certain patient-related non-solicitation restrictions, and (iv) certain other restrictions. The costs associated with compliance with the CIA could be substantial and may be greater than we currently anticipate. In addition, in the event of a breach of the CIA, we could become liable for payment of certain stipulated penalties, and could be excluded from participation in federal healthcare programs. The OIG notified us that it considered us to be previously in breach of the CIA because of three implementation deficiencies. While we have remediated the deficiencies and have paid certain stipulated penalties, we cannot provide any assurances that we may not be found in breach of the CIA in the future. In general, the costs associated with compliance with the CIA, or any liability or consequences associated with a breach, could have a material adverse effect on our revenues, earnings and cash flows. For our domestic dialysis business, we are required under the CIA to report to the OIG (i) probable violations of criminal, civil or administrative laws applicable to any federal health care program for which penalties or exclusions may be authorized under applicable laws and regulations, (ii) substantial overpayments of amounts of money we have received in excess of the amounts due and payable under the federal healthcare program requirements, and (iii) employment of or contracting with individuals ineligible from participating in the federal healthcare programs (we refer to these collectively as Reportable Events). We have provided the OIG notice of Reportable Events and we may identify and report additional events in the future. If any of our operations are found to violate government laws and regulations, we could suffer severe consequences that would have a material adverse effect on our revenues, earnings, cash flows and stock price, including those consequences described under the risk factor "If we fail to adhere to all of the complex government regulations that apply to our business, we could suffer severe consequences that would substantially reduce our revenues, earnings, cash flows and stock price."

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

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

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

As of December 31, 2015, we owned a controlling interest in numerous dialysis-related joint ventures, which represented approximately 23% of our dialysis and related lab services revenues for the year ended December 31, 2015. In addition, we also owned minority equity investments in several other dialysis related joint ventures. We may continue to increase the number of our joint ventures. Many of our joint ventures with physicians or physician groups also have certain physician owners providing medical director services to centers we own and operate. Because our relationships with physicians are governed by the federal and state anti-kickback statutes, we have sought to structure our joint venture arrangements to satisfy as many federal safe harbor requirements as we believe are commercially reasonable. However, although our joint venture arrangements do not satisfy all of the elements of any safe harbor under the federal Anti-Kickback Statute, they are not automatically prohibited under the federal Anti-Kickback Statute but are susceptible to government scrutiny. In October 2014, we entered into a Settlement Agreement with the United States and relator David Barbetta to resolve the then pending 2010 and 2011 U.S. Attorney physician relationship investigations regarding certain of our joint ventures and paid $406 million in settlement amounts, civil forfeiture, and interest to the United States and certain states. For further details, please see "If we fail to comply with our CIA, we could be subject to substantial penalties and exclusion from participation in federal healthcare programs that may adversely impact our revenues, earnings and cash flows".

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

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

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

Our ancillary services and strategic initiatives currently include pharmacy services, disease management services, vascular access services, ESRD clinical research programs, physician services, physician practice management services, direct primary care and our international dialysis operations. We expect to add additional service offerings and pursue additional strategic initiatives in the future as circumstances warrant, which could include healthcare services not related to dialysis. Many of these initiatives require or would require investments of both management and financial resources and can generate significant losses for a substantial period of time and may not become profitable. There can be no assurance that any such strategic initiative will ultimately be successful. Any significant change in market conditions, or business performance, or in the political, legislative or regulatory environment, may impact the economic viability of any of these strategic initiatives. If any of our ancillary services or strategic initiatives, including our international dialysis operations, do not perform as planned, we may incur a material write-off or an impairment of our investment, including goodwill, in one or more of these activities or we could incur significant termination costs if we were to exit a certain line of business.

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

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

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

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

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

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

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

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

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

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

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

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

We recently launched a new billing system that is critical to our billing operations. If there are defects in the new billing system, we may experience difficulties in our ability to successfully bill and collect for services rendered, including a delay in collections, a reduction in the amounts collected, increased risk of retractions from and refunds to commercial and government payors, an increase in our provision for uncollectible accounts receivable and noncompliance with reimbursement regulations. To mitigate this risk, we launched the new system in phases; however, any defects in the new billing and collection system could have a material adverse effect on our revenues, cash flows and operating results.

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

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

Risk factors related to HCP:

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

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

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

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

Over 90% of HCP's revenue for the year ended December 31, 2015 is derived from fixed PMPM fees paid by health plans under capitation agreements with HCP or its associated physician groups. While there are variations specific to each arrangement, HCP, through DHPP and, in certain instances, HCP's associated physician groups generally contract with health plans to receive a PMPM fee for professional services and assume the financial responsibility for professional services only. In some cases, the health plans separately enter into capitation contracts with third parties (typically hospitals) who receive directly a PMPM fee and assume contractual financial responsibility for hospital services. In other cases, the health plan does not pay any portion of the PMPM fee to the hospital, but rather administers claims for hospital expenses itself. In both scenarios, HCP enters into managed care-related administrative services agreements or similar arrangements with those third parties (typically hospitals) under which HCP agrees to be responsible for utilization review, quality assurance, and other managed care-related administrative functions and claim payments. As compensation for such administrative services, HCP is entitled to receive a percentage of the amount by which the institutional

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

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

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

- the health status of members;
- higher than expected utilization of new or existing healthcare services or technologies;
- an increase in the cost of healthcare services and supplies, including pharmaceuticals, whether as a result of inflation or otherwise;
- changes to mandated benefits or other changes in healthcare laws, regulations, and practices;
- periodic renegotiation of provider contracts with specialist physicians, hospitals, and ancillary providers;
- periodic renegotiation of contracts with HCP's affiliated primary care physicians and specialists;
- changes in the demographics of the participating members and medical trends;
- contractual or claims disputes with providers, hospitals, or other service providers within a health plan's network;
- the occurrence of catastrophes, major epidemics, or acts of terrorism; and
- the reduction of health plan premiums.

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

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

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

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

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

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

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

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

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

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

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

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

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

- Maintain, at all times, a minimum TNE;
- Submit periodic financial solvency reports to the DMHC containing various data regarding performance and financial solvency;
- Comply with extensive regulatory requirements; and
- Submit to periodic regulatory audits and reviews concerning DaVita HealthCare Partner Plan operations and compliance with Knox-Keene.

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

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

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

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

In the event that HCP's associated physician group is not in compliance with any of the above criteria, HCP's associated physician group could be subject to sanctions, or limitations on, or removal of, its ability to do business in California.

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

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

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

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

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

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

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

- Medicare Advantage benchmarks for 2011 were frozen at 2010 levels. Beginning in 2012, Medicare Advantage benchmark rates are being phased down from prior levels to levels that are between 95% and 115% of the Medicare FFS costs, depending on a plan's geographic area. If our costs escalate faster than can be absorbed by the level of revenues implied by these benchmark rates, then it could have a significant negative impact on HCP's earnings and cash flows.

- Rebates received by Medicare Advantage plans that underbid based on payment benchmarks will be reduced, with larger reductions for plans failing to receive certain quality ratings.

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

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

- Prescription drug plans are now required to cover all drugs on a list developed by the Secretary of HHS, which could increase the cost of providing care to Medicare Advantage enrollees, and thereby reduce HCP's revenues and earnings. The Medicare Part D premium subsidy for high-income beneficiaries has been reduced by 25%, which could lower the number of Medicare Advantage enrollees, which would have a negative impact on HCP's revenues, earnings and cash flows.

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

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

There is uncertainty regarding both Medicare Advantage payment rates and beneficiary enrollment, which, if reduced as a result of the implementation of the Health Reform Acts, would reduce HCP's overall revenues and net income. For example, although the CBO predicted in 2012 that Medicare Advantage participation would drop precipitously by 2020, in 2013 the CBO reversed its prediction and instead predicted that enrollment in Medicare Advantage could increase by up to 50% in the next decade. Although Medicare Advantage enrollment increased by approximately 5.6 million, or by 50 percent, between the enactment of the ACA in 2010 and 2015, there can be no assurance that this trend will continue. Further, fluctuation in Medicare Advantage payment rates were evidenced by CMS's announcement in its final 2015 Call Letter that Medicare Advantage rates would rise an average of 0.4% in 2015, instead of falling 1.9% as it had predicted in February 2014. On April 6, 2015, CMS announced its Medicare Advantage rates for 2016. See above for further details. Uncertainty over Medicare Advantage enrollment and payment rates present a continuing risk to HCP's business.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The penalties for a violation of the FCA range from $5,500 to $11,000 (adjusted for inflation) for each false claim plus three times the amount of damages caused by each such claim which generally means the amount received directly or indirectly from the government. Given the high volume of claims processed by our various operating units, the potential is high for substantial penalties in connection with any alleged FCA violations. The federal government has used the FCA to prosecute a wide variety of alleged false claims and fraud allegedly perpetrated against Medicare and state healthcare programs, including coding errors, billing for services not rendered, the submission of false cost reports, billing for services at a higher payment rate than appropriate, billing under a comprehensive code as well as under one or more component codes included in the comprehensive code and billing for care that is not considered medically necessary. In addition to the provisions of the FCA, which provide for civil enforcement, the federal government can use several criminal statutes to prosecute persons who are alleged to have submitted false or fraudulent claims for payment to the federal government. The Civil Investigative Demand (CID) received by our wholly owned pharmacy services subsidiary, DaVita Rx, LLC, specifically references that it is in connection with an FCA investigation concerning allegations that this subsidiary presented or caused to be presented false claims for payment to the government. See the risk factor that immediately follows below for further details.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

We must comply with numerous federal and state laws and regulations governing the collection, dissemination, access, use, security and privacy of PHI, including HIPAA and its implementing privacy and security regulations, as amended by the federal HITECH Act and collectively referred to as HIPAA. If we fail to comply with applicable privacy and security laws, regulations and standards, including with respect to third-party service providers that utilize sensitive personal information, including PHI, on our behalf, properly maintain the integrity of our data, protect our proprietary rights to our systems, or defend against cybersecurity attacks, our business, reputation, results of operations, financial position and cash flows could be materially and adversely affected.

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

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

Any security breach involving the misappropriation, loss or other unauthorized disclosure or use of confidential information, including PHI, financial data, competitively sensitive information, or other proprietary data, whether by us or a third party, could have a material adverse effect on our business, reputation, financial condition, cash flows, or results of operations. The occurrence of any of these events could result in interruptions, delays, the loss or corruption of data, cessations in the availability of systems or liability under privacy and security laws, all of which could have a material adverse effect on our financial position and results of operations and harm our business reputation. If we are unable to protect the physical and electronic security and privacy of our databases and transactions, we could be subject to potential liability and regulatory action, our reputation and relationships with our patients and vendors would be harmed, and our business, operations, and financial results may be materially adversely affected. Failure to adequately protect and maintain the integrity of our information systems (including our networks) and data, or to defend against cybersecurity attacks, could subject us to monetary fines, civil suits, civil penalties or criminal sanctions and requirements to disclose the breach publicly, and may further result in a material adverse effect on our results of operations, financial position, and cash flows.

There have been increased federal and state HIPAA privacy and security enforcement efforts and we expect this trend to continue. Under HITECH, state attorneys general have the right to prosecute HIPAA violations committed against residents of their states. Several such actions have already been brought against both covered entities and a business associate, and continued enforcement actions are likely to occur in the future. In addition, HITECH mandates that the Secretary of HHS conduct periodic compliance audits of HIPAA covered entities and business associates. It also tasks HHS with establishing a methodology whereby individuals who are harmed by HIPAA violations may receive a percentage of the civil monetary penalty fine or monetary settlement paid by the violator.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Most of our outstanding employee stock-based compensation awards include a provision accelerating the vesting of the awards in the event of a change of control. We also maintain a change of control protection program for our employees who do not have a significant number of stock awards, which has been in place since 2001, and which provides for cash bonuses to the employees in the event of a change of control. Based on the market price of our common stock and shares outstanding on December 31, 2015, these cash bonuses would total approximately $577 million if a change of control transaction occurred at that price and our Board of Directors did not modify this program. These change of control provisions may affect the price an acquirer would be willing to pay for our Company.

We are also subject to Section 203 of the Delaware General Corporation Law that, subject to exceptions, would prohibit us from engaging in any business combinations with any interested stockholder, as defined in that section, for a period of three years following the date on which that stockholder became an interested stockholder.

These provisions may discourage, delay or prevent an acquisition of our Company at a price that our stockholders may find attractive. These provisions could also make it more difficult for our stockholders to elect directors and take other corporate actions and could limit the price that investors might be willing to pay for shares of our common stock.

Item 1B. Unresolved Staff Comments.

None.

Item 2. Properties.

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

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

Our leases for our dialysis and related lab services and for HCP generally cover periods from five to 20 years and typically contain renewal options of five to ten years at the fair rental value at the time of renewal. Our leases are generally subject to periodic consumer price index increases, or contain fixed escalation clauses. Our outpatient dialysis centers range in size from approximately 500 to 33,000 square feet, with an average size of approximately 7,500 square feet. HCP's clinics range in size from approximately

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

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

Office	Location	Square Feet	Expiration
U.S. Dialysis and related lab service and other ancillary business:			
Corporate Headquarters	Denver, CO	240,000	Owned
Corporate Headquarters	Denver, CO	116,000	2018
Administrative Office	Vernon Hills, IL	33,000	2019
Administrative Office	Washington DC	4,000	2019
Administrative Office	Centennial, CO	29,000	2018
Business Office	El Segundo, CA	73,700	2017 through 2023
Business Office	Tacoma, WA	119,000	2021
Business Office	Malvern, PA	138,000	2026
Business Office	Brentwood, TN	129,000	2016 through 2025
Business Office	Irvine, CA	66,000	2024
Business Office	Federal Way, WA	188,000	2023
DaVita Rx	Orlando, FL	51,000	2020
DaVita Rx	Coppell, TX	135,000	2019
DaVita Rx	Chandler, AZ	75,000	2027
DaVita Rx	San Bruno, CA	22,200	2017
Laboratory	DeLand, FL	36,000	Owned
Laboratory Warehouse and Offices	DeLand, FL	52,000	2014 through 2016
Laboratory	Hollywood, FL	43,000	2019
Laboratory Office	Miami, FL	1,000	2016
HCP business:			
Administrative Office	Albuquerque, NM	135,000	2016
Administrative Office	Arcadia, CA	24,000	2019
Administrative Office	Colorado Springs, CO	42,000	2018 through 2019
Administrative Office	Coral Springs, FL	4,000	2018
Administrative Office	Costa Mesa, CA	27,000	2017
Administrative Office	El Segundo, CA	185,000	2025
Administrative Office	Fort Harrison, FL	2,000	2018
Administrative Office	Las Vegas, NV	37,000	2016 and Month to Month
Administrative Office	Los Angeles, CA	46,000	2021
Administrative Office	Orlando, FL	2,000	Month-to-Month
Administrative Office	Palm Harbor, FL	3,000	2017
Administrative Office	Peoria, AZ	6,000	2016
Administrative Office	Phoenix, AZ	14,000	2019
Administrative Office	St. Petersburg, FL	43,000	2020
Administrative Office	Torrance, CA	151,000	2017 through 2021
International business:			
Administrative Office	Bogota, Colombia	7,496	2023
Administrative Office	Singapore, Singapore	5,302	2017
Administrative Office	Bangalore, India	4,628	2016 through 2021
Administrative Office	Benxi, China	3,632	2016
Administrative Office	Amsterdam, Netherlands	3,296	2020
Administrative Office	Riyadh, Saudi Arabia	3,122	2017
Administrative Office	Kuala Lumpur, Malaysia	3,115	2016
Administrative Office	Shanghai, China	2,920	2016
Administrative Office	Hamburg, Germany	2,205	2020
Administrative Office	Taipei , Taiwan	2,160	2017
Administrative Office	Wroclaw, Poland	1,162	2017
Administrative Office	Carnaxide, Portugal	842	2016

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

Item 3. Legal Proceedings.

Inquiries by the Federal Government and Certain Related Civil Proceedings

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

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

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

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

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

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

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

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

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

Other

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

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

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

Item 4. Mine Safety Disclosures.

Not applicable.

PART II

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

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

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

The closing price of our common stock on January 29, 2016 was $67.12 per share. According to Computershare, our registrar and transfer agent, as of January 29, 2016, there were 10,273 holders of record of our common stock. We have not declared or paid cash dividends to holders of our common stock since 1994. We have no current plans to pay cash dividends and we are restricted from paying dividends under the terms of our Senior Secured Credit Facilities and the indentures governing our senior notes. Also, see the heading "Liquidity and Capital Resources" under "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations" and the notes to our consolidated financial statements.

Stock Repurchases

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

Period	Total Number of Shares Purchased	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs(1)	Approximate Dollar Value of Shares that May Yet Be Purchased Under the Plans or Programs (in millions)
October 1 - October 31, 2015	2,200	$ 71.01	2,200	$ 659.3
November 1 - November 30, 2015	—	$ —	—	$ 659.3
December 1 - December 31, 2015	2,154,751	$ 69.85	2,154,751	$ 508.7
Total	2,156,951	$ 69.86	2,156,951	$ 508.7

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

Item 6. Selected Financial Data.

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

	Year ended December 31,				
	2015	2014	2013	2012 (5)	2011
	(in thousands, except share data)				
Income statement data:					
Net revenues(1)	$ 13,781,837	$ 12,795,106	$ 11,764,050	$ 8,186,280	$ 6,731,806
Operating expenses and charges(2)	12,611,142	10,979,965	10,213,916	6,889,196	5,577,093
Operating income	1,170,695	1,815,141	1,550,134	1,297,084	1,154,713
Debt expense	(408,380)	(410,294)	(429,943)	(288,554)	(241,090)
Debt refinancing and redemption charges	(48,072)	(97,548)	—	(10,963)	—
Other income, net	8,893	2,374	4,787	3,737	2,982
Income from continuing operations before income taxes	723,136	1,309,673	1,124,978	1,001,304	916,605
Income tax expense	295,726	446,343	381,013	359,845	325,292
Income from continuing operations	427,410	863,330	743,965	641,459	591,313
Income from operations of discontinued operations, net of tax(3)	—	—	(139)	(222)	(13,162)
Loss on disposal of discontinued operations, net of tax(3)	—	—	13,375	—	(4,756)
Net income	$ 427,410	$ 863,330	$ 757,201	$ 641,237	573,395
Less: Net income attributable to noncontrolling interests	(157,678)	(140,216)	(123,755)	(105,220)	(95,394)
Net income attributable to DaVita HealthCare Partners Inc.	$ 269,732	$ 723,114	$ 633,446	$ 536,017	$ 478,001
Basic income from continuing operations per share attributable to DaVita HealthCare Partners Inc.(3)(4)	$ 1.27	$ 3.41	$ 2.95	$ 2.79	$ 2.62
Diluted income from continuing operations per share attributable to DaVita HealthCare Partners Inc.(3)(4)	$ 1.25	$ 3.33	$ 2.89	$ 2.74	$ 2.57
Weighted average shares outstanding:(4)					
Basic	211,868,000	212,302,000	209,939,000	192,036,000	189,316,000
Diluted	216,252,000	216,928,000	214,764,000	195,942,000	193,064,000
Ratio of earnings to fixed charges(6)	1.95:1	3.05:1	2.73:1	3.17:1	3.39:1
Balance sheet data:					
Working capital(1)	$ 2,104,142	$ 1,547,519	$ 600,788	$ 546,478	$ 848,110
Total assets(1)	18,514,875	17,617,432	16,612,401	15,594,345	8,570,168
Long-term debt(1)	9,001,308	8,298,624	8,064,196	8,230,393	4,364,366
Total DaVita HealthCare Partners Inc. shareholders equity(4)	4,870,780	5,170,513	4,432,479	3,763,137	2,141,075

(1) Effective January 1, 2012, we were required to present our provision for uncollectible accounts related to patient service revenues as a reduction from our patient service revenues, which changed the classification of our provision for uncollectible accounts related to patient service revenues. In 2015, we retrospectively adopted ASU 2015-03 related to simplification of debt issuance costs as well as ASU 2015-17 related to classification of deferred taxes (see "New Accounting Standards" below). All prior periods have been recast to conform to the current year presentation.

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

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

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

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

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

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

Forward-looking statements

This Annual Report on Form 10-K, including this Management's Discussion and Analysis of Financial Condition and Results of Operations, contains statements that are forward-looking statements within the meaning of the federal securities laws. All statements that do not concern historical facts are forward-looking statements and include, among other things, statements about our expectations, beliefs, intentions and/or strategies for the future. These forward-looking statements include statements regarding our future operations, financial condition and prospects, expectations for treatment growth rates, revenue per treatment, expense growth, levels of the provision for uncollectible accounts receivable, operating income, cash flow, operating cash flow, estimated tax rates, capital expenditures, the development of new dialysis centers and dialysis center acquisitions, government and commercial payment rates, revenue estimating risk and the impact of our level of indebtedness on our financial performance and including earnings per share. These statements involve substantial known and unknown risks and uncertainties that could cause our actual results to differ materially from those described in the forward-looking statements, including but not limited to, risks resulting from the concentration of profits generated by higher-paying commercial payor plans for which there is continued downward pressure on average realized payment rates, and a reduction in the number of patients under such plans, which may result in the loss of revenues or patients, a reduction in government payment rates under the Medicare ESRD program or other government-based programs, the impact of the CMS 2015 Medicare Advantage benchmark structure, risks arising from potential federal and/or state legislation that could have an adverse effect on our operations and profitability, changes in pharmaceutical or anemia management practice patterns, payment policies, or pharmaceutical pricing, legal compliance risks, including our continued compliance with complex government regulations including compliance with the provisions of our current CIA and current or potential investigations by various government entities and related government or private-party proceedings, and the related restrictions on our business and operations required by the CIA and other settlement terms, and the financial impact thereof, continued increased competition from large- and medium-sized dialysis providers that compete directly with us, our ability to maintain contracts with physician medical directors, changing affiliation models for physicians, and the emergence of new models of care introduced by the government or private sector that may erode our patient base and reimbursement rates such as ACOs, IPAs and integrated delivery systems, or to businesses outside of dialysis and HCP's business, our ability to complete acquisitions, mergers or dispositions that we might be considering or announce, or to integrate and successfully operate any business we may acquire or have acquired, including HCP, or to expand our operations and services to markets outside the U.S., the variability of our cash flows, the risk that we might invest material amounts of capital and incur significant costs in connection with the growth and development of our international operations, yet we might not be able to operate them profitably anytime soon, if at all, risks arising from the use of accounting estimates, judgments and interpretations in our financial statements, risk of losing key HCP employees, potential disruption from the HCP transaction making it more difficult to maintain business and operational relationships with customers, partners, associated physicians and physician groups, hospitals and others, the risk that laws regulating the corporate practice of medicine could restrict the manner in which HCP conducts its business, the risk that the cost of providing services under HCP's agreements may exceed our compensation, the risk that reductions in reimbursement rates, including Medicare Advantage rates, and future regulations may negatively impact HCP's business, revenue and profitability, the risk that HCP may not be able to successfully establish a presence in new geographic regions or successfully address competitive threats that could reduce its profitability, the risk that a disruption in HCP's healthcare provider networks could have an adverse effect on HCP's business operations and profitability, the risk that reductions in the quality ratings of health maintenance organization plan customers of HCP could have an adverse effect on HCP's business, or the risk that health plans that acquire health maintenance organizations may not be willing to contract with HCP or may be willing to contract only on less favorable terms, and the other risk factors set forth in Part II, Item 1A. of this Annual Report on Form 10-K. We base our forward-looking statements on information currently available to us at the time of this Annual Report on Form 10-K, and except as required by law we undertake no obligation to update or revise any forward-looking statements, whether as a result of changes in underlying factors, new information, future events or otherwise.

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

Company overview

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

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

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

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

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

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

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

The following table summarizes consolidated net revenues:

	Year ended December 31,		
	2015	2014	2013
	(dollar amounts rounded to nearest million)		
Net revenues:			
Dialysis and related lab services patient service revenues	$ 9,034	$ 8,551	$ 8,033
Less: Provision for uncollectible accounts	(406)	(353)	(281)
Dialysis and related lab services net patient service revenues	8,628	8,198	7,752
Other revenues	14	13	12
Total net dialysis and related lab services revenues	8,642	8,211	7,764
HCP capitated revenues	3,437	3,191	2,920
HCP net patient service revenues (less provision for uncollectible accounts of $15, $13 and $12, respectively)	318	219	220
Other revenue	82	92	56
Total net HCP revenues	3,837	3,502	3,196
Other-ancillary services and strategic initiatives revenues	1,150	947	709
Other-capitated revenues	72	70	67
Other-ancillary services and strategic initiatives net patient service revenues (less provision for uncollectible accounts)	160	122	76
Total net other-ancillary services and strategic initiatives revenues	1,382	1,139	852
Total net segment revenues	13,861	12,852	11,812
Elimination of intersegment revenues	(79)	(57)	(48)
Consolidated net revenues	$ 13,782	$ 12,795	$ 11,764

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

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

(1) For the year ended December 31, 2015, we have excluded estimated non-cash goodwill and other intangible asset impairment charges of $210 million primarily related to certain HCP reporting units, an estimated accrual of $22 million for damages and liabilities associated with our pharmacy business, which is included in general and administrative expenses, and $495 million related to a settlement charge in connection with the Vainer private civil suit. In addition, for the years ended December 31, 2014 and 2013, we have excluded $17 million and $397 million, respectively, related to loss contingency accruals for the settlement of the 2010 and 2011 U.S. Attorney physician relationship investigations. In 2013, we have also excluded $57 million related to a decrease in HCP's 2013 contingent earn-out obligation and an adjustment of $8 million to reduce a tax asset associated with the HCP acquisition escrow provisions. These are non-GAAP measures and are not intended as substitutes for the GAAP equivalent measures. We have presented these adjusted amounts because management believes that these presentations enhance a user's understanding of our normal consolidated operating income by excluding certain unusual items which we do not believe are indicative of our ordinary results of operations. As a result, adjusting for these amounts allows for comparison to our normal prior period results.

Consolidated net revenues

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

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

Consolidated operating income

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

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

U.S. dialysis and related lab services business

Our U.S. dialysis and related lab services business is a leading provider of kidney dialysis services through a network of 2,251 outpatient dialysis centers in 46 states and the District of Columbia, serving a total of approximately 180,000 patients. We also provide acute inpatient dialysis services in approximately 900 hospitals. We estimate that we have approximately a 36% market share in the U.S. based upon the number of patients that we serve. In 2015, our overall network of U.S. outpatient dialysis centers net increased by 72 dialysis centers primarily as a result of the opening new dialysis centers and from acquisitions of dialysis centers. In addition, the overall number of patients that we serve in the U.S. increased by approximately 4.1% in 2015 as compared to 2014. All references in this document to dialysis and related lab services refer only to our U.S. dialysis and related lab services business.

Our dialysis and related lab services stated mission is to be the provider, partner and employer of choice. We believe our attention to these three stakeholders—our patients, our business partners, and our teammates—represents the major driver of our long-term performance, although we are subject to the impact of several external factors such as government policy, physician practice patterns, commercial payor payment rates and the mix of commercial and government patients. Two principal non-financial metrics we track are quality clinical outcomes and teammate turnover. We have developed our own composite index for measuring improvements in our clinical outcomes, which we refer to as the DaVita Quality Index (DQI). Our clinical outcomes as measured by DQI have improved over each of the past several years which we believe directly decreases patient mortalities. Our patient mortality percentages have decreased from 19.0% in 2001 to 13.7% in 2014. Although it is difficult to reliably measure clinical performance across our industry, we believe our clinical outcomes compare favorably with other dialysis providers in the U.S. and generally exceed the dialysis outcome quality indicators of the National Kidney Foundation. In addition, over the past several years our clinical teammate turnover has remained relatively constant and we believe that a relatively stable teammate turnover in 2015 was a major

contributor to our continued clinical performance improvements and can also be a major driver of our ability to maintain or improve clinical hours per treatment. We will continue to focus on these three stakeholders and our clinical outcomes as we believe these are fundamental long-term value drivers.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dialysis payment rates from commercial payors can vary and a major portion of our commercial rates are set at contracted amounts with payors and are subject to intense negotiation pressure. Our commercial payment rates also include payments for out-of-network patients that on average are higher than our in-network commercial contract rates. In 2015, we were successful in increasing some of our commercial contracted payment rates which contributed to an increase in our average dialysis revenue per treatment. We continue to enter into some commercial contracts covering certain patients that will primarily pay us a single bundled payment rate for all dialysis services provided to these patients. However, some of the contracts will pay us for certain other services and pharmaceuticals in addition to the bundled payment. We are continuously in the process of negotiating agreements with our commercial payors, and if our negotiations result in overall commercial contract payment rate reductions in excess of our commercial contract payment rate increases, our revenues and operating results could be negatively impacted. In addition, if there is an increase in job losses in the U.S., or depending upon changes to the healthcare regulatory system by CMS and/or the impact of healthcare insurance exchanges, we could experience a decrease in the number of patients covered under traditional commercial insurance plans. Patients with commercial insurance who cannot otherwise maintain coverage frequently rely on financial assistance from charitable

organizations, such as the American Kidney Fund. If these patients are unable to obtain or continue to receive such financial assistance, our revenues, earnings, and cash flows could be substantially reduced.

Approximately 2% of our dialysis and related lab services revenues for the year ended December 31, 2015, were from physician-prescribed pharmaceuticals that are separately billable, with EPO accounting for approximately 1% of our dialysis and related lab services revenues. The impact of physician-prescribed pharmaceuticals on our overall revenues that are separately billable has significantly decreased since Medicare's single bundled payment system went into effect, as well as some additional commercial contracts that pay us a single bundled payment rate.

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

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

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

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

The principal drivers of our dialysis and related lab services patient care costs are clinical hours per treatment, labor rates, vendor pricing of pharmaceuticals, utilization levels of pharmaceuticals, business infrastructure costs, which include the operating costs of our dialysis centers, and certain professional fees. However, other cost categories can also represent significant cost variability, such as employee benefit costs, payroll taxes, insurance costs and medical supply costs. Our average clinical hours per treatment or productivity levels in 2015 improved slightly compared to 2014, which was primarily the result of improvements in our internal procedures and processes. We are always striving for improved productivity levels, however, changes in federal and state policies or regulatory billing requirements can lead to increased labor costs in order to implement these new requirements, which can adversely impact our ability to achieve optimal productivity levels. In addition, improvements in the U.S. economy have stimulated additional competition for skilled clinical personnel resulting in slightly higher teammate turnover in 2015, which we believe negatively affected productivity levels. In 2015 and 2014, we experienced an increase in our clinical labor rates of approximately 0.9% and 1.5%, respectively, as clinical labor rates have increased consistent with general industry trends, mainly due to the high demand for skilled clinical personnel, along with general inflation increases. In 2015, we experienced a significant increase in our pharmaceutical unit costs. We also continue to experience increases in our infrastructure and operating costs of our dialysis centers, primarily due to the number of new dialysis centers opened, and general increases in rent, utilities and repairs and maintenance. However, in 2015, we continued to implement certain cost control initiatives to manage our overall operating costs, including labor productivity.

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

Results of Operations

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

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

Net revenues

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

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

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

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

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

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

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

Operating expenses and charges

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

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

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

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

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

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

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

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

Segment operating income

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

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

HCP business

HCP is a patient- and physician-focused, integrated healthcare delivery and management company with over two decades of experience providing coordinated, outcomes-based medical care in a cost-effective manner. As of December 31, 2015, HCP had approximately 807,400 members under its care in southern California, Colorado, central and south Florida, southern Nevada, central New Mexico and central Arizona through capitation contracts with some of the nation's leading health plans. Of these 807,400 members, approximately 317,400 individuals were patients enrolled in Medicare Advantage, and the remaining approximately 490,000 individuals were managed care members whose health coverage is provided through their employer or who have individually acquired health coverage directly from a health plan or as a result of their eligibility for Medicaid benefits. In addition to its managed care business, during the year ended December 31, 2015, HCP provided care in all markets to over 612,100 patients whose health coverage is structured on a FFS basis, including patients enrolled through traditional Medicare and Medicaid programs, preferred provider organizations and other third party payors.

HCP's patients as well as the patients of HCP's associated physicians, physician groups and IPAs benefit from an integrated approach to medical care that places the physician at the center of patient care. As of December 31, 2015, HCP delivered services to its members via a network of approximately 547 associated full-time primary care physicians, over 2,900 associated groups and other network primary care physicians, 240 network hospitals, and several thousand associated group and network specialists. Together with

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

Key Financial Measures and Indicators

Operating revenues

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

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

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

- *Risk-sharing model*. As compensation under its various managed care-related administrative services agreements with hospitals, HCP is entitled to receive a percentage of the amount by which the institutional capitation revenue received from health plans exceeds institutional expenses, and any such risk-share amount to which HCP is entitled is recorded as medical revenues. In addition, pursuant to such managed care-related administrative services agreements, HCP agrees to be responsible should the third party incur institutional expenses in excess of institutional capitation revenue. As with global capitation, revenue with respect to professional capitation is reported in the month in which enrollees are entitled to receive healthcare. However, risk-share revenues (that is, the portion of the excess or deficit of institutional capitation revenue to which HCP is entitled less institutional expenses), in contrast, are based on the number of enrollees and estimates of institutional utilization and associated costs incurred by assigned health plan enrollees, and the amounts accrued when earned can be reasonably estimated. Differences between actual contract settlements and estimated receivables and payables are recorded in the year of final settlement. In December 2013, HCP obtained a restricted Knox-Keene license in California, which permits HCP to enter into global capitation agreements with health plans that allow HCP to assume financial responsibility for both professional and institutional services. HCP is in the process of evaluating and identifying which risk-sharing arrangements, if any, will be converted to global capitation arrangements, subject to HCP's and the applicable health plan's satisfactory negotiation and approval, as well as approval from the Department of Managed Healthcare. Completion of such evaluation and possible conversion is expected to occur over time.

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

- *Patient service revenues.* Patient service revenues are recorded when the services are provided. Such revenues are based on a negotiated fixed-fee schedule with the applicable health plan.

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

Patient care costs

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

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

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

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

Other operating expenses

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

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

Results of Operations

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

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

Capitated membership information

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

	Members at December 31,			Member months for the year ended December 31,		
	2015	2014	2013	2015	2014	2013
Payor classification:						
Senior	317,400	310,500	265,000	3,774,300	3,587,900	2,911,700
Commercial	367,400	387,400	403,400	4,497,900	4,713,100	4,955,000
Medicaid	122,600	139,400	96,100	1,556,400	1,465,200	1,106,700
	807,400	837,300	764,500	9,828,600	9,766,200	8,973,400

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

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

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

Revenues

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

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

Net revenues

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

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

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

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

Patient care costs

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

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

Operating expenses

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

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

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

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

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

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

Goodwill and other intangible asset impairment charges. During the quarter ended December 31, 2015, we determined that circumstances indicated it had become more likely than not that the goodwill and an indefinite-lived intangible asset of certain HCP reporting units had become impaired. These circumstances included underperformance of the business in recent quarters, as well as changes in other market conditions, including government reimbursement cuts and our expected ability to mitigate them. We are performing the required valuation of these reporting units and have estimated the fair value of their net assets and implied goodwill with the assistance of a third-party valuation firm. Based on the current assessments, we recorded an estimated $206 million in goodwill and other intangible asset impairment charges. The final amount of these impairment charges will depend upon the final outcome of this valuation work, which we expect will be completed in the first quarter of 2016.

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

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

Segment operating income

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

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

Other—Ancillary services and strategic initiatives business

Our other operations include ancillary services and strategic initiatives which are primarily aligned with our core business of providing dialysis services to our network of patients. As of December 31, 2015, these consisted primarily of pharmacy services, disease management services, vascular access services, clinical research programs, physician services, direct primary care and our international dialysis operations. The ancillary services and strategic initiatives generated approximately $1.382 billion of net revenues in 2015, representing approximately 10% of our consolidated net revenues. We currently expect to continue to invest in our ancillary services and strategic initiatives including our continued expansion into certain international markets as we work to develop successful new business operations. However, any significant change in market conditions, business performance or in the regulatory environment may impact the economic viability of any of these strategic initiatives. Any unfavorable changes in these strategic initiatives could result in a write-off or an impairment of some or all of our investments, including goodwill, and could also result in significant termination costs if we were to exit a certain line of business or one or more of our international markets.

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

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

	Year ended December 31,		
	2015	2014	2013
	(dollar amounts rounded to nearest million)		
U.S. revenues			
Net patient service revenues	$ 26	$ 20	$ 15
Other revenues	1,144	941	703
Capitated revenues	72	70	67
Total	1,242	1,031	785
International revenues			
Net patient service revenues	134	102	61
Other revenues	6	6	6
Total	140	108	67
Total net revenues	$ 1,382	$ 1,139	$ 852
Total segment operating loss	$ (104)	$ (25)	$ (39)

Net revenues

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

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

Operating expenses

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

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

Operating loss

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

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

Corporate level charges

Debt expense. Debt expense for 2015, 2014, and 2013 consisted of interest expense of approximately $390 million, $386 million, and $401 million, respectively, and the amortization and accretion of debt discounts and premiums, the amortization of deferred financing costs and the amortization of interest rate cap agreements of approximately $18 million in 2015, $25 million in 2014 and $29 million in 2013. The increase in debt expense in 2015 as compared to 2014, was primarily related to an increase in weighted average outstanding principal balances offset by lower weighted average interest rates as a result of the issuance of our 5.0% Senior Notes in April 2015, as well as the entry into a new credit agreement and the issuance of senior notes in June 2014, as discussed below. Our overall weighted average effective interest rate in 2015 was 4.42% as compared to 4.68% in 2014.

The decrease in debt expense in 2014 as compared to 2013 was primarily related to our credit agreement issued in June 2014, as well as the issuance of our 5 ⅛% Senior Notes that were entered into in the second quarter of 2014 that contain lower weighted average interest rates and from lower average interest rates associated with the unhedged portion of Term Loan A. Our overall weighted average effective interest rate in 2014 was 4.68% as compared to 4.84% in 2013.

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

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

Noncontrolling interests

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

Accounts receivable

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

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

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

Liquidity and capital resources

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

Cash flow from operations during 2015 amounted to $1.6 billion, compared with $1.5 billion for 2014. The increase in our operating cash flows in 2015 as compared to 2014 was primarily due to the timing of other working capital items, a decrease in our income tax payments and a reduction in our net settlement payments and charges, offset by an increase in our cash interest payments. Cash flow from operations in 2015 included cash interest payments of approximately $405 million and cash tax payments of $156 million. Cash flow from operations in 2014 included cash interest payments of approximately $352 million and cash tax payments of $239 million.

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

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

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

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

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

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

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

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

Debt transactions

In April 2015, we issued $1.5 billion 5.0% Senior Notes due 2025 (5.0% Senior Notes). The 5.0% Senior Notes pay interest on May 1 and November 1 of each year beginning November 1, 2015. The 5.0% Senior Notes are unsecured senior obligations and rank equally in right of payment with our existing and future unsecured senior indebtedness. The 5.0% Senior Notes are guaranteed by certain of our domestic subsidiaries. We may redeem up to 35% of the 5.0% Senior Notes at any time prior to May 1, 2018 at a certain specified price from the proceeds of one or more equity offerings. In addition, we may redeem some or all of the 5.0% Senior Notes at any time prior to May 1, 2020 at make whole redemption rates and on or after such date at certain specified redemption prices. The net proceeds from the 5.0% Senior Notes offering were used to repurchase all of the outstanding $775 million aggregate principal amount of 6 ⅝% Senior Notes due 2020 (6 ⅝% Senior Notes) through a combination of a tender offer and a redemption process and to pay fees and expenses. The remaining net offering proceeds will be used for general corporate purposes, future acquisitions and share repurchases. As a result of these transactions, we incurred $48 million in debt redemption charges consisting of tender and redemption premiums as well as the write-off of deferred financing fees associated with the repurchase of the 6 ⅝% Senior Notes.

Interest rate swap and cap agreements

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

As of December 31, 2015, we maintain several forward interest rate cap agreements that were entered into in October 2015 with notional amounts totaling $3.5 billion. These forward cap agreements will be effective June 29, 2018 and will have the economic effect of capping the LIBOR variable component of our interest rate at a maximum of 3.50% on an equivalent amount of our debt. These cap agreements expire on June 30, 2020. As of December 31, 2015, the total fair value of these cap agreements was an asset of approximately $13.8 million. During the year ended December 31, 2015, we recorded a loss of $3.5 million in other comprehensive income due to a decrease in the unrealized fair value of these cap agreements.

As of December 31, 2015, we maintain several forward interest rate cap agreements that were entered into in November 2014 with notional amounts totaling $3.5 billion. These forward cap agreements will be effective September 30, 2016 and will have the economic effect of capping the LIBOR variable component of our interest rate at a maximum of 3.50% on an equivalent amount of our debt. The cap agreements expire on June 30, 2018. As of December 31, 2015, the total fair value of these cap agreements was an asset of approximately $1.3 million. During the year ended December 31, 2015, we recorded a loss of $11.0 million in other comprehensive income due to a decrease in the unrealized fair value of these cap agreements.

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

Other items

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

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

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

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

Goodwill and indefinite-lived intangible assets

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

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

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

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

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

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

Long-term incentive compensation

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

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

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

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

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

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

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

Stock repurchases

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

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

approval announced in November 2010. As a result of the above transactions, there was approximately $259 million available under our current Board authorizations for additional share repurchases as of January 31, 2016. Our share repurchase authorizations have no expiration dates. However, we are subject to share repurchase limitations under the terms of our Senior Secured Credit Facility and the indentures governing our senior notes.

Off-balance sheet arrangements and aggregate contractual obligations

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

We also have certain other potential commitments to provide operating capital to several dialysis centers that are wholly-owned by third parties or centers in which we own a minority equity investment as well as to physician-owned vascular access clinics or medical practices that we operate under management and administrative services agreements. We have certain other potential commitments related to service agreements of approximately $5.6 million.

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

	Less Than 1 year	2-3 years	4-5 years	After 5 years	Total
Scheduled payments under contractual obligations:					
Long-term debt	$ 113	$ 284	$ 765	$ 7,781	$ 8,943
Interest payments on the senior notes	237	473	473	840	2,023
Interest payments on the Term Loan B(1)	122	240	235	58	655
Interest payments on the Term Loan A(2)	20	35	7	—	62
Capital lease obligations	16	35	41	191	283
Operating leases	432	791	615	1,084	2,922
	$ 940	$ 1,858	$ 2,136	$ 9,954	$ 14,888
Potential cash requirements under existing commitments:					
Letters of credit	$ 94	$ —	$ —	$ —	$ 94
Noncontrolling interests subject to put provisions	501	126	128	109	864
Non-owned and minority owned put provisions	47	—	—	—	47
Operating capital advances	6	—	—	—	6
	$ 648	$ 126	$ 128	$ 109	$ 1,011

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

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

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

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

In January 2010, we entered into and subsequently extended an agreement with FMC to purchase a certain amount of dialysis equipment, parts and supplies from FMC through February 29, 2016. We are currently renegotiating this agreement to extend the period of the agreement and to finalize the costs of our dialysis products. Our total expenditures for the year ended December 31, 2015 on such products were approximately 2% of our total U.S. operating expenses. The actual amount of purchases in future years from FMC will depend upon a number of factors, including the operating requirements of our centers, the number of centers we acquire, and growth of our existing centers.

In November 2011, we entered into a seven year Sourcing and Supply Agreement with Amgen that expires on December 31, 2018. Under the terms of the agreement we will purchase EPO in amounts necessary to meet no less than 90% of our requirements for ESAs. The actual amount of EPO that we will purchase from Amgen will depend upon the amount of EPO administered during dialysis as prescribed by physicians and the overall number of patients that we serve.

Settlements of approximately $51 million of existing income tax liabilities for unrecognized tax benefits, including interest, penalties and other long-term tax liabilities, are excluded from the above table as reasonably reliable estimates of their timing cannot be made.

Supplemental information concerning certain Physician Groups and unrestricted subsidiaries

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

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

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

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

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

Contingencies

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

Critical accounting policies, estimates and judgments

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

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

Revenues associated with Medicare and Medicaid programs are recognized based on (a) the payment rates that are established by statute or regulation for the portion of the payment rates paid by the government payor (e.g., 80% for Medicare patients) and (b) for the portion not paid by the primary government payor, the estimated amounts that will ultimately be collectible from other government programs paying secondary coverage (e.g., Medicaid secondary coverage), the patient's commercial health plan secondary coverage, or the patient. Effective January 1, 2011, our dialysis related reimbursements from Medicare became subject to certain variations under Medicare's new single bundled payment rate system whereby our reimbursements can be adjusted for certain patient characteristics and certain other factors. Our revenue recognition depends upon our ability to effectively capture, document and bill for Medicare's base payment rate and these other factors. In addition, as a result of the potential range of variations that can occur in our dialysis-related reimbursements from Medicare under the new single bundled payment rate system, our revenue recognition is now subject to a greater degree of estimating risk.

Commercial healthcare plans, including contracted managed-care payors, are billed at our usual and customary rates; however, revenue is recognized based on estimated net realizable revenue for the services provided. Net realizable revenue is estimated based on contractual terms for the patients covered under commercial healthcare plans with which we have formal agreements, non-contracted commercial healthcare plan coverage terms if known, estimated secondary collections, historical collection experience, historical trends of refunds and payor payment adjustments (retractions), inefficiencies in our billing and collection processes that can result in denied claims for payments, a slowdown in collections, a reduction in the amounts that we expect to collect and regulatory compliance issues. Determining applicable primary and secondary coverage for our approximately 180,000 U.S. patients at any point in time, together with the changes in patient coverage's that occur each month, requires complex, resource-intensive processes. Collections, refunds and payor retractions typically continue to occur for up to three years or longer after services are provided.

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

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

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

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

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

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

Accounting for income taxes. Our income tax expense, deferred tax assets and liabilities, and liabilities for unrecognized tax benefits reflect management's best assessment of estimated current and future taxes to be paid. We are subject to income taxes in the United States and numerous state and foreign jurisdictions. Significant judgments and estimates are required in determining the consolidated income tax expense. Deferred income taxes arise from temporary differences between the tax basis of assets and liabilities and their reported amounts in the financial statements, which will result in taxable or deductible amounts in the future. In evaluating our ability to recover our deferred tax assets within the jurisdiction from which they arise, we consider all available positive and negative evidence, including scheduled reversals of deferred tax liabilities, projected future taxable income, tax-planning strategies, and results of recent operations, assumptions about the amount of future state, federal, and foreign pre-tax operating income adjusted for items that do not have tax consequences. The assumptions about future taxable income require significant judgment and are consistent with the plans and estimates we are using to manage the underlying businesses. To the extent that recovery is not likely, a valuation allowance is established. The allowance is regularly reviewed and updated for changes in circumstances that would cause a change in judgment about the realizability of the related deferred tax assets.

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

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

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

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

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

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

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

Significant new accounting standards

New accounting standards

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

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

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

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

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

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

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

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

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

In May 2014, the FASB issued ASU No. 2014-09, *Revenue from Contracts with Customers*, which requires an entity to recognize the amount of revenue to which it expects to be entitled for the transfer of promised goods or services to customers. The ASU will replace most existing revenue recognition guidance in U.S. GAAP when it becomes effective. The new standard as issued

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

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

Interest rate sensitivity

The tables below provide information about our financial instruments that are sensitive to changes in interest rates. The table below presents principal repayments and current weighted average interest rates on our debt obligations as of December 31, 2015. The variable rates presented reflect the weighted average LIBOR rates in effect for all debt tranches plus interest rate margins in effect as of December 31, 2015. The Term Loan A margin in effect is 1.75% at December 31, 2015, and along with the revolving line of credit, is subject to adjustment depending upon changes in certain of our financial ratios, including a leverage ratio. The Term Loan B currently bears interest at LIBOR (floor of 0.75%) plus an interest rate margin of 2.75%.

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

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

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

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

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

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

As of December 31, 2015, we maintain several forward interest rate cap agreements that were entered into in October 2015 with notional amounts totaling $3.5 billion. These forward cap agreements will be effective June 29, 2018 and will have the economic effect of capping the LIBOR variable component of our interest rate at a maximum of 3.50% on an equivalent amount of our debt. These cap agreements expire on June 30, 2020. As of December 31, 2015, the total fair value of these cap agreements was an asset of approximately $13.8 million. During the year ended December 31, 2015, we recorded a loss of $3.5 million in other comprehensive income due to a decrease in the unrealized fair value of these cap agreements.

As of December 31, 2015, we maintain several forward interest rate cap agreements that were entered into in November 2014 with notional amounts totaling $3.5 billion. These forward cap agreements will be effective September 30, 2016 and will have the economic effect of capping the LIBOR variable component of our interest rate at a maximum of 3.50% on an equivalent amount of our debt. The cap agreements expire on June 30, 2018. As of December 31, 2015, the total fair value of these cap agreements was an asset of approximately $1.3 million. During the year ended December 31, 2015, we recorded a loss of $11.0 million in other comprehensive income due to a decrease in the unrealized fair value of these cap agreements.

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

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

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

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

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

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

One mean of assessing exposure to debt-related interest rate changes is a duration-based analysis that measures the potential loss in net income resulting from a hypothetical increase in interest rates of 100 basis points across all variable rate maturities (referred to as a parallel shift in the yield curve). Under this model, with all else constant, it is estimated that such an increase would have reduced net income by approximately $6.3 million, $5.7 million, and $4.0 million, net of tax, for the years ended December 31, 2015, 2014, and 2013, respectively.

Exchange rate sensitivity

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

Item 8. Financial Statements and Supplementary Data.

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

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

None.

Item 9A. Controls and Procedures.

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

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

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

Item 9B. Other Information.

None.

PART III

Item 10. Directors, Executive Officers and Corporate Governance.

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

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

The other information required to be disclosed by this item will appear in, and is incorporated by reference from, the sections entitled "Proposal No. 1. Election of Directors", "Corporate Governance", and "Security Ownership of Certain Beneficial Owners and Management" included in our definitive proxy statement relating to our 2016 annual stockholder meeting.

Item 11. Executive Compensation.

The information required by this item will appear in, and is incorporated by reference from, the sections entitled "Executive Compensation" and "Compensation Committee Interlocks and Insider Participations" included in our definitive proxy statement relating to our 2016 annual stockholder meeting. The information required by Item 407(e)(5) of Regulation S-K will appear in and is incorporated by reference from the section entitled "Compensation Committee Report" included in our definitive proxy statement relating to our 2016 annual stockholder meeting; however, this information shall not be deemed to be filed.

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

The following table provides information about our common stock that may be issued upon the exercise of stock-settled stock appreciation rights, restricted stock units and other rights under all of our existing equity compensation plans as of December 31, 2015, which consist of our 2011 Incentive Award Plan and our Employee Stock Purchase Plan. The material terms of these plans are described in Note 19 to the Consolidated Financial Statements.

Plan category	Number of shares to be issued upon exercise of outstanding options, warrants and rights	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	9,298,621	$ 54.19	32,906,935	42,205,556
Equity compensation plans not requiring shareholder approval	—	—	—	—
Total	9,298,621	$ 54.19	32,906,935	42,205,556

Other information required to be disclosed by Item 12 will appear in, and is incorporated by reference from, the section entitled "Security Ownership of Certain Beneficial Owners and Management" included in our definitive proxy statement relating to our 2016 annual stockholder meeting.

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

The information required by this item will appear in, and is incorporated by reference from, the section entitled "Certain Relationships and Related Transactions" and the section entitled "Corporate Governance" included in our definitive proxy statement relating to our 2016 annual stockholder meeting.

Item 14. Principal Accounting Fees and Services.

The information required by this item will appear in, and is incorporated by reference from, the section entitled "Ratification of Appointment of Independent Registered Public Accounting Firm" included in our definitive proxy statement relating to our 2016 annual stockholder meeting.

PART IV

Item 15. Exhibits, Financial Statement Schedules.

(a) Documents filed as part of this Report:

(1) Index to Financial Statements:

	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, 2015, 2014, and 2013	F-4
Consolidated Statements of Comprehensive Income for the years ended December 31, 2015, 2014, and 2013	F-5
Consolidated Balance Sheets as of December 31, 2015, and 2014	F-6
Consolidated Statements of Cash Flow for the years ended December 31, 2015, 2014, and 2013	F-7
Consolidated Statements of Equity for the years ended December 31, 2015, 2014, and 2013	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.(36)
2.2	Amendment, dated as of July 6, 2012, to the Agreement and Plan of Merger, dated as of May 20, 2012, by and among DaVita Inc., Seismic Acquisition LLC, HealthCare Partners Holdings, LLC, and the Member Representative.(37)
3.1	Amended and Restated Certificate of Incorporation of Total Renal Care Holdings, Inc. (TRCH), dated December 4, 1995.(1)
3.2	Certificate of Amendment of Certificate of Incorporation of TRCH, dated February 26, 1998.(2)
3.3	Certificate of Amendment of Certificate of Incorporation of DaVita Inc. (formerly Total Renal Care Holdings, Inc.), dated October 5, 2000.(3)
3.4	Certificate of Amendment of Amended and Restated Certificate of Incorporation of DaVita Inc., as amended dated May 30, 2007.(16)
3.5	Certificate of Ownership and Merger Merging DaVita Name Change, Inc. with and into DaVita Inc., as filed with Secretary of State of the State of Delaware on November 1, 2012.(40)
3.6	Amended and Restated Bylaws for DaVita Inc. dated as of March 10, 2011.(17)
4.1	Indenture, dated August 28, 2012, by and among DaVita Inc., the Guarantors named therein and The Bank of New York Mellon Trust Company, N.A., as Trustee.(38)
4.2	Form of 5.750% Senior Notes due 2022 and related Guarantee (included in Exhibit 4.1).(38)
4.3	Indenture, dated June 13, 2014, by and among DaVita HealthCare Partners Inc., the Guarantors named therein and The Bank of New York Mellon Trust Company, N.A., as Trustee. (44)
4.4	Form of 5.125% Senior Notes due 2024 and related Guarantee (included in Exhibit 4.3). (44)

4.5	Second Supplemental Indenture for the 5.750% Senior Notes due 2022, dated June 13, 2014, by and among DaVita HealthCare Partners Inc., the guarantors named therein and The Bank of New York Mellon Trust Company, N.A., as Trustee. (45)
4.6	Indenture for the 5.000% Senior Notes due 2025, dated April 17, 2015, by and among DaVita HealthCare Partners Inc., the Guarantors named therein and The Bank of New York Mellon Trust Company, N.A., as Trustee. (28)
4.7	Form of 5.000% Senior Notes due 2025 and related Guarantee (included in Exhibit 4.6). (28)
10.1	Employment Agreement, dated as of October 19, 2009, by and between DaVita Inc. and Kim M. Rivera.(29)*
10.2	Employment Agreement, dated as of October 31, 2005, effective October 24, 2005, by and between DaVita Inc. and Dennis Kogod.(8)*
10.3	Amendment to Mr. Kogod's Employment Agreement, effective December 12, 2008.(23)*
10.4	Second Amendment to Mr. Kogod's Employment Agreement, effective December 31, 2012.(23)*
10.5	Employment Agreement, effective September 22, 2005, by and between DaVita Inc. and James Hilger.(10)*
10.6	Amendment to Mr. Hilger's Employment Agreement, effective December 12, 2008.(23)*
10.7	Second Amendment to Mr. Hilger's Employment Agreement, effective December 27, 2012.(42)*
10.8	Employment Agreement, effective July 25, 2008, between DaVita Inc. and Kent J. Thiry.(20)*
10.9	Employment Agreement, effective August 1, 2008, between DaVita Inc. and Allen Nissenson.(21)*
10.10	Employment Agreement, effective March 3, 2008, between DaVita Inc. and David Shapiro.(23)*
10.11	Amendment to Mr. Shapiro's Employment Agreement, effective December 4, 2008.(23)*
10.12	Employment Agreement, effective March 17, 2010, by and between DaVita Inc. and Javier Rodriguez.(25)*
10.13	Memorandum Relating to Bonus Structure for Kent J. Thiry.(26)*
10.14	Memorandum Relating to Bonus Structure for Dennis L. Kogod.(26)*
10.15	Form of Indemnity Agreement.(15)*
10.16	Form of Indemnity Agreement.(9)*
10.17	Executive Incentive Plan (as Amended and Restated effective January 1, 2009).(24)*
10.18	Executive Retirement Plan.(23)*
10.19	DaVita Voluntary Deferral Plan.(7)*
10.20	Deferred Bonus Plan (Prosperity Plan).(22)*
10.21	Amendment No. 1 to Deferred Bonus Plan (Prosperity Plan).(23)*
10.22	Amended and Restated Employee Stock Purchase Plan.(18)*
10.23	Amended and Restated DaVita Healthcare Partners Inc. Severance Plan.(42)*
10.24	Change in Control Bonus Program.(23)*
10.25	Non-Management Director Compensation Philosophy and Plan.(19)*
10.26	Amended and Restated 2002 Equity Compensation Plan.(6)*
10.27	Amended and Restated 2002 Equity Compensation Plan.(14)*
10.28	Amended and Restated 2002 Equity Compensation Plan.(18)*
10.29	Amended and Restated 2002 Equity Compensation Plan.(23)*
10.30	DaVita Inc. 2002 Equity Compensation Plan.(27)*
10.31	Form of Non-Qualified Stock Option Agreement—Employee (DaVita Inc. 1999 Non-Executive Officer and Non-Director Equity Compensation Plan.(13)*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10.52 Credit Agreement, dated as of June 24, 2014, by and among DaVita Healthcare Partners Inc., the guarantors the guarantors party thereto, the lenders party thereto, JPMorgan Chase Bank, N.A., as Administrative Agent and Collateral Agent, Barclays Bank PLC, and Wells Fargo Bank, National Association as Co-Syndication Agents, Bank of America, N.A., Credit Suisse AG, Goldman Sachs Bank USA, JPMorgan Chase Bank, N.A., Morgan Stanley Senior Funding, Inc., and SunTrust Bank, as Co-Documentation Agents, Barclays Bank PLC, Wells Fargo Securities, LLC, Credit Suisse Securities (USA) LLC, Goldman Sachs Bank USA, J.P. Morgan Securities, LLC, Bank of America, N.A., Morgan Stanley Senior Funding, Inc., and SunTrust Robinson Humphrey, Inc. as Joint Lead Arrangers and Joint Bookrunners, The Bank of Nova Scotia, Credit Agricole Securities (USA) Inc., The Bank of Tokyo-Mitsubishi UFJ, Ltd., and Sumitomo Mitsui Banking Corporation, as Senior Managing Agents, HSBC Securities (USA) Inc., Fifth Third Bank, and Compass Bank as Managing Agents. (45)

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

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

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

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

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

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

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

10.60	Voting Agreement, dated as of May 20, 2012, by and among DaVita Inc., HealthCare Partners Holdings, LLC, and HealthCare Partners Medical Group.(36)
10.61	Support Agreement, dated as of May 20, 2012, by and among DaVita Inc., HealthCare Partners Holdings, LLC, and Dr. Robert Margolis.(36)
10.62	Support Agreement, dated as of May 20, 2012, by and among DaVita Inc., HealthCare Partners Holdings, LLC, and Dr. William Chin.(36)
10.63	Support Agreement, dated as of May 20, 2012, by and among DaVita Inc., HealthCare Partners Holdings, LLC, and Matthew Mazdyasni.(36)
10.64	Support Agreement, dated as of May 20, 2012, by and among DaVita Inc., HealthCare Partners Holdings, LLC, and Dr. Thomas Paulsen.(36)
10.65	Form of Non-Competition and Non-Solicitation Agreement, dated as of May 20, 2012, between DaVita Inc. and Dr. Robert Margolis, Dr. William Chin, Dr. Thomas Paulsen, Mr. Zan Calhoun, and Ms. Lori Glisson.(36)
10.66	Form of Non-Competition and Non-Solicitation Agreement, dated as of May 20, 2012, between DaVita Inc. and Mr. Matthew Mazdyasni, Dr. Sherif Abdou, and Dr. Amir Bacchus.(36)
10.67	Escrow Agreement, dated as of August 28, 2012, by and among DaVita Inc., The Bank of New York Mellon Trust Company, N.A., as trustee, The Bank of New York Mellon Trust Company, N.A., as escrow agent and The Bank of New York Mellon Trust Company, N.A., as bank and securities intermediary.(38)
10.68	Employment Agreement, dated as of May 20, 2012, effective as of the November 1, 2012, by and among Dr. Robert Margolis, DaVita Inc. and HealthCare Partners Holdings, LLC.(39)*
10.69	Amendment to Dr. Margolis' Employment Agreement, effective December 31, 2012. (42)*
10.70	Employment Agreement, effective July 5, 2013, between DaVita HealthCare Partners Inc. and Garry E. Menzel.(41)*
10.71	Form of 2014 Long Term Incentive Program Cash Performance Award Agreement under the DaVita HealthCare Partners Inc. 2011 Incentive Award Plan and Long-Term Incentive Program (for 162(m) designated teammates). (46) * **
10.72	Form of 2014 Long Term Incentive Program Cash Performance Award Agreement under the DaVita HealthCare Partners Inc. 2011 Incentive Award Plan and Long-Term Incentive Program. (46)* **
10.73	Form of 2014 Long Term Incentive Program Performance Stock Units Agreement under the DaVita HealthCare Partners Inc. 2011 Incentive Award Plan and Long-Term Incentive Program (for 162(m) designated teammates). (46) * **
10.74	Form of 2014 Long Term Incentive Program Restricted Stock Units Agreement under the DaVita HealthCare Partners Inc. 2011 Incentive Award Plan and Long-Term Incentive Program. (46)*
10.75	Form of 2014 Long Term Incentive Program Stock Appreciation Rights Agreement under the DaVita HealthCare Partners Inc. 2011 Incentive Award Plan and Long-Term Incentive Program. (46)*
10.76	Corporate Integrity Agreement, dated as of October 22, 2014, by and among the Office of Inspector General of The Department of Health and Human Services and DaVita HealthCare Partners, Inc. (47)
12.1	Computation of Ratio of Earnings to Fixed Charges.✓
14.1	DaVita Inc. Corporate Governance Code of Ethics.(5)
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 26, 2016, pursuant to Rule 13a-14(a) or 15d-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.✓
31.2	Certification of the Chief Financial Officer, dated February 26, 2016, pursuant to Rule 13a-14(a) or 15d-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.✓
32.1	Certification of the Chief Executive Officer, dated February 26, 2016, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.✓

32.2	Certification of the Chief Financial Officer, dated February 26, 2016, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.✓
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 March 18, 1996 as an exhibit to the Company's Transitional Report on Form 10-K for the transition period from June 1, 1995 to December 31, 1995.
(2) Filed on March 31, 1998 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 1997.
(3) Filed on March 20, 2001 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 2000.
(4) Filed on November 8, 2004 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2004.
(5) Filed on February 27, 2004 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 2003.
(6) Filed on May 4, 2005 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2005.
(7) Filed on November 8, 2005 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2005.
(8) Filed on November 4, 2005 as an exhibit to the Company's Current Report on Form 8-K.
(9) Filed on March 3, 2005 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 2004.
(10) Filed on August 7, 2006 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ending June 30, 2006.
(11) Filed on July 6, 2006 as an exhibit to the Company's Current Report on Form 8-K.
(12) Filed on November 3, 2006 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2006.
(13) Filed on October 18, 2006 as an exhibit to the Company's Current Report on Form 8-K.
(14) Filed on July 31, 2006 as an exhibit to the Company's Current Report on Form 8-K.
(15) Filed on December 20, 2006 as an exhibit to the Company's Current Report on Form 8-K.
(16) Filed on August 6, 2007 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2007.
(17) Filed on March 17, 2011 as an exhibit to the Company's Current Report on Form 8-K/A.
(18) Filed on June 4, 2007 as an exhibit to the Company's Current Report on Form 8-K.
(19) Filed on May 8, 2008 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2008.
(20) Filed on July 31, 2008 as an exhibit to the Company's Current Report on Form 8-K.
(21) Filed on November 6, 2008 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2008.
(22) Filed on February 29, 2008 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 2007.
(23) Filed on February 27, 2009 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 2008
(24) Filed on June 18, 2009 as an exhibit to the Company's Current Report on Form 8-K.
(25) Filed on April 14, 2010 as an exhibit to the Company's Current Report on Form 8-K.
(26) Filed on May 3, 2010 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2010.
(27) Filed on April 28, 2010 as Appendix A to the Company's Definitive Proxy Statement on Schedule 14A.
(28) Filed on April 17, 2015 as an exhibit to the Company's Current Report on Form 8-K.
(29) Filed on February 25, 2010 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 2009.
(30) Filed on December 29, 2011 as an exhibit to the Company's Annual Report on Form 10-K/A for the year ended December 31, 2010.
(31) Filed on April 28, 2014 as Appendix A to the Company's Definitive Proxy Statement on Schedule 14A.
(32) Filed on August 4, 2011 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2011.

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

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

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

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

Based upon our evaluation under the COSO framework, we have concluded that the Company's internal control over financial reporting was effective as of December 31, 2015.

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

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Shareholders
DaVita HealthCare Partners Inc.:

We have audited the accompanying consolidated balance sheets of DaVita HealthCare Partners Inc. and subsidiaries as of December 31, 2015 and 2014, and the related consolidated statements of income, comprehensive income, equity, and cash flows for each of the years in the three-year period ended December 31, 2015. These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

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

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

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

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

/s/ KPMG LLP
Seattle, Washington

February 26, 2016

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Stockholders
DaVita HealthCare Partners Inc.:

We have audited DaVita HealthCare Partners Inc.'s internal control over financial reporting as of December 31, 2015, based on criteria established in *Internal Control – Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). DaVita HealthCare Partners, Inc.'s management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying "Management's Report on Internal Control Over Financial Reporting." Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit.

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

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

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

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

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of DaVita HealthCare Partners Inc. and subsidiaries as of December 31, 2015 and 2014, and the related consolidated statements of income, comprehensive income, equity, and cash flows for each of the years in the three-year period ended December 31, 2015, and our report dated February 26, 2016 expressed an unqualified opinion on those consolidated financial statements.

/s/ KPMG LLP
Seattle, Washington

February 26, 2016

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

	Year ended December 31,		
	2015	2014	2013
Patient service revenues	$ 9,480,279	$ 8,868,338	$ 8,307,195
Less: Provision for uncollectible accounts	(427,860)	(366,884)	(293,546)
Net patient service revenues	9,052,419	8,501,454	8,013,649
Capitated revenues	3,509,095	3,261,288	2,987,315
Other revenues	1,220,323	1,032,364	763,086
Total net revenues	13,781,837	12,795,106	11,764,050
Operating expenses and charges:			
Patient care costs and other costs	9,824,834	9,119,305	8,198,377
General and administrative	1,452,135	1,261,506	1,176,485
Depreciation and amortization	638,024	590,935	528,737
Provision for uncollectible accounts	9,240	14,453	4,852
Equity investment income	(18,325)	(23,234)	(34,558)
Goodwill and other intangible asset impairment charges	210,234	—	—
Settlement charge and loss contingency accrual	495,000	17,000	397,000
Contingent earn-out obligation adjustment	—	—	(56,977)
Total operating expenses and charges	12,611,142	10,979,965	10,213,916
Operating income	1,170,695	1,815,141	1,550,134
Debt expense	(408,380)	(410,294)	(429,943)
Debt redemption and refinancing charges	(48,072)	(97,548)	—
Other income, net	8,893	2,374	4,787
Income from continuing operations before income taxes	723,136	1,309,673	1,124,978
Income tax expense	295,726	446,343	381,013
Income from continuing operations	427,410	863,330	743,965
Discontinued operations:			
Loss from operations of discontinued operations, net of tax	—	—	(139)
Gain on disposal of discontinued operations, net of tax	—	—	13,375
Net income	427,410	863,330	757,201
Less: Net income attributable to noncontrolling interests	(157,678)	(140,216)	(123,755)
Net income attributable to DaVita HealthCare Partners Inc.	$ 269,732	$ 723,114	$ 633,446
Earnings per share:			
Basic income from continuing operations per share attributable to DaVita HealthCare Partners Inc.	$ 1.27	$ 3.41	$ 2.95
Basic net income per share attributable to DaVita HealthCare Partners Inc.	$ 1.27	$ 3.41	$ 3.02
Diluted income from continuing operations per share attributable to DaVita HealthCare Partners Inc.	$ 1.25	$ 3.33	$ 2.89
Diluted net income per share attributable to DaVita HealthCare Partners Inc.	$ 1.25	$ 3.33	$ 2.95
Weighted average shares for earnings per share:			
Basic	211,867,714	212,301,827	209,939,364
Diluted	216,251,807	216,927,681	214,763,887
Amounts attributable to DaVita HealthCare Partners Inc.:			
Income from continuing operations	$ 269,732	$ 723,114	$ 620,197
Discontinued operations	—	—	13,249
Net income	$ 269,732	$ 723,114	$ 633,446

See notes to consolidated financial statements.

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

	Year ended December 31,		
	2015	2014	2013
Net income	$ 427,410	$ 863,330	$ 757,201
Other comprehensive income (losses), net of tax:			
Unrealized (losses) gain on interest rate swap and cap agreements:			
Unrealized (losses) gain on interest rate swap and cap agreements	(12,241)	(10,059)	169
Reclassifications of net swap and cap agreements realized losses into net income	3,111	10,608	12,889
Unrealized (losses) gains on investments:			
Unrealized (losses) gains on investments	(1,413)	238	2,300
Reclassification of net investment realized losses into net income	(377)	(207)	(490)
Foreign currency translation adjustments	(23,889)	(22,952)	(2,216)
Other comprehensive (loss) income	(34,809)	(22,372)	12,652
Total comprehensive income	392,601	840,958	769,853
Less: Comprehensive income attributable to noncontrolling interests	(157,678)	(140,216)	(123,755)
Comprehensive income attributable to DaVita HealthCare Partners Inc.	$ 234,923	$ 700,742	$ 646,098

See notes to consolidated financial statements.

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

	December 31, 2015	December 31, 2014
ASSETS		
Cash and cash equivalents	$ 1,499,116	$ 965,241
Short-term investments	408,084	337,399
Accounts receivable, less allowance of $264,144 and $242,674	1,724,228	1,525,849
Inventories	185,575	136,084
Other receivables	435,885	400,916
Other current assets	190,322	186,842
Income tax receivable	60,070	83,839
Total current assets	4,503,280	3,636,170
Property and equipment, net	2,788,740	2,469,099
Intangible assets, net	1,687,326	1,864,842
Equity investments	73,368	65,637
Long-term investments	94,122	89,389
Other long-term assets	73,560	77,000
Goodwill	9,294,479	9,415,295
	$ 18,514,875	$ 17,617,432
LIABILITIES AND EQUITY		
Accounts payable	$ 513,950	$ 445,453
Other liabilities	682,123	510,223
Accrued compensation and benefits	741,926	698,475
Medical payables	332,102	314,346
Current portion of long-term debt	129,037	120,154
Total current liabilities	2,399,138	2,088,651
Long-term debt	9,001,308	8,298,624
Other long-term liabilities	439,229	389,806
Deferred income taxes	726,962	650,075
Total liabilities	12,566,637	11,427,156
Commitments and contingencies		
Noncontrolling interests subject to put provisions	864,066	829,965
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; 217,120,346 and 215,640,968 shares issued and 209,754,247 and 215,640,968 shares outstanding, respectively)	217	216
Additional paid-in capital	1,118,326	1,108,211
Retained earnings	4,356,835	4,087,103
Treasury stock (7,366,099 shares)	(544,772)	—
Accumulated other comprehensive loss	(59,826)	(25,017)
Total DaVita HealthCare Partners Inc. shareholders' equity	4,870,780	5,170,513
Noncontrolling interests not subject to put provisions	213,392	189,798
Total equity	5,084,172	5,360,311
	$ 18,514,875	$ 17,617,432

See notes to consolidated financial statements.

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

	Year ended December 31,		
	2015	**2014**	**2013**
Cash flows from operating activities:			
Net income	$ 427,410	$ 863,330	$ 757,201
Adjustments to reconcile net income to cash provided by operating activities:			
Settlement charge and loss contingency accrual	495,000	17,000	397,000
Depreciation and amortization	638,024	590,935	528,119
Goodwill and other intangible asset impairment charges	210,234	—	—
Debt redemption and refinancing charges	48,072	97,548	—
Stock-based compensation expense	56,664	56,743	59,998
Tax benefits from stock award exercises	45,749	59,119	46,898
Excess tax benefits from stock award exercises	(28,157)	(45,271)	(36,197)
Deferred income taxes	61,744	210,955	(25,380)
Equity investment income, net	9,293	10,125	2,872
Other non-cash charges	44,691	39,274	(31,351)
Changes in operating assets and liabilities, net of effect of acquisitions and divestitures:			
Accounts receivable	(202,867)	(40,676)	(59,640)
Inventories	(48,313)	(46,398)	(8,971)
Other receivables and other current assets	32,761	(61,674)	(108,434)
Other long-term assets	3,723	2,916	17,731
Accounts payable	30,998	(2,956)	16,666
Accrued compensation and benefits	54,950	97,261	38,368
Other current liabilities	113,470	83,590	78,817
Settlement payments	(493,775)	(410,356)	—
Income taxes	24,175	(60,475)	33,499
Other long-term liabilities	33,354	(1,583)	66,145
Net cash provided by operating activities	1,557,200	1,459,407	1,773,341
Cash flows from investing activities:			
Additions of property and equipment	(707,998)	(641,330)	(617,597)
Acquisitions	(96,469)	(272,094)	(310,394)
Proceeds from asset and business sales	19,715	8,791	62,258
Purchase of investments available-for-sale	(8,783)	(8,440)	(12,445)
Purchase of investments held-to-maturity	(1,709,883)	(472,628)	(1,039)
Proceeds from sale of investments available-for-sale	2,058	2,475	4,158
Proceeds from investments held-to-maturity	1,637,358	141,072	1,376
Purchase of intangible assets	—	(1,018)	(2,391)
Purchase of equity investments	(17,911)	(35,382)	(1,305)
Distributions received on equity investments	129	825	497
Net cash used in investing activities	(881,784)	(1,277,729)	(876,882)
Cash flows from financing activities:			
Borrowings	54,541,988	60,038,508	66,286,097
Payments on long-term debt and other financing costs	(53,922,290)	(60,046,487)	(66,723,385)
Deferred financing and debt redemption and refinancing costs	(76,672)	(122,988)	(719)
Purchase of treasury stock	(549,935)	—	—
Distributions to noncontrolling interests	(174,635)	(149,339)	(139,326)
Stock award exercises and other share issuances, net	26,155	19,500	16,423
Excess tax benefits from stock award exercises	28,157	45,271	36,197
Contributions from noncontrolling interests	54,644	64,655	36,996
Proceeds from sales of additional noncontrolling interests	—	3,777	8,295
Purchases of noncontrolling interests	(66,382)	(17,876)	(3,569)
Net cash used in financing activities	(138,970)	(164,979)	(482,991)
Effect of exchange rate changes on cash and cash equivalents	(2,571)	2,293	(967)
Net increase in cash and cash equivalents	533,875	18,992	412,501
Cash and cash equivalents at beginning of the year	965,241	946,249	533,748
Cash and cash equivalents at end of the year	$ 1,499,116	$ 965,241	$ 946,249

See notes to consolidated financial statements.

DAVITA HEALTHCARE PARTNERS INC.
CONSOLIDATED STATEMENTS OF EQUITY
(dollars and shares in thousands)

	Non-controlling interests subject to put provisions	DaVita HealthCare Partners 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, 2012	$ 580,692	269,725	$ 270	$ 1,208,665	$ 3,731,835	(58,728)	$ (1,162,336)	$ (15,297)	$ 3,763,137	$ 153,788
Comprehensive income:										
Net income	78,215				633,446				633,446	45,540
Other comprehensive income								12,652	12,652	
Stock purchase shares issued		238		12,817					12,817	
Stock unit shares issued		7		(3,286)		164	3,247		(39)	
Stock-settled SAR shares issued		313		(29,025)		1,444	28,561		(464)	
Stock-based compensation expense				59,998					59,998	
Excess tax benefits from stock awards exercised				36,197					36,197	
Distributions to noncontrolling interests	(80,353)									(58,973)
Contributions from noncontrolling interests	22,053									14,943
Sales and assumptions of additional noncontrolling interests	23,642			(1,442)					(1,442)	10,770
Purchases from noncontrolling interests	(512)			(3,119)					(3,119)	(147)
Expiration of put option and other reclassification	(7,141)									7,141
Changes in fair value of noncontrolling interests	80,704			(80,704)					(80,704)	
Treasury stock retirement		(57,120)	(57)	(129,179)	(1,001,292)	57,120	1,130,528		—	
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

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

	Non-controlling interests subject to put provisions	DaVita HealthCare Partners 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	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

See notes to consolidated financial statements.

1. Organization and summary of significant accounting policies

Organization

DaVita HealthCare Partners Inc. operates two major divisions, Kidney Care and HealthCare Partners (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 disease also known as end stage renal disease (ESRD). As of December 31, 2015, the Company operated or provided administrative services through a network of 2,251 U.S. outpatient dialysis centers in 46 states and the District of Columbia, serving approximately 180,000 patients. The Company's HCP 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, 2015, the Company operated or provided administrative services to 118 outpatient dialysis centers serving approximately 10,000 patients located in ten countries outside of the U.S.

The Company's U.S. dialysis and related lab services business and HCP 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 HealthCare Partners Inc. and its subsidiaries, partnerships and other entities in which it maintains a 100% or majority voting interest, another controlling financial interest, or of which it is considered the primary beneficiary (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 and retrospectively revised to reflect purchase accounting entries.

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 including 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

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.

Patient service revenues earned by HCP 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

HCP 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, Nevada and Arizona. HCP'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, Nevada and Arizona 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). HCP recently obtained a restricted Knox-Keene license in California, which now

permits HCP to enter into contracts with health plans allowing it to recognize revenue effective in 2014 under global capitation arrangements for both professional and institutional services.

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 HCP's capitated revenues.

Other capitated revenues

One of the Company's subsidiaries operates a Medicare Advantage ESRD Special Needs Plan in partnership with a payor that works with CMS to provide ESRD patients full service healthcare. 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 minority equity interest, retail pharmacies and medical consulting services. The Company also provides administrative and management support services to a medical services joint venture in which the Company owns a 50% 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 and other non-operating gains from investment transactions.

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 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 $82,679 in such funds as of December 31, 2015, 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, ten to twenty years; trade names, provider networks and practice management tools, two to fifteen 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.

Investments

Based upon the Company's intentions and strategy concerning investments in debt and equity securities, the Company classifies certain debt securities as held-to-maturity and measures them at amortized cost. The Company classifies equity securities that have readily determinable fair values and certain other debt securities as available for sale and measures them at fair value. Unrealized gains or losses from available for sale investments are recorded in other comprehensive income until realized.

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 for valuation impairment as circumstances warrant and at least annually. An impairment charge would be 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 the 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. 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 maintains insurance reserves 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, HCP has purchased its 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 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 has several interest rate swap agreements as a means of hedging its exposure to and volatility from LIBOR variable-based interest rate changes as part of its overall interest rate risk management strategy. These agreements are designated as cash flow hedges and are not held for trading or speculative purposes. The swap agreements have the economic effect of converting the majority of the LIBOR variable component of the Company's interest rate to fixed rates on the Company's Term Loan A outstanding balances. In addition, the Company has several interest rate cap agreements that have the economic effect of capping the Company's maximum exposure to LIBOR variable interest rate changes on specific portions of the Company's Term Loan B totaling $2,735,000. The Company also maintains several forward interest rate cap agreements with notional amounts totaling $7,000,000, of which $3,500,000 will be effective September 30, 2016 and the remainder of the cap agreements will be effective June 29, 2018. These cap agreements will have economic effect of capping the LIBOR variable component of the Company's interest rate at a maximum of 3.50% on an equivalent of the Company's debt. See Note 14 to the consolidated financial statements for further details.

Noncontrolling interests

Noncontrolling interests represent third-party minority equity ownership interests in consolidated entities which are majority-owned by the Company, as well as the equity ownership interests in entities that are not owned by the Company but which are consolidated for financial statement reporting purposes. As of December 31, 2015, third parties held noncontrolling ownership interests in 440 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 certain 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

The Company elected to early adopt Accounting Standards Update (ASU) No. 2015-03, *Interest - Imputation of Interest (Subtopic 835-30): Simplifying the Presentation of Debt Issuance Costs*, retrospectively effective as of January 1, 2014. The amendments in this ASU require that debt issuance costs related to a recognized debt liability be presented in the balance sheet as a direct deduction from the carrying amount of that debt liability, consistent with debt discounts. In August 2015, the FASB issued ASU 2015-15, *Interest – Imputation of Interest (Subtopic 835-30) – Presentation and Subsequent Measurement of Debt Issuance Costs Associated with Line-of-Credit Arrangements,* which clarifies that the treatment of debt issuance costs related to a line-of-credit may continue to be deferred in an asset position and subsequently amortized over the term of the line-of-credit arrangement, regardless of whether there are any outstanding borrowings on the line-of-credit arrangement. The recognition and measurement guidance for debt issuance costs are not affected by the amendments in this ASU. Adoption of this standard did not have a material impact on the Company's consolidated financial statements. The following table summarizes the retrospective adjustments made to conform prior period classifications to the new guidance:

	December 31, 2014		
	As filed	Reclassification	As Adjusted
Intangible assets, net of accumulated amortization (included deferred financing costs)	$ 1,949,498	$ (84,656)	$ 1,864,842
Long-term debt, net of current portion and deferred financing costs	$ (8,383,280)	$ 84,656	$ (8,298,624)

The Company elected to early adopt ASU No. 2015-17, *Income Taxes (ASC 740): Balance Sheet Classification of Deferred Taxes*, retrospectively effective as of January 1, 2014. The amendments in this ASU serve to simplify the presentation of deferred income taxes. The update requires that deferred tax liabilities and assets be classified as noncurrent in a classified statement of financial position. Adoption of this standard did not have a material impact on the Company's consolidated financial statements. The following table summarizes the adjustments made to conform prior period classifications to the new guidance:

	December 31, 2014		
	As filed	Reclassification	As Adjusted
Current deferred income tax assets	$ 240,626	$ (240,626)	$ —
Long-term deferred income tax liabilities	$ (890,701)	$ 240,626	$ (650,075)
Net deferred tax liability	$ (650,075)	$ —	$ (650,075)

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

In January 2016, the FASB issued ASU No. 2016-01, *Financial Statements – Overall (Subtopic 825-10): Recognition and Measurement of Financial Assets and Financial Liabilities.* The amendments in this ASU revise the accounting related to (1) the classification and measurement of investments in equity securities and (2) 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 should be applied through a cumulative-effect adjustment to the statement of financial position. Early adoption is permitted under certain circumstances. The adoption of this standard is not expected to have a material impact on the Company's consolidated financial statements.

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

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

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

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

In May 2014, the FASB issued ASU No. 2014-09, *Revenue from Contracts with Customers*, which requires an entity to recognize the amount of revenue to which it expects to be entitled for the transfer of promised goods or services to customers. The ASU will replace most existing revenue recognition guidance in U.S. GAAP when it becomes effective. The new standard as issued was to be effective for the Company on January 1, 2017. In July 2015, the FASB issued ASU 2015-14, *Revenue from Contracts with Customers (Topic 606): Deferral of Effective Date*. This guidance approves a one-year deferral of the effective date of ASU 2014-09. The final ASU now requires the Company to adopt this standard on January 1, 2018. Early application is permitted as of the initial effective date of January 1, 2017, but not prior to that date. The standard permits the use of either the retrospective or cumulative effect transition method. 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, as well as the expected timing and method of adoption. The Company has not yet selected a transition method nor has it determined the effect of the standard on its ongoing financial reporting.

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,		
	2015	2014	2013
	(shares in thousands)		
Basic:			
Income from continuing operations attributable to DaVita HealthCare Partners Inc.	$ 269,732	$ 723,114	$ 620,197
Discontinued operations attributable to DaVita HealthCare Partners Inc.	—	—	13,249
Net income attributable to DaVita HealthCare Partners Inc. for basic earnings per share calculation	$ 269,732	$ 723,114	$ 633,446
Weighted average shares outstanding during the period	214,062	214,496	212,128
Vested stock units	—	—	5
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	211,868	212,302	209,939
Basic income from continuing operations per share attributable to DaVita HealthCare Partners Inc.	$ 1.27	$ 3.41	$ 2.95
Basic income from discontinued operations per share attributable to DaVita HealthCare Partners Inc.	—	—	0.07
Basic net income per share attributable to DaVita HealthCare Partners Inc.	$ 1.27	$ 3.41	$ 3.02
Diluted:			
Income from continuing operations attributable to DaVita HealthCare Partners Inc.	$ 269,732	$ 723,114	$ 620,197
Discontinued operations attributable to DaVita HealthCare Partners Inc.	—	—	13,249
Net income attributable to DaVita HealthCare Partners Inc. for diluted earnings per share calculation	$ 269,732	$ 723,114	$ 633,446
Weighted average shares outstanding during the period	214,062	214,496	212,128
Vested stock units	—	—	5
Assumed incremental shares from stock plans	2,190	2,432	2,631
Weighted average shares for diluted earnings per share calculation	216,252	216,928	214,764
Diluted income from continuing operations per share attributable to DaVita HealthCare Partners Inc.	$ 1.25	$ 3.33	$ 2.89
Diluted income from discontinued operations per share attributable to DaVita HealthCare Partners Inc.	—	—	0.06
Diluted net income per share attributable to DaVita HealthCare Partners Inc.	$ 1.25	$ 3.33	$ 2.95
Anti-dilutive stock-settled awards excluded from calculation(1)	1,365	1,715	4,194

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

3. Accounts receivable

Approximately 14% and 11% of the Company's net accounts receivable balances as of December 31, 2015 and 2014, 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 of its government payors and commercial payors to estimate the adequacy of the allowance for doubtful accounts and the amount of the provision for uncollectible accounts. Management regularly updates its analysis based upon the most recent information available to 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. Approximately 1% of the Company'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 four 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. The increase was also due to an increase in the reserved amounts for accounts receivable older than six months. During the year ended December 31, 2014, the Company's allowance for doubtful accounts increased by $5,531. The increase in 2014 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,	
	2015	2014
Supplier rebates and non-trade receivables	$ 316,644	$ 265,693
Medicare bad debt claims	105,714	118,504
Operating advances under management and administrative services agreements	13,527	16,719
	$ 435,885	$ 400,916

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

5. Other current assets

Other current assets consist principally of prepaid expenses and funds on deposit with third parties.

	December 31,	
	2015	2014
Prepaid expenses	$ 105,216	$ 102,466
Funds on deposit with third parties	82,679	81,276
Other	2,427	3,100
	$ 190,322	$ 186,842

6. Property and equipment

Property and equipment were comprised of the following:

	December 31,	
	2015	2014
Land	$ 42,080	$ 35,885
Buildings	437,283	387,621
Leasehold improvements	2,289,425	2,002,735
Equipment and information systems, including internally developed software	2,080,446	1,836,704
New center and capital asset projects in progress	336,513	235,660
	5,185,747	4,498,605
Less accumulated depreciation	(2,397,007)	(2,029,506)
	$ 2,788,740	$ 2,469,099

Depreciation expense on property and equipment was $475,484, $428,309 and $373,107 for 2015, 2014 and 2013, 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 $9,723, $7,888 and $6,408 for 2015, 2014 and 2013, respectively.

7. Intangibles

Intangible assets other than goodwill were comprised of the following:

	December 31,	
	2015	2014
Customer relationships	$ 1,575,865	$ 1,575,865
Trade names	170,883	171,168
Provider network and practice management tools	183,724	183,688
Noncompetition and other agreements	510,521	506,867
Lease agreements	7,306	7,982
Indefinite-lived assets	9,310	24,818
Other	408	402
	2,458,017	2,470,790
Less accumulated amortization	(770,691)	(605,948)
	$ 1,687,326	$ 1,864,842

The 2014 intangible assets have been retrospectively recast as a result of the Company adopting ASU No. 2015-03. See Note 1 to the consolidated financial statements for further details. Amortization expense from amortizable intangible assets, other than lease agreements, was $166,537, $167,956 and $160,960 for 2015, 2014 and 2013, respectively. Lease agreement intangible assets and liabilities were amortized to rent expense in the amounts of $(1,613), $(1,798) and $(1,447) for 2015, 2014 and 2013, respectively.

During the quarter ended December 31, 2015, and in conjunction with the annual goodwill impairment assessment for its HCP reporting units as of November 1, the Company determined that circumstances indicated it had become more likely than not that an indefinite-lived intangible asset of the Company's HCP Nevada reporting unit had become impaired. See Note 10 to the consolidated financial statements for further details.

Amortizable intangible liabilities were comprised of the following:

	December 31,	
	2015	2014
Alliance and product supply agreement	$ 68,200	$ 68,200
Less accumulated amortization	(68,200)	(64,203)
Net Alliance and product supply agreement	—	3,997
Lease agreements (net of accumulated amortization of $6,936 and $4,785)	8,969	10,407
	$ 8,969	$ 14,404

Amortization benefit recognized from the alliance and product supply agreement was $3,997 for 2015 and $5,330 for both 2014 and 2013. 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, 2015 were as follows:

	Customer relationships	Trade names	Provider network and practice management tools	Noncompetition and other agreements	Lease agreements	Other
2016	82,617	16,634	26,187	30,619	(1,549)	67
2017	82,685	16,623	26,250	29,775	(1,228)	102
2018	82,638	16,235	26,273	19,545	(892)	53
2019	82,408	16,235	22,536	15,817	(832)	3
2020	82,066	16,235	541	10,209	(678)	2
Thereafter	909,798	37,320	—	28,543	(3,790)	—

8. Equity investments and other investments

Equity investments in non-consolidated businesses were $73,368 and $65,637 at December 31, 2015 and 2014, respectively. During 2015, 2014 and 2013, the Company recognized income of $18,325, $23,234 and $34,558, respectively, relating to equity investments in non-consolidated businesses under the equity method of accounting.

9. Investments in debt and equity securities

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

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

	December 31, 2015			December 31, 2014		
	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	$ 406,884	$ —	$ 406,884	$ 335,975	$ —	$ 335,975
Investments in mutual funds and common stock	—	33,482	33,482	—	28,123	28,123
	$ 406,884	$ 33,482	$ 440,366	$ 335,975	$ 28,123	$ 364,098
Short-term investments	$ 406,884	$ 1,200	$ 408,084	$ 335,975	$ 1,424	$ 337,399
Long-term investments	—	32,282	32,282	—	26,699	26,699
	$ 406,884	$ 33,482	$ 440,366	$ 335,975	$ 28,123	$ 364,098

The cost of certificates of deposit, commercial paper and money market funds at December 31, 2015 and 2014 approximate their fair value. As of December 31, 2015 and 2014, available for sale investments included $2,589 and $5,181, respectively, of gross pre-tax unrealized gains. During 2015 and 2014 the Company recorded gross pre-tax unrealized (losses) and gains of $(1,974) and $425, respectively, in other comprehensive income associated with changes in the fair value of these investments. 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. During 2014, the Company sold investments in mutual funds for net proceeds of $1,262, and recognized a pre-tax gain of $340, or $207 after tax, that was previously recorded in other comprehensive income.

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

10. Goodwill

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

	U.S. dialysis and related lab services	HCP	Other ancillary services and strategic initiatives	Consolidated total
Balance at January 1, 2014	$ 5,469,473	$ 3,516,162	$ 227,339	$ 9,212,974
Acquisitions	143,021	48,649	29,844	$ 221,514
Divestitures	(1,851)	—	—	$ (1,851)
Foreign currency and other adjustments	—	(2,277)	(15,065)	$ (17,342)
Balance at December 31, 2014	$ 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

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 our 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 its consolidated HCP 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 reporting unit, and to the dialysis centers within each international reporting unit. For the Company's other operating segments, no component below the operating segment level is considered a discrete business and therefore these operating segments directly constitute individual reporting units.

During the quarter ended December 31, 2015, and in conjunction with the annual goodwill impairment assessment for its HCP reporting units as of November 1, the Company determined that circumstances indicated it had become more likely than not that the goodwill and an indefinite-lived intangible asset of certain HCP reporting units had become impaired.

These circumstances included underperformance of the business in recent quarters as well as changes in other market conditions, including government reimbursement cuts and our expected ability to mitigate them. We are performing the required "step 1" and "step 2" valuations for these HCP reporting units and have estimated the fair value of their net assets and implied goodwill with the assistance of a third-party valuation firm. The Company also recorded a minor goodwill impairment charge on one of its international operations during 2015.

Based on these preliminary assessments of the HCP reporting units as well as assessments of other reporting units, the Company recorded the following goodwill and indefinite-lived intangible asset impairment charges during the year ended December 31, 2015:

Reporting unit	Impairment charge	Intangible asset impaired	Quarter ended
HCP Nevada	181,253	Goodwill	December 31, 2015
HCP Arizona	1,716	Goodwill	December 31, 2015
HCP Florida	5,800	Goodwill	December 31, 2015
International operations	4,065	Goodwill	June 30, 2015
Total goodwill impairment charges	192,834		
HCP Nevada	17,400	Indefinite-lived license	December 31, 2015
Total intangible impairment charges	$ 210,234		

The final amount of the impairment charges for the Company's HCP reporting units included above will depend upon the final outcome of the related valuation work, which we expect will be completed in the first quarter of 2016.

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

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

Except as described above, none of the goodwill associated with the Company's various other reporting units was considered at risk of impairment as of December 31, 2015. 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, these did not cause management to believe it is more likely than not that the fair value of any of its reporting units would be less than its carrying amount.

11. Other liabilities

Other liabilities were comprised of the following:

	December 31,	
	2015	2014
Payor refunds and retractions	$ 153,104	$ 125,435
Contingent earn-out consideration	29,050	15,614
Insurance and self-insurance accruals	80,355	92,928
Accrued interest	81,585	87,224
Other medical payables	53,687	39,867
Accrued non-income tax liabilities	29,291	25,909
Other	255,051	123,246
	$ 682,123	$ 510,223

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, 2015 and 2014:

	December 31,	
	2015	2014
Healthcare costs payable, beginning of the year	$ 214,405	$ 172,310
Add: Components of incurred healthcare costs		
Current year	1,587,036	1,572,723
Prior years	1,523	3,429
Total incurred healthcare costs	1,588,559	1,576,152
Less: Claims paid		
Current year	1,397,378	1,378,137
Prior years	192,945	155,920
Total claims paid	1,590,323	1,534,057
Healthcare costs payable, end of the year	$ 212,641	$ 214,405

The Company's prior year estimates of healthcare costs payable increased by $1,523 and $3,429 in 2015 and 2014, respectively. The increase in 2015 resulted from certain medical claims being settled for amounts more 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 tax expense (benefit) consisted of the following:

	Year ended December 31,		
	2015	2014	2013
Current:			
Federal	$ 183,263	$ 188,302	$ 334,258
State	30,766	30,789	68,715
International	856	1,687	1,764
Total current income tax	$ 214,885	$ 220,778	$ 404,737
Deferred:			
Federal	88,718	192,267	(6,695)
State	(8,307)	32,360	(8,941)
International	430	938	746
Total deferred income tax	$ 80,841	$ 225,565	$ (14,890)
	$ 295,726	$ 446,343	$ 389,847

The allocation of income tax expense (benefit) was as follows:

	Year ended December 31,		
	2015	2014	2013
Continuing operations	$ 295,726	$ 446,343	$ 381,013
Discontinued operations	—	—	(84)
Gain on discontinued operations	—	—	8,918
	$ 295,726	$ 446,343	$ 389,847

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

	Year ended December 31,		
	2015	2014	2013
Federal income tax rate	35.0%	35.0%	35.0%
State income taxes, net of federal benefit	2.5	3.5	3.8
International rate differential	(1.1)	(0.2)	0.1
Goodwill and intangible impairments	11.7	—	—
Changes in deferred tax valuation allowances	2.6	0.6	0.3
Contingent earn-out adjustments	—	—	(2.6)
Other	1.5	(0.8)	1.4
Impact of noncontrolling interests primarily attributable to non-tax paying entities	(11.3)	(4.0)	(4.1)
Effective tax rate	40.9%	34.1%	33.9%

The Company has not recognized any deferred taxes for the undistributed earnings of its foreign subsidiaries because the Company currently expects those earnings to be permanently reinvested. Determination of the amount of unrecognized deferred taxes related to undistributed earnings of foreign subsidiaries is not practicable because such liability, if any, is dependent on circumstances that will exist if and when remittance occurs.

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

	December 31,	
	2015	2014
Receivables	$ 43,393	$ 42,976
Accrued liabilities	272,080	253,228
Net operating loss carryforwards	130,977	102,212
Other	114,805	93,567
Deferred tax assets	561,255	491,983
Valuation allowance	(57,811)	(28,784)
Net deferred tax assets	503,444	463,199
Intangible assets	(927,761)	(839,824)
Property and equipment	(205,071)	(187,198)
Investments in partnerships	(83,584)	(78,619)
Other	(13,990)	(7,633)
Deferred tax liabilities	(1,230,406)	(1,113,274)
Net deferred tax liabilities	$ (726,962)	$ (650,075)

At December 31, 2015, the Company had federal net operating loss carryforwards of approximately $182,200 that expire through 2035, although a substantial amount expire by 2028. The Company also had state net operating loss carryforwards of $761,686 that expire through 2035 and international net operating loss carryforwards of $96,847, 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 increase of $29,027 is primarily due to the realizability of losses in certain foreign and state jurisdictions.

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,	
	2015	2014
Balance beginning	$ 31,877	$ 60,538
Additions for tax positions related to current year	6,131	914
Additions (reductions) for tax positions related to prior years	2,999	(27,312)
Reductions related to lapse of applicable statute	(1,996)	(2,077)
Reductions related to settlements with taxing authorities	—	(186)
Balance ending	$ 39,011	$ 31,877

As of December 31, 2015, the Company's total liability for unrecognized tax benefits relating to tax positions that do not meet the more-likely-than-not threshold is $39,011, all of which would impact the Company's effective tax rate if recognized. This balance represents an increase of $7,134 from the December 31, 2014 balance of $31,877.

The Company recognizes accrued interest and penalties related to unrecognized tax benefits in its income tax expense. At December 31, 2015 and 2014, the Company had approximately $9,918 and $10,123, 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 2011 and 2008, respectively.

14. Long-term debt

Long-term debt was comprised of the following:

	December 31,	
	2015	2014
Senior Secured Credit Facilities:		
Term Loan A	$ 925,000	$ 975,000
Term Loan B	3,447,500	3,482,500
Senior notes	4,500,000	3,775,000
Acquisition obligations and other notes payable	70,645	69,045
Capital lease obligations	283,185	218,097
Total debt principal outstanding	9,226,330	8,519,642
Discount and deferred financing costs	(95,985)	(100,864)
	9,130,345	8,418,778
Less current portion	(129,037)	(120,154)
	$ 9,001,308	$ 8,298,624

Scheduled maturities of long-term debt at December 31, 2015 were as follows:

2016	129,037
2017	152,768
2018	166,132
2019	740,895
2020	65,171
Thereafter	7,972,327

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). Each tranche for the Term Loan A bears interest at a London Interbank Offered Rate (LIBOR) rate determined by the duration of such tranche plus an interest rate margin, currently 1.75%. 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, 2015, the overall weighted average interest rate for the Term Loan A was determined based upon the LIBOR interest rates in effect for all of the individual tranches plus the interest rate margin. The Company has several interest rate swap agreements that have the economic effect of fixing the majority of the Term Loan A LIBOR variable component of the Company's interest rate, as described below. At December 31, 2015, the Term Loan B bears interest at LIBOR (floor of 0.75%) plus a margin of 2.75%. The Company is subject to a LIBOR-based floor until such time as the LIBOR-based component of the interest rate exceeds 0.75% on the Term Loan B. At such time, the Company will then be subject to LIBOR-based interest rate volatility on the LIBOR variable component of its interest rate and the overall weighted average interest rate for the Term Loan B will then be 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 2.50% on $2,735,000 of outstanding principal debt. The remaining $712,500 outstanding principal balance of the Term Loan B would still be subject to LIBOR-based interest rate volatility above a floor of 0.75%. In addition, the Company maintains several forward interest rate cap agreements with notional amounts totaling $7,000,000 of which $3,500,000 will be effective September 30, 2016 and the remainder of the cap agreements 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.

During the year ended December 31, 2015, the Company made mandatory principal payments under its then existing Senior Secured Credit Facilities totaling $50,000 on the Term Loan A and $35,000 on the Term Loan B.

Credit agreement and other debt transactions

In June 2014 the Company entered into a Credit Agreement that consists of a five year Revolving Credit Facility in the aggregate principal amount of $1,000,000 (the Revolver), a five year Term Loan A facility in the aggregate principal amount of $1,000,000 (the Term Loan A) and a seven year Term Loan B facility in the aggregate principal amount of $3,500,000 (the Term Loan B). In addition, the Company can increase the existing revolving commitments and enter into one or more incremental term loan facilities in an amount not to exceed the sum of $1,500,000 (less the amount of other permitted indebtedness incurred or issued in reliance on such amount), plus an amount of indebtedness such that the senior secured leverage ratio is not in excess of 3.50 to 1.00 after giving effect to such borrowings. The Credit Agreement contains certain customary affirmative and negative covenants such as various restrictions or limitations on certain items depending on the Company's leverage ratio.

In addition, in June 2014, the Company issued $1,750,000 5 1/8% Senior Notes due 2024 (5 1/8% Senior Notes). The 5 1/8% Senior Notes pay interest on January 15 and July 15 and are unsecured and are guaranteed by the Company's domestic subsidiaries as discussed above.

The Company used a portion of the proceeds to pay off the total outstanding principal balances under the Company's then existing Senior Secured Credit Facilities plus accrued interest totaling $5,362,400 and in addition, paid off the outstanding principal balances of the Company's $775,000 6 3/8% Senior Notes plus accrued interest.

The Company also terminated $1,137,500 notional amounts of amortizing swaps and also terminated $600,000 of forward swaps during June 2014.

As a result of the 2014 transactions, the Company recorded debt refinancing charges of $97,548 that consist of the cash tender premiums, the redemption premium, the write-off of existing deferred financing costs, the write-off of certain new refinancing costs, other professional fees and losses associated with the termination of several of the Company's interest rate swap agreements.

In 2014, the Company made mandatory principal payments under its then existing New Senior Secured Credit Facility (before entering into a secured credit agreement and repaying all outstanding amounts under the then existing Senior Secured Credit Facilities, as discussed below) totaling $62,500 on the Term Loan A, $16,875 on the Term Loan A-3, $21,875 on the Term Loan B and $4,125 on the Term Loan B-2.

Revolving lines of credit

The Company has an undrawn revolving line under the Senior Secured Credit Facilities totaling $1,000,000, of which approximately $92,238 was committed for outstanding letters of credit. In addition, the Company has approximately $1,286 of committed outstanding letters of credit related to HCP, which is backed by a certificate of deposit.

Senior Notes

The Company's senior notes as of December 31, 2015, 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), as described below.

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 and rank equally in right of payment with the Company's existing and future unsecured senior indebtedness. The 5.0% Senior Notes 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 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 will be used for general corporate purposes, future 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.

The Senior Notes are also unsecured obligations and rank equally in right of payment with the Company's existing and future unsecured senior indebtedness. These Senior Notes 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.

Interest rate swaps and caps

The Company has entered into several interest rate swap agreements as a means of hedging its exposure to and volatility from variable-based interest rate changes as part of its overall interest rate risk management strategy. These agreements are not held for trading or speculative purposes and have the economic effect of converting the LIBOR variable component of the Company's interest rate to a fixed rate. These swap agreements are designated as cash flow hedges, and as a result, hedge-effective gains or losses resulting from changes in the fair values of these swaps are reported in other comprehensive income until such time as the hedged forecasted cash flows occur, at which time the amounts are reclassified into net income. Net amounts paid or received for each specific swap tranche that have settled have been reflected as adjustments to debt expense. In addition, the Company has entered into several interest rate cap agreements 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. Certain 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, 2015, the Company maintains several interest rate swap agreements that were entered into in March 2013 with amortizing notional amounts totaling $760,000. These agreements have the economic effect of modifying the LIBOR variable component of the Company's interest rate on an equivalent amount of the Company's Term Loan A to fixed rates ranging from 0.49% to 0.52%, resulting in an overall weighted average effective interest rate of 2.26%, including the Term Loan A margin of 1.75%. The overall weighted average effective interest rate also includes the effects of $165,000 of unhedged Term Loan A debt that bears interest at LIBOR plus an interest rate margin of 1.75%. The swap agreements expire on September 30, 2016 and require monthly interest payments. During the year ended December 31, 2015, the Company recognized debt expense of $2,664 from these swaps. As of December 31, 2015, the total fair value of these swap agreements was a net asset of approximately $516. During the year ended December 31, 2015, the Company recorded a loss of $3,971 in other comprehensive income due to a decrease in the unrealized fair value of these swap agreements. The Company estimates that approximately $516 of existing unrealized pre-tax gains in other comprehensive income at December 31, 2015 will be reclassified into income over the next twelve months.

As of December 31, 2015, 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 be 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, 2015, the total fair value of these cap agreements was an asset of approximately $13,815. During the year ended December 31, 2015, the Company recorded a loss of $3,492 in other comprehensive income due to a decrease in the unrealized fair value of these cap agreements.

As of December 31, 2015, the Company maintains several forward interest rate cap agreements that were entered into in November 2014 with notional amounts totaling $3,500,000. These forward cap agreements will be effective September 30, 2016 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 the Company's debt. The cap agreements expire on June 30, 2018. As of December 31, 2015, the total fair value of these cap agreements was an asset of approximately $1,312. During the year ended December 31, 2015, the Company recorded a loss of $11,029 in other comprehensive income due to a decrease in the unrealized fair value of these cap agreements.

As of December 31, 2015, the Company maintains several interest rate cap agreements that were entered into in March 2013 with notional amounts totaling $2,735,000 on the Company's Term Loan B debt. These agreements have the economic effect of capping the LIBOR variable component of the Company's interest rate at a maximum of 2.50% on an equivalent amount of the Company's Term Loan B. During the year ended December 31, 2015, the Company recognized debt expense of $2,439 from these caps. The cap agreements expire on September 30, 2016. As of December 31, 2015, the total fair value of these cap agreements was immaterial. During the year ended December 31, 2015, the Company recorded a loss of $1,593 in other comprehensive income due to a decrease in the unrealized fair value of these cap agreements.

The following table summarizes the Company's derivative instruments as of December 31, 2015 and 2014:

	Interest rate swap and cap agreements (liabilities and assets)			
	December 31, 2015		December 31, 2014	
Derivatives designated as hedging instruments	Balance sheet location	Fair value	Balance sheet location	Fair value
Interest rate swap agreements	Other short-term assets	$ 516	Other short-term liabilities	$ 1,457
Interest rate swap agreements	Other long-term assets	$ —	Other long-term assets	$ 3,281
Interest rate cap agreements	Other long-term assets	$ 15,127	Other long-term assets	$ 13,934

The following table summarizes the effects of the Company's interest rate swap and cap agreements for the years ended December 31, 2015, 2014 and 2013:

	Amount of gains (losses) recognized in OCI on interest rate swap and cap agreements			Location of (losses) gains reclassified from accumulated OCI into income	Amount of gains (losses) reclassified from accumulated OCI into income		
	Years ended December 31,				Years ended December 31,		
Derivatives designated as cash flow hedges	2015	2014	2013		2015	2014	2013
Interest rate swap agreements	$ (3,971)	$ (8,390)	$ 1,251	Debt expense	$ 2,664	$ 12,279	$ 15,678
Interest rate cap agreements	(16,114)	(8,119)	(974)	Debt expense	2,439	5,130	5,418
Tax (expense) benefit	7,844	6,450	(108)		(1,992)	(6,801)	(8,207)
Total	$ (12,241)	$ (10,059)	$ 169		$ 3,111	$ 10,608	$ 12,889

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

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

The Company's overall weighted average effective interest rate for the year ended December 31, 2015 was 4.42% and as of December 31, 2015 was 4.39%.

Debt expense

Debt expense consisted of interest expense of $389,755, $385,750 and $401,140, and the amortization and accretion of debt discounts and premiums, amortization of deferred financing costs and the amortization of interest rate cap agreements of $18,625, $24,544 and $28,803 for 2015, 2014 and 2013, 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, which contain renewal options of five to ten years at the fair rental value at the time of renewal. The Company's leases are 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 leases and capital leases are as follows:

	Operating leases	Capital leases
2016	$ 431,658	$ 30,538
2017	415,746	30,848
2018	375,516	31,196
2019	331,575	32,065
2020	283,633	32,443
Thereafter	1,083,825	235,285
	$ 2,921,953	392,375
Less portion representing interest		(109,190)
Total capital lease obligations, including current portion		$ 283,185

Rent expense under all operating leases for 2015, 2014, and 2013 was $514,287, $460,093 and $424,096, 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 $261,960 and $197,344 at December 31, 2015 and 2014, respectively. Capital lease obligations are included in long-term debt. See Note 14 to the consolidated financial statements.

16. Employee benefit plans

The Company has a savings plan for substantially all of its non-HCP 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.

The Company also has various savings plans covering substantially all of its HCP employees which have been established pursuant to the provisions of Section 401(k) of the IRC. These plans provide for multiple employer matching contributions ranging from 0% to 6% of employee contributions. For the year ended December 31, 2015, the Company made matching contributions totaling approximately $8,324.

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 2015, 2014 and 2013 were $4,234, $3,772 and $4,089, 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 2015, 2014 and

2013 the Company distributed $1,270, $1,111 and $4,158, 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, 2015 and 2014, the total fair value of assets held in this plan's trust were $23,800 and $21,208, respectively. In addition, the Company maintains a non-qualified voluntary compensation deferral plan, the HealthCare Partners, LLC Deferred Compensation Plan. As of December 31, 2015 and 2014, the total fair value of the assets held in this plan's trust were $8,578 and $5,347, respectively.

The Company 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 2015 and 2014 the Company distributed $25 and $152, respectively, to participants in this plan. During 2013 the Company did not make any distributions to participants under this plan. As of December 31, 2015 and 2014, the total fair value of assets held under this plan's trust was $1,104 and $1,344, respectively.

The Company also maintains a non-qualified deferred compensation program for certain key employees of HCP. Under the program, the employees can defer a portion of their salary which is invested at the direction of the employee into certain phantom investments as offered by the program. A portion of the amount deferred by the employees is used to purchase life insurance policies on each of the participating employees, with the Company named as beneficiary of the policies. The total cash surrender value of all of the life insurance policies totaled approximately $56,840 and $57,690 at December 31, 2015 and 2014, respectively, and is included in long-term investments. In addition, the total deferred compensation liabilities owed to the participants totaled approximately $52,128 and $60,409 at December 31, 2015 and 2014, respectively, and are included in other long-term liabilities. During 2015 and 2014, the Company did not make any contributions on behalf of its participants. During the year ended December 31, 2013, the Company contributed a total of approximately $4,658 into the deferred compensation program on behalf of its participants.

The fair value of all of the assets held in plan trusts as of December 31, 2015, and 2014 totaled $33,482 and $27,899, respectively. These assets 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 the 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, 2015, these cash bonuses would total approximately $577,363 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, 2015, 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.

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. 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 has cooperated with the government and produced the requested documents. In April 2014, the Company reached an agreement in principle with the government and expects to execute in the first quarter of 2016 the settlement agreements with the government and the state of New York to finalize the terms of the settlement and to resolve this matter, and has accrued an amount that is immaterial.

Swoben Private Civil Suit: In April 2013, the Company's HCP subsidiary was served with a civil complaint filed by a former employee of SCAN Health Plan (SCAN), a health maintenance organization (HMO). On July 13, 2009, pursuant to the *qui tam* provisions of the federal False Claims Act (FCA) and the California False Claims Act, James M. Swoben, as relator, filed a *qui tam* action in the United States District Court for the Central District of California purportedly on behalf of the United States of America and the State of California against SCAN, and certain other defendants whose identities were under seal. The allegations in the complaint relate to alleged overpayments received from government healthcare programs. In or about August 2012, SCAN entered into a Settlement Agreement with the United States of America and the State of California. The United States and the State of California partially intervened in the action for the purpose of settlement with and dismissal of the action against SCAN. In or about November 2011, the relator filed his Third Amended Complaint under seal alleging violations of the federal FCA and the California False Claims Act, which named additional defendants, including HCP and certain health insurance companies (the defendant HMOs). The allegations in the complaint against HCP relate to patient diagnosis coding to determine reimbursement in the Medicare Advantage program, referred to as Hierarchical Condition Coding (HCC) and Risk Adjustment Factor (RAF) scores. The complaint sought monetary damages and civil penalties as well as costs and expenses. The United States Department of Justice reviewed these allegations and in January 2013 declined to intervene in the case. On June 26, 2013, HCP and the defendant HMOs filed their respective motions to dismiss the Third Amended Complaint pursuant to Federal Rules of Civil Procedure 12(b)(6) and 9(b), challenging the legal sufficiency of the claims asserted in the complaint. On July 30, 2013, the court granted HCP's motion and dismissed with prejudice all of the claims in the Third Amended Complaint and judgment was entered in September 2013. The court specifically determined that further amendments to the complaint would be futile because, in part, the allegations were publicly disclosed in reports and other sources relating to audits conducted by the Centers of Medicare & Medicaid Services (CMS). In October 2013, the plaintiff appealed to the United States Court of Appeals for the Ninth Circuit and the court's disposition of the appeal is pending.

2015 U.S. Attorney Transportation Investigation: In February 2015, 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 seeks 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. The Company has been advised by an attorney with the United States Attorney's Office for the Central District of California that the subpoenas relate to an investigation concerning the medical necessity of patient transportation. The Company does not provide transportation nor does it bill for the transport of its dialysis patients. The Company does not know the scope of the investigation by the government, nor what conduct or activities might be the subject of the investigation.

2015 U.S. OIG Medicare Advantage Civil Investigation: In March 2015, JSA HealthCare Corporation (JSA), a subsidiary of HCP, received a subpoena from the OIG. The Company has been advised by an attorney with the Civil Division of the United States Department of Justice 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 HealthCare Partners and its subsidiary JSA HealthCare Corporation) provision of services to Medicare Advantage plans and related patient diagnosis coding and risk adjustment submissions and payments. 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. Some of the information requested relates to what the Company first disclosed in the risk factors of the Company's quarterly report on Form 10-Q for the first quarter of 2015 as a potentially improper historical HCP coding practice related to a particular condition. The practice in question was discontinued following the Company's November 1, 2012 acquisition of HCP and, as the Company previously disclosed, the Company notified CMS of the coding practice and potential overpayments. In connection with the HCP merger, the Company has certain indemnification rights against the sellers and an escrow was established as security for the indemnification. The Company would pursue an indemnification claim against the sellers secured by the escrow for any and all liabilities incurred. The Company can make no assurances that the indemnification and escrow would cover the full amount of the Company's potential losses related to this matter. The Company is cooperating with the government and is producing the requested information.

2015 U.S. Department of Justice Vascular Access Investigation: 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 U.S. Department of Justice (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 appears to be looking at whether the angiograms of 10 patients performed at the two centers were medically unnecessary and therefore whether related claims filed with federal healthcare programs possibly violated the FCA. Lifeline does not perform dialysis services but instead provides vascular access management services for dialysis patients. The Company is in the process of producing the requested documents to the DOJ.

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. Based on the language of the CID, it appears the government is conducting an FCA investigation concerning allegations that DaVita Rx presented or caused to be presented false claims for payment to the government for prescription medications. The CID covers the period from January 1, 2006 through the present. In the spring of 2015, 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 of 2015 that it was conducting this review of DaVita Rx and began providing regular updates of its review. In the fourth quarter of 2015, the Company recorded an estimated accrual of $22 million for potential damages and liabilities associated with write-offs and discounts of patient co-payment obligations, and credits to payors for returns of prescriptions drugs, related to DaVita Rx that were identified during the course of this internal compliance review. The Company may accrue additional reserves for refunds and related damages and potential liabilities arising out of this 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 overlaps with information requested by the U.S. Attorney's Office. 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 late February 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 intends to cooperate with the government in this matter.

Except for the private civil complaints filed by the relators as described above, to the Company's knowledge, no proceedings have been initiated against the Company at this time in connection with any of the inquiries by the federal government. Although the Company cannot predict whether or when proceedings might be initiated or when these matters may be resolved, it is not unusual for inquiries such as these to continue for a considerable period of time through the various phases of document and witness requests and on-going discussions with regulators. Responding to the subpoenas or inquiries and defending the Company in the relator proceedings will continue to require management's attention and significant legal expense. Any negative findings in the inquiries or relator

proceedings could result in substantial financial penalties or awards against the Company, exclusion from future participation in the Medicare and Medicaid programs and if criminal proceedings were initiated against the Company, possible criminal penalties. At this time, the Company cannot predict the ultimate outcome of these inquiries, or the potential outcome of the relators' claims (except as described above), or the potential range of damages, if any.

Shareholder Derivative Claims

DaVita HealthCare Partners Inc. Derivative Litigation: On January 7, 2014, the U.S. District Court for the District of Colorado consolidated the two previously disclosed shareholder derivative lawsuits: the Haverhill Retirement System action filed on May 17, 2013 and the Clark Shareholder action filed on August 7, 2012. The court appointed Haverhill lead plaintiff. The complaints filed against the directors of the Company and against the Company, as nominal defendant allege, among other things, that the Company's directors breached fiduciary duties to the Company relating to the 2010 and 2011 U.S. Attorney physician relationship investigations described above, the Vainer *qui tam* private civil suit described above and the Woodard *qui tam* private civil suit for which the Company previously announced a settlement in July 2012. The Company entered into a settlement with the lead plaintiff, which as previously disclosed, were described in a court-ordered notice sent to shareholders in late January 2015, and included enhancements to the Company's corporate governance practices and provides that the Company will not oppose the derivative plaintiff's application for an award of fees and expenses, the dollar amount of which is not material to the Company. The Court approved the settlement and entered an order granting final approval of the settlement on June 5, 2015 and final judgment in the case was entered on June 9, 2015.

Other

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

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

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

18. Noncontrolling interests subject to put provisions and other commitments

Noncontrolling interests subject to put provisions

The Company has potential obligations to purchase the noncontrolling interests held by third parties in several of its majority-owned joint ventures, non-owned and minority-owned entities. These obligations are in the form of put provisions and are exercisable at the third-party owners' discretion within specified periods as outlined in each specific put provision. If these put provisions were exercised, the Company would be required to purchase the third-party owners' noncontrolling interests at either the appraised fair market value or a predetermined multiple of earnings or cash flow attributable to the noncontrolling interests put to the Company, which is intended to approximate fair value. The methodology the Company uses to estimate the fair values of noncontrolling interests subject to put provisions assumes 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' noncontrolling interests. The amount of noncontrolling interests subject to put provisions that employ a contractually predetermined multiple of earnings rather than fair value are immaterial.

Additionally, the Company has certain other potential commitments to provide operating capital to several dialysis centers that are wholly-owned by third parties or centers in which the Company owns a minority equity investment as well as to physician-owned vascular access clinics or medical practices that the Company operates under management and administrative service agreements of approximately $5,600.

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 November 2011, the Company entered into a seven year Sourcing and Supply Agreement with Amgen USA Inc. (Amgen) that expires on December 31, 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. The actual amount of EPO that the Company 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 the Company serves.

In December 2012, the Company entered into an amendment to its agreement with Amgen that made non-material changes to certain terms of the agreement for the period from January 1, 2013 through December 31, 2013. Under the terms of the original agreement before the amendment, the Company was required to purchase EPO in amounts necessary to meet no less than 90% of its requirements of ESAs and is still required to do so after 2013. In addition, all of the other conditions as specified in the original agreement entered into in November 2011 still apply.

In January 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 February 2016. During 2015, 2014 and 2013, the Company purchased $154,566 and $154,266 and $144,030, 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 2015, 2014 and 2013, the Company purchased $112,931, $112,645 and $124,555 of hemodialysis product supplies from Baxter under this agreement and a prior agreement with Gambro Healthcare Inc. which was acquired by Baxter.

Certain HCP 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, 2015, this minimum cash balance was approximately $59,897.

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, 2015.

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 dialysis and related lab services business, the HCP 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 authorized but unissued shares.

Stock split

In the third quarter of 2013, the Board of Directors approved a two-for-one stock split of the Company's common stock in the form of a stock dividend payable on September 6, 2013 to stockholders of record on August 23, 2013. The Company's common stock began trading on a post-split basis on September 9, 2013. All share and per share data for all periods presented have been adjusted to reflect the effects of the stock split.

Long-term incentive compensation plans

On June 17, 2013, the stockholders of the Company approved an amendment to the DaVita HealthCare Partners Inc. 2011 Incentive Award Plan to increase the number of shares of common stock available for issuance under the Plan by 17,000,000 shares.

On June 11, 2012, the Company's stockholders approved an amendment to the Company's 2011 Incentive Award Plan (the 2011 Plan) to increase the number of shares of common stock available for issuance under the plan by 9,000,000 shares and to increase the amount by which share reserves under the plan are reduced by grants of full value share awards to 3.5 times from 3.0 times the number of shares subject to the award.

The Company's 2011 Incentive Award 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 Plan at a ratio of 3.5:1. The Company's nonqualified stock appreciation rights and stock units awarded under the Plan generally vest over 36 to 48 months from the date of grant. At December 31, 2015, there were 8,533,561 stock-settled stock appreciation rights, 765,060 stock-settled stock units, 54,688 cash-settled stock appreciation rights and 3,867 cash-settled stock units outstanding, and 32,484,534 shares available for future grants, under the Plan.

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, 2015				
	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	10,585,172	$ 53.21		921,898	
Granted	993,953	81.22		279,485	
Exercised	(2,409,579)	41.62		(348,127)	
Cancelled	(635,985)	62.42		(88,196)	
Outstanding at end of period	8,533,561	$ 59.05	2.3	765,060	0.4
Exercisable at end of period	2,856,959	$ 47.88	1.2	—	—
Weighted-average fair value of grants in 2015	$ 17.97			$ 80.25	
Weighted-average fair value of grants in 2014	$ 16.41			$ 72.24	
Weighted-average fair value of grants in 2013	$ 13.47			$ 58.90	

Range of SSAR base prices	Awards outstanding	Weighted average exercise price	Awards exercisable	Weighted average exercise price
$30.01–$40.00	369,301	36.56	358,969	36.54
$40.01–$50.00	1,437,708	43.02	1,390,300	42.86
$50.01–$60.00	4,143,205	57.54	843,384	55.30
$60.01–$70.00	1,293,564	68.12	216,000	65.08
$70.01–$80.00	588,733	73.80	48,306	70.31
$80.01–$90.00	701,050	83.60	—	—
Total	8,533,561	$ 59.05	2,856,959	$ 47.88

Liability-classified awards contributed $(236), $1,774 and $338 to stock-based compensation expense for the years ended December 31, 2015, 2014 and 2013, respectively. As of December 31, 2015 the Company had 58,555 liability-classified share awards outstanding, 10,313 of which were vested, and a total stock-based compensation liability balance of $691. The Company did not grant any cash-settled stock-based awards during 2015.

For the years ended December 31, 2015, 2014, and 2013, the aggregate intrinsic value of stock-based awards exercised was $116,933, $151,342 and $120,775, respectively. At December 31, 2015, the aggregate intrinsic value of stock awards outstanding was $157,397 and the aggregate intrinsic value of stock awards exercisable was $62,655.

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. 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 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,		
	2015	2014	2013
Expected term	4.1 years	4.2 years	4.1 years
Expected volatility	24.6%	25.8%	27.2%
Expected dividend yield	0.0%	0.0%	0.0%
Risk-free interest rate	1.5%	1.5%	0.7%

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. Payroll withholdings and lump-sum payments related to the plan, included in accrued compensation and benefits and used to purchase the Company's common stock for 2015, 2014 and 2013 participation periods, were $24,523, $19,010 and $12,817, respectively. Shares purchased pursuant to the plan's 2015, 2014 and 2013 participation periods were 413,859, 297,954 and 237,961, respectively. At December 31, 2015, there were 422,401 shares remaining available for future grants under this plan.

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 2015, 2014 and 2013, respectively: expected volatility of 26%, 27% and 28%; risk-free interest rate of 0.2%, 0.2% and 0.2%, and no dividends. Using these assumptions, the weighted average estimated fair value of these purchase rights was $18.76, $16.40 and $14.24 for 2015, 2014 and 2013, respectively.

Long-term incentive compensation expense and proceeds

For the years ended December 31, 2015, 2014 and 2013, the Company recognized $130,682, $118,970 and $84,841, respectively, in total LTIP expense, of which $56,664, $56,743 and $59,998, respectively, was stock-based compensation expense for stock appreciation rights, stock options, 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 2015, 2014 and 2013 were $19,689, $20,351 and $22,187, respectively. As of December 31, 2015, there was $123,966 total estimated unrecognized compensation cost for outstanding LTIP awards, including $63,599 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 1.3 years.

For the years ended December 31, 2015, 2014 and 2013, the Company received $45,749, $59,119 and $46,898, respectively, in actual tax benefits upon the exercise of stock awards. As a result of the Company issuing SSARs, beginning in 2013, the Company no longer has stock options outstanding and did not receive cash proceeds from stock option exercises during the years ended December 31, 2015, 2014 and 2013.

Stock repurchases

During the year ended December 31, 2015, the Company repurchased a total of 7,779,958 shares of its common stock for $575,380, or an average price of $73.96 per share. The Company also repurchased a total of 3,689,738 shares of its common stock during January 2016 for $249,481, or an average price of $67.61 per share.

On April 14, 2015, the Company's Board of Directors approved additional share repurchases in the amount of $725,944. These share repurchases are in addition to the $274,056 remaining at that time under the Company's Board of Directors' prior share repurchase approval announced in November 2010. As a result of these transactions, the Company now has a total of $259,225 available under the current Board authorizations for additional share repurchases as of January 31, 2016. These share repurchase authorizations have no expiration dates. However, the Company is subject to share repurchase limitations under the terms of its Senior Secured Credit Facilities and the indentures governing its Senior Notes.

The Company did not repurchase any of its common stock during 2014 or 2013.

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 that, 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 HealthCare Partners Inc.'s ownership interest in consolidated subsidiaries

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

	Year ended December 31,		
	2015	2014	2013
Net income attributable to DaVita HealthCare Partners Inc.	$ 269,732	$ 723,114	$ 633,446
Increase (decrease) in paid-in capital for sales of noncontrolling interest	—	355	(1,442)
Decrease in paid-in capital for the purchase of noncontrolling interests	(55,826)	(5,357)	(3,119)
Net transfer to noncontrolling interests	(55,826)	(5,002)	(4,561)
Change from net income attributable to DaVita HealthCare Partners Inc. and transfers to noncontrolling interests	$ 213,906	$ 718,112	$ 628,885

During 2015, the Company acquired additional ownership interests in several existing majority-owned joint ventures for $66,382 in cash. In 2014, the Company also acquired additional ownership interests in several existing majority-owned joint ventures for $17,876 in cash and deferred purchase price of $136. In 2013, the Company acquired additional ownership interest in several existing majority-owned joint ventures for $3,569 and deferred purchase price of $209.

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, 2012	$ (15,402)	$ 1,310	$ (1,205)	$ (15,297)
Unrealized (losses) gains	277	3,752	(2,216)	1,813
Related income tax	(108)	(1,452)	—	(1,560)
	169	2,300	(2,216)	253
Reclassification from accumulated other comprehensive losses (income) into net income	21,096	(802)	—	20,294
Related income tax	(8,207)	312	—	(7,895)
	12,889	(490)	—	12,399
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)

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 the 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 the consolidated financial statements for further details.

21. Acquisitions

On August 17, 2015, the Company entered into a definitive agreement to acquire Colorado-based Renal Ventures Limited, LLC (Renal Ventures), including a 100 percent interest in all dialysis centers owned by Renal Ventures, for approximately $415,000 in cash, subject to, among other things, adjustments for certain items such as working capital. Renal Ventures currently operates 36 dialysis clinics in six states serving approximately 2,400 patients, and also operates other ancillary businesses. The transaction is subject to approval by the Federal Trade Commission (FTC) including Hart-Scott-Rodino antitrust clearance. The Company anticipates that it will be required by the FTC to divest a certain number of outpatient dialysis centers as a condition of the transaction. The Company currently expects this transaction to close in 2016.

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

During 2015, the Company acquired dialysis-related and other ancillary businesses consisting of six dialysis centers in the U.S., 21 dialysis centers outside of 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 of the U.S. and other medical businesses for a total of $272,094 in net cash and deferred purchase price of $23,781. During 2013, the Company acquired dialysis-related and other ancillary businesses consisting of 26 dialysis centers in the U.S., 38 dialysis centers outside of the U.S. and other medical businesses for a total of $310,394 in net cash and deferred purchase price of $24,683.

The assets and liabilities for all acquisitions were recorded at their estimated fair values at the dates of the acquisitions and are included in the Company's financial statements and operating results from the effective dates of the acquisitions. For several of the 2015 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,		
	2015	2014	2013
Current assets	$ 3,843	$ 915	$ 7,215
Property and equipment	12,436	5,999	23,760
Customer relationships	—	74,515	31,838
Non-compete agreements	8,959	16,585	17,710
Amortizable intangible and other long-term assets	4,345	4,193	31,098
Goodwill	97,093	221,514	271,267
Long-term deferred income taxes	(1,467)	—	(5,666)
Noncontrolling interests assumed	(18,905)	(25,963)	(22,880)
Liabilities assumed	(1,440)	(1,883)	(19,265)
Aggregate purchase cost	$ 104,864	$ 295,875	$ 335,077

Amortizable intangible assets acquired during 2015, 2014 and 2013 had weighted-average estimated useful lives of 8, 10 and 14 years, respectively. The majority of the intangible assets acquired relate to customer relationships and non-compete agreements. The weighted-average amortization period for customer relationships was 10 and 17 years for 2014 and 2013, respectively. The weighted-average amortization period for non-compete agreements was 8 years for both 2015 and 2014, and 9 years for 2013. The total amount of goodwill deductible for tax purposes associated with these acquisitions for 2015, 2014, and 2013 was approximately $73,733, $175,247 and $221,454, respectively.

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 $129,626 if certain EBITDA, operating income performance targets or quality margins are met over the next one to two 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 the consolidated financial statements for further details. As of December 31, 2015, the Company has estimated the fair value of these contingent earn-out obligations to be $34,135, of which a total of $29,050 is included in other liabilities and the remaining $5,085 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, 2015:

Beginning balance, January 1, 2015	$ 39,129
Contingent earn-out obligations associated with acquisitions	990
Remeasurement of fair value	(428)
Payments of contingent earn-out obligations	(5,556)
	$ 34,135

Pro forma financial information (unaudited)

The following summary, prepared on a pro forma basis, combines the results of operations as if all acquisitions and divestitures in 2015 and 2014 had been consummated as of the beginning of 2014, including the impact of certain adjustments such as amortization of intangibles, interest expense on acquisition financing and income tax effects.

	Year ended December 31,	
	2015	2014
	(unaudited)	
Pro forma net revenues	$ 13,798,581	$ 13,040,206
Pro forma net income attributable to DaVita HealthCare Partners Inc.	273,614	738,991
Pro forma basic net income per share attributable to DaVita HealthCare Partners Inc.	1.29	3.48
Pro forma diluted net income per share attributable to DaVita HealthCare Partners Inc.	1.27	3.41

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, 2015, these consolidated financial statements include total assets of VIEs of $706,978 and total liabilities and noncontrolling interests of VIEs to third parties of $330,213.

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 for disclosures on the assets of these consolidated non-qualified deferred compensation plans.

23. Concentrations

Approximately 66%, 67% and 66% of total U.S. dialysis services revenues in 2015, 2014 and 2013, 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 $827,258 and $705,532, as of December 31, 2015 and 2014, respectively.

Approximately 70%, 71% and 69% of HCP's revenues in 2015, 2014 and 2013, respectively, are from government-based programs, principally Medicare and Medicaid. Approximately 61%, 64% and 67% for 2015, 2014 and 2013, respectively, of HCP's capitated medical revenues are associated with three health plans. In addition, approximately 71% and 73% at December 31, 2015 and 2014, respectively, of HCP's capitated accounts receivables are associated with three health plans.

There is no single commercial payor that accounted for more than 10% of total consolidated accounts receivable at December 31, 2015 and 2014.

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, 2015 and 2014:

	Total	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
December 31, 2015				
Assets				
Available for sale securities	$ 33,482	$ 33,482	$ —	$ —
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
December 31, 2014				
Assets				
Available for sale securities	$ 28,123	$ 28,123	$ —	$ —
Interest rate cap agreements	$ 13,934	$ —	$ 13,934	$ —
Interest rate swap agreements	$ 3,281	$ —	$ 3,281	$ —
Funds on deposit with third parties	$ 81,276	$ 81,276	$ —	$ —
Liabilities				
Interest rate swap agreements	$ 1,457	$ —	$ 1,457	$ —
Contingent earn-out obligations	$ 39,129	$ —	$ —	$ 39,129
Temporary equity				
Noncontrolling interests subject to put provisions	$ 829,965	$ —	$ —	$ 829,965

The available for sale securities represent investments in various open-ended registered investment companies, or mutual funds, and are recorded at fair value based upon quoted prices reported by each mutual fund. See Note 9 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 the 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 results amounts. The estimated fair value of these contingent earn-out obligations will be remeasured as of each reporting date and could fluctuate based upon any significant changes in key assumptions, such as changes in the Company credit risk adjusted rate that is used to discount obligations to present value.

See Note 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, 2015 and 2014 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 $4,372,500 as of December 31, 2015, and the fair value was approximately $4,370,188 based upon quoted market prices. The fair value of the Company's senior notes was approximately $4,463,750 at December 31, 2015 based upon quoted market prices, as compared to the carrying amount of $4,500,000.

25. Segment reporting

The Company operates two major divisions, Kidney Care and HCP. The Kidney Care division is comprised of the Company's U.S. dialysis and related lab services business, various other 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 the Company's 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 HCP division is a patient- and physician-focused integrated healthcare delivery and management company with over two decades of providing coordinated outcomes-based medical care in a cost-effective manner.

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 results of the Company's different 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 HCP operations in each region, each of its ancillary services and strategic initiatives, and its international operations in the Asia Pacific, Latin American, and European and Middle Eastern markets and under the Saudi Ministry of Health charter. The U.S. dialysis and related lab services business and the HCP business each qualify as separately reportable segments, while all of the other ancillary services and strategic initiatives operating segments, including the international operating segments, have been combined and disclosed in the other segments category.

The Company's operating segment financial information included in this report is prepared on the internal management reporting basis that the chief operating decision maker uses to allocate resources and assess the financial results of the operating segments. For internal management reporting, segment operations include direct segment operating expenses but exclude (i) the HCP contingent earn-out obligation adjustment, (ii) corporate administrative support costs, which consists primarily of indirect labor, benefits and long-term incentive based compensation of certain departments which provide support to all of the Company's different operating lines of business and the reduction of a tax asset associated with the HCP acquisition escrow provisions.

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,		
	2015	2014	2013
Segment revenues:			
U.S. dialysis and related lab services			
Patient service revenues:			
External sources	$ 8,980,515	$ 8,513,089	$ 7,998,692
Intersegment revenues	53,476	37,112	34,080
Total dialysis and related lab services revenues	9,033,991	8,550,201	8,032,772
Less: Provision for uncollectible accounts	(406,530)	(353,028)	(281,146)
Net dialysis and related lab services patient service revenues	8,627,461	8,197,173	7,751,626
Other revenues(1)	13,971	13,498	12,600
Total net dialysis and related lab services revenues	8,641,432	8,210,671	7,764,226
HCP			
HCP revenues:			
Capitated revenues	$ 3,436,705	$ 3,190,903	$ 2,919,964
Net patient service revenues	317,950	219,306	220,251
Other revenues(2)	82,470	91,374	55,723
Intersegment capitated and other revenues	136	716	250
Total revenues	$ 3,837,261	$ 3,502,299	$ 3,196,188
Other - Ancillary services and strategic initiatives			
Net patient service revenues	$ 160,484	$ 122,087	$ 75,852
Capitated revenues	72,390	70,385	67,351
Other external sources	1,123,882	927,492	694,763
Intersegment revenues	25,674	19,535	13,916
Total ancillary services and strategic initiatives revenues	1,382,430	1,139,499	851,882
Total net segment revenues	13,861,123	12,852,469	11,812,296
Elimination of intersegment revenues	(79,286)	(57,363)	(48,246)
Consolidated net revenues	$ 13,781,837	$ 12,795,106	$ 11,764,050
Segment operating margin (loss):(3)			
U.S. dialysis and related lab services	$ 1,259,632	$ 1,637,626	$ 1,200,198
HCP	33,929	214,983	385,253
Other—Ancillary services and strategic initiatives	(103,901)	(24,456)	(38,595)
Total segment margin	1,189,660	1,828,153	1,546,856
Reconciliation of segment operating margin to consolidated income from continuing operations before income taxes:			
Contingent earn-out obligation adjustment	—	—	56,977
Corporate administrative support(4)	(18,965)	(13,012)	(53,699)
Consolidated operating income	1,170,695	1,815,141	1,550,134
Debt expense	(408,380)	(410,294)	(429,943)
Debt refinancing and redemption charges	(48,072)	(97,548)	—
Other income	8,893	2,374	4,787
Consolidated income from continuing operations before income taxes	$ 723,136	$ 1,309,673	$ 1,124,978

(1) Includes management fees for providing management and administrative services to dialysis centers in which the Company owns a minority equity investment or which are wholly-owned by third parties.
(2) Other revenues primarily relate to providing medical consulting services.

(3) Certain costs previously reported in the ancillary services and strategic initiatives have been reclassified to U.S. dialysis and related lab services to conform to the current year presentation.

(4) Corporate administrative support costs in 2013 also include $7,721 of an adjustment to reduce a tax asset associated with the HCP acquisition escrow provisions.

Depreciation and amortization expense by segment is as follows:

	December 31,		
	2015	2014	2013
U.S. dialysis and related lab services	$ 438,238	$ 402,767	$ 355,879
HCP	174,118	169,485	158,356
Other - Ancillary services and strategic initiatives	25,668	18,683	14,502
	$ 638,024	$ 590,935	$ 528,737

Summary of assets by segment is as follows:

	December 31,	
	2015	2014
Segment assets		
U.S. dialysis and related lab services (including equity investments of $29,801 and $28,138, respectively)	$ 11,591,507	$ 10,633,813
HCP (including equity investments of $22,714 and $15,393, respectively)	6,150,666	6,285,984
Other - Ancillary services and strategic initiatives(1) (including equity investments of $20,853 and $22,106, respectively)	772,702	697,635
Consolidated assets	$ 18,514,875	$ 17,617,432

(1) Includes approximately $69,519 and $ 44,146 in 2015 and 2014, 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,		
	2015	2014	2013
U.S. dialysis and related lab services	$ 584,513	$ 560,610	$ 554,345
HCP	66,800	27,885	31,582
Other - Ancillary services and strategic initiatives	56,685	52,835	31,670
	$ 707,998	$ 641,330	$ 617,597

26. Supplemental cash flow information

The table below provides supplemental cash flow information:

	Year ended December 31,		
	2015	2014	2013
Cash paid:			
Income taxes	$ 156,075	$ 238,615	$ 341,426
Interest	405,120	351,967	405,030
Non-cash investing and financing activities:			
Fixed assets under capital lease obligations	74,035	72,389	60,920

27. Selected quarterly financial data (unaudited)

	2015				2014			
	December 31	September 30	June 30	March 31	December 31	September 30	June 30	March 31
Net revenues	$ 3,533,589	$ 3,525,665	$ 3,434,618	$ 3,287,965	$ 3,328,017	$ 3,251,824	$ 3,172,489	$ 3,042,776
Operating income (loss)	$ 244,935	$ 509,368	$ 480,548	$ (64,156)	$ 452,085	$ 437,536	$ 484,295	$ 441,225
Income (loss) before income taxes	$ 146,307	$ 408,371	$ 330,539	$ (162,081)	$ 354,365	$ 336,412	$ 282,308	$ 336,588
Net (loss) income attributable to DaVita HealthCare Partners Inc.	$ (6,000)	$ 215,872	$ 170,477	$ (110,617)	$ 208,020	$ 184,122	$ 147,683	$ 183,289
Basic (loss) income per share attributable to DaVita HealthCare Partners Inc.	$ (0.03)	$ 1.02	$ 0.80	$ (0.52)	$ 0.98	$ 0.87	$ 0.70	$ 0.87
Basic net (loss) income per share attributable to DaVita HealthCare Partners Inc.	$ (0.03)	$ 1.02	$ 0.80	$ (0.52)	$ 0.98	$ 0.87	$ 0.70	$ 0.87
Diluted (loss) income per share attributable to DaVita HealthCare Partners Inc.	$ (0.03)	$ 1.00	$ 0.78	$ (0.52)	$ 0.96	$ 0.85	$ 0.68	$ 0.85
Diluted net (loss) income per share attributable to DaVita HealthCare Partners Inc.	$ (0.03)	$ 1.00	$ 0.78	$ (0.52)	$ 0.96	$ 0.85	$ 0.68	$ 0.85

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 HealthCare Partners Inc.	Guarantor Subsidiaries	Non-Guarantor Subsidiaries	Consolidating Adjustments	Consolidated Total
For the year ended December 31, 2015					
Patient services revenues	$ —	$ 6,576,380	$ 3,050,003	$ (146,104)	$ 9,480,279
Less: Provision for uncollectible accounts	—	(285,454)	(142,406)	—	(427,860)
Net patient service revenues	—	6,290,926	2,907,597	(146,104)	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	9,942,370	4,672,761	(1,561,181)	13,781,837
Operating expenses and charges	488,595	9,563,862	4,119,866	(1,561,181)	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 HealthCare Partners Inc.	$ 269,732	$ 195,507	$ 476,354	$ (671,861)	$ 269,732

Consolidating Statements of Income

	DaVita HealthCare Partners Inc.	Guarantor Subsidiaries	Non-Guarantor Subsidiaries	Consolidating Adjustments	Consolidated Total
For the year ended December 31, 2014					
Patient services revenues	$ —	$ 6,246,683	$ 2,739,996	$ (118,341)	$ 8,868,338
Less: Provision for uncollectible accounts	—	(238,600)	(128,284)	—	(366,884)
Net patient service revenues	—	6,008,083	2,611,712	(118,341)	8,501,454
Capitated revenues	—	1,689,634	1,579,804	(8,150)	3,261,288
Other revenues	684,066	1,639,828	24,155	(1,315,685)	1,032,364
Total net revenues	684,066	9,337,545	4,215,671	(1,442,176)	12,795,106
Operating expenses and charges	443,951	8,276,991	3,701,199	(1,442,176)	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 HealthCare Partners Inc.	$ 723,114	$ 647,085	$ 475,907	$ (1,122,992)	$ 723,114
For the year ended December 31, 2013					
Patient services revenues	$ —	$ 5,989,658	$ 2,420,975	$ (103,438)	$ 8,307,195
Less: Provision for uncollectible accounts	—	(177,415)	(116,131)	—	(293,546)
Net patient service revenues	—	5,812,243	2,304,844	(103,438)	8,013,649
Capitated revenues	—	1,427,321	1,560,244	(250)	2,987,315
Other revenues	616,155	1,534,310	17,867	(1,405,246)	763,086
Total net revenues	616,155	8,773,874	3,882,955	(1,508,934)	11,764,050
Operating expenses and charges	434,776	7,843,476	3,444,598	(1,508,934)	10,213,916
Operating income	181,379	930,398	438,357	—	1,550,134
Debt (expense)	(427,141)	(366,188)	(39,413)	402,799	(429,943)
Other income, net	402,910	1,903	2,773	(402,799)	4,787
Income tax expense	59,716	303,603	17,694	—	381,013
Equity earnings in subsidiaries	536,014	260,268	—	(796,282)	—
Income from continuing operations	633,446	522,778	384,023	(796,282)	743,965
Discontinued operations net of gain on disposal of discontinued operations	—	—	13,236	—	13,236
Net income	633,446	522,778	397,259	(796,282)	757,201
Less: Net income attributable to noncontrolling interests	—	—	—	(123,755)	(123,755)
Net income attributable to DaVita HealthCare Partners Inc.	$ 633,446	$ 522,778	$ 397,259	$ (920,037)	$ 633,446

Consolidating Statements of Comprehensive Income

	DaVita HealthCare Partners Inc.	Guarantor Subsidiaries	Non-Guarantor Subsidiaries	Consolidating Adjustments	Consolidated Total
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 HealthCare Partners 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 HealthCare Partners Inc.	$ 723,694	$ 647,085	$ 452,955	$ (1,122,992)	$ 700,742
For the year ended December 31, 2013					
Net income	$ 633,446	$ 522,778	$ 397,259	$ (796,282)	$ 757,201
Other comprehensive income (losses)	14,868	—	(2,216)	—	12,652
Total comprehensive income	648,314	522,778	395,043	(796,282)	769,853
Less: Comprehensive income attributable to noncontrolling interest	—	—	—	(123,755)	(123,755)
Comprehensive income attributable to DaVita HealthCare Partners Inc.	$ 648,314	$ 522,778	$ 395,043	$ (920,037)	$ 646,098

Consolidating Balance Sheets

	DaVita HealthCare Partners Inc.	Guarantor Subsidiaries	Non-Guarantor Subsidiaries	Consolidating Adjustments	Consolidated Total
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 HealthCare Partners 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
As of December 31, 2014					
Cash and cash equivalents	$ 698,876	$ 77,921	$ 188,444	$ —	$ 965,241
Accounts receivable, net	—	915,851	609,998	—	1,525,849
Other current assets	362,045	715,012	68,023	—	1,145,080
Total current assets	1,060,921	1,708,784	866,465	—	3,636,170
Property and equipment, net	195,690	1,473,188	800,221	—	2,469,099
Intangible assets, net	682	1,811,250	52,910	—	1,864,842
Investments in subsidiaries	8,868,335	1,561,195	—	(10,429,530)	—
Intercompany receivables	3,723,453	—	564,241	(4,287,694)	—
Other long-term assets and investments	70,309	60,385	101,332	—	232,026
Goodwill	—	7,958,221	1,457,074	—	9,415,295
Total assets	$ 13,919,390	$ 14,573,023	$ 3,842,243	$ (14,717,224)	$ 17,617,432
Current liabilities	$ 180,977	$ 1,493,242	$ 414,432	$ —	$ 2,088,651
Intercompany payables	—	3,126,261	1,161,433	(4,287,694)	—
Long-term debt and other long-term liabilities	8,039,579	1,085,185	213,741	—	9,338,505
Noncontrolling interests subject to put provisions	528,321	—	—	301,644	829,965
Total DaVita HealthCare Partners Inc. shareholders' equity	5,170,513	8,868,335	1,561,195	(10,429,530)	5,170,513
Noncontrolling interests not subject to put provisions	—	—	491,442	(301,644)	189,798
Total equity	5,170,513	8,868,335	2,052,637	(10,731,174)	5,360,311
Total liabilities and equity	$ 13,919,390	$ 14,573,023	$ 3,842,243	$ (14,717,224)	$ 17,617,432

Consolidating Statements of Cash Flows

	DaVita HealthCare Partners Inc.	Guarantor Subsidiaries	Non-Guarantor Subsidiaries	Consolidating Adjustments	Consolidated Total
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
Purchase of 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
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
Purchase of 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

Consolidating Statements of Cash Flows

	DaVita HealthCare Partners Inc.	Guarantor Subsidiaries	Non-Guarantor Subsidiaries	Consolidating Adjustments	Consolidated Total
For the year ended December 31, 2013					
Cash flows from operating activities:					
Net income	$ 633,446	$ 522,778	$ 397,259	$ (796,282)	$ 757,201
Changes in operating assets and liabilities and non-cash items included in net income	(443,071)	523,440	139,489	796,282	1,016,140
Net cash provided by operating activities	190,375	1,046,218	536,748	—	1,773,341
Cash flows from investing activities:					
Additions of property and equipment, net	(55,252)	(337,919)	(224,426)	—	(617,597)
Acquisitions	—	(156,830)	(153,564)	—	(310,394)
Proceeds from asset sales	60,650	1,608	—	—	62,258
Purchase of investments and other items	(4,944)	(3,502)	(2,703)	—	(11,149)
Net cash provided by (used in) by investing activities	454	(496,643)	(380,693)	—	(876,882)
Cash flows from financing activities:					
Long-term debt and related financing costs, net	(421,739)	(11,061)	(5,207)	—	(438,007)
Intercompany borrowing	585,441	(557,893)	(27,548)	—	—
Other items	52,620	4,726	(102,330)	—	(44,984)
Net cash provided by (used in) financing activities	216,322	(564,228)	(135,085)	—	(482,991)
Effect of exchange rate changes on cash	—	—	(967)	—	(967)
Net increase (decrease) in cash and cash equivalents	407,151	(14,653)	20,003	—	412,501
Cash and cash equivalents at beginning of the year	195,037	166,107	172,604	—	533,748
Cash and cash equivalents at the end of the year	$ 602,188	$ 151,454	$ 192,607	$ —	$ 946,249

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, 2015				
Patient services revenues	$ 9,480,279	$ 133,036	$ —	$ 9,347,243
Less: Provision for uncollectible accounts	(427,860)	(7,937)	—	(419,923)
Net patient service revenues	9,052,419	125,099	—	8,927,320
Capitated revenues	3,509,095	1,649,176	—	1,859,919
Other revenues	1,220,323	7,849	—	1,212,474
Total net revenues	13,781,837	1,782,124	—	11,999,713
Operating expenses and charges	12,611,142	1,700,384	(13)	10,910,771
Operating income	1,170,695	81,740	13	1,088,942
Debt (expense) and refinancing charges	(456,452)	(9,986)	—	(446,466)
Other income, net	8,893	434	—	8,459
Income tax expense	295,726	20,491	5	275,230
Net income	427,410	51,697	8	375,705
Less: Net income attributable to noncontrolling interests	(157,678)	—	—	(157,678)
Net income attributable to DaVita HealthCare Partners Inc.	$ 269,732	$ 51,697	$ 8	$ 218,027

Condensed Consolidating Statements of Comprehensive Income

	Consolidated Total	Physician Groups	Unrestricted Subsidiaries	Company and Restricted Subsidiaries(1)
For the year ended December 31, 2015				
Net income (losses)	$ 427,410	$ 51,697	$ 8	$ 375,705
Other comprehensive losses	(34,809)	—	—	(34,809)
Total comprehensive income (losses)	392,601	51,697	8	340,896
Less: Comprehensive income attributable to noncontrolling interest	(157,678)	—	—	(157,678)
Comprehensive income (losses) attributable to DaVita HealthCare Partners Inc.	$ 234,923	$ 51,697	$ 8	$ 183,218

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

Condensed Consolidating Balance Sheets

	Consolidated Total	Physician Groups	Unrestricted Subsidiaries	Company and Restricted Subsidiaries(1)
As of December 31, 2015				
Cash and cash equivalents	$ 1,499,116	$ 88,245	$ —	$ 1,410,871
Accounts receivable, net	1,724,228	357,126	—	1,367,102
Other current assets	1,279,936	15,714	—	1,264,222
Total current assets	4,503,280	461,085	—	4,042,195
Property and equipment, net	2,788,740	1,836	—	2,786,904
Amortizable intangibles, net	1,687,326	5,937	—	1,681,389
Other long-term assets	241,050	73,794	2,824	164,432
Goodwill	9,294,479	15,967	—	9,278,512
Total assets	$ 18,514,875	$ 558,619	$ 2,824	$ 17,953,432
Current liabilities	$ 2,399,138	$ 234,182	$ —	$ 2,164,956
Payables to parent	—	206,429	2,824	(209,253)
Long-term debt and other long-term liabilities	10,167,499	49,782	—	10,117,717
Noncontrolling interests subject to put provisions	864,066	—	—	864,066
Total DaVita HealthCare Partners Inc. shareholders" equity	4,870,780	68,226	—	4,802,554
Noncontrolling interests not subject to put provisions	213,392	—	—	213,392
Shareholders' equity	5,084,172	68,226	—	5,015,946
Total liabilities and shareholder's equity	$ 18,514,875	$ 558,619	$ 2,824	$ 17,953,432

Condensed Consolidating Statements of Cash Flows

	Consolidated Total	Physician Groups	Unrestricted Subsidiaries	Company and Restricted Subsidiaries(1)
For the year ended December 31, 2015				
Cash flows from operating activities:				
Net income	$ 427,410	$ 51,697	$ 8	$ 375,705
Changes in operating and intercompany assets and liabilities and non-cash items included in net income	1,129,790	(101,217)	(8)	1,231,015
Net cash provided by operating activities	1,557,200	(49,520)	—	1,606,720
Cash flows from investing activities:				
Additions of property and equipment	(707,998)	(355)	—	(707,643)
Acquisitions and divestitures, net	(96,469)	—	—	(96,469)
Proceeds from asset sales	19,715	—	—	19,715
Investments and other items	(97,032)	(3,124)	—	(93,908)
Net cash used in investing activities	(881,784)	(3,479)	—	(878,305)
Cash flows from financing activities:				
Long-term debt and related financing costs, net	619,698	—	—	619,698
Intercompany	—	28,796	—	(28,796)
Other items	(758,668)	—	—	(758,668)
Net cash used in financing activities	(138,970)	28,796	—	(167,766)
Effect of exchange rate changes on cash	(2,571)	—	—	(2,571)
Net increase (decrease) in cash	533,875	(24,203)	—	558,078
Cash at beginning of the year	965,241	112,448	—	852,793
Cash at the end of the year	$ 1,499,116	$ 88,245	$ —	$ 1,410,871

(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 26, 2016.

DAVITA HEALTHCARE PARTNERS 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 Martha Ha, 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 26, 2016
/s/ JAMES K. HILGER James K. Hilger	Interim Chief Financial Officer and Chief Accounting Officer (Principal Accounting Officer)	February 26, 2016
/s/ PAMELA M. ARWAY Pamela M. Arway	Director	February 26, 2016
/s/ CHARLES G. BERG Charles G. Berg	Director	February 26, 2016
/s/ CAROL A. DAVIDSON Carol A. Davidson	Director	February 26, 2016
/s/ BARBARA J. DESOER Barbara J. Desoer	Director	February 26, 2016
/s/ PAUL J. DIAZ Paul J. Diaz	Director	February 26, 2016
/s/ PETER T. GRAUER Peter T. Grauer	Director	February 26, 2016
/s/ JOHN M. NEHRA John M. Nehra	Director	February 26, 2016

Signature	Title	Date
/s/ WILLIAM L. ROPER William L. Roper	Director	February 26, 2016
/s/ ROGER J. VALINE Roger J. Valine	Director	February 26, 2016

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Shareholders
DaVita HealthCare Partners Inc.:

Under date of February 26, 2016, we reported on the consolidated balance sheets of DaVita HealthCare Partners Inc. and subsidiaries as of December 31, 2015 and 2014, and the related consolidated statements of income, comprehensive income, equity, and cash flows for each of the years in the three-year period ended December 31, 2015, 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 financial statement 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 26, 2016

DAVITA HEALTHCARE PARTNERS 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, 2013	$ 245,122	$ —	$ 298,711	$ 306,690	$ 237,143
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

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.(36)
2.2	Amendment, dated as of July 6, 2012, to the Agreement and Plan of Merger, dated as of May 20, 2012, by and among DaVita Inc., Seismic Acquisition LLC, HealthCare Partners Holdings, LLC, and the Member Representative.(37)
3.1	Amended and Restated Certificate of Incorporation of Total Renal Care Holdings, Inc. (TRCH), dated December 4, 1995.(1)
3.2	Certificate of Amendment of Certificate of Incorporation of TRCH, dated February 26, 1998.(2)
3.3	Certificate of Amendment of Certificate of Incorporation of DaVita Inc. (formerly Total Renal Care Holdings, Inc.), dated October 5, 2000.(3)
3.4	Certificate of Amendment of Amended and Restated Certificate of Incorporation of DaVita Inc., as amended dated May 30, 2007.(16)
3.5	Certificate of Ownership and Merger Merging DaVita Name Change, Inc. with and into DaVita Inc., as filed with Secretary of State of the State of Delaware on November 1, 2012.(40)
3.6	Amended and Restated Bylaws for DaVita Inc. dated as of March 10, 2011.(17)
4.1	Indenture, dated August 28, 2012, by and among DaVita Inc., the guarantors named therein and The Bank of New York Mellon Trust Company, N.A., as Trustee.(38)
4.2	Form of 5.750% Senior Notes due 2022 and related Guarantee (included in Exhibit 4.1).(38)
4.3	Indenture, dated June 13, 2014, by and among DaVita HealthCare Partners Inc., the Guarantors named therein and The Bank of New York Mellon Trust Company, N.A., as Trustee. (44)
4.4	Form of 5.125% Senior Notes due 2024 and related Guarantee (included in Exhibit 4.3). (44)
4.5	Second Supplemental Indenture for the 5.750% Senior Notes due 2022, dated June 13, 2014, by and among DaVita HealthCare Partners Inc., the Guarantors named therein and The Bank of New York Mellon Trust Company, N.A., as Trustee. (45)
4.6	Indenture for the 5.000% Senior Notes due 2025, dated April 17, 2015, by and among DaVita HealthCare Partners Inc., the guarantors named therein and The Bank of New York Mellon Trust Company, N.A., as Trustee. (28)
4.7	Form of 5.000% Senior Notes due 2025 and related Guarantee (included in Exhibit 4.6). (28)
10.1	Employment Agreement, dated as of October 19, 2009, by and between DaVita Inc. and Kim M. Rivera.(29)*
10.2	Employment Agreement, dated as of October 31, 2005, effective October 24, 2005, by and between DaVita Inc. and Dennis Kogod.(8)*
10.3	Amendment to Mr. Kogod's Employment Agreement, effective December 12, 2008.(23)*
10.4	Second Amendment to Mr. Kogod's Employment Agreement, effective December 31, 2012.(23)*
10.5	Employment Agreement, effective September 22, 2005, by and between DaVita Inc. and James Hilger.(10)*
10.6	Amendment to Mr. Hilger's Employment Agreement, effective December 12, 2008.(23)*
10.7	Second Amendment to Mr. Hilger's Employment Agreement, effective December 27, 2012.(42)*
10.8	Employment Agreement, effective July 25, 2008, between DaVita Inc. and Kent J. Thiry.(20)*
10.9	Employment Agreement, effective August 1, 2008, between DaVita Inc. and Allen Nissenson.(21)*
10.10	Employment Agreement, effective March 3, 2008, between DaVita Inc. and David Shapiro.(23)*
10.11	Amendment to Mr. Shapiro's Employment Agreement, effective December 4, 2008.(23)*
10.12	Employment Agreement, effective March 17, 2010, by and between DaVita Inc. and Javier Rodriguez.(25)*
10.13	Memorandum Relating to Bonus Structure for Kent J. Thiry.(26)*

10.14	Memorandum Relating to Bonus Structure for Dennis L. Kogod.(26)*
10.15	Form of Indemnity Agreement.(15)*
10.16	Form of Indemnity Agreement.(9)*
10.17	Executive Incentive Plan (as Amended and Restated effective January 1, 2009).(24)*
10.18	Executive Retirement Plan.(23)*
10.19	DaVita Voluntary Deferral Plan.(7)*
10.20	Deferred Bonus Plan (Prosperity Plan).(22)*
10.21	Amendment No. 1 to Deferred Bonus Plan (Prosperity Plan).(23)*
10.22	Amended and Restated Employee Stock Purchase Plan.(18)*
10.23	Amended and Restated DaVita Healthcare Partners Inc. Severance Plan. (42)*
10.24	Change in Control Bonus Program.(23)*
10.25	Non-Management Director Compensation Philosophy and Plan.(19)*
10.26	Amended and Restated 2002 Equity Compensation Plan.(6)*
10.27	Amended and Restated 2002 Equity Compensation Plan.(14)*
10.28	Amended and Restated 2002 Equity Compensation Plan.(18)*
10.29	Amended and Restated 2002 Equity Compensation Plan.(23)*
10.30	DaVita Inc. 2002 Equity Compensation Plan.(27)*
10.31	Form of Non-Qualified Stock Option Agreement—Employee (DaVita Inc. 1999 Non-Executive Officer and Non-Director Equity Compensation Plan.(13)*
10.32	Form of Non-Qualified Stock Option Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(4)*
10.33	Form of Non-Qualified Stock Option Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(11)*
10.34	Form of Non-Qualified Stock Option Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(13)*
10.35	Form of Restricted Stock Units Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(4)*
10.36	Form of Restricted Stock Units Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(11)*
10.37	Form of Restricted Stock Units Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(13)*
10.38	Form of Restricted Stock Units Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(23)*
10.39	Form of Stock Appreciation Rights Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(11)*
10.40	Form of Stock Appreciation Rights Agreement—Employee (DaVita Inc. 2002 Equity Compensation Plan).(13)*
10.41	Form of Stock Appreciation Rights Agreement—Board (DaVita Inc. 2002 Equity Compensation Plan).(21)*
10.42	Form of Stock Appreciation Rights Agreement—Board members (DaVita Inc. 2011 Incentive Award Plan).(32)*
10.43	Form of Restricted Stock Units Agreement—Board (DaVita Inc. 2002 Equity Compensation Plan).(21)*
10.44	Form of Restricted Stock Units Agreement—Board members (DaVita Inc. 2011 Incentive Award Plan).(32)*
10.45	Form of Non-Qualified Stock Option Agreement—Board (DaVita Inc. 2002 Equity Compensation Plan).(21)*
10.46	Form of Stock Appreciation Rights Agreement—Executives (DaVita Inc. 2011 Incentive Award Plan).(32)*
10.47	Form of Restricted Stock Units Agreement—Executives (DaVita Inc. 2011 Incentive Award Plan).(32)*
10.48	Form of Restricted Stock Units Agreement (DaVita Inc. 2011 Incentive Award Plan). (42)*
10.49	Form of Stock Appreciation Rights Agreement (DaVita Inc. 2011 Incentive Award Plan). (42)*

10.50	Form of Long-Term Incentive Program Award Agreement (For 162(m) designated teammates) (DaVita Inc. 2011 Incentive Award Plan).(42) *
10.51	Form of Long-Term Incentive Program Award Agreement (DaVita Inc. 2011 Incentive Award Plan). (42)*
10.52	Credit Agreement, dated as of June 24, 2014, by and among DaVita Healthcare Partners Inc., the guarantors the guarantors party thereto, the lenders party thereto, JPMorgan Chase Bank, N.A., as Administrative Agent and Collateral Agent, Barclays Bank PLC, and Wells Fargo Bank, National Association as Co-Syndication Agents, Bank of America, N.A., Credit Suisse AG, Goldman Sachs Bank USA, JPMorgan Chase Bank, N.A., Morgan Stanley Senior Funding, Inc., and SunTrust Bank, as Co-Documentation Agents, Barclays Bank PLC, Wells Fargo Securities, LLC, Credit Suisse Securities (USA) LLC, Goldman Sachs Bank USA, J.P. Morgan Securities, LLC, Bank of America, N.A., Morgan Stanley Senior Funding, Inc., and SunTrust Robinson Humphrey, Inc. as Joint Lead Arrangers and Joint Bookrunners, The Bank of Nova Scotia, Credit Agricole Securities (USA) Inc., The Bank of Tokyo-Mitsubishi UFJ, Ltd., and Sumitomo Mitsui Banking Corporation, as Senior Managing Agents, HSBC Securities (USA) Inc., Fifth Third Bank, and Compass Bank as Managing Agents. (45)
10.53	Perfection Certificate executed as of October 20, 2010 and delivered in connection with the closing of the Credit Agreement filed as Exhibit 10.68.(34)**
10.54	Dialysis Organization Agreement between DaVita Inc. and Amgen USA Inc. dated December 20, 2007.(22)**
10.55	Dialysis Organization Agreement between DaVita Inc. and Amgen USA Inc. dated December 17, 2010.(30)**
10.56	Amended and Restated DaVita HealthCare Partners Inc. 2011 Incentive Award Plan.(45)*
10.57	Amendment No. 2 to Dialysis Organization Agreement between DaVita Inc. and Amgen USA Inc. effective as of July 1, 2011.(33)**
10.58	Sourcing and Supply Agreement between DaVita Inc. and Amgen USA Inc. effective as of January 1, 2012.(35)**
10.59	Amendment No. 1 to Sourcing and Supply Agreement between DaVita HealthCare Partners Inc. and Amgen USA Inc. effective as of January 1, 2013.(42)**
10.60	Voting Agreement, dated as of May 20, 2012, by and among DaVita Inc., HealthCare Partners Holdings, LLC, and HealthCare Partners Medical Group.(36)
10.61	Support Agreement, dated as of May 20, 2012, by and among DaVita Inc., HealthCare Partners Holdings, LLC, and Dr. Robert Margolis.(36)
10.62	Support Agreement, dated as of May 20, 2012, by and among DaVita Inc., HealthCare Partners Holdings, LLC, and Dr. William Chin.(36)
10.63	Support Agreement, dated as of May 20, 2012, by and among DaVita Inc., HealthCare Partners Holdings, LLC, and Matthew Mazdyasni.(36)
10.64	Support Agreement, dated as of May 20, 2012, by and among DaVita Inc., HealthCare Partners Holdings, LLC, and Dr. Thomas Paulsen.(36)
10.65	Form of Non-Competition and Non-Solicitation Agreement, dated as of May 20, 2012, between DaVita Inc. and Dr. Robert Margolis, Dr. William Chin, Dr. Thomas Paulsen, Mr. Zan Calhoun, and Ms. Lori Glisson.(36)
10.66	Form of Non-Competition and Non-Solicitation Agreement, dated as of May 20, 2012, between DaVita Inc. and Mr. Matthew Mazdyasni, Dr. Sherif Abdou, and Dr. Amir Bacchus.(36)
10.67	Escrow Agreement, dated as of August 28, 2012, by and among DaVita Inc., The Bank of New York Mellon Trust Company, N.A., as trustee, The Bank of New York Mellon Trust Company, N.A., as escrow agent and The Bank of New York Mellon Trust Company, N.A., as bank and securities intermediary.(38)
10.68	Employment Agreement, dated as of May 20, 2012, effective as of the November 1, 2012, by and among Dr. Robert Margolis, DaVita Inc. and HealthCare Partners Holdings, LLC.(39)*
10.69	Amendment to Dr. Margolis' Employment Agreement, effective December 31, 2012.(42)*
10.70	Employment Agreement, effective July 5, 2013, between DaVita HealthCare Partners Inc. and Garry E. Menzel.(41)*
10.71	Form of 2014 Long Term Incentive Program Cash Performance Award Agreement under the DaVita HealthCare Partners Inc. 2011 Incentive Award Plan and Long-Term Incentive Program (for 162(m) designated teammates). (46) * **

10.72	Form of 2014 Long Term Incentive Program Cash Performance Award Agreement under the DaVita HealthCare Partners Inc. 2011 Incentive Award Plan and Long-Term Incentive Program. (46)* **
10.73	Form of 2014 Long Term Incentive Program Performance Stock Units Agreement under the DaVita HealthCare Partners Inc. 2011 Incentive Award Plan and Long-Term Incentive Program (for 162(m) designated teammates). (46) * **
10.74	Form of 2014 Long Term Incentive Program Restricted Stock Units Agreement under the DaVita HealthCare Partners Inc. 2011 Incentive Award Plan and Long-Term Incentive Program. (46) *
10.75	Form of 2014 Long Term Incentive Program Stock Appreciation Rights Agreement under the DaVita HealthCare Partners Inc. 2011 Incentive Award Plan and Long-Term Incentive Program. (46) *
10.76	Corporate Integrity Agreement, dated as of October 22, 2014, by and among the Office of Inspector General of The Department of Health and Human Services and DaVita HealthCare Partners, Inc. (47)
12.1	Computation of Ratio of Earnings to Fixed Charges.✓
14.1	DaVita Inc. Corporate Governance Code of Ethics.(5)
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 26, 2016, pursuant to Rule 13a-14(a) or 15d-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.✓
31.2	Certification of the Chief Financial Officer, dated February 26, 2016, pursuant to Rule 13a-14(a) or 15d-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.✓
32.1	Certification of the Chief Executive Officer, dated February 26, 2016, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.✓
32.2	Certification of the Chief Financial Officer, dated February 26, 2016, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.✓
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 March 18, 1996 as an exhibit to the Company's Transitional Report on Form 10-K for the transition period from June 1, 1995 to December 31, 1995.
(2) Filed on March 31, 1998 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 1997.
(3) Filed on March 20, 2001 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 2000.
(4) Filed on November 8, 2004 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2004.
(5) Filed on February 27, 2004 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 2003.
(6) Filed on May 4, 2005 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2005.
(7) Filed on November 8, 2005 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2005.
(8) Filed on November 4, 2005 as an exhibit to the Company's Current Report on Form 8-K.
(9) Filed on March 3, 2005 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 2004.

(10) Filed on August 7, 2006 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ending June 30, 2006.
(11) Filed on July 6, 2006 as an exhibit to the Company's Current Report on Form 8-K.
(12) Filed on November 3, 2006 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2006.
(13) Filed on October 18, 2006 as an exhibit to the Company's Current Report on Form 8-K.
(14) Filed on July 31, 2006 as an exhibit to the Company's Current Report on Form 8-K.
(15) Filed on December 20, 2006 as an exhibit to the Company's Current Report on Form 8-K.
(16) Filed on August 6, 2007 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2007.
(17) Filed on March 17, 2011 as an exhibit to the Company's Current Report on Form 8-K/A.
(18) Filed on June 4, 2007 as an exhibit to the Company's Current Report on Form 8-K.
(19) Filed on May 8, 2008 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2008.
(20) Filed on July 31, 2008 as an exhibit to the Company's Current Report on Form 8-K.
(21) Filed on November 6, 2008 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2008.
(22) Filed on February 29, 2008 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 2007.
(23) Filed on February 27, 2009 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 2008
(24) Filed on June 18, 2009 as an exhibit to the Company's Current Report on Form 8-K.
(25) Filed on April 14, 2010 as an exhibit to the Company's Current Report on Form 8-K.
(26) Filed on May 3, 2010 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2010.
(27) Filed on April 28, 2010 as Appendix A to the Company's Definitive Proxy Statement on Schedule 14A.
(28) Filed on April 17, 2015 as an exhibit to the Company's Current Report on Form 8-K.
(29) Filed on February 25, 2010 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 2009.
(30) Filed on December 29, 2011 as an exhibit to the Company's Annual Report on Form 10-K/A for the year ended December 31, 2010.
(31) Filed on April 28, 2014 as Appendix A to the Company's Definitive Proxy Statement on Schedule 14A.
(32) Filed on August 4, 2011 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2011.
(33) Filed on December 29, 2011 as an exhibit to the Company's Quarterly Report on Form 10-Q/A for the quarter ended June 30, 2011.
(34) Filed on January 17, 2012 as an exhibit to the Company's Quarterly Report on Form 10-Q/A for the quarter ended March 31, 2011.
(35) Filed on February 24, 2012 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 2011.
(36) Filed on May 21, 2012 as an exhibit to the Company's Current Report on Form 8-K.
(37) Filed on July 9, 2012 as an exhibit to the Company's Current Report on Form 8-K.
(38) Filed on August 28, 2012 as an exhibit to the Company's Current Report on Form 8-K.
(39) Filed on September 18, 2012 as an exhibit to Amendment No. 2 to the Company's Registration Statement on Form S-4.
(40) Filed on November 1, 2012 as an exhibit to the Company's Current Report on Form 8-K.
(41) Filed on August 7, 2013 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2013.
(42) Filed on February 28, 2013 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 2012.
(43) Filed on February 21, 2014 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 2013.
(44) Filed on June 16, 2014 as an exhibit to the Company's Current Report on Form 8-K.
(45) Filed on August 1, 2014 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2014.
(46) Filed on November 6, 2014 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2014.
(47) Filed on October 23, 2014 as an exhibit to the Company's Current Report on Form 8-K.

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,				
	2015	2014	2013	2012	2011
	(in thousands, except share data)				
Earnings adjusted for fixed charges:					
Income from continuing operations before income taxes	$ 723,136	$ 1,309,673	$ 1,124,978	$ 1,001,304	$ 916,605
Add:					
Debt expense	408,380	410,294	429,943	288,554	241,090
Interest portion of rent expense	166,821	149,432	137,558	112,424	95,919
Less: Noncontrolling interests	(158,304)	(140,949)	(124,276)	(105,891)	(95,899)
	416,897	418,777	443,225	295,087	241,110
	$ 1,140,033	$ 1,728,450	$ 1,568,203	$ 1,296,391	$ 1,157,715
Fixed charges:					
Debt expense	408,380	410,294	429,943	288,554	241,090
Interest portion of rent expense	166,821	149,432	137,558	112,424	95,919
Capitalized interest	9,723	7,888	6,408	8,127	4,887
	$ 584,924	$ 567,614	$ 573,909	$ 409,105	$ 341,896
Ratio of earnings to fixed charges	1.95	3.05	2.73	3.17	3.39

Exhibit 21.1

SUBSIDIARIES OF THE COMPANY
(as of December 31, 2015)

Name	Jurisdiction of Incorporation
ABQ Health Partners, LLC	Delaware
Afton Dialysis, LLC	Delaware
Ahern Dialysis, LLC	Delaware
Alamosa Dialysis, LLC	Delaware
Andrews Dialysis, LLC	Delaware
Argyle Dialysis, LLC	Delaware
Arizona Integrated Physicians, Inc.	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
Beachside Dialysis, LLC	Delaware
Bedell Dialysis, LLC	Delaware
Belfair 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
Brook Dialysis LLC	Delaware
Bullards Dialysis, LLC	Delaware
Butano 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
Caswell Dialysis, LLC	Delaware
Caverns Dialysis, LLC	Delaware
Central Carolina Dialysis Centers, LLC	Delaware
Central Georgia Dialysis, 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 Incorporation
Clinica Central do Bonfim, S.A.	Portugal
Clough Dialysis, LLC	Delaware
Clover Dialysis, LLC	Delaware
Clyfee Dialysis, LLC	Delaware
Cobbles Dialysis, LLC	Delaware
Colorado Springs Health Partners, LLC	Colorado
Conconully Dialysis, LLC	Delaware
Continental Dialysis Center of Springfield-Fairfax, Inc.	Virginia
Continental Dialysis Center, Inc.	Virginia
Coral Dialysis, LLC	Delaware
Croft Dialysis, LLC	Delaware
Crowder Dialysis, LLC	Delaware
Cuivre Dialysis, LLC	Delaware
Curlew Dialysis, LLC	Delaware
Dallas-Fort Worth Nephrology, L.P.	Delaware
Davis Dialysis, LLC	Delaware
DaVita Brasil Participacoes e Servicos de Gestao Ltda.	Brazil
DaVita Care (India) Private Limited	India
DaVita Care (Saudi Arabia)	Saudi Arabia
DaVita Care (Taiwan) Private Limited	Taiwan, Province Of China
DaVita Care Pte. Ltd.	Singapore
DaVita China Pte. Ltd.	Singapore
DaVita Deutschland AG	Germany
DaVita Deutschland Beteiligungs GmbH & Co. KG	Germany
DaVita DPC Holding Co., LLC	Delaware
DaVita Sud-Niedersachsen GmbH	Germany
DaVita Germany GmbH	Germany
DaVita Healthcare Partners Plan, Inc.	Delaware
DaVita of New York, Inc.	New York
DaVita Rx, LLC	Delaware
DaVita S.A.S.	Colombia
DaVita Sp. z o.o.	Poland
DaVita-Riverside, LLC	Delaware
Dawson Dialysis, LLC	Delaware
DC Healthcare International, 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
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, Inc.	Pennsylvania

Name	Jurisdiction of Incorporation
DVA Healthcare of Tuscaloosa, LLC	Tennessee
DVA Healthcare Renal Care, Inc.	Nevada
DVA Laboratory Services, Inc.	Florida
DVA of New York, Inc.	New York
DVA Renal Care Portugal, Unipessoal LDA	Portugal
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
Empire State DC, Inc.	New York
Enchanted Dialysis, LLC	New York
Etowah Dialysis, LLC	Delaware
Eufaula Dialysis, LLC	Delaware
Eurodial - Centro de Nefrologia e Dialise de Leiria, S.A.	Portugal
Falcon, LLC	Delaware
Farragut Dialysis, LLC	Delaware
Fields 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
Frontenac Dialysis, LLC	Delaware
Frontier Dialysis, LLC	Delaware
Garner Dialysis, LLC	Delaware
Garrett Dialysis, LLC	Delaware
Gate Dialysis, LLC	Delaware
Genesis KC Development, LLC	Delaware
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
Hanford Dialysis, LLC	Delaware
Harmony Dialysis, LLC	Delaware
Hazelton Dialysis, LLC	Delaware
Headlands Dialysis, LLC	Delaware
HealthCare Partners Arizona, LLC	Arizona
HealthCare Partners ASC-LB, LLC	California

Name	Jurisdiction of Incorporation
HealthCare Partners Colorado, LLC	Colorado
HealthCare Partners Holdings, LLC	California
HealthCare Partners Nevada, LLC	Nevada
HealthCare Partners South Florida, LLC	Florida
HealthCare Partners, LLC	California
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
Hummer Dialysis, LLC	Delaware
Huntington Artificial Kidney Center, Ltd.	New York
IDC - International Dialysis Centers, Lda.	Portugal
Iroquois Dialysis, LLC	Delaware
ISD Buffalo Grove, 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
JSA Healthcare Corporation	Delaware
JSA Healthcare Nevada, L.L.C.	Nevada
JSA Holdings, Inc.	Delaware
JSA P5 Nevada, L.L.C.	Nevada
Kadden Dialysis, LLC	Delaware
Kamakee Dialysis, LLC	Delaware
Kamiah Dialysis, LLC	Delaware
Kavett Dialysis, LLC	Delaware
Kerricher Dialysis, LLC	Delaware
Kidney Center South LLC	Delaware
Kidney Home Center, LLC	Delaware
Kimball Dialysis, LLC	Delaware
Knickerbocker Dialysis, Inc.	New York
Las Vegas Solari Hospice Care, LLC	Delaware
Lassen Dialysis, LLC	Delaware
Lees Dialysis, LLC	Delaware
Liberty RC, Inc.	New York
Lifeline Vascular Associates Of Allen Park, LLC	Delaware
Lifeline Vascular Center- Albany, LLC	Delaware
Lifeline Vascular Center Of South Orlando, LLC	Delaware
Lifeline Vascular Center- Orlando, LLC	Delaware
Lincoln Park Dialysis Services, Inc.	Illinois
Livingston Dialysis, LLC	Delaware

Name	Jurisdiction of Incorporation
Lory Dialysis, LLC	Delaware
Lourdes Dialysis, LLC	Delaware
Madigan Dialysis, LLC	Delaware
Magnolia Dialysis, LLC	Delaware
Magoffin Dialysis, LLC	Delaware
Manchester Dialysis, LLC	Delaware
Manito Dialysis, LLC	Delaware
Maple Grove Dialysis, LLC	Delaware
Margette Dialysis, LLC	Delaware
Martin Dialysis, LLC	Delaware
Mashero Dialysis, LLC	Delaware
Mason-Dixon Dialysis Facilities, Inc.	Maryland
Mazonia Dialysis, LLC	Delaware
Meadows Dialysis, LLC	Delaware
Meesa Dialysis, LLC	Delaware
Memorial Dialysis Center, L.P.	Delaware
Meridian Dialysis, LLC	Delaware
Milo Dialysis, LLC	Delaware
Minam Dialysis, LLC	Delaware
Mocca Dialysis, LLC	Delaware
Montauk Dialysis, LLC	Delaware
Moraine Dialysis, LLC	Delaware
Mountain West Dialysis Services, LLC	Delaware
Mulgee Dialysis, LLC	Delaware
MVZ DaVita Alzey GmbH	Germany
MVZ DaVita Emden GmbH	Germany
MVZ DaVita Gera GmbH	Germany
MVZ DaVita Neuss GmbH	Germany
MVZ DaVita Rhein Ruhr GmbH	Germany
MVZ DaVita Salzgitter-Seesen GmbH	Germany
Myrtle Dialysis, LLC	Delaware
Navarro Dialysis, LLC	Delaware
Naville Dialysis, LLC	Delaware
Nephrology Medical Associates of Georgia, LLC	Georgia
Neptune Artificial Kidney Center, L.L.C.	New Jersey
Nolia Dialysis, LLC	Delaware
Norbert Dialysis, LLC	Delaware
Norte Dialysis, LLC	Delaware
North Colorado Springs Dialysis, LLC	Delaware
Noster Dialysis, LLC	Delaware
Ohio River Dialysis, LLC	Delaware
Olive Dialysis, LLC	Delaware
Open Access Lifeline, LLC	Delaware
Orange Dialysis, LLC	California
Paladina Health, LLC	Delaware

Name	Jurisdiction of Incorporation
Parkside Dialysis, LLC	Delaware
Patient Pathways, LLC	Delaware
Pedernales Dialysis, LLC	Delaware
Pendster Dialysis, LLC	Delaware
Physicians Choice Dialysis Of Alabama, LLC	Delaware
Physicians Dialysis Acquisitions, Inc.	Delaware
Physicians Dialysis of Lancaster, LLC	Pennsylvania
Physicians Dialysis Ventures, LLC	Delaware
Physicians Dialysis, Inc.	Delaware
Pible Dialysis, LLC	Delaware
Pike Dialysis, LLC	Delaware
Pine Dialysis, LLC	Delaware
Platte Dialysis, LLC	Delaware
Pokagon 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
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 - Illinois, Inc.	Delaware
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
River Valley Dialysis, LLC	Delaware
RMS Lifeline Inc.	Delaware
Rocky Mountain Dialysis Services, LLC	Delaware
Roose Dialysis, 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

Name	Jurisdiction of Incorporation
Shetek Dialysis, LLC	Delaware
Shining Star Dialysis, Inc.	New Jersey
Shoals Dialysis, LLC	Delaware
Shone Dialysis, LLC	Delaware
Shoshone Dialysis, LLC	Delaware
Silverwood Dialysis, LLC	Delaware
Simeon Dialysis, LLC	Delaware
Skagit Dialysis, LLC	Delaware
Smithgall Dialysis, LLC	Delaware
Soledad Dialysis Center, LLC	Delaware
South Central Florida Dialysis Partners, LLC	Delaware
South Fork Dialysis, LLC	Delaware
Southwest Atlanta Dialysis Centers, LLC	Delaware
St. Luke's Dialysis, LLC	Delaware
Star Dialysis, LLC	Delaware
Starks Dialysis, LLC	Delaware
Stearns Dialysis, LLC	Delaware
Stockton Dialysis, LLC	Delaware
Storrie Dialysis, LLC	Delaware
Taum Dialysis, LLC	Delaware
Tel-Huron Dialysis, LLC	Delaware
Tonka Bay Dialysis, LLC	Delaware
Total Renal Care of North Carolina, LLC	Delaware
Total Renal Care Texas Limited Partnership	Delaware
Total Renal Care, Inc.	California
Total Renal Care/Eaton Canyon Dialysis Center Partnership	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

Name	Jurisdiction of Incorporation
VillageHealth DM, LLC	Delaware
Volo Dialysis, LLC	Delaware
Walcott Dialysis, LLC	Delaware
Walker Dialysis, LLC	Delaware
Walton Dialysis, LLC	Delaware
Weldon Dialysis, LLC	California

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. 333-190434, No. 333-169467, No. 333-34693, No. 333-34695, No. 333-46887, No. 333-75361, No. 333-56149, No. 333-30734, No. 333-30736, No. 333-63158, No. 333-86550, No. 333-86556, No. 333-144097 and No. 333-158220), Form S-4 (No. 333-182572) and Forms S-3 (No. 333-196630, 333-203394, No. 333-169690 and No. 333-183285) of DaVita HealthCare Partners Inc. of our reports dated February 26, 2016, with respect to the consolidated balance sheets of DaVita HealthCare Partners Inc. and subsidiaries as of December 31, 2015 and 2014, and the related consolidated statements of income, comprehensive income, equity, and cash flows for each of the years in the three-year period ended December 31, 2015, and the related financial statement schedule, and the effectiveness of internal control over financial reporting as of December 31, 2015, which reports appear in the December 31, 2015 annual report on Form 10-K of DaVita HealthCare Partners Inc.

Our report refers to a change in the method of accounting for the presentation of debt issuance cost and to a change in the method of accounting for the presentation of deferred tax liabilities and deferred tax assets.

/s/ KPMG LLP

Seattle, Washington
February 26, 2016

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 26, 2016

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 26, 2016

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, 2015 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 26, 2016

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, 2015 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 26, 2016

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.

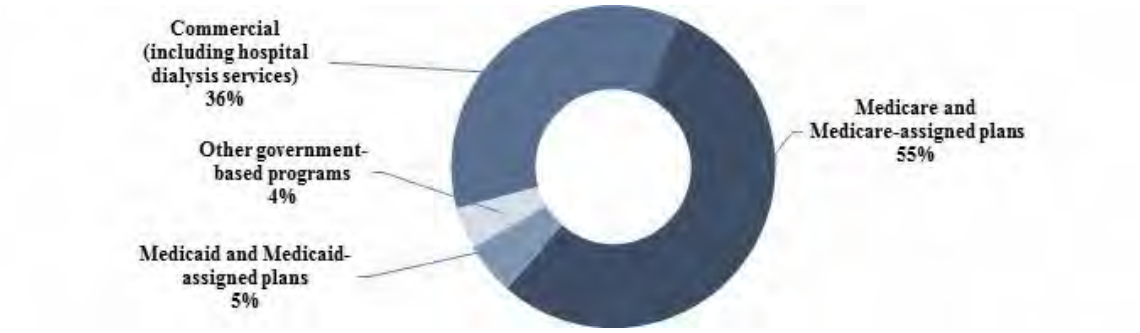
Our physician leadership in the Office of the Chief Medical Officer (OCMO) for our dialysis and related lab services business includes 13 senior nephrologists, led by our Chief Medical Officer, with a variety of academic, clinical practice, and clinical research backgrounds. Our Physician Council is 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

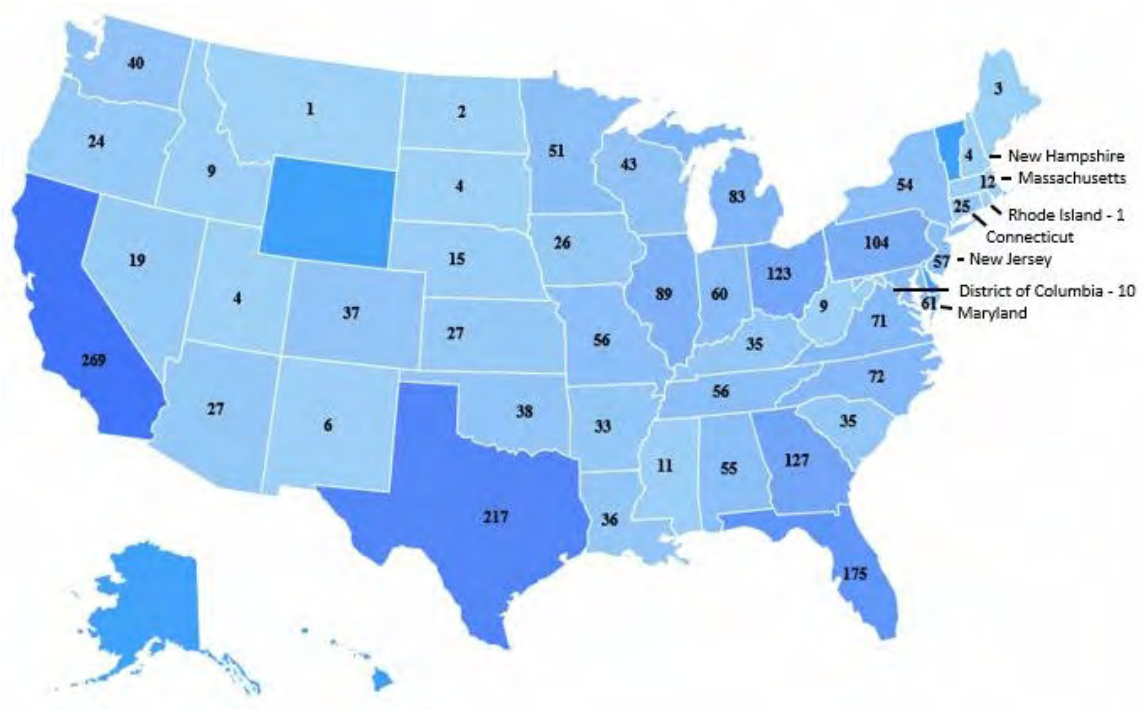
Typically we are able to increase our capacity by extending hours at our existing dialysis centers, expanding our existing dialysis centers, relocating our dialysis centers, developing new dialysis centers and by acquiring dialysis centers. The development of a typical outpatient dialysis center by us 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

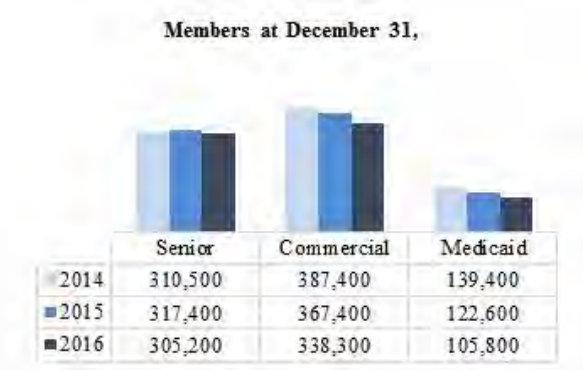
The following table reflects the results of operations for the DMG business:

	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.





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:

Reporting unit	Year ended December 31, 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.

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.

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)	—

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.

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

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

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

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.

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.

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

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

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.

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

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.

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.

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

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

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

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.

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.

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.

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

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

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

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

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

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

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

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

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

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

FORM 10-K

ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the Fiscal Year Ended December 31, 2017

Commission File Number: 1-14106



DAVITA INC.

(Exact name of registrant as specified in charter)

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

2000 16th Street
Denver, CO 80202
Telephone number (303) 405-2100

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

Title of each class:	**Name of each exchange on which registered:**
Common Stock, $0.001 par value	**New York Stock Exchange**

Securities registered pursuant to Section 12(g) of the Act:
None

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 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 if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) 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 is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company" and "emerging growth 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	☐
		Emerging growth company	☐

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

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

As of June 30, 2017, the aggregate market value of the Registrant's common stock outstanding held by non-affiliates based upon the closing price on the New York Stock Exchange was approximately $12.4 billion.

As of January 31, 2018, the number of shares of the Registrant's common stock outstanding was approximately 182.0 million shares.

Documents incorporated by reference

Portions of the Registrant's proxy statement for its 2018 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 has consisted 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 and 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.

On December 5, 2017, we entered into an equity purchase agreement to sell our DMG division to Collaborative Care Holdings, LLC (Optum), a subsidiary of UnitedHealth Group Inc. The transaction is expected to close in 2018 and is subject to regulatory approval and other customary closing conditions. As a result of this pending transaction, the DMG business has been reclassified as held for sale and its results of operations are reported as discontinued operations for all periods presented in our consolidated financial statements included in this report.

For financial information about our DMG business see Note 21 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, 2017, we provided dialysis and administrative services in the U.S. through a network of 2,510 outpatient dialysis centers in 46 states and the District of Columbia, serving a total of approximately 197,800 patients. We also provide acute inpatient dialysis services in approximately 900 hospitals and related laboratory services throughout the U.S.

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 over 495,000 ESRD dialysis patients in the U.S. in 2015. The underlying ESRD dialysis patient population has grown at an approximate compound rate of 3.8% from 2000 to 2015, 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 6 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, 2017, approximately 89.5% of our total dialysis patients were covered under some form of

government-based programs, with approximately 74.9% 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.

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.

U.S. Dialysis and related lab services we provide

Outpatient hemodialysis services

As of December 31, 2017, we operated or provided administrative services through a network of 2,510 outpatient dialysis centers in the U.S. that are designed specifically for outpatient hemodialysis. In 2017, our overall network of U.S. outpatient dialysis centers increased by 160 primarily as a result of the opening of new dialysis centers, net of center closures, divestitures, and acquisitions, representing a total increase of approximately 6.8% from 2016.

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 26% in 2017 and 25% in 2016. However, in 2017, the overall number of patients to whom we provided services in the U.S. increased by approximately 5.4% from 2016, primarily from the opening of new dialysis centers and acquisitions, and continued growth within the industry.

Hospital inpatient hemodialysis services

As of December 31, 2017, 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 2017, hospital inpatient hemodialysis services accounted for approximately 5.0% 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 39 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) 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 fifth year in a row, we are an industry leader in QIP standards. We are industry leaders for catheter rates and also lead the industry for the total number of patients in our peritoneal dialysis program.

In addition, 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 last three years in which data is available, we have been a leader in the industry under the CMS Five-Star Quality Rating system.

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 who aim to achieve superior clinical outcomes at our centers.

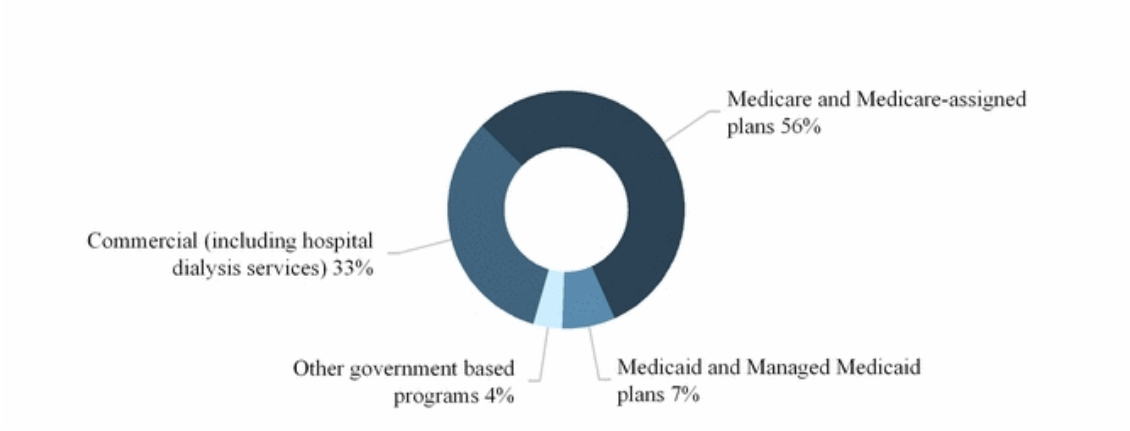
Our physician leadership in the Office of the Chief Medical Officer (OCMO) for our U.S. dialysis and related lab services business includes 16 senior nephrologists, led by our Chief Medical Officer, with a variety of academic, clinical practice, and clinical research backgrounds. Our Physician Council is an advisory body to senior management composed of eight physicians with extensive experience in clinical practice. In addition, we currently have nine Group Medical Directors.

Sources of revenue—concentrations and risks

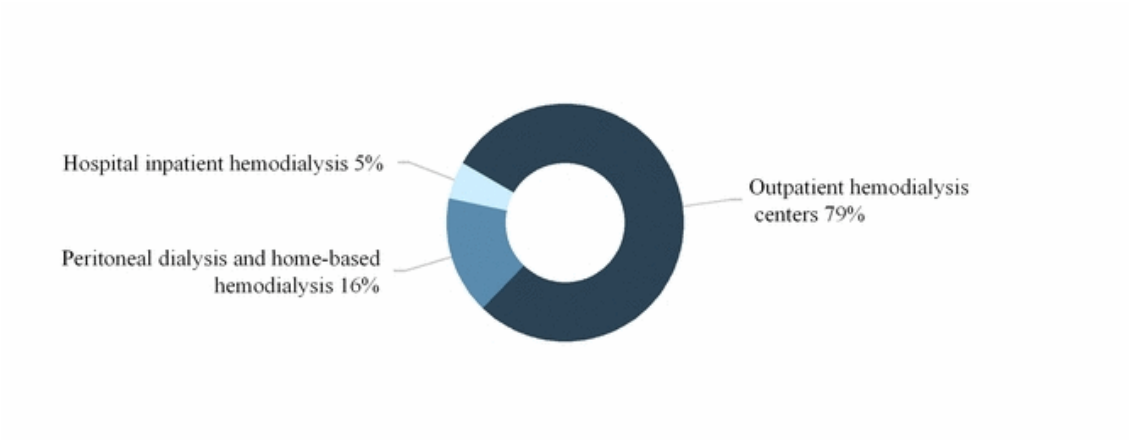
Our U.S. dialysis and related lab services business net revenues represent approximately 86% of our consolidated net revenues for the year ended December 31, 2017. Our U.S. dialysis and related lab services revenues are derived primarily from our core business of providing dialysis services and related 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 U.S. dialysis and related lab services revenues are principally from government-based programs, including Medicare and Medicare-assigned plans, Medicaid and Managed Medicaid plans and commercial insurance plans.

The following graph summarizes our U.S. dialysis services revenues by source for the year ended December 31, 2017:



The following graph summarizes our U.S. dialysis services revenues by modality for the year ended December 31, 2017:



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.

Uncertainty about future payment rates remains a material risk to our business, as well as the potential implementation of or changes in coverage determinations or other rules or regulations by CMS or Medicare Administrative Contractors (MACs) that may impact reimbursement. An important provision in the law is an annual adjustment, or market basket update, to the ESRD PPS base rate. Absent action by Congress, the ESRD 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 both 2016 and 2017, and by 1% in 2018. In November 2017, CMS published the 2018 final rule for the ESRD PPS, which increased dialysis facilities' bundled payment rate for 2018 relative to prior years. In particular, CMS projects that the 2018 final rule for the ESRD PPS will (i) increase the total payments to all ESRD facilities by 0.5% in 2018 compared to 2017; (ii) increase total payments to hospital-based ESRD facilities by 0.7% in 2018 compared to 2017; and (iii) increase total payments for freestanding facilities by 0.5% in 2018 compared to 2017. The 2018 final rule for the ESRD PPS also implements changes to the ESRD PPS outlier policy, broadening the pricing methodologies used to determine the cost of certain service drugs and biologicals in computing outlier payments when average sales price data is not available.

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 2027. These across-the-board spending cuts have affected and will continue to adversely affect our business, results of operations and financial condition. Although the Bipartisan Budget Act (BBA) of 2018 passed in February 2018 enacts a two-year federal spending agreement and raises the federal spending cap on non-defense spending for fiscal years 2018 and 2019, the Medicare program is frequently mentioned as a target for spending cuts.

The CMS Center for Medicare & Medicaid Innovation Center (Innovation Center) is 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 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 flows. 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 2018 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, including increases in maintenance costs and capital expenditures to improve, renovate and maintain our facilities, equipment and

information technology to meet changing regulatory requirements, 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 on average 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 in the form of a Medicare Supplement Plan, can apply for premium payment assistance from charitable organizations to obtain secondary coverage. 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 elect to have Medicare as their primary payor for dialysis services, a patient's commercial insurance plan, if any, is generally responsible for payment of such dialysis services for up to 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, or if commercial payors implement plans that restrict access to coverage or the duration or breadth of benefits or impose restrictions or limitations on patient access to commercial plans on non-contracted or out-of-network providers, it could have a material adverse effect on our business, results of operations and financial condition. 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 commercial insurance plans and/or an increase in uninsured or underinsured patients. 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 or receive for a limited duration such financial assistance, or if our assumptions about how patients will respond to any change in such financial assistance are incorrect, it could have a material adverse effect on our business, results of operations and financial condition.

Approximately 28% of our dialysis services revenues and approximately 10.5% of our dialysis patients are associated with non-acute commercial payors for the year ended December 31, 2017. Non-acute commercial patients as a percentage of our total dialysis patients for 2017 decreased 1.4% as compared to 2016. Less than 1% of our U.S. 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 U.S. dialysis and related lab services revenues for the year ended December 31, 2017. 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, it could have a material adverse effect on our business, results of operations and financial condition. Although we cannot predict the short- or long-term effects of these factors, we believe the healthcare insurance exchanges could result in a reduction in ESRD patients covered by traditional commercial insurance policies and an increase in the number of patients covered through the exchanges under more restrictive commercial plans with lower reimbursement rates or higher deductibles and co-payments that patients may not be able to pay. To the extent that the ongoing implementation of such exchanges or changes in statutes or regulations, or enforcement of statutes or regulations regarding the exchanges results in a reduction in reimbursement rates for our services from commercial and/or government payors, it could have a material adverse effect on our business, results of operations and financial condition.

In addition, in December 2016, CMS published an interim final rule that questioned the use of charitable premium assistance for ESRD patients and would have established new conditions for coverage standards for dialysis facilities. In January 2017, a federal court issued a preliminary injunction on CMS' interim final rule and in June 2017, at the request of CMS, the court stayed the proceedings while CMS pursues new rulemaking options. In November 2017, when CMS published the 2018 final rule that updates payment policies and rates under the ESRD PPS, and the 2019 proposed Notice of Benefit and Payment Parameters, it did not pursue further discussion or rule making related to charitable premium assistance or propose changes to historical charitable premium assistance guidelines. This does not preclude CMS or another regulatory agency or legislative authority from issuing a new rule or guidance that challenges charitable premium assistance. Additionally, any other law, rule, or guidance issued by CMS or other regulatory or legislative authorities restricting or prohibiting the ability of patients with access to alternative coverage from selecting a marketplace plan on or off exchange, and/or otherwise restricting or prohibiting the use of charitable premium assistance, could adversely impact dialysis centers across the U.S. making certain centers economically unviable, restrict the ability of dialysis patients to obtain and maintain optimal insurance coverage, and have a material adverse effect on our business, results of operations, and financial condition.

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 U.S. dialysis and related lab services net patient services revenues for the years ended December 31, 2017 and 2016, 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 U.S. dialysis and related lab services business for both years. EPO is produced by a single manufacturer, Amgen USA Inc. (Amgen). In 2017, we entered into a Sourcing and Supply Agreement with Amgen that expires on December 31, 2022. Under the terms of the agreement, we will purchase EPO in amounts necessary to meet no less than 90% of our requirements for erythropoiesis-stimulating agents (ESAs) through the expiration of the contract. The actual amount of EPO that we will purchase from Amgen will depend upon the amount of EPO administered during dialysis treatments as prescribed by physicians and the overall number of patients that we serve. Any interruption in the supply of EPO or product cost increases that we are unable to mitigate could materially impact our operations.

In addition to EPO, other drugs are included in and, in the future, other drugs will be added to the ESRD PPS. On January 1, 2018, calcimimetics, a drug class taken by many ESRD patients to treat mineral bone disease, became part of the ESRD PPS. The drug has both an oral form (Sensipar) and IV form (Parsabiv). Because the IV form is a new injectable for which there is no current functional category, neither Parsabiv nor Sensipar are considered accounted for in the ESRD PPS base rate and are reimbursed through a Transitional Drug Add-on Payment Adjustment (TDAPA). The TDAPA period is expected to continue for a period of two years. Currently, the oral and IV forms of the drug are produced and sold by a single manufacturer, Amgen. In December 2017, we entered into a Sourcing and Supply Agreement with Amgen for both the oral and IV versions of calcimimetics. Our operating results could be materially impacted by certain factors, including physician prescribing patterns, vendor contracts with Amgen and other suppliers, the timing of the entry into the market of a generic oral equivalent, whether

the drug enters into the ESRD PPS and becomes part of its bundled payment following TDAPA and, if so, at what rate, and how commercial payors will treat reimbursement of the drug.

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 5,300 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 1,000 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, it would have a material adverse effect on our business, results of operations and financial condition.

Government regulation

Our dialysis operations are subject to extensive federal, state and local governmental laws and regulations. These laws and 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.

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

- Suspension or termination of our participation in government payment programs;
- Refund 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 or elsewhere;

- Reductions in payment rates or 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 contained in the Social Security Act of 1935, as amended (Anti-Kickback Statute), Stark Law and False Claims Act (FCA), and other 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) has been used, disclosed or not properly safeguarded in violation of federal or state patient privacy laws including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Privacy Act of 1974;
- Mandated changes to our practices or procedures that significantly increase operating expenses;
- Imposition of and compliance with corporate integrity agreements that could subject us to ongoing audits and reporting requirements as well as increased scrutiny of our billing and business practices and 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 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 experienced some delays in obtaining Medicare certifications from CMS. Recent legislation will allow private entities to perform initial dialysis facilities certifications beginning in 2019. We may choose to use these private companies in the future, although the number of companies who will enter the market and the cost of surveys they might perform has yet to be determined.

Federal Anti-Kickback Statute

The federal 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 ten years and fines of up to $100,000 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 $100,000 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, 2017, these joint ventures represented approximately 24% of our net U.S. 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, 2017. We believe that 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 at a discount that may be reimbursed by a federal healthcare program. 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, among other things, 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 business, results of operations, financial condition and stock price.

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 of DHS, unless an exception applies. DHS is defined to mean any of the following enumerated items or services; clinical laboratory services; physical therapy services; occupational therapy services; radiology services, including magnetic resonance imaging, computerized axial tomography scans, and ultrasound services; radiation therapy services and supplies; durable medical equipment and supplies; parenteral and enteral nutrients, equipment, and supplies; prosthetics, orthotics and prosthetic devices and supplies; home health services; outpatient prescription drugs; inpatient and outpatient hospital services; and outpatient speech-language pathology 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. If the Stark Law is implicated, the financial relationship must fully satisfy a Stark Law exception. If an exception is not satisfied, then the arrangement could be subject to sanctions. 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. 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 bundled rate, the services performed in our facilities generally are not DHS, and the Stark Law referral prohibition does not apply to those services. Certain separately billable drugs (drugs furnished to an ESRD patient that are not for the treatment of ESRD that CMS allows our centers to bill for using the so-called AY modifier) may be considered DHS. However, for compliance with the law we have implemented certain billing controls to limit DHS being billed out of our dialysis clinics. 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 our dialysis centers were to bill for a non-exempted drug and the financial relationships with the referring

physician did not satisfy an 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 endeavor to structure our leases and subleases with referring physicians to 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.

Other Operations. The operations of our ancillary and subsidiary businesses are also subject to compliance with the Stark Law, and any failure to comply with these requirements, particularly in light of the strict liability nature of the Stark Law, could subject these operations to the Stark Law penalties and sanctions 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 of the Stark Law, or otherwise violated 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, or take other actions to modify our operations. Any such penalties and restructuring or other required actions could have a material adverse effect on our business, results of operations and financial condition.

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 we disclose PHI. Covered entities may be subject to penalties for, among other activities, failing to enter into a business associate agreement where required by law or 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 we act as a business associate to a covered entity, there is the potential for additional liability beyond our status as a covered entity.

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. through the ACA. Although many of the provisions of the ACA 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 federal and state healthcare reform legislation or what form many of these regulations will take before implementation.

The ACA introduced healthcare insurance exchanges, which provide a marketplace for eligible individuals and small employers to purchase healthcare insurance. The business and regulatory environment continues to evolve as the exchanges mature, and statutes and regulations are challenged, changed and enforced.

The ACA also 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.

On February 25, 2013, 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 forth 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 and subsequent developments 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. Further, in October 2017, the federal government announced that cost-sharing reduction payments to insurers would end, effective immediately, unless Congress appropriated the funds, and, in December 2017, Congress passed the Tax Cuts and Jobs Act, which includes a provision that eliminates the penalty under the ACA's individual mandate and could impact the future state of the exchanges. Moreover, in February 2018, Congress passed the BBA which, among other things, repealed the Independent Payment Advisory Board that was established by the ACA and intended to reduce the rate of growth in Medicare spending. While certain provisions of the BBA may increase the scope of benefits available for certain chronically ill Federal health care program beneficiaries beginning in 2020, the ultimate impact of such changes cannot be predicted. While there may be significant changes to the healthcare environment in the future, the specific changes and their timing are not yet apparent. As a result, there is considerable uncertainty regarding the future with respect to the exchanges, and, indeed, many core aspects of the current health care marketplace. While specific changes and their timing are not yet apparent, the enacted reforms as well as

future legislative, regulatory, and executive changes could have a material adverse effect on our results of operations, including lowering our reimbursement rates and/or increasing our expenses.

Other regulations

Our U.S. 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 $2.1 million for leasehold improvements and other capital expenditures. 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.

	2017	2016	2015	2014	2013
Number of centers at beginning of year	2,350	2,251	2,179	2,074	1,954
Acquired centers	66	8	6	18	26
Developed centers	121	100	72	105	98
Net change in centers with management and administrative services agreements[1]	(2)	—	2	—	4
Sold and closed centers[2][3]	(15)	(4)	(3)	(2)	(5)
Closed centers[4]	(10)	(5)	(5)	(16)	(3)
Number of centers at end of year	2,510	2,350	2,251	2,179	2,074

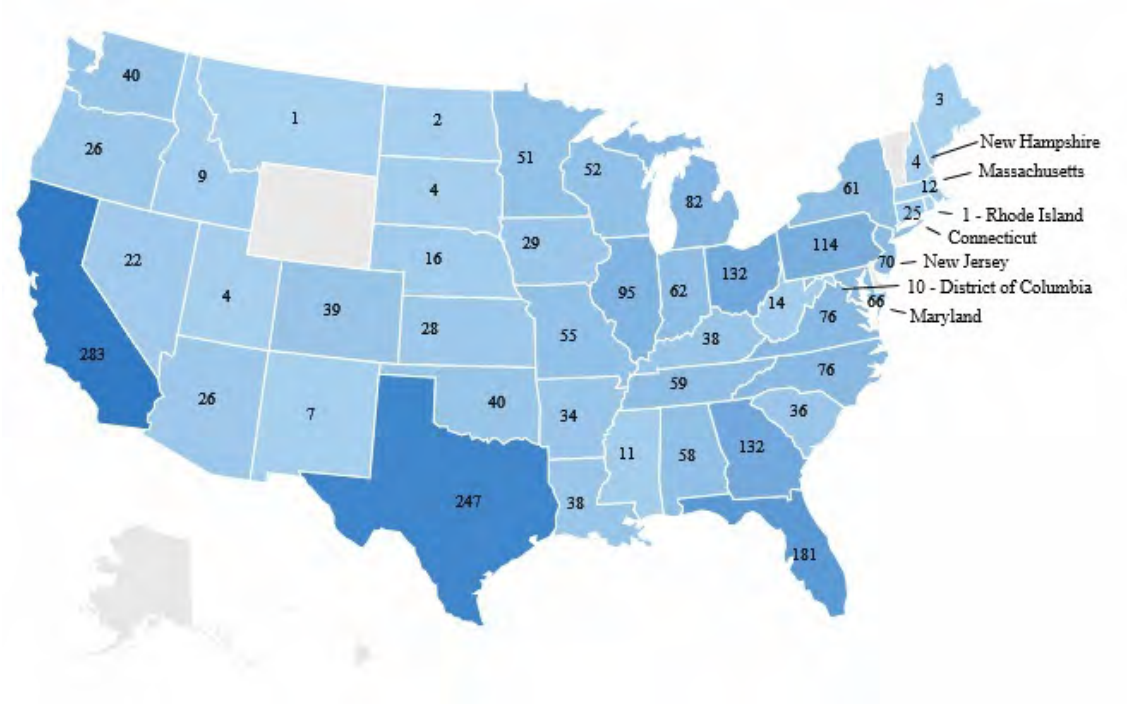
(1) Represents dialysis centers in which we either own a noncontrolling equity investment, or are wholly-owned by third parties, and also includes dialysis centers we deconsolidated and transferred to management services agreements.

(2) Includes centers that were divested as a part of our Renal Ventures acquisition.

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

(4) Represents dialysis centers that were closed for which the majority of patients were retained and transferred to one of our other existing outpatient dialysis centers.

As of December 31, 2017, we operated or provided administrative services to a total of 2,510 U.S. outpatient dialysis centers. A total of 2,471 of such centers are consolidated in our financial statements. Of the remaining 39 unconsolidated U.S. outpatient dialysis centers, we own a noncontrolling interest in 34 centers and provide management and administrative services to five centers that are wholly-owned by third parties. The locations of the 2,471 U.S. outpatient dialysis centers consolidated in our financial statements at December 31, 2017 were as follows:



Ancillary services and strategic initiatives businesses, including our international operations

As of December 31, 2017, our ancillary services and strategic initiatives consisted primarily of pharmacy services, disease management services, vascular access services, clinical research programs, physician services, direct primary care, ESRD seamless care organizations, comprehensive care, and our international operations and relate primarily to our core business of providing kidney care services.

Ancillary services and strategic initiatives consist primarily of the following:

- *Pharmacy services*. DaVita Rx is a pharmacy that specializes in providing oral medications and medication management services to patients with ESRD. 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, chronic kidney failure, and/or poly-comorbid conditions. 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 management service agreements to support three ESCO joint ventures in which we are an investor through certain wholly- or majority-owned dialysis clinics.

- *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. 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.

- *ESRD Seamless Care Organization joint ventures (ESCO JVs).* In October 2015, certain of our dialysis clinics entered into partnerships with various nephrology practices, DaVita Rx and health systems to establish three ESCO JVs in Phoenix-Tucson Arizona, South Florida, and Philadelphia Pennsylvania-Camden, New Jersey. The ESCO JVs were formed under the CMS Innovation Center's Comprehensive ESRD Care (CEC) Model, a demonstration to assess the impact of care coordination for ESRD patients in a dialysis-center oriented ACO setting. Each ESCO JV has a shared risk arrangement with CMS and the programs are evaluated on a performance year basis. The delivery of improved quality outcomes for patients and program savings depend on the contributions of the dialysis center teammates, nephrologists, health system and hospital partners, pharmacy providers including DaVita Rx, other primary care and specialty care providers and facilities, and integrated care management support from VillageHealth, which is also the manager of the ESCO JVs. In October 2017, CMS published the results for the first performance year, covering the period from October 2015 to December 2016, and all three ESCO JVs earned shared savings payments.

- *Comprehensive care.* DaVita Health Solutions provides high-quality, comprehensive medical care for high-risk patients when and where they need it most - at home, in a post-acute care facility or within the dialysis center. DaVita Health Solutions offers a broad suite of home- and outpatient-based care programs, including primary care, behavioral health, palliative care, comprehensive health assessments and other clinical services through 24/7 house calls at home, at skilled nursing facilities and at dialysis centers.

International dialysis operations

As of December 31, 2017, we operated or provided administrative services to a total of 237 outpatient dialysis centers, which includes consolidated and nonconsolidated centers located in 11 countries outside of the U.S., serving approximately 22,900 patients. Our international dialysis operations have continued 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.

	2017	2016	2015	2014	2013
Number of centers at beginning of year	154	118	91	73	36
Acquired centers	68	21	21	9	38
Developed and hospital operated centers	8	12	7	11	2
Managed centers, net	—	—	(1)	—	—
Closed centers	(1)	—	—	(2)	(3)
Net change in Asia Pacific Joint Venture (APAC JV) operated centers	8	66	—	—	—
Deconsolidated centers due to formation of APAC JV	—	(63)	—	—	—
Number of centers at end of year	237	154	118	91	73

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

Poland	51
Germany	44
Malaysia[(1)]	38
India[(1)]	24
Saudi Arabia	22
Colombia	20
Brazil	18
Portugal	8
Taiwan[(1)]	7
China[(1)]	4
Singapore[(1)]	1
	237

(1) Includes centers that are operated or managed by our 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

On December 5, 2017, we entered into an equity purchase agreement to sell our DMG division to Optum, a subsidiary of UnitedHealth Group Inc. The transaction is expected to close in 2018 and is subject to regulatory approval and other customary closing conditions. As a result of this pending transaction, the DMG business is classified as held for sale and its results of operations are reported as discontinued operations. In addition, prior periods' presentation has been revised to conform to current year presentation.

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, 2017, DMG served approximately 763,000 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 319,900 individuals were patients enrolled in Medicare and Medicare Advantage, and the remaining approximately 443,100 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, 2017, DMG provided care across all markets to approximately 966,600 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, 2017, DMG delivered services to its members via a network of over 750 primary care physicians, over 3,500 associated group and other network primary care physicians, approximately 180 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, unhealthy behavioral and lifestyle choices 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 2016, CMS reported that healthcare accounted for 17.9% of the U.S. gross domestic product and that healthcare spending increased 4.3% to reach $3.3 trillion. Medicare spending grew 3.6% to $672 billion in 2016 or 20% of National Health Expenditures, according to CMS. Medicare's share of the federal budget was approximately 15.0% in 2017 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 demographic changes. 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 per-member monthly premium payment from CMS. The monthly premium varies based on the county in which the member resides, further adjusted to reflect the plan members' expected medical cost risk. 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 2017, Medicare Advantage represented 33% 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 2016, the number of uninsured nonelderly Americans was 27.6 million, a decrease of over 16 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 and subsequent developments, including recent federal tax reform legislation, have caused the future state of the ACA to become less clear.

One of the primary ways in which the ACA funded expanded health insurance coverage is through cuts in Medicare Advantage reimbursement. County benchmarks have transitioned to a system in which each county's benchmark is a certain percentage (ranging from 95% to 115%) of FFS Medicare. In a March 2017 report to Congress, the Medicare Payment Advisory Commission (MedPAC) estimated that 2017 Medicare Advantage benchmarks (including the average 4% for quality bonuses), bids, and payments would average 106%, 90%, and 100% 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 88% of FFS spending, yet 2017 payments for HMO enrollees are estimated to average 99% of FFS spending (including the quality bonuses).

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 knowledge 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 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 below 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 exposure 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, also have established physician performance metrics that allow them to monitor quality and service outcomes achieved by participating physicians in order to reward efficient, high quality care delivered to members and initiate improvement efforts for physicians whose results can be enhanced.

Healthcare reform

The U.S. healthcare system, including the Medicare Advantage program, is subject to a broad array of new laws and regulations as a result of the 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, if 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 and uncertain. 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 and subsequent developments have caused the future state of the ACA to be unclear. In October 2017, the federal government announced that cost-sharing reduction payments to insurers would end, effective immediately, unless Congress appropriated the funds, and, in December 2017, Congress passed the Tax Cuts and Jobs Act, which includes a provision that eliminates the penalty under the ACA's individual mandate and could impact the future state of the exchanges. Further, in February 2018, Congress passed the BBA, which, among other things, repealed the Independent Payment Advisory Board that was established by the ACA and intended to reduce the rate of growth in Medicare spending. While certain provisions of the BBA may increase the scope of benefits available for certain chronically ill federal health care program beneficiaries beginning in 2020, the ultimate impact of such changes cannot be predicted. While specific changes and their timing are not yet apparent, the enacted reforms as well as future legislative, regulatory, or executive 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. For the 2016 MSSP program, DMG achieved approximately $3 million in savings however was not able to benefit in these savings as the minimum savings rate was not reached. In 2017, DMG participated in the CMS Innovation Center's Next Generation ACO and will continue to participate through 2018. Results for 2017 participation will be available in the third quarter of 2018.

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 $672 billion program in 2016, 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 $595 billion in 2017 to $1.2 trillion in 2027.

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 the Alternate Payment Model (APM) in which 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 2027.

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. Although the BBA passed in February 2018 enacts a two-year federal spending agreement and raises the federal spending cap on non-defense spending for fiscal years 2018 and 2019, 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 33% in 2017 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 94,800 Medicaid managed care members in its southern California market.

Commercial payors

According to the 2017 Annual Survey conducted by the Kaiser Family Foundation, approximately 151 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 2017 and 2016. 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 amount for each service or procedure 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. 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 senior members and members with multiple diseases. 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 knowledge 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 converted three separate contracts to global risk in 2016, and converted two additional contracts in 2017. In total, approximately 28% of DMG's membership is now covered under global risk plans. DMG is in the approval and implementation process to convert additional contracts to global risk in 2018. 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 U.S. 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 U.S. 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 U.S. 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 Knox-Keene, 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 licensed 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 monitors and evaluates the financial viability of health plans to ensure continued access to health care services. Financial examination reviews include examinations of financial statements and financial arrangements, both by routine and non-routine examinations. 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 DHPC, 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. Additionally, a licensed HCSP is subject to additional DMHC reporting requirements and financial oversight if the HCSP fails to maintain at least 130% of its required minimum TNE. During the 2016 financial examination, DHPC 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 HCSP licensing requirements to apply to both full-service HCSPs and downstream restricted HCSP 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 not required to meet Knox-Keene requirements for functions they are not delegated such as marketing. 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 allows DHPC to contract directly with full service HCSPs to simplify DMG's 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, 2017 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 some 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.

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, over 750 primary care physicians. Through its IPA model, DMG contracts with a network of approximately 3,500 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 180 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 750 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 18 to 22 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 to 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 of approximately 19 years, as of December 31, 2017.

Locations of DMG clinics

As of December 31, 2017, DMG managed a total of 280 medical clinics, of which 68 clinics were located in California, 27 clinics were located in Colorado, 87 clinics were located in Florida, 60 clinics were located in Nevada, 14 clinics were located in New Mexico, and 24 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.

Together with Fresenius Medical Care (FMC), we account for approximately 73% of outpatient dialysis patients in the U.S. with our Company serving approximately 37% of the total outpatient dialysis patients. Approximately 45% of the centers not owned by us or FMC are owned or controlled by hospitals or non-profit organizations. Hospital-based and non-profit dialysis units typically are more difficult to acquire than physician-owned dialysis centers.

FMC also manufactures a full line of dialysis supplies and equipment in addition to owning and operating outpatient dialysis centers worldwide. This may give FMC cost advantages over us because of its ability to manufacture its own products. Additionally, FMC has been one of our largest suppliers of dialysis products and equipment over the last several years. In 2018, 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, 2020. 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's competitors include 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 considerably in type and identity by region.

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 criminal, civil or

administrative laws or regulations applicable to any Federal health care program for which penalties and exclusions may be authorized and anti-corruption laws 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 these laws;
- Developing and implementing compliance policies and procedures and creating controls to support compliance with these laws 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. In April 2015, 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. If we fail to comply with our CIA, we could be subject to substantial penalties and exclusion from participation in federal healthcare programs that could have a material adverse effect on our business, results of operations and financial condition.

Insurance

We are predominantly self-insured with respect to professional and general liability and workers' compensation risks through wholly-owned captive insurance companies. The Company is also predominantly self-insured with respect to employee medical and other health benefits. We also maintain insurance, excess coverage, or reinsurance 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, 2017, we employed approximately 74,500 teammates, including our international teammates:

• Licensed professional staff (physicians, nurses and other healthcare professionals)	25,800
• Other patient care and center support staff and laboratory personnel	28,100
• Corporate, billing and regional administrative staff	8,200
• DMG	12,400

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 those discussed below. The risks and uncertainties discussed below are not the only ones facing our business. In addition, 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 laws and regulations that apply to our business, we could suffer severe consequences that could have a material adverse effect on our business, results of operations, financial condition and stock price.

Our operations are subject to extensive federal, state and local government laws and regulations, such as Medicare and Medicaid payment rules and regulations, federal and state anti-kickback laws, the Stark Law and analogous state self-referral prohibition statutes, the 21st Century Cures Act, 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, shipment, disposal and/or dispensing of pharmaceuticals and blood products and other biological materials. The Medicare and Medicaid reimbursement rules impose complex and extensive requirements upon healthcare providers as well. Moreover, additional laws and regulations potentially affecting providers continue to be promulgated that may impact us. A violation or departure from any of these legal requirements may result in government audits, lower reimbursements, significant fines and penalties, the potential loss of certification, recoupment efforts or voluntary repayments, among other things.

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

In addition, failure to report and return overpayments within 60 days of when the overpayment is 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 $20,000 (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 investments in resources to decrease the time it takes to identify, quantify and process overpayments, and we may be required to make additional investments in the future. From time to time we may conduct internal compliance reviews, the results of which may involve the identification of overpayments or other liabilities. An acceleration in our ability to identify and process overpayments could result in us refunding overpayments to government and other payors more rapidly than we have in the past which could have a material adverse effect on our operating cash flows. Overpayments subject us to refunds and related damages and potential liabilities.

Additionally, the federal government has used the FCA to prosecute a wide variety of alleged false claims and fraud allegedly perpetrated against Medicare and state health care programs. Moreover, amendments to the federal Anti-Kickback Statute in the 2010 Affordable Care Act (ACA) make claims tainted by anti-kickback violations potentially subject to liability under the FCA, including *qui tam* or whistleblower suits. The penalties for a violation of the FCA range from $5,500 to $11,000 (adjusted for inflation) for each false claim plus three times the amount of damages caused by each such claim which generally means the amount received directly or indirectly from the government. On February 3, 2017, the Department of Justice (DOJ) issued a final rule announcing adjustments to FCA penalties, under which the per claim penalty range increases to a range from $10,957 to $21,916 for penalties assessed after February 3, 2017, so long as the underlying conduct occurred after November 2, 2015. Given the high volume of claims processed by our various operating units, the potential is high for substantial penalties in connection with any alleged FCA violations.

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

Certain civil investigative demands received by us or our subsidiaries specifically reference that they are in connection with FCA investigations alleging, among other things, that we or our subsidiaries presented or caused to be presented false claims for payment to the government. See "Item 3. Legal Proceedings" in Part I of this report and Note 16 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 could have a material adverse effect on our business, results of operations and financial condition."

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

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

We are, and may in the future be, a party to various lawsuits, demands, claims, *qui tam* suits, 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, required changes to our business practices, exclusion from future participation in the Medicare, Medicaid and other federal healthcare programs and possible criminal penalties, any of which could have a material adverse effect on our business, results of operations and financial condition and materially harm our reputation.

We are the subject of a number of investigations and audits by the federal government, as further described in Note 16 to the consolidated financial statements included in this report. We may be 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, demands, 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 and/or individuals in our business in connection with investigations by the federal government. Other than as described in "Item 3. Legal Proceedings" in Part I of this report and Note 16 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 business results of operations and financial condition. See "Item 3. Legal Proceedings" in Part I of this report and Note 16 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 business, results of operations and financial condition.

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

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

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

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

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

With the ACA, new models of care emerge and evolve and other initiatives in the government or private sector may arise, which could adversely impact our business. For example, the CMS Innovation Center (Innovation Center) is currently working with various healthcare providers to develop, refine and implement Accountable Care Organizations (ACOs) and other innovative models of care for Medicare and Medicaid beneficiaries, including Bundled Payments for Care Improvement

Initiative, CEC Model (which includes the development of ESRD Seamless Care Organizations), the Duals Demonstration, and other models. We are currently participating in the CEC Model with the Innovation Center, including with organizations in Arizona, Florida, and adjacent markets in New Jersey and Pennsylvania. Our U.S. dialysis business may choose to participate in additional models either as a partner with other providers or independently. Even in areas where we are not directly participating in these or other Innovation Center models, some of our patients may be assigned to an ACO, another ESRD Care Model, or another program, in which case the quality and cost of care that we furnish will be included in an ACO's, another ESRD Care Model's, or other program's calculations. Additionally, CMS instituted new screening procedures, as required by the ACA, which we expect will delay the Medicare contractor approval process, potentially causing a delay in reimbursement. We anticipate the new screening and enrollment requirements will require additional personnel and financial resources and will potentially delay the enrollment and revalidation of our centers which in turn will delay payment. These delays could adversely affect our business, results of operations and financial condition. The BBA revised the manner in which beneficiaries are assigned to an ACO, specifically giving ACOs the choice to have beneficiaries assigned prospectively at the beginning of a performance year and giving beneficiaries the option to voluntarily align to the ACO in which the beneficiary's main primary care provider participates. While prospective assignment may allow ACOs to identify beneficiaries for whom they will be held accountable and proactively take steps to ensure appropriate care, the ultimate impact of such changes on our business, results of operations and financial condition is not yet known.

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

There is also a considerable amount of uncertainty as to the prospective implementation of the ACA and what similar measures or other changes might be enacted at the federal and/or state level. There have been multiple attempts through legislative action and legal challenges to repeal or amend the ACA. In addition, the 2016 Presidential and Congressional elections and subsequent developments in 2017 have caused the future state of the exchanges and other ACA reforms to be unclear. For example, in October 2017, the federal government announced that cost-sharing reduction payments to insurers would end, effective immediately, unless Congress appropriated the funds, and, in December 2017, Congress passed the Tax Cuts and Jobs Act, which includes a provision that eliminates the penalty under the ACA's individual mandate and could impact the future state of the exchanges. Further, in February 2018, Congress passed the BBA which, among other things, repealed the Independent Payment Advisory Board that was established by the ACA and intended to reduce the rate of growth in Medicare spending. While certain provisions of the BBA may increase the scope of benefits available for certain chronically ill Federal health care program beneficiaries beginning in 2020, the ultimate impact of such changes cannot be predicted. While there may be significant changes to the healthcare environment in the future, the specific changes and their timing are not yet apparent. As a result, there is considerable uncertainty surrounding the ACA including the exchanges, and, indeed, many core aspects of the current health care marketplace. Previously enacted reforms and future changes could have a material adverse effect on our business, financial condition and results of operations, including, for example, by limiting the scope of coverage or the number of patients who are able to obtain coverage through the exchanges and other health insurance programs, lowering or eliminating the cost-sharing reduction subsidies under the ACA, lowering our reimbursement rates, and/or increasing our expenses.

In addition, in December 2016, CMS published an interim final rule that questioned the use of charitable premium assistance for ESRD patients and would have established new conditions for coverage standards for dialysis facilities. In January 2017, a federal district court in Texas issued a preliminary injunction on CMS' interim final rule and in June 2017, at the request of CMS, the court stayed the proceedings while CMS pursues new rulemaking options. In November 2017, when CMS published the 2018 final rule that updates payment policies and rates under the ESRD PPS, and the 2019 proposed Notice of Benefit and Payment Parameters, it did not pursue further discussion or rule making related to charitable premium assistance or propose changes to historical charitable premium assistance guidelines. This does not preclude CMS or another regulatory agency or legislative authority from issuing a new rule or guidance that challenges charitable premium assistance. Additionally, any other law, rule, or guidance issued by CMS or other regulatory or legislative authorities restricting or prohibiting the ability of patients with access to alternative coverage from selecting a marketplace plan on or off exchange, and/or otherwise restricting or prohibiting the use of charitable premium assistance, could adversely impact dialysis centers across the U.S. making certain centers economically unviable, restrict the ability of dialysis patients to obtain and maintain optimal insurance coverage, and have a material adverse effect on our business, results of operations, and financial condition.

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

We must comply with numerous federal and state laws and regulations in both the U.S. and the foreign jurisdictions in which we operate governing the collection, dissemination, access, use, security and privacy of PHI, including HIPAA and its implementing privacy, security, and related regulations, as amended by the federal Health Information Technology for Economic and Clinical Health Act (HITECH) and collectively referred to as HIPAA. We are also required to report known breaches of PHI consistent with applicable breach reporting requirements set forth in applicable laws and regulations. From time to time, we may be subject to both federal and state inquiries or audits related to HIPAA, HITECH and related state laws associated with complaints, desk audits, and self-reported breaches. 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, or defend against cybersecurity attacks, it could harm our reputation or have a material adverse effect on our business, results of operations and financial condition.

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 business and operations rely on the secure processing, transmission and storage of confidential, proprietary and other information in our computer systems and networks, including sensitive personal information, including PHI, social security numbers, and credit card information of our patients, teammates, physicians, business partners and others.

We are continuously implementing multiple layers of security measures through technology, processes, and our people. We utilize security technologies to protect and maintain the integrity of our information systems and data 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. Internal or external parties may attempt to circumvent our security systems, and we have in the past, and expect that we will in the future, experience external attacks on our network including reconnaissance probes, denial of service attempts, malicious software attacks including attacks intended to render our internal operating systems unavailable, and phishing attacks. Cybersecurity requires ongoing investment and diligence against evolving threats. Emerging and advanced security threats, including coordinated attacks, require additional layers of security which may disrupt or impact efficiency of operations. As with any security program, there always exists the risk that employees will violate our policies despite our compliance efforts or that certain attacks may be beyond the ability of our security and other systems to detect. There can be no assurance that investments and diligence will be sufficient to prevent or timely discover an attack.

Any security breach involving the misappropriation, loss or other unauthorized disclosure or use of confidential information, including PHI, financial data, competitively sensitive information, or other proprietary data, whether by us or a third party, could have a material adverse effect on our business, financial condition, and results of operations and materially harm our reputation. We may be required to expend significant additional resources to modify our protective measures, to investigate and remediate vulnerabilities or other exposures, or to make required notifications. The occurrence of any of these events could, among other things, result in interruptions, delays, the loss or corruption of data, cessations in the availability of systems and liability under privacy and security laws, all of which could have a material adverse effect on our business, financial condition or results of operations, materially harm our reputation and trigger regulatory actions and private party litigation. If we are unable to protect the physical and electronic security and privacy of our databases and transactions, we could be subject to potential liability and regulatory action, our reputation and relationships with our patients and vendors would be harmed, and our business, results of operations and financial condition could be materially and adversely affected. Failure to adequately protect and maintain the integrity of our information systems (including our networks) and data, or to defend against cybersecurity attacks, could subject us to monetary fines, civil suits, civil penalties or criminal sanctions and requirements to disclose the breach publicly, and could further result in a material adverse effect on our business, results of operations and financial condition or harm our reputation. As malicious cyber activity escalates, including activity that originates outside of the United States, the risks we face relating to transmission of data and our use of service providers outside of our network, as well as the storing or processing of data within our network, intensify. There have been increased federal and state HIPAA and other privacy and security enforcement efforts and we expect this trend to continue. While we

maintain cyber liability insurance, this insurance may not cover us for all types of losses and may not be sufficient to protect us against the amount of all losses.

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

Our business strategy includes growth through acquisitions of dialysis centers and other businesses, as well as entry into joint ventures. We may engage in acquisitions, mergers, joint ventures or dispositions or expand into 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 buyers for dispositions or that, if identified, we will be able to agree to terms with merger partners, acquire these targets or make these dispositions on acceptable terms or on the desired timetable. There can also be no assurance that we will be successful in completing any acquisitions, mergers or dispositions that we announce, executing new business models or integrating any acquired business into our overall operations. There is no guarantee that we will be able to operate acquired businesses successfully as stand-alone businesses, or that any such acquired business will operate profitably or will not otherwise have a material adverse effect on our business, results of operations and financial condition. Further, we cannot be certain that key talented individuals at the business being acquired will continue to work for us after the acquisition or that they will be able to continue to successfully manage or have adequate resources to successfully operate any acquired business. In addition, certain of our newly and previously acquired dialysis centers and facilities have been in service for many years, which may result in a higher level of maintenance costs. Further, our facilities, equipment and information technology may need to be improved or renovated to maintain or increase operational efficiency, compete for patients and medical directors, or meet changing regulatory requirements. Increases in maintenance costs and capital expenditures could have a material adverse effect on our financial condition, results of operations and cash flows.

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

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

If we are not able to continue to make acquisitions at the desired pace or at all, or maintain an acceptable level of non-acquired growth, or if we face significant patient attrition to our competitors or we are not able to retain or contract with an adequate number of medical directors or associated physicians, it could adversely affect our business, results of operations and financial condition.

Acquisitions, patient retention and medical director and physician retention are an important part of our growth strategy. We face intense competition from other companies for acquisition targets. In our U.S. dialysis business, we continue to face increased competition from large and medium-sized providers, which compete directly with us for the limited acquisition targets as well as for individual patients and medical directors. In addition, we compete for individual patients and medical directors based in part on the quality of our facilities. Moreover, as we continue our international expansion into various international markets, we will face competition from large and medium-sized providers for these acquisition targets as well. As we and our competitors continue to grow and open new dialysis centers, each center is required by applicable regulations to have a medical director, and we may not be able to retain an adequate number of nephrologists to serve as medical directors. Because of the ease of entry into the dialysis business and the ability of physicians to be medical directors for their own centers, competition for growth in existing and expanding markets is not limited to large competitors with substantial financial

resources. Individual nephrologists have opened their own dialysis units or facilities. In addition, Fresenius USA, our largest competitor, manufactures a full line of dialysis supplies and equipment in addition to owning and operating dialysis centers. This may give it cost advantages over us because of its ability to manufacture its own products. If we are not able to continue to make acquisitions at the desired pace or at all, continue to maintain acceptable levels of non-acquired growth, or if we face significant patient attrition to our competitors or if a physician chooses not to refer to DaVita, it could adversely affect our business, results of operations and financial condition.

If certain of our suppliers do not meet our needs, if there are material price increases, if we are not reimbursed or adequately reimbursed for drugs we purchase or if we are unable to effectively access new technology or superior products, it could negatively impact our ability to effectively provide the services we offer and could have a material adverse effect on our business, results of operations and financial condition.

We have significant suppliers that may be the sole or primary source of products critical to the services we provide, or to which we have committed obligations to make purchases, sometimes at particular prices. 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 or government payors, it could have a material adverse impact on our business, results of operations and financial condition. In addition, the technology related to the products critical to the services we provide is subject to new developments which may result in superior products. If we are not able to access superior products on a cost-effective basis or if suppliers are not able to fulfill our requirements for such products, we could face patient attrition which could have a material adverse effect on our business, results of operations and financial condition.

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

DMG operates in a different line of business from our historical business. We may not have the expertise, experience and resources to pursue all of our businesses at once, and we may be unable to successfully operate all businesses in the combined company. The administration of DMG requires implementation of appropriate operations, management, forecasting, and financial reporting systems and controls. We have experienced difficulties in effectively implementing these and other systems. The management of DMG requires and will continue to require the focused attention of our management team, including a significant commitment of its time and resources. The need for management to focus on these matters could have a material adverse effect on our business, results of operations and financial condition. If the DMG operations continue to be less profitable than we currently anticipate or we do not have the experience, the appropriate expertise or the resources to pursue all businesses in the combined company, our results of operations and financial condition may be materially and adversely affected. In that regard, we have taken goodwill impairment charges of $1.093 billion in total and may continue incurring additional impairment charges.

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

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

DMG and other DaVita entities operate by maintaining long-term contracts with their 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 and such other DaVita entities provide management services and receive a management fee for providing non-medical management services; however, DMG and such other DaVita entities do not represent that they offer medical services, and do 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 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. The other DaVita entities operating in these and multiple other states have similar agreements and arrangements. 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 or any of the other DaVita entities 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 the business, results of operations and financial condition of DMG and such other DaVita entities.

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 and the way DMG carries out these arrangements as described above, either independently or coupled with the management services agreements with such associated physician groups, are in violation of the corporate practice of medicine doctrine. As a result, these arrangements could be deemed invalid, potentially resulting in a loss of revenues and an adverse effect on results of operations derived from such associated physician groups. Such a determination could force a restructuring of DMG's management arrangements with associated physician groups in California, Colorado, Nevada and/or Washington, which might include revisions of the management services agreements, including a modification of the management fee and/or establishing an alternative structure that would permit DMG to contract with a physician network without violating the corporate practice of medicine prohibition. There can be no assurance that such a restructuring would be feasible, or that it could be accomplished within a reasonable time frame without a material adverse effect on DMG's business, results of operations and financial condition. These same risks exist for the other DaVita entities utilizing similar structures.

In December 2013, DHPC obtained a restricted Knox-Keene license in California, which permits DHPC to contract with health plans in California to accept global risk without violating the corporate practice of medicine prohibition. However, DMG and DMG's Colorado, Nevada and Washington associated physician groups, as well as those physician equity holders of associated physician groups who are subject to succession agreements with DMG, could be subject to criminal or civil penalties or an injunction for practicing medicine without a license or aiding and abetting the unlicensed practice of medicine.

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

We have substantial debt outstanding, we incurred a substantial amount of additional debt in connection with the acquisition of DMG and we may incur additional indebtedness in the future, including in anticipation of receiving the cash proceeds from the sale of DMG. For additional details regarding specific risks we face regarding the sale of DMG, see the discussion in the risk factors under the heading "Risk factors related to the sale of DMG." Our inability to generate sufficient cash to service our substantial indebtedness and for other intended purposes 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 flows from operations to payments on our indebtedness, thereby reducing the availability of our cash flow to fund working capital, capital expenditures, acquisitions and investments, repurchases of stock at the levels intended or announced, or at all, and other general corporate purposes;
- limit our flexibility in planning for, or reacting to, changes in our business and the markets in which we operate;
- expose us to interest rate volatility that could adversely affect our business, results of operations and financial condition, and our ability to service our indebtedness;
- place us at a competitive disadvantage compared to our competitors that have less debt; and
- limit our ability to borrow additional funds, or to refinance existing debt on favorable terms when otherwise available.

In addition, we expect to continue to incur additional indebtedness in the future, and the amount of that additional indebtedness may be substantial. Although the indentures governing our senior notes and the agreement governing our senior secured credit facilities include covenants that could limit our indebtedness, we currently have the ability to incur substantial additional debt. If new debt is added to current debt levels, the related risks described above could intensify, in particular, if we

were to borrow new debt in anticipation of receiving the cash proceeds from the pending sale of DMG and if there is a delay in closing the sale of DMG or the sale of DMG does not close.

Our ability to make payments on our indebtedness, to fund planned capital expenditures and expansion efforts, including any strategic acquisitions we may make in the future, to repurchase our stock at the levels intended or announced and to meet our other liquidity needs, 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.

After the pending sale of DMG closes, our cash flows will be reduced accordingly. We cannot provide assurances that our business will generate sufficient cash flows 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, including those described above. If we are unable to generate sufficient funds to service our outstanding indebtedness or to meet our other liquidity needs, including the intended purposes described above, we may be required to refinance, restructure, or otherwise amend some or all of such obligations, sell assets, change our intended or announced uses or strategy for capital deployment, including for stock repurchases, reduce capital expenditures or planned expansions or raise additional cash through the sale of our equity. We cannot make any assurances that any such refinancing, restructurings, sales of assets, or issuances of equity can be accomplished or, if accomplished, can be accomplished on favorable terms or that if accomplished that they would raise sufficient funds to meet these obligations or our other liquidity needs.

The borrowings under our senior secured credit facilities are guaranteed by a substantial portion of our direct and indirect wholly owned domestic subsidiaries, including certain of DMG's subsidiaries, and are secured by a substantial portion of our and our subsidiaries' assets, including those of certain of DMG's subsidiaries. After the sale of DMG closes, we will have fewer assets with which to secure future debt or refinance or restructure existing debt. This will likely reduce the total amount of secured debt that we will be able to incur and may increase the interest rate we are required to pay on our existing secured debt and any secured debt we issue in the future. In addition, by reducing the amount of assets available to meet the claims of our secured creditors, it may also adversely affect the interest rates on our existing unsecured debt and any unsecured debt we issue in the future.

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

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 notices of claims from commercial payors and other third parties, as well as subpoenas and CIDs from the federal government, related to our business practices, including our historical billing practices and the historical billing practices of acquired businesses. Although the ultimate outcome of these claims cannot be predicted, an adverse result with respect to one or more of these claims could have a material adverse effect on our business, results of operations and financial condition. We maintain insurance coverage for those risks we deem are appropriate to insure against and make determinations about whether to self-insure as to other risks or layers of coverage. However, a successful claim, including a professional liability, malpractice or negligence claim which is in excess of any applicable insurance coverage, or that is subject to our self-insurance retentions, could have a material adverse effect on our business, results of operations, financial condition and reputation. Additionally, as a result of the broad scope of our DMG division's medical practice, we are exposed to medical malpractice claims, as well as claims for damages and other expenses, that may not be covered by insurance or for which adequate limits of insurance coverage may not be available.

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

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

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

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

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

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

We could be subject to adverse changes in tax laws, regulations and interpretations or challenges to our tax positions.

We are subject to tax laws and regulations of the U.S. federal, state and local governments as well as various foreign jurisdictions. We compute our income tax provision based on enacted tax rates in the jurisdictions in which we operate. As the tax rates vary among jurisdictions, a change in earnings attributable to the various jurisdictions in which we operate could result in an unfavorable change in our overall tax provision.

From time to time, changes in tax laws or regulations may be proposed or enacted that could adversely affect our overall tax liability. For example, the recent U.S. tax legislation enacted on December 22, 2017 represents a significant overhaul of the U.S. federal tax code. This tax legislation significantly reduced the U.S. statutory corporate tax rate and made other changes that we expect will reduce our effective U.S. federal tax rate in future periods. However, the tax legislation also included a number of provisions, including, but not limited to, the limitation or elimination of various deductions or credits (including for interest expense and for performance-based compensation under Section 162(m)), the imposition of taxes on certain cross-border payments or transfers, the changing of the timing of the recognition of certain income and deductions or their character, and the limitation of asset basis under certain circumstances, any of which could significantly and adversely affect our U.S. federal income tax position. The legislation also made significant changes to the tax rules applicable to insurance companies and other entities with which we do business. The estimated impact of the new law is based on management's current knowledge and assumptions. We are continuing to evaluate the overall impact of this tax legislation on our operations and U.S. federal and state income tax position. The actual impact of the new law could be materially different from our current estimates based on our actual results and our further analysis of the new law. There can be no assurance that changes in tax laws or regulations, both within the U.S. and the other jurisdictions in which we operate, will not materially and adversely affect our effective tax rate, tax payments, financial condition and results of operations. Similarly, changes in tax laws and regulations that impact our patients, business partners and counterparties or the economy generally may also impact our financial condition and results of operations.

In addition, tax laws and regulations are complex and subject to varying interpretations, and any significant failure to comply with applicable tax laws and regulations in all relevant jurisdictions could give rise to substantial penalties and liabilities. We are regularly subject to audits by tax authorities and, although we believe our tax estimates are appropriate, the final determination of tax audits and any related litigation could be materially different from our historical income tax provisions and accruals. Any changes in enacted tax laws (such as the recent U.S. tax legislation), rules or regulatory or judicial interpretations; any adverse outcome in connection with tax audits in any jurisdiction; or any change in the pronouncements

relating to accounting for income taxes could materially and adversely impact our effective tax rate, tax payments, financial condition and results of operations.

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

We are continuing to expand our operations by offering our services and entering new lines of business in certain markets 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;
- 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; and
- data and privacy restrictions.

Issues relating to the failure to comply with any of the above may also 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.

Any expansion of our international operations through acquisitions or through organic growth could increase these risks. Additionally, while we may invest material amounts of capital and incur significant costs in connection with the growth and development of our international operations, including to start up or acquire new operations, we may not be able to operate them profitably on the anticipated timeline, or at all.

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

Risk factors related to the sale of DMG:

The announcement and pendency of the sale of DMG may adversely affect our business, results of operations and financial condition.

The announcement and pending sale of DMG may be disruptive to our business and may adversely affect our relationships with current and prospective teammates, patients, physicians, payors, suppliers and other business partners. Uncertainties related to the pending sale of DMG may impair our ability to attract, retain and motivate key personnel and could cause suppliers and other business partners to defer entering into contracts with us or seek to change existing business relationships with us. The loss or deterioration of significant business and operational relationships could have an adverse effect on our business, results of operations and financial condition. In addition, activities relating to the pending sale and related uncertainties could divert the attention of our management and other teammates from our day-to-day business or disrupt our operations in preparation for and during the post-closing separation of DMG. It is also possible that we could have stranded costs following the closing of the pending sale, which could be material. If we are unable to effectively manage these risks, our business, results of operations and financial condition may be adversely affected.

If we fail to complete the proposed sale of DMG, or if there is a significant delay in completing the sale, our business, results of operations, financial condition and stock price may be materially adversely affected.

The completion of the proposed sale of DMG is subject to customary closing conditions, including the expiration or termination of the applicable waiting period under the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended, and the approval of a notice of material modification by the California Department of Managed Health Care. If any condition to the closing of the sale of DMG is neither satisfied nor, where permissible, waived, the sale of DMG will not be completed. In addition, satisfying the closing conditions to the sale of DMG may take longer than expected. Regulators may impose material conditions, terms, obligations, costs or restrictions in connection with their approval of or consent to the sale of DMG, which could delay completion of the transaction, or if such approvals or consents are not obtained, could prevent completion of the transaction. There can be no assurance that all of the closing conditions will be satisfied or waived or that other events will not intervene to delay, or result in a failure to close, the sale of DMG. In addition, either we or Optum may terminate the equity purchase agreement if, among other things, the sale has not been consummated by June 4, 2018 (subject to two three-month extensions that can be exercised by either party unilaterally). If the equity purchase agreement is terminated and our Board of Directors seeks an alternative transaction or another acquiror for the sale of the DMG business, we may not be able to negotiate a transaction with another party on terms comparable to, or better than, the terms of the equity purchase agreement with Optum.

If the sale of DMG is not completed for any reason, investor confidence could decline. A failed transaction may result in negative publicity and may affect our relationships with teammates, patients, physicians, payors, suppliers, regulators and other business partners. In addition, in the event of a failed transaction, we will have expended significant management resources in an effort to complete the sale, we have incurred additional debt in anticipation of receiving the sale proceeds but not have received the sale proceeds to repay such debt, and we will have incurred significant transaction costs, including legal fees, financial advisor fees and other related costs, without any commensurate benefit. Accordingly, if the proposed sale of DMG is not completed, or if there is a significant delay in completing the sale, our business, results of operations, financial condition and stock price may be materially adversely affected.

We may not be able to use the proceeds from the sale of DMG as planned or we may spend or invest the proceeds in ways that may not improve our results of operations or enhance the value of our common stock.

The purchase price for the sale of the DMG business is subject to customary adjustments, both upward and downward, which could be significant. We plan to use the proceeds from the sale of DMG for significant stock repurchases, to repay debt and for general corporate purposes, including growth investments. A number of factors may impact our ability to repurchase stock and the timing of any such stock repurchases, including market conditions, the price of our common stock, our cash flow position, leverage ratios, and legal, regulatory and contractual requirements and restrictions.

In addition, we may identify investments or other uses for the proceeds from the sale of DMG that we believe are more attractive than our current intended uses. Further, there can be no assurance that any investment of the proceeds from the sale of DMG will yield a favorable return.

Under the terms of the equity purchase agreement, we are subject to certain contractual restrictions while the sale of DMG is pending, and certain post-closing contractual obligations that, in some cases, could have a material adverse effect on our business, results of operations and financial condition.

Under the terms of the equity purchase agreement, we are subject to certain restrictions on the conduct of the DMG business prior to completing the sale of DMG, which may adversely affect our ability to execute certain of our business strategies, including the ability in certain cases to enter into or amend contracts, acquire or dispose of assets, incur indebtedness or incur capital expenditures. Such limitations could negatively affect our business and operations prior to the completion of the sale of DMG. Each of these risks may be exacerbated by delays or other adverse developments with respect to the completion of the sale of DMG.

In addition, we agreed to retain certain liabilities of the DMG business for which we have certain indemnification rights against the original 2012 HealthCare Partners ("HCP") sellers. An escrow was established in connection with our acquisition of the DMG business from the HCP sellers as security for these indemnification rights, including with respect to the OIG investigation into certain patient diagnosis coding practices. 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, which could have a material adverse effect on our business, results of operations and financial condition.

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

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

Approximately 33% of our dialysis services revenues for the year ended December 31, 2017 were generated from patients who have commercial payors (including hospital dialysis services) as their primary payor. The majority of these patients have insurance policies that pay us on terms and at rates that are generally significantly higher than Medicare rates. The payments we receive from commercial payors generate nearly all of our profit and all of our nonacute dialysis profits come from commercial payors. We continue to experience downward pressure on some of our commercial payment rates as a result of general conditions in the market, including as employers shift to less expensive options for medical services, recent and future consolidations among commercial payors, increased focus on dialysis services and other factors. In addition, many commercial payors that sell individual plans both on and off exchange have publicly announced losses in the marketplace. These payors may seek discounts on rates for marketplace plans on and off exchange. Commercial payment rates could be materially lower in the future.

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

A number of commercial payors have incorporated policies into their provider manuals limiting or refusing to accept charitable premium assistance from non-profit organizations, such as the American Kidney Fund, which may impact the number of patients who are able to afford commercial exchange plans. Paying for coverage is a significant financial burden for many patients, and ESRD disproportionately affects the low-income population. Charitable premium assistance supports continuity of coverage and access to care for patients, many of whom are unable to continue working full-time as a result of their severe condition. A material restriction in patients' ability to access charitable premium assistance may restrict the ability of dialysis patients to obtain and maintain optimal insurance coverage, and may adversely impact a large number of dialysis centers across the U.S. by making certain centers economically unviable, and may have a material adverse effect on our business, results of operations and financial condition.

We also believe commercial payors have or will begin to restructure their benefits to create disincentives for patients to stay with commercial insurance or to select or remain with out-of-network providers. In addition, payors may seek to decrease payment rates for out-of-network providers. Decreases in the number of patients with commercial plans, decreases in out-of-network rates and restrictions on out-of-network access, our turning away new patients in instances where we are unable to come to agreement on rates, or decreases in contracted rates could result in a significant decrease in our overall revenues derived from commercial payors. If the average rates that commercial payors pay us decline significantly, or if we see a decline in commercial patients, it would have a material adverse effect on our business, results of operations and financial condition. For additional details regarding specific risks we face regarding regulatory changes that could result in fewer patients covered under commercial plans or an increase of patients covered under more restrictive commercial plans with lower reimbursement rates, see the discussion in the risk factor under the heading "Healthcare reform could have a material adverse effect on our business, financial condition and results of operations."

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

Our revenue levels are sensitive to the percentage of our patients with higher-paying commercial insurance coverage. A patient's insurance coverage may change for a number of reasons, including changes in the patient's or a family member's employment status. Any changes impacting our highest paying commercial payors will have a disproportionate impact on us. In addition, many patients with commercial and government insurance rely on financial assistance from charitable organizations, such as the American Kidney Fund. Certain payors have challenged 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. CMS or another regulatory agency or legislative authority may issue a new rule or guidance that challenges charitable premium assistance. If any of these challenges to kidney patients' use of premium assistance are successful or restrictions are imposed on the use of financial assistance from such charitable organizations such that kidney patients are unable to obtain, or continue to receive or receive for a limited duration, such financial assistance, it could have a material adverse effect on our business, results of operations and financial condition. In addition, if our assumptions about how kidney patients will respond to any change in financial assistance from charitable organizations are incorrect, it could have a material adverse effect on our business, results of operations and financial condition.

When Medicare becomes the primary payor, the payment rate we receive for that patient decreases from the employer group health plan or commercial 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 and/or an increase in uninsured and underinsured patients. 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. Additionally, we continue to experience higher amounts of write-offs due to uninsured and underinsured patients, which has resulted in an increase in uncollectible accounts. Commercial payors could also cease paying in the primary position after providing 30 months of coverage resulting in a material reduction in payment as the patient moves to Medicare primary. 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 or a significant increase in the number of patients that are uninsured and underinsured, it would have a material adverse effect on our business, results of operations and financial condition.

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

Approximately 42% of our dialysis services revenues for the year ended December 31, 2017 were generated from patients who have Medicare as their primary payor. For patients with Medicare coverage, all ESRD payments for dialysis treatments are made under a single bundled payment rate which provides a fixed payment rate to encompass all goods and services provided during the dialysis treatment, including pharmaceuticals that were historically separately reimbursed to the

dialysis providers, such as EPO, vitamin D analogs and iron supplements, irrespective of the level of pharmaceuticals administered or additional services performed. Most lab services are also included in the bundled payment. Under the ESRD 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. In addition, the ESRD PPS is subject to rebasing, which can have a positive financial effect, or a negative one if the government fails to rebase in a manner that adequately addresses the costs borne by dialysis facilities. Similarly, as new drugs, services or labs are added to the ESRD bundle, CMS' failure to adequately calculate the costs associated with the drugs, services or labs could have a material adverse effect on our business, results of operations and financial condition.

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 PPS, which has been phasing in reductions to the PPS base rate mandated by the American Taxpayer Relief Act of 2012 as modified by the Protecting Access to Medicare Act of 2014.

- Risk that CMS, through its contracted MACs or otherwise, implements Local Coverage Determinations (LCDs) or other decisions that limit the frequency a provider can bill Medicare for home dialysis treatments or other rules that may impact reimbursement. Such coverage determinations could have an adverse impact on our revenue. There is also risk commercial insurers could incorporate the requirements or limitations associated with such LCDs into their contracted terms with dialysis providers, which could have an adverse impact on our revenue.

- Risk that a MAC, or multiple MACs, change their interpretations of existing regulations, manual provisions and/or guidance; or seek to implement or enforce new interpretations that are inconsistent with how we have interpreted existing regulations, manual provisions and/or guidance.

- 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, including increases in maintenance costs and capital expenditures to improve, renovate and maintain our facilities, equipment and information technology to meet changing regulatory requirements, 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 BBA, an annual 2% reduction to Medicare payments took effect on April 1, 2013 and has been extended through 2027. These across-the-board spending cuts have affected and will continue to adversely affect our business, results of operations and financial condition.

- Risk that, if our clinical systems fail to accurately capture the data we report to CMS in connection with claims for which at least part of the government's payments to us is based on clinical performance or patient outcomes or co-morbidities, we might be over-reimbursed by the government, which could subject us to certain liability. For example, CMS published a final rule that implemented a provision of the ACA, requiring providers to report and return Medicare and Medicaid overpayments within the later of (a) 60 days after the overpayment is identified, or (b) the date any corresponding cost report is due, if applicable. An overpayment impermissibly retained under this statute could subject us to liability under the FCA, exclusion, and penalties under the federal Civil Monetary Penalty statute.

For additional details regarding the risks we face for failing to adhere to our Medicare and Medicaid regulatory compliance obligations, see the risk factor above under the heading "If we fail to adhere to all of the complex government laws and regulations that apply to our business, we could suffer severe consequences that could have a material adverse effect on our business, results of operations, financial condition and stock price."

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

Approximately 25% of our dialysis services revenues for the year ended December 31, 2017 were generated from patients who have state Medicaid or other non-Medicare government-based programs, such as coverage through the Department of Veterans Affairs (VA), as their primary coverage. As state governments and other governmental organizations

face increasing budgetary pressure, we may in turn face reductions in payment rates, delays in the receipt of payments, limitations on enrollee eligibility or other changes to the applicable programs. For example, certain state Medicaid programs and the VA have recently considered, proposed or implemented payment rate reductions.

The VA adopted Medicare's bundled PPS pricing methodology for any veterans receiving treatment from non-VA providers under a national contracting initiative. Since we are a non-VA provider, these reimbursements are tied to a percentage of Medicare reimbursement, and we have exposure to any dialysis reimbursement changes made by CMS. Approximately 3% of our dialysis services revenues for the year ended December 31, 2017 were generated by the VA.

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

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

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

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

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

Additionally, as of January 1, 2018, calcimimetics entered the Medicare ESRD bundle. We implemented processes to provide the drug as required under the regulations and prescribed by physicians and have entered into agreements to provide for access to and distribution of the drug. If Medicare Advantage plans and/or Medicaid do not pay as required or the processes we have implemented to provide the drug do not perform as anticipated, then we could be subject to both financial and operational risk.

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

in the Medicare and Medicaid programs, and could have a material adverse effect on our business, results of operations and financial condition.

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

In October 2014, we entered into a Settlement Agreement with the United States and relator David Barbetta to resolve the then pending 2010 and 2011 U.S. Attorney physician relationship investigations and paid $406 million in settlement amounts, civil forfeiture, and interest to the United States and certain states. In connection with the resolution of these matters, and in exchange for the OIG's agreement not to exclude us from participating in the federal healthcare programs, we have entered into a five-year CIA with the OIG. The CIA (i) requires that we maintain certain elements of our compliance programs; (ii) imposes certain expanded compliance-related requirements during the term of the CIA; (iii) requires ongoing monitoring and reporting by an independent monitor, imposes certain reporting, certification, records retention and training obligations, allocates certain oversight responsibility to the Board's Compliance Committee, and necessitates the creation of a Management Compliance Committee and the retention of an independent compliance advisor to the Board; and (iv) contains certain business restrictions related to a subset of our joint venture arrangements, including our agreeing to (1) unwind 11 joint venture transactions that were created through partial divestitures to, or partial acquisitions from, nephrologists, and that cover 26 of our 2,119 clinics that existed at the time we entered into the Settlement Agreement, all of which have been completed, (2) not enter into certain types of partial divestiture joint venture transactions with nephrologists during the term of the CIA, (3) non-enforcement of certain patient-related non-solicitation restrictions, and (4) certain other restrictions. The costs associated with compliance with the CIA could be substantial and may be greater than we currently anticipate. In addition, in the event of a breach of the CIA, we could become liable for payment of certain stipulated penalties, and could be excluded from participation in federal healthcare programs. The OIG notified us that it considered us to be previously in breach of the CIA because of three implementation deficiencies. While we have remediated the deficiencies and have paid certain stipulated penalties, we cannot provide any assurances that we may not be found in breach of the CIA in the future. In general, the costs associated with compliance with the CIA, or any liability or consequences associated with a breach, could have a material adverse effect on our business, results of operations and financial condition. For our domestic dialysis business, we are required under the CIA to report to the OIG (i) probable violations of criminal, civil or administrative laws applicable to any federal health care program for which penalties or exclusions may be authorized under applicable laws and regulations; (ii) substantial overpayments of amounts of money we have received in excess of the amounts due and payable under the federal healthcare program requirements; and (iii) employment of or contracting with individuals ineligible from participating in the federal healthcare programs (we refer to these collectively as Reportable Events). We have provided the OIG notice of Reportable Events, and we may identify and report additional events in the future. If any of our operations are found to violate government laws and regulations, we could suffer severe consequences that could have a material adverse effect on our business, results of operations, financial condition and stock price, including those consequences described under the risk factor "If we fail to adhere to all of the complex government laws and regulations that apply to our business, we could suffer severe consequences that could have a material adverse effect on our business, results of operations, financial condition and stock price."

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

Before we can begin billing for patients treated in our outpatient dialysis centers who are enrolled in government-based programs, we are required to obtain state and federal certification for participation in the Medicare and Medicaid programs. As state agencies responsible for surveying dialysis centers on behalf of the state and Medicare program face increasing budgetary pressure, certain states are having difficulty keeping up with certifying dialysis centers in the normal course resulting in significant delays in certification. If state governments continue to have difficulty keeping up with certifying new centers in the normal course and we continue to experience significant delays in our ability to treat and bill for services provided to patients covered under government programs, it could cause us to incur write-offs of investments or accelerate the recognition of lease obligations in the event we have to close centers or our centers' operating performance deteriorates, and it could have an adverse effect on our business, results of operations and financial condition. Although the BBA passed in February 2018 allows for organizations approved by the Department of Health and Human Services (HHS) to accredit dialysis facilities and imposes certain timing requirements regarding the initiation of initial surveys to determine if certain conditions and requirements for payment have been satisfied, the ultimate impact of these changes cannot be predicted. In addition to certifications for Medicare and Medicaid, some states have licensing requirements for ESRD facilities. Delays in licensure, denials of licensure, or withdrawal of licensure could also adversely affect our business, results of operations and financial condition.

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

As of December 31, 2017, we owned a controlling interest in numerous dialysis-related joint ventures, which represented approximately 24% of our net U.S. dialysis and related lab services revenues for the year ended December 31, 2017. In addition, we also owned noncontrolling equity investments in several other dialysis related joint ventures. We may continue to increase the number of our joint ventures. Many of our joint ventures with physicians or physician groups also have certain physician owners providing medical director services to centers we own and operate. Because our relationships with physicians are governed by the federal and state anti-kickback statutes, we have sought to structure our joint venture arrangements to satisfy as many federal safe harbor requirements as we believe are commercially reasonable. However, although our joint venture arrangements do not satisfy all of the elements of any safe harbor under the federal Anti-Kickback Statute, they are not automatically prohibited under the federal Anti-Kickback Statute but are susceptible to government scrutiny. For example, in October 2014, we entered into a Settlement Agreement with the United States and relator David Barbetta to resolve the then pending 2010 and 2011 U.S. Attorney physician relationship investigations regarding certain of our joint ventures and paid $406 million in settlement amounts, civil forfeiture, and interest to the United States and certain states. For further details, see "If we fail to comply with our Corporate Integrity Agreement, we could be subject to substantial penalties and exclusion from participation in federal healthcare programs that could have a material adverse effect on our business, results of operations and financial condition".

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

There are significant risks associated with estimating the amount of U.S. 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 197,800 U.S. patients at any point in time, together with the changes in patient coverage that occur each month, requires complex, resource-intensive processes. Errors in determining the correct coordination of benefits may result in refunds to payors. Revenues associated with Medicare and Medicaid programs are also subject to estimating risk related to the amounts not paid by the primary government payor that will ultimately be collectible from other government programs paying secondary coverage, the patient's commercial health plan secondary coverage or the patient. Collections, refunds and payor retractions typically continue to occur for up to three years and longer after services are provided. We generally expect our range of U.S. dialysis and related lab services revenues estimating risk to be within 1% of net revenues for the segment. If our estimates of U.S. dialysis and related lab services revenues and related refund liabilities are materially inaccurate, it could impact the timing and the amount of our revenues recognition and have a material adverse impact on our business, results of operations and financial condition.

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

Our ancillary services and strategic initiatives are subject to many of the same risks, regulations and laws, as described in the risk factors related to our dialysis business set forth in this Part I, Item 1A, and are also subject to additional risks, regulations and laws specific to the nature of the particular strategic initiative. We expect to add additional service offerings to our business 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 in the expected timeframe or at all. 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 operations, are unsuccessful, it would have a negative impact on our business, results of operations and financial condition, and we may determine to exit that line of business. We could incur significant termination costs if we were to exit certain of these lines of business. In addition, we may incur a material write-off or an impairment of our investment, including goodwill, in one or more of our ancillary services or strategic initiatives. In that regard, we have taken, and may in the future take, impairment charges related to our ancillary services and strategic initiatives, including in our international and pharmacy businesses.

If a significant number of physicians were to cease referring patients to our dialysis centers, whether due to regulatory or other reasons, it would have a material adverse effect on our business, results of operations and financial condition.

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

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

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

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

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

We face increasing labor costs generally, and in particular, face 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. Furthermore, changes in certification requirements can impact our ability to maintain sufficient staff levels, including to the extent our teammates are not able to meet new requirements, among other things. In addition, if we experience a higher than normal turnover rate for our skilled clinical personnel, our operations and treatment growth may be negatively impacted, which could adversely affect our business, results of operations and financial condition.

In addition, currently pending and future proposed ballot initiatives or referendums, legislation or policy changes could cause us to incur substantial costs to challenge and, if implemented, impose additional requirements on our operations, including increases in the required staffing levels or staffing ratios for clinical personnel, minimum transition times between treatments, limits on how much patients may be charged for care, limitations as to the amount that can be spent on certain medical costs, and a ceiling on the percent of profit for such care. Changes such as these mandated by currently pending and future ballot initiatives or referendums, legislation or policy changes would likely materially reduce our revenues and increase our operating expense and impact our ability to staff our clinics to the new, elevated staffing levels, in particular given the ongoing nationwide shortage of healthcare workers, especially nurses. Any of these events or circumstances could materially reduce our revenues and increase our operating and other costs, require us to close dialysis centers or reduce shifts, and could have a material adverse effect on our employee relations, treatment growth, productivity, business, results of operations and financial condition.

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

Our business is labor intensive, and our financial and operating results have been and continue to be subject to variations in labor-related costs, productivity and the number of pending or potential claims against us related to labor and employment

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

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

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

Risk factors primarily related to DMG:

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

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

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

Approximately 83% of DMG's revenue for the year ended December 31, 2017 is derived from fixed per member per month (PMPM) fees paid by health plans under capitation agreements with DMG or its associated physician groups. While there are variations specific to each arrangement, DMG, through DaVita Health Plan of California, Inc. (DHPC), a subsidiary of HealthCare Partners Holdings, LLC and a restricted Knox-Keene licensed entity, and, in certain instances, DMG's associated physician groups generally contract with health plans to receive a PMPM fee for professional services and assume the financial responsibility for professional services only. In some cases, the health plans separately enter into capitation contracts with third parties (typically hospitals) who receive directly a PMPM fee and assume contractual financial responsibility for hospital services. In other cases, the health plan does not pay any portion of the PMPM fee to the hospital, but rather administers claims for hospital expenses itself. In both scenarios, DMG enters into managed care-related administrative services agreements or similar arrangements with those third parties (typically hospitals) under which DMG agrees to be responsible for utilization review, quality assurance, and other managed care-related administrative functions and claim payments. As compensation for such administrative services, DMG is entitled to receive a percentage of the amount by which the institutional capitation revenue received from health plans exceeds institutional expenses; any such risk-share amount to which DMG is entitled is recorded as medical revenues, and DMG is also responsible for a percentage of any short-fall in the event that institutional expenses exceed institutional revenues. To the extent that members require more care than is anticipated and/or the cost of care increases, aggregate fixed PMPM amounts, or capitation payments, may be insufficient to cover the costs associated with treatment. If medical costs and 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 costs and expenses and to make reasonable estimates and maintain adequate accruals for incurred but not reported claims, could have a material adverse effect on DMG's business, results of operations and financial condition.

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

- the health status of members;
- higher than expected utilization of new or existing healthcare services or technologies;
- an increase in the cost of healthcare services and supplies, including pharmaceuticals, whether as a result of inflation or otherwise;

- changes to mandated benefits or other changes in healthcare laws, regulations and practices;
- periodic renegotiation of provider contracts with specialist physicians, hospitals and ancillary providers;
- periodic renegotiation of contracts with DMG's affiliated primary care physicians and specialists;
- changes in the demographics of the participating members and medical trends;
- contractual or claims disputes with providers, hospitals or other service providers within a health plan's network;
- the occurrence of catastrophes, major epidemics or acts of terrorism; and
- the reduction of health plan premiums.

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

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

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

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

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

DMG's financial statements are consolidated in accordance with applicable accounting standards and include the accounts of its majority-owned subsidiaries and certain non-owned DMG-associated and managed physician groups. Such consolidation for accounting and/or tax purposes does not, is not intended to, and should not be deemed to, imply or provide to DMG any control over the medical or clinical affairs of such physician groups. In the event of a change in accounting standards promulgated by FASB or in interpretation of its standards, or if there is an adverse determination by a regulatory agency or a court, or a change in state or federal law relating to the ability to maintain present agreements or arrangements with such

physician groups, DMG may not be permitted to continue to consolidate the total revenues of such organizations. A change in accounting for consolidation with respect to DMG's present agreement or arrangements would diminish DMG's reported revenues but would not be expected to materially and adversely affect its reported results of operations, while regulatory or legal rulings or changes in law interfering with DMG's ability to maintain its present agreements or arrangements could materially diminish both revenues and results of operations.

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

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

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

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

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

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

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

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

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

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

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

We took impairment charges against the goodwill of several of our DMG reporting units in five of the nine quarters since the fourth quarter of 2015 based on continuing developments in our DMG business, including recent annual updates to Medicare Advantage benchmark reimbursement rates, changes in our expectations concerning future government reimbursement rates and our expected ability to mitigate them, medical cost and utilization trends, commercial pricing pressures, commercial membership rates, underperformance of certain at-risk reporting units and other market factors. We may also need to take additional impairment charges against earnings in a future period, depending on the impact of continuing developments on the value of our DMG business. Specifically, if DMG's fair value less the costs incurred in the sale of DMG falls below its carrying amount, we may need to recognize additional impairment charges on this business, and the amount of such charges, if any, could be significant. Our estimates of the fair value of this business rely on certain estimates and assumptions, including the terms and pricing agreed for the sale of this business, as well as applicable market multiples, discount and long-term growth rates, market data and future reimbursement rates, as applicable. Our estimates of the fair value of the DMG business could differ from the actual value that a market participant would pay for this business.

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

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

- Medicare Advantage benchmarks for 2011 were frozen at 2010 levels. From 2012 through 2016, Medicare Advantage benchmark rates were phased down from prior levels. The new benchmarks were fully phased-in in 2017 and range between 95% and 115% of the Medicare FFS costs, depending on a plan's geographic area. If our costs escalate faster than can be absorbed by the level of revenues implied by these benchmark rates, then it could have a material adverse effect on DMG's business and results of operations.

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

- The Secretary of the HHS has been granted the explicit authority to deny Medicare Advantage plan bids that propose significant increases in cost sharing or decreases in benefits. If the bids submitted by plans contracted with DMG are denied, this could have a material adverse effect on DMG's business and results of operations.

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

- Prescription drug plans are required to provide coverage of certain drug categories on a list developed by the Secretary of HHS, which could increase the cost of providing care to Medicare Advantage enrollees, and thereby reduce DMG's revenues and earnings. The Medicare Part D premium amount subsidized for high-income beneficiaries has been reduced, which could lower the number of Medicare Advantage enrollees, which would have a negative impact on DMG's business and results of operations.

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

Recent legislative and executive efforts to enact further healthcare reform legislation have caused the future state of the exchanges, other ACA reforms, and many core aspects of the current U.S. health care system to be unclear. For example, in October 2017, the federal government announced that cost-sharing reduction payments to insurers would end, effective immediately, unless Congress appropriated the funds, and, in December 2017, Congress passed the Tax Cuts and Jobs Act, which includes a provision that eliminates the penalty under the ACA's individual mandate and could impact the future state of the exchanges. Further, in February 2018, Congress passed the BBA which, among other things, repealed the Independent Payment Advisory Board that was established by the ACA and intended to reduce the rate of growth in Medicare spending. While certain provisions of the BBA may increase the scope of benefits available for certain chronically ill Federal health care program beneficiaries beginning in 2020, the ultimate impact of such changes cannot be predicted. While specific changes and their timing are not yet apparent, enacted reforms and future legislative, regulatory, or executive changes could have a material adverse effect on DMG's business, results of operations and financial condition.

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

According to the Kaiser Family Foundation (KFF), Medicare Advantage enrollment continues to be highly concentrated among a few payors, both nationally and in local regions. In 2017, the KFF reported that three payors together accounted for more than half of Medicare Advantage enrollment and eight firms accounted for approximately 75% of the lives. In 441 counties in 2018, only one company will offer Medicare Advantage plans. Consolidation among Medicare Advantage plans in certain regions, or the Medicare program's failure to attract additional plans to participate in the Medicare Advantage program, could have a material adverse effect on DMG's business, results of operations and financial condition.

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

For the year ended December 31, 2017, 68% of DMG's consolidated capitated medical revenues were earned through contracts with three health plans.

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

Notwithstanding each health plan's and DMG's current shared interest in providing service to DMG's members who are enrolled in the subject health plans, the health plans may have different and, at times, opposing economic interests from those of DMG. The health plans provide a wide range of health insurance services across a wide range of geographic regions, utilizing a vast network of providers. As a result, they and DMG may have different views regarding the proper pricing of services and/or the proper pricing of the various service providers in their provider networks, the cost of which DMG bears to the extent that the services of such service providers are utilized. These health plans may also have different views than DMG regarding the efforts and expenditures that they, DMG, and/or other service providers should make to achieve and/or maintain various quality ratings. In addition, several health plans have acquired or announced their intent to acquire provider organizations. If health plans with which DMG contracts acquire a significant number of provider organizations, they may not continue to contract with DMG or contract on less favorable terms or seek to prevent DMG from acquiring or entering into arrangements with certain providers. Similarly, as a result of changes in laws, regulations, consumer preferences, or other factors, the health plans may find it in their best interest to provide health insurance services pursuant to another payment or reimbursement structure. In the event DMG's interests diverge from the interests of the health plans, DMG may have limited recourse or alternative options in light of its dependence on these health plans. There can be no assurances that DMG will continue to find it mutually beneficial to work with these health plans. As a result of various restrictive provisions that appear in some of the managed care agreements with health plans, DMG may at times have limitations on its ability to cancel an

agreement with a particular health plan and immediately thereafter contract with a competing health plan with respect to the same service area.

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

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

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

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

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

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

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

Given each health plan's control of its plans and the many other providers that serve such plans, DMG believes that it will have limited ability to influence the overall quality rating of any such plan. The BBA passed in February 2018 implements certain changes to prevent artificial inflation of star ratings for Medicare Advantage plans offered by the same organization. In addition, CMS has terminated 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. Although CMS' authority to terminate plans solely for failing to achieve the minimum quality star ratings has been suspended through the end of plan year 2018, low quality ratings can still potentially lead to the termination of a plan that DMG serves, DMG may not be able to prevent the potential termination of a contracting plan or a shift of patients to other plans based upon quality issues which could, in turn, have a material adverse effect on DMG's business, results of operations and financial condition.

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

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

In June 2015, we received a subpoena from the OIG requesting information relating to our and our subsidiaries' (including DMG's and its subsidiary JSA's) provision of services to Medicare Advantage plans and related patient diagnosis coding and risk adjustment submissions and payments. See "Item 3. Legal Proceedings" in Part I of this report and Note 16 to the consolidated financial statements included in this report for further details and discussions of legal proceedings elsewhere in these Risk Factors.

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

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

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

Separately, as described in further detail in "Item 3. Legal Proceedings" in Part I of this report and Note 16 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. See also discussions of legal proceedings elsewhere in these Risk Factors.

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

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

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

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

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

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

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

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

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

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

disrupted by the financial insolvency of a large provider group. Any disruption in DMG's provider networks could result in a loss of members or higher healthcare costs.

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

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

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

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

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

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

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

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

DMG maintains primary professional liability insurance and other insurance coverage through California Medical Group Insurance Company, Risk Retention Group, an Arizona corporation in which DMG is the majority owner, and through excess coverage contracted through third-party insurers. DMG believes such insurance is adequate based on its review of what it believes to be all applicable factors, including industry standards. Nonetheless, potential liabilities may not be covered by insurance, insurers may dispute coverage or may be unable to meet their obligations, the amount of insurance coverage and/or related reserves may be inadequate, or the amount of any DMG self-insured retention may be substantial. There can be no

assurances that DMG will be able to obtain insurance coverage in the future, or that insurance will continue to be available on a cost-effective basis, if at all. Moreover, even if claims brought against DMG are unsuccessful or without merit, DMG would have to defend itself against such claims. The defense of any such actions may be time-consuming and costly and may distract DMG management's attention. As a result, DMG may incur significant expenses and may be unable to effectively operate its business.

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

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

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

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

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

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

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

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

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

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

Risk factors related to ownership of our common stock:

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

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

Most of our outstanding employee stock-based compensation awards include a provision accelerating the vesting of the awards in the event of a change of control. We also maintain a change of control protection program for our employees who do not have a significant number of stock awards, which has been in place since 2001, and which provides for cash bonuses to the employees in the event of a change of control. Based on the market price of our common stock and shares outstanding on December 31, 2017, these cash bonuses would total approximately $521 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 two leased locations consisting of 164,800 square feet. 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 three buildings located in 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 2036 for Kidney Care and through the year 2037 for DMG.

For our U.S. dialysis and related lab services business we own the land and buildings for 14 of our outpatient dialysis centers. We also own 14 separate land and buildings and seven land parcels for development. We lease a total of four 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 23 of our clinics. We also 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 700 to 33,000 square feet, with an average size of approximately 7,600 square feet. DMG's clinics range in size from approximately 1,000 to 136,000 square feet, with an average size of approximately 10,200 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, *qui tam* suits, governmental investigations and audits (including investigations resulting from our obligation to self-report suspected violations of law) and other legal proceedings. We record accruals for certain legal proceedings and regulatory matters to the extent that we determine an unfavorable outcome is probable and the amount of the loss can be reasonably estimated. As of December 31, 2017 and December 31, 2016, our total recorded accruals, including DMG, with respect to legal proceedings and regulatory matters, net of anticipated third party recoveries, were approximately $6 million and $69 million, respectively. While these accruals reflect our best estimate of the probable loss for those matters as of the dates of those accruals, the recorded amounts may differ materially from the actual amount of the losses for those matters, and any anticipated third party recoveries for any such losses may not ultimately be recoverable. Additionally, in some cases, no estimate of the possible loss or range of loss in excess of amounts accrued, if any, can be made because of the inherently unpredictable nature of legal proceedings and regulatory matters, which also may be impacted by various factors, including that they may involve indeterminate claims for monetary damages or may involve fines, penalties or non-monetary remedies; present novel legal theories or legal uncertainties; involve disputed facts; represent a shift in regulatory policy; are in the early stages of the proceedings; or result in a change of business practices. Further, there may be various levels of judicial review available to us in connection with any such proceeding.

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

Inquiries by the Federal Government and Certain Related Civil Proceedings

Swoben Private Civil Suit: On July 13, 2009, pursuant to the *qui tam* provisions of the federal FCA and the California False Claims Act, James M. Swoben, as relator, filed his initial *qui tam* action in the United States District Court for the Central District of California purportedly on behalf of the United States of America and the State of California against SCAN, and certain other defendants whose identities were under seal. In April 2013, HealthCare Partners (HCP), now known as our DMG subsidiary, was one of several defendants served with a civil complaint filed by a former employee of SCAN Health Plan (SCAN), an HMO. The allegations in the complaint relate to alleged overpayments received from government healthcare programs, including allegations of violations of the federal FCA and the California False Claims Act and allegations against HCP relating to patient diagnosis coding. The complaint sought monetary damages and civil penalties as well as costs and expenses. On October 18, 2017, the relator filed a Notice of Dismissal of the action as to HCP, and the government consented to the dismissal, as a result of which the suit is now dismissed, without prejudice.

2015 U.S. Office of Inspector General (OIG) Medicare Advantage Civil Investigation: In March 2015, JSA HealthCare Corporation (JSA), a subsidiary of DMG, received a subpoena from the Office of Inspector General (OIG) for the U.S. Department of Health and Human Services (HHS) requesting documents and information for the period from January 1, 2008

through December 31, 2013, for certain Medicare Advantage (MA) plans for which JSA provided services. It also requests information regarding JSA's communications about patient diagnoses as they relate to certain MA plans generally, and more specifically as related to two Florida physicians with whom JSA previously contracted. We are producing the requested information and are cooperating with the government's investigation.

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

2016 U.S. Attorney Prescription Drug Investigation: In early February 2016, we announced that our pharmacy services' wholly-owned subsidiary, DaVita Rx, received a Civil Investigative Demand (CID) from the U.S. Attorney's Office for the Northern District of Texas. The government is conducting an FCA investigation concerning allegations that DaVita Rx presented or caused to be presented false claims for payment to the government for prescription medications, as well as into our relationship with pharmaceutical manufacturers. The CID covers the period from January 1, 2006 through the present. In the spring of 2015, we initiated an internal compliance review of DaVita Rx during which we identified potential billing and operational issues, including potential write-offs and discounts of patient co-payment obligations, and credits to payors for returns of prescription drugs related to DaVita Rx. We notified the government in September 2015 that we were conducting this review of DaVita Rx and began providing regular updates of our review. Upon completion of our review, we filed a self-disclosure with the OIG in February 2016 and we have been working to address and update the practices we identified in the self-disclosure, some of which overlap with information requested by the U.S. Attorney's Office. The OIG informed us in February 2016 that our submission was not accepted. They indicated that the OIG is not expressing an opinion regarding the conduct disclosed or our legal positions. In connection with our ongoing efforts working with the government we learned that a *qui tam* complaint had been filed covering some of the issues in the CID and our self-disclosure. In December 2017, we finalized and executed a settlement agreement with the government and relators in the *qui tam* matter that included total monetary consideration of $63.7 million, as previously announced, of which $41.5 million was an incremental cash payment and $21.2 million was for amounts previously refunded, and all of which was previously accrued. The government's investigation into our relationship with pharmaceutical manufacturers is ongoing and we are continuing to cooperate with the government in this investigation.

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

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

other federal health care programs and, if criminal proceedings were initiated against us, possible criminal penalties, any of which could have a material adverse effect on us.

Shareholder Claims

Peace Officers' Annuity and Benefit Fund of Georgia Securities Class Action Civil Suit: On February 1, 2017, the Peace Officers' Annuity and Benefit Fund of Georgia filed a putative federal securities class action complaint in the U.S. District Court for the District of Colorado against us and certain executives. The complaint covers the time period of August 2015 to October 2016 and alleges, generally, that we and our executives violated federal securities laws concerning our financial results and revenue derived from patients who received charitable premium assistance from an industry-funded non-profit organization. The complaint further alleges that the process by which patients obtained commercial insurance and received charitable premium assistance was improper and "created a false impression of DaVita's business and operational status and future growth prospects." In November 2017, the court appointed the lead plaintiff and an amended complaint was filed on January 12, 2018. Our response is due March 13, 2018. We dispute these allegations and intend to defend this action accordingly.

In re DaVita Inc. Stockholder Derivative Litigation: On August 15, 2017, the U.S. District Court for the District of Delaware consolidated the three previously disclosed shareholder derivative lawsuits: the Blackburn Shareholder action filed on February 10, 2017, the Gabilondo Shareholder action filed on May 30, 2017, and the City of Warren Police and Fire Retirement System Shareholder action filed on June 9, 2017. The complaint covers the time period from 2015 to present and alleges, generally, breach of fiduciary duty, unjust enrichment, abuse of control, gross mismanagement, corporate waste, and misrepresentations and/or failures to disclose certain information in violation of the federal securities laws in connection with an alleged practice to direct patients with government-subsidized health insurance into private health insurance plans to maximize our profits. An amended complaint was filed in September 2017, and on December 18, 2017 we filed a motion to dismiss and a motion to stay proceedings in the alternative. We dispute these allegations and intend to defend this action accordingly.

Other Proceedings

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

* * *

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" in Part I of this report or the timing of their resolution or the ultimate losses or impact of developments in those matters, which could have a material adverse effect on our revenues, earnings and cash flows. Further, any legal proceedings or regulatory matters we are involved in, whether meritorious or not, are time consuming, and often require management's attention and result in significant legal expense, and may result in the diversion of significant operational resources, or otherwise harm our business, financial results or reputation.

Item 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, 2017:		
1st quarter	$ 70.14	$ 62.24
2nd quarter	70.16	61.48
3rd quarter	66.64	55.59
4th quarter	72.93	52.51
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

The closing price of our common stock on January 31, 2018 was $78.04 per share. According to Computershare, our registrar and transfer agent, as of January 31, 2018, there were 9,207 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 2017:

Period	Total Number of Shares Purchased	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs[1]	Approximate Dollar Value of Shares that May Yet Be Purchased Under the Plans or Programs (in millions)
October 1 - October 31, 2017	5,457,839	$ 59.90	5,457,839	$ 1,254.3
November 1 - November 30, 2017	431,645	$ 60.10	431,645	$ 1,228.4
December 1 - December 31, 2017	1,520,365	$ 71.87	1,520,365	$ 1,119.1
Total	7,409,849	$ 62.37	7,409,849	$ 1,119.1

(1) On October 10, 2017, our Board of Directors approved an additional share repurchase authorization in the amount of $1.3 billion. This share repurchase authorization was in addition to the $247 million remaining at that time under our Board of Directors' prior share repurchase authorization announced in July 2016. We are authorized to make purchases from time to time in the open market or in privately negotiated transactions, including without limitations, through accelerated share repurchase transactions, derivative transactions, tender offers, Rule 10b5-1 plans or any combination of the foregoing, depending upon market conditions and other considerations. During the quarter ended December 31, 2017, we repurchased a total of 7,409,849 shares of our common stock for approximately $462 million at an average price of $62.37 per share. As of February 22, 2018, we have a total of $1.0 billion remaining in Board authorizations available for share repurchases under our repurchase programs. Although these share repurchase authorizations have no expiration dates, we are subject to share repurchase limitations under the terms of our 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.

	Year ended December 31,				
	2017	2016	2015	2014	2013
	(in thousands, except share data)				
Income statement data:					
Net revenues	$ 10,876,634	$ 10,707,467	$ 9,982,245	$ 9,312,049	$ 8,580,225
Operating expenses and charges[2]	9,063,879	8,677,757	8,845,479	7,711,891	7,464,599
Operating income	1,812,755	2,029,710	1,136,766	1,600,158	1,115,626
Debt expense	(430,634)	(414,116)	(408,380)	(410,223)	(429,938)
Debt refinancing and redemption charges	—	—	(48,072)	(97,548)	—
Other income, net	17,665	7,511	8,073	1,935	6,750
Income from continuing operations before income taxes	1,399,786	1,623,105	688,387	1,094,322	692,438
Income tax expense[3]	323,859	431,761	207,510	366,894	246,795
Net income from continuing operations	1,075,927	1,191,344	480,877	727,428	445,643
Net (loss) income from discontinued operations, net of tax[4]	(245,372)	(158,262)	(53,467)	135,902	298,182
Gain on disposal of discontinued operations, net of tax[4]	—	—	—	—	13,375
Net income	830,555	1,033,082	427,410	863,330	757,200
Less: Net income attributable to noncontrolling interests	(166,937)	(153,208)	(157,678)	(140,216)	(123,755)
Net income attributable to DaVita Inc.	$ 663,618	$ 879,874	$ 269,732	$ 723,114	$ 633,445
Basic income from continuing operations per share attributable to DaVita Inc.[5]	$ 4.78	$ 5.12	$ 1.53	$ 2.77	$ 1.53
Diluted income from continuing operations per share attributable to DaVita Inc.[5]	$ 4.71	$ 5.04	$ 1.49	$ 2.71	$ 1.50
Weighted average shares outstanding:[5]					
Basic	188,626,000	201,641,000	211,868,000	212,302,000	209,939,000
Diluted	191,349,000	204,905,000	216,252,000	216,928,000	214,764,000
Ratio of earnings to fixed charges[6]	2.94:1	3.49:1	1.93:1	2.72:1	2.01:1
Balance sheet data:					
Working capital[1]	$ 5,703,181	$ 1,283,784	$ 2,104,143	$ 1,547,518	$ 600,789
Total assets[1]	$ 18,948,193	$ 18,755,776	$ 18,524,224	$ 17,624,137	$ 16,614,893
Long-term debt[1]	$ 9,158,018	$ 8,944,676	$ 12,972,282	$ 8,298,624	$ 8,064,196
Total DaVita Inc. shareholders' equity[5]	$ 4,690,029	$ 4,648,047	$ 4,870,781	$ 5,170,513	$ 4,432,480

(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. All periods prior to 2015 have been recast to conform to the revised presentation.

(2) Operating expenses and charges in 2017 includes goodwill impairment charges of $34,696 related to our vascular access reporting unit, an equity investment loss of $6,293 for goodwill impairments at our APAC JV, an impairment on our investment in the APAC JV of $280,066, an asset impairment of $15,168 related to the restructuring of our pharmacy business, restructuring charges related to our international business of $2,700, a net gain on settlement of $529,504 and a gain adjustment on the 2016 ownership change of our APAC JV of $6,273. Operating expenses and charges in 2016 included goodwill impairment charges of $28,415 related to our vascular access reporting unit, an impairment of an investment of $14,993, an estimated gain on the ownership change of our APAC JV of $374,374, and an estimated accrual for certain legal matters of $15,770. Operating expenses and charges for 2015 included a settlement charge of $495,000 related to a private civil suit, goodwill impairment charges of $4,066 related to our international business, and an estimated accrual for certain legal matters of $22,530. Operating expenses and charges in 2014 and 2013 included 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.

(3) Tax expense includes a net tax benefit of $251,510 related to U.S. tax legislation passed in December 2017.

(4) On December 5, 2017, we entered into an equity purchase agreement to sell our DMG division to Collaborative Care Holdings, LLC (Optum), a subsidiary of UnitedHealth Group Inc. As a result of this pending transaction, the DMG business has been reclassified as held for sale and its results of operations are reported as net (loss) income from discontinued operations, net of tax for all periods presented. Net (loss) income from discontinued operations, net of tax, also includes HomeChoice Partners Inc. (HomeChoice) which was divested on February 1, 2013. Net (loss) income from discontinued operations, net of tax, in 2017 includes estimated goodwill impairment charges of $651,659 related to certain DMG reporting units, a net tax benefit of $163,555 due to a remeasurement of deferred taxes resulting from DMG's reclassification to held for sale, a non-cash gain associated with our Magan acquisition of $17,129, restructuring charges of $9,569, and a reduction in estimated accruals for legal matters of $14,700. Net (loss) income from discontinued operations, net of tax, in 2016 included goodwill impairment charges of $253,000 related to certain DMG reporting units, a gain related to the partial sale of our interest in Tandigm of $40,280, a loss on the DMG Arizona sale of $10,489, an adjustment to reduce receivables associated with the DMG acquisition escrow provision relating to income tax items of $30,934, and estimated accruals for legal matters of $16,000. Net (loss) income from discontinued operations, net of tax, in 2015 included estimated goodwill and other intangible asset impairment charges of $206,169 related to certain DMG reporting units. Net (loss) income from discontinued operations, net of tax, in 2013 includes contingent earn-out obligation, a 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.

(5) In the third quarter of 2013, the Board of Directors approved a two-for-one 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. Share repurchases consisted of 12,966,672 shares of common stock for $810,949 in 2017, 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. No repurchases of common stock were made in 2014 or 2013. Shares issued in connection with stock awards were 514,091 in 2017, 1,011,328 in 2016, 1,479,217 in 2015, 2,179,766 in 2014, and 1,928,137 in 2013.

(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 may include statements regarding our future operations, financial condition and prospects, such as expectations for treatment growth rates, revenue per treatment, expense growth, levels of the provision for uncollectible accounts receivable, operating income, cash flow, operating cash flow, estimated tax rates, estimated charges and accruals, capital expenditures, the development of new dialysis centers and dialysis center acquisitions, government and commercial payment rates, revenue estimating risk and the impact of our level of indebtedness on our financial performance, and including earnings per share. These statements involve substantial known and unknown risks and uncertainties that could cause our actual results to differ materially from those described in the forward-looking statements, including risks resulting from the concentration of profits generated by higher-paying commercial payor plans for which there is continued downward pressure on average realized payment rates, and a reduction in the number of patients under such plans, including as a result of restrictions or prohibitions on the use and/or availability of charitable premium assistance, which may result in the loss of revenues or patients, or our making incorrect assumptions about how our patients will respond to any change in financial assistance from charitable organizations; the extent to which the ongoing implementation of healthcare exchanges or changes in or new legislation, regulations or guidance, or enforcement thereof, including among other things those regarding the exchanges, results in a reduction in reimbursement rates for our services from and/or the number of patients enrolled in higher-paying commercial plans; a reduction in government payment rates under the Medicare End Stage Renal Disease program or other government-based programs; the impact of the Medicare Advantage benchmark structure; risks arising from potential and proposed federal and/or state legislation or regulation, including healthcare-related and labor-related legislation or regulation, that could have a material adverse effect on our operations and profitability; the impact of the changing political environment and related developments on the current health care marketplace and on our business, including with respect to the future of the Affordable Care Act, the exchanges and many other core aspects of the current health care marketplace; uncertainties related to the impact of federal tax reform legislation; changes in pharmaceutical or anemia management practice patterns, payment policies, or pharmaceutical pricing; legal compliance risks, including our continued compliance with complex government regulations and the provisions of our current Corporate Integrity Agreement (CIA) and current or potential investigations by various government entities and related government or private-party proceedings, and restrictions on our business and operations required by our corporate integrity agreement and other current or potential settlement terms, and the financial impact thereof and our ability to recover any losses related to such legal matters from third parties; continued increased competition from large- and medium-sized dialysis providers that compete directly with us; our ability to reduce administrative expenses while maintaining targeted levels of service and operating performance, including our ability to achieve anticipated savings from our recent restructurings; our ability to maintain contracts with physician medical directors, changing affiliation models for physicians, and the emergence of new models of care introduced by the government or private sector, that may erode our patient base and reimbursement rates, such as accountable care organizations (ACOs), independent practice associations (IPAs) and integrated delivery systems; our ability to complete acquisitions, mergers or dispositions that we might announce or be considering, on terms favorable to us or at all, or to integrate and successfully operate any business we may acquire or have acquired, or to successfully expand our operations and services to markets outside the United States, or to businesses outside of dialysis; noncompliance by us or our business associates with any privacy laws or any security breach involving the misappropriation, loss or other unauthorized use or disclosure of confidential information; the variability of our cash flows; factors that may impact our ability to repurchase stock under our stock repurchase program and the timing of any such stock repurchases, including market conditions, the price of our common stock, our cash flow position and leverage ratios, and legal, regulatory and contractual requirements; the risk that we might invest material amounts of capital and incur significant costs in connection with the growth and development of our international operations, yet we might not be able to operate them profitably anytime soon, if at all; risks arising from the use of accounting estimates, judgments and interpretations in our financial statements; impairment of our goodwill, investments or other assets; the risks and uncertainties associated with the timing, conditions and receipt of regulatory approvals and satisfaction of other closing conditions of the DMG sale transaction, potential disruption in connection with the DMG sale transaction making it more difficult to maintain business and operational relationships, and uncertainties related to our use of proceeds from the DMG sale transaction, including our ability to repurchase stock; the risk that laws regulating the corporate practice of medicine could restrict the manner in which DMG conducts its business; the risk that the cost of providing services under DMG's agreements may exceed our compensation; the risk that reductions in reimbursement rates, including Medicare Advantage rates, and future regulations may negatively impact DMG's business, revenue and profitability; the risk that DMG may not be able to successfully establish a presence in new geographic regions or successfully address competitive threats that could reduce its profitability; the risk that a disruption in DMG's healthcare provider networks could have an adverse effect on DMG's business operations and profitability; the risk that

reductions in the quality ratings of health maintenance organization plan customers of DMG could have an adverse effect on DMG's business; the risk that health plans that acquire health maintenance organizations may not be willing to contract with DMG or may be willing to contract only on less favorable terms; and the other risk factors set forth in Part I, Item 1A. of this Annual Report on Form 10-K. We base our forward-looking statements on information currently available to us, and we undertake no obligation to update or revise any forward-looking statements, whether as a result of changes in underlying factors, new information, future events or otherwise.

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

Company overview

The Company has consisted 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 and 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.

On December 5, 2017, we entered into an equity purchase agreement to sell our DMG division to Collaborative Care Holdings, LLC (Optum), a subsidiary of UnitedHealth Group Inc. The transaction is expected to close in 2018 and is subject to regulatory approval and other customary closing conditions. As a result of this pending transaction, the DMG business is classified as held for sale and its results of operations are reported as discontinued operations. In addition, prior periods' presentation has been revised to conform to current year presentation and DMG is not included in our Management's Discussion and Analysis below.

The overall financial performance of our U.S. dialysis and related lab services in 2017 benefited from increased treatment volume from acquired and non-acquired growth and cost control initiatives in our dialysis business. This was partially offset by an increase in labor costs and other center related costs.

Some of our major accomplishments and financial operating performance indicators in 2017 and year over year were as follows:

- improved clinical outcomes in our U.S. dialysis operations, including the fifth consecutive year as a leader in CMS' Quality Incentive Program;
- consolidated net revenue growth of 1.6%, which included 2.4% total net revenue growth in our U.S. dialysis segment, despite a decrease of $5 in average dialysis net patient service revenue per treatment;
- solid performance in our normalized non-acquired U.S. dialysis treatment growth of 3.5%, which contributed to an increase of approximately 4.1% in the overall number of U.S. dialysis treatments;
- a net increase of 160 U.S. dialysis centers, including dialysis centers from the Renal Ventures acquisition, and a net increase of 83 international dialysis centers;
- an increase in our overall number of patients we serve in the U.S. of approximately 5.4% in 2017;
- a decrease in U.S. dialysis and lab related services patient care costs of approximately $2 per treatment and a decrease in general and administrative expenses of approximately $1 per treatment; and
- consolidated operating cash flows of $1.9 billion, or $1.6 billion from continuing operations, which included the net VA settlement of $332 million.

We believe 2018 will be challenging. We continue to expect clinical costs to increase due to inflation and a tight labor market and we do not foresee an opportunity to offset these pressures with productivity improvements. With labor cost inflation continuing to outpace Medicare reimbursement, we anticipate that margins on our Medicare business will continue to experience pressure. In addition, we will experience an increase in benefit costs as we transition to a 401(k) plan match program as our 2017 benefit costs did not include a comparable expense. In 2018 we also anticipate additional reimbursement pressure on our pharmacy business. We remain committed to our plans for international expansion in certain regions, which will continue to require investment. We anticipate that these challenges will be partially offset in 2018 by the expected reduction in income taxes as a result of recent U.S. tax reform legislation. In addition, in connection with our previously announced capital allocation strategy, in 2018 we plan to continue our evaluation of strategic alternatives for various assets in our portfolio.

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

	Year ended December 31,					
	2017		2016		2015	
	(dollars in millions)					
Net revenues:						
Dialysis and related lab patient service revenues	$ 10,094		$ 9,727		$ 9,155	
Less: Provision for uncollectible accounts	(485)		(431)		(413)	
Net dialysis and related lab patient service revenues	9,608		9,296		8,743	
Other revenues	1,268		1,411		1,240	
Total net consolidated revenues	10,877	100 %	10,707	100 %	9,982	100 %
Operating expenses and charges:						
Patient care costs	7,640	70 %	7,432	69 %	6,856	69 %
General and administrative	1,064	10 %	1,073	10 %	1,031	10 %
Depreciation and amortization	560	5 %	509	5 %	464	5 %
Provision for uncollectible accounts	(7)	— %	12	— %	9	— %
Equity investment loss (income)	9	— %	(17)	— %	(14)	— %
Investment and other asset impairments	295	3 %	15	— %	—	— %
Goodwill impairment charges	36	— %	28	— %	4	— %
Gain on changes in ownership interests	(6)	— %	(374)	(3)%	—	— %
Gain on settlement, net	(527)	(5)%	—	— %	—	— %
Settlement charge	—	— %	—	— %	495	5 %
Total operating expenses and charges	9,064	83 %	8,678	81 %	8,845	89 %
Operating income	$ 1,813	17 %	$ 2,030	19 %	$ 1,137	11 %

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

The following table summarizes our consolidated net revenues among our reportable segments:

	Year ended December 31,		
	2017	2016	2015
	(dollars in millions)		
Net revenues:			
U.S. dialysis and related lab patient service revenues	$ 9,822	$ 9,551	$ 9,034
Less: Provision for uncollectible accounts	(482)	(430)	(406)
U.S. dialysis and related lab net patient service revenues	9,340	9,121	8,628
Other revenues	20	17	14
Total net U.S. dialysis and related lab services revenues	9,360	9,138	8,642
Other-ancillary services and strategic initiatives other revenues	1,273	1,420	1,248
Other-ancillary services and strategic initiatives net patient service revenues (less provision for uncollectible accounts)	323	202	134
Total net other-ancillary services and strategic initiatives revenues	1,596	1,621	1,382
Total net segment revenues	10,956	10,759	10,024
Elimination of intersegment revenues	(80)	(52)	(42)
Consolidated net revenues	$ 10,877	$ 10,707	$ 9,982

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

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

	Year ended December 31,		
	2017	2016	2015
	(dollars in millions)		
U.S. dialysis and related lab services	$ 2,297	$ 1,777	$ 1,260
Other — ancillary services and strategic initiatives	(439)	267	(104)
Total segment operating income	1,858	2,044	1,156
Reconciling corporate items:			
Corporate administrative support	(45)	(14)	(19)
Consolidated operating income	$ 1,813	$ 2,030	$ 1,137
Reconciliation of non-GAAP measure:			
Goodwill impairment charges	35	28	4
Equity investment loss related to APAC JV goodwill impairment	6	—	—
Impairment of investment	280	15	—
Impairment of assets	15	—	—
Restructuring charges	2	—	—
Equity investment loss related to restructuring charges	1	—	—
Gain on settlement, net	(527)	—	—
Equity investment income related to gain on settlement	(3)	—	—
Gain on APAC JV ownership changes	(6)	(374)	—
Accruals for legal matters	—	16	22
Settlement charge	—	—	495
Adjusted consolidated operating income[1]	$ 1,616	$ 1,715	$ 1,658

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

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

Consolidated net revenues

Consolidated net revenues for 2017 increased by approximately $170 million, or 1.6%, from 2016. This increase in consolidated net revenues was due to an increase in U.S. dialysis and related lab services net revenues of approximately $222 million, principally as a result of solid volume growth from additional treatments, partially offset by a decrease of approximately $5 in average dialysis net patient service revenue per treatment and by one less treatment day in 2017, as discussed below. Revenue for 2017 was negatively impacted by a decrease of approximately $25 million from 2016 in our ancillary services and strategic initiatives driven primarily from decreases in revenue from our pharmaceutical business, partially offset by an increase in net revenues from expansion in our international business and increases in VillageHealth revenues, as described below.

Consolidated net revenues for 2016 increased by approximately $725 million, or 7.3%, from 2015. This increase in consolidated net revenues was due to an increase in U.S. dialysis and related lab services net revenues of approximately $496 million, principally resulted from solid volume growth from additional treatments, one additional treatment day in 2016, and an increase of $4 in the average dialysis net patient service revenue per treatment, as discussed below. In addition, revenue for 2016 increased by approximately $239 million from 2015 in our ancillary services and strategic initiatives driven primarily from growth in our pharmaceutical business and from expansion in our international business and other strategic initiatives.

Consolidated operating income

Consolidated operating income of $1.813 billion for 2017, which includes goodwill impairment charges of $35 million related to our vascular access reporting unit, an equity investment loss of $6 million for goodwill impairments at our APAC JV, an impairment of $280 million on our investment in the APAC JV, an asset impairment of $15 million related to the restructuring of our pharmacy business, restructuring charges in our international business of $3 million, a net gain on settlement of $530 million, and a gain adjustment on the 2016 ownership change of our APAC JV of $6 million, as discussed below, decreased by $217 million as compared to 2016, which included goodwill impairment charges of $28 million, an investment impairment of $15 million, an estimated gain on the ownership change of our APAC JV of $374 million and estimated accruals for legal matters of $16 million. Excluding these items from their respective periods, adjusted consolidated operating income for 2017 decreased by approximately $99 million due to an increase in adjusted operating losses in our ancillary and strategic initiatives of $59 million, an increase in expenses in our corporate administrative support of $31 million, and a decrease in adjusted operating income in U.S. dialysis and related lab services of $9 million, as described below.

Consolidated operating income of $2.030 billion for 2016, which included goodwill impairment charges of $28 million related to our vascular access reporting unit, an investment impairment of $15 million, an estimated gain on the ownership change of our APAC JV of $374 million and estimated accruals for legal matters of $16 million increased by approximately $893 million from 2015, which included estimated impairment charges of approximately $4 million, estimated accruals for legal matters of $22 million and a settlement charge of $495 million. Excluding these items from their respective periods, adjusted consolidated operating income for 2016 increased by approximately $57 million. Adjusted consolidated operating income increased primarily as a result of an increase in adjusted operating income in U.S. dialysis and related lab services of $22 million, a decrease in adjusted operating losses in our ancillary and strategic initiatives of $30 million, and a decrease in expenses in our corporate administrative support of $5 million, as described below.

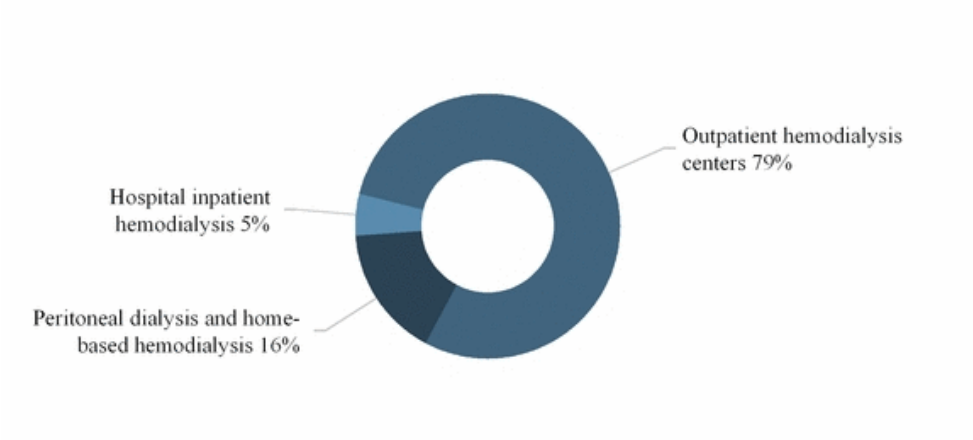
U.S. dialysis and related lab services business

Our U.S. dialysis and related lab services business is a leading provider of kidney dialysis services through a network of 2,510 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 197,800 patients. We also provide acute inpatient dialysis services in approximately 900 hospitals. We estimate that we have approximately a 37% share of the U.S. dialysis market based upon the number of patients we serve. In 2017, our overall network of U.S. outpatient dialysis centers increased by 160 dialysis centers, primarily as a result of opening new dialysis centers and from acquisitions of existing dialysis centers. The overall number of patients that we serve in the U.S. increased by approximately 5.4% in 2017, including dialysis patients from the Renal Ventures acquisition, as compared to 2016.

The stated mission of our U.S. dialysis and related lab services 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 a major driver of our long-term performance, although we are subject to the impact of external factors such as government policy, physician practice patterns, commercial payor payment rates and the mix of commercial and government patients, as further described in Item 1A Risk Factors. 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 2016. For the fifth year in a row, we have been a leader in the industry in QIP standards and for the last three years for which data is available, we have been a leader in the industry under the CMS Five-Star Quality Rating systems. Over the last two years our clinical teammate turnover has increased slightly due to increased competition for skilled clinical personnel; however, despite this headwind, 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 in turn provides our dialysis patient base with a large number of outpatient dialysis centers to choose from with convenient locations and access to a full range of other integrated services, which in turn 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 U.S. dialysis services revenues by modality for the year ended December 31, 2017:



Approximately 86% of our 2017 consolidated net revenues were derived directly from our U.S. dialysis and related lab services business. Approximately 79% of our 2017 dialysis services revenues were derived from outpatient hemodialysis services in our 2,471 consolidated U.S. dialysis centers. Other dialysis services, which are operationally integrated with our dialysis operations, are peritoneal dialysis, home-based hemodialysis, hospital inpatient hemodialysis 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 2017 U.S. dialysis and related lab services revenues.

The principal drivers of our U.S. 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 and home-based dialysis and hospital inpatient dialysis; and
- average dialysis net patient service revenue per treatment, including the mix of commercial and government patients.

The total U.S. dialysis patient base is a relatively stable and growing factor, and is fundamentally influenced by a demographically growing need for dialysis services, as well as mortality rates that are common for patients with ESRD. The United States Renal Data System has reported an approximate compound annual growth rate of 3.8% from 2000 to 2015 for the U.S. dialysis patient population.

We believe our ability to maintain a stable or growing share of the U.S. dialysis patient base is influenced by the quality of our relationships with referring physicians and the quality of our clinical care, which can lead to reduced patient mortality rates, as described above, as well as our ability to open and acquire new dialysis centers.

Our average U.S. dialysis and related lab services net patient service 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 net patient service revenue per treatment. The percentage of commercial patients covered under contracted plans as compared to commercial patients with out-of-network providers has continued to increase, which can significantly affect our average dialysis net patient service 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.

In addition, growth of our government-based patients outpaced the growth of our commercial patients in 2017 due to a decrease in exchange patients. 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 amount of pharmaceuticals administered to the patient or additional services performed. Most lab services are also included in the bundled payment. Under the ESRD 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.

This bundled payment system presents certain operating, clinical and financial risks as further described in the risk factor in Item 1A Risk Factors under the heading "Changes in the structure of and payment rates under the Medicare ESRD program could have a material adverse effect on our business, results of operations and financial condition." 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. In addition, as new drugs, services or labs are added to the ESRD bundle, CMS' failure to adequately calculate the costs associated with the drugs, services or labs could have a material adverse effect on our business, results of operations and financial condition.

Uncertainty about future payment rates remains a material risk to our business, as well as the potential implementation of or changes in coverage determinations or other rules or regulations by CMS or MACs that may impact reimbursement. An important provision in the law is an annual adjustment, or market basket inflation update, to the ESRD PPS base rate. Absent action by Congress, the PPS base rate is automatically updated annually by a formulaic inflation adjustment.

In December 2013, CMS issued the 2014 final rule for the ESRD PPS, which phases in the payment reductions mandated by ATRA, as modified by the Protecting Access to Medicare Act of 2014 which reduced our market basket inflation adjustment by 1.25% in 2016 and 2017, and by 1% in 2018. In November 2017, CMS published the 2018 final rule for the ESRD PPS, which increased dialysis facilities' bundled payment rate for 2018 relative to prior years. In particular, CMS projects that the 2018 final rule for the ESRD PPS will (i) increase the total payments to all ESRD facilities by 0.5% in 2018 compared to 2017; (ii) increase total payments to hospital-based ESRD facilities by 0.7% in 2018 compared to 2017; and (iii) increase total payments for freestanding facilities by 0.5% in 2018 compared to 2017. The 2018 final rule for ESRD PPS also implements changes to the PPS outlier policy, broadening the pricing methodologies used to determine the cost of certain service drugs and biologicals in computing outlier payments when average sales price data is not available.

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 April 1, 2013, reducing Medicare payments by 2% which was subsequently extended through fiscal year 2027. These across-the-board spending cuts have affected and will continue to adversely affect our business, results of operations and financial condition.

The CMS Innovation Center is working with various healthcare providers to develop, refine and implement ACOs and other innovative models of care for Medicare and Medicaid beneficiaries. We are 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 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 programs' 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 material adverse effect on our revenues, earnings and cash flows. 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 2018 that will outpace any net Medicare rate increases that we may receive, which could significantly impact our operating results. In particular, we expect to continue experiencing increases in operating costs that are subject to inflation, such as labor and supply costs, including increases in maintenance costs and capital expenditures to improve, renovate and maintain our facilities, equipment and information technology to meet changing regulatory requirements, 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, or if commercial payors implement plans that restrict access to coverage or the duration or breadth of benefits or impose restrictions or limitations on patient access to commercial plans on non-contracted or out-of-network providers, it could have a material adverse effect on our business, results of operations and financial condition. 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 commercial insurance plans and/or an increase in uninsured or underinsured patients. 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 or receive for a limited duration, such financial assistance, or if our assumptions about how patients will respond to any change in such financial assistance are incorrect, it could have a material adverse effect on our business, results of operations and financial condition. 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 business, results of operations and financial condition."

Our operating performance with respect to dialysis services billing and collection can also be a significant factor in the average U.S. dialysis and related lab services net patient service 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; however, as we continue to make upgrades to our systems and processes, or as payors change their systems and requirements, such as changes to what is included in the bundled payment from Medicare, we could experience a negative impact to our cash collection performance, which would affect our average U.S. dialysis and related lab services net patient service revenue per treatment.

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

Our average U.S. dialysis and related lab services net patient service 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.

Our annual average U.S. dialysis and related lab services net patient service revenue per treatment was approximately $330, $336 and $332 for 2017, 2016 and 2015, respectively. In 2017, our average U.S. dialysis and related lab services net patient service revenue per treatment decreased by approximately $5 per treatment due to a decrease in our commercial treatment volume, a decline in our commercial payor mix, including exchange patients, and an increase in our provision for uncollectible accounts. In 2016, our average U.S. dialysis and related lab services net patient service 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, partially offset by an increase in our provision for uncollectible accounts.

The principal drivers of our U.S. 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 present significant cost variability, such as employee benefit costs, payroll taxes, insurance costs and medical supply costs. In addition, currently pending and future proposed ballot initiatives or referendums, legislation or policy changes could cause us to incur substantial costs to challenge and, if implemented, impose additional requirements on our operations, including increases in the required staffing levels or staffing ratios for clinical personnel, minimum transition times between treatments, limits on how much patients may be charged for care, limitations as to the amount that can be spent on certain medical costs, and a ceiling on the percent of profit for such care. Changes such as these mandated by currently pending and future ballot initiatives or

referendums, legislation or policy changes would likely materially reduce our revenues and increase our operating expense and impact our ability to staff our clinics to the new, elevated staffing levels, in particular given the ongoing nationwide shortage of healthcare workers, especially nurses.

Our average clinical hours per treatment, or productivity levels, were flat in 2017 compared to 2016. 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 2017, which we believe negatively affected productivity levels. In 2017 and 2016, we experienced an increase in our clinical labor rates of approximately 4.0% and 2.8%, respectively, consistent with general industry trends, mainly due to the high demand for and nationwide shortage of skilled clinical personnel, along with general inflation increases. In 2018, we will have a year-over-year accounting headwind of up to $100 million as we finish the transition from a profit sharing program to a 401(k) match program. With the old program, we accrued for the expense in the calendar year before payout; with the new program, we will accrue for the expense as we pay out. This accounting change created a one-year gap in 2017 when we did not need to accrue for any such payouts. We also continue to experience increases in the 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 2017, we continued to implement certain cost control initiatives to manage our overall operating costs, including labor productivity.

Our U.S. dialysis and related lab services general and administrative expenses represented 8.1% and 8.2% of our U.S. dialysis and related lab services net revenues in 2017 and 2016, respectively. Although slightly down as a percent of net revenues, general and administrative expenses increased by $9 million, primarily due to an increase in labor and benefit costs and occupancy costs, partially offset by a decrease in long-term compensation, profit sharing and travel expenses. Increases in general and administrative expenses over the last several years were 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 U.S. dialysis and related lab services general and administrative expenses will continue in 2018 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 our U.S. dialysis and related lab services business:

	Year ended December 31,		
	2017	2016	2015
	(dollars in millions, except treatment data)		
U.S. dialysis and related lab patient service revenues	$ 9,822	$ 9,551	$ 9,034
Less: Provision for uncollectible accounts	(482)	(430)	(406)
U.S. dialysis and related lab net patient service revenues	9,340	9,121	8,628
Other revenues	20	17	14
Total U.S. dialysis and related lab net services revenues	9,360	9,138	8,642
Operating expenses and charges:			
Patient care costs	6,334	6,145	5,755
General and administrative	760	751	709
Depreciation and amortization	521	483	438
Equity investment income	(25)	(18)	(15)
Gain on settlement	(527)	—	—
Settlement charge and loss contingency accruals	—	—	495
Total operating expenses and charges	7,063	7,361	7,382
Operating income	$ 2,297	$ 1,777	$ 1,260
Reconciliation of non-GAAP measures:			
Gain on settlement, net	(527)	—	—
Equity investment income related to gain on settlement	(3)	—	—
Settlement charge	—	—	495
Adjusted operating income[(1)]	$ 1,768	$ 1,777	$ 1,755
Dialysis treatments	28,271,113	27,162,545	25,986,719
Average dialysis treatments per treatment day	90,468	86,532	83,104
Average U.S. dialysis and related lab services patient service revenue per treatment	$ 347.43	$ 351.64	$ 347.64
Less: Provision for uncollectible accounts per treatment	(17.05)	(15.83)	(15.64)
Average U.S. dialysis and related lab services net patient service revenue per treatment	$ 330.38	$ 335.81	$ 332.00

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

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

Net revenues

U.S. dialysis and related lab services net revenues for 2017 increased by approximately $222 million, or 2.4%, from 2016. This increase in net revenues was primarily driven by solid volume growth from additional treatments of approximately 4.1% due to an increase in acquired and non-acquired treatments, including the acquisition of Renal Ventures. U.S. dialysis and related lab services' net revenues was negatively impacted by approximately one less treatment day in 2017 as compared to 2016, a decrease in the average dialysis net patient service revenue per treatment of approximately $5, primarily due to a decrease in our commercial payor mix, including exchange patients. In addition, our provision for uncollectible accounts increased by $52 million in 2017.

U.S. dialysis and related lab services net revenues for 2016 increased by approximately $496 million, or 5.7%, from 2015. This 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. U.S. dialysis and related lab services' net revenues also benefited from an increase in the average dialysis net patient service revenue per treatment of approximately $4, primarily due to an increase in our average commercial payment rates and improvements in our commercial payor mix. In addition, our provision for uncollectible accounts increased by $24 million in 2016.

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

	2017	2016	2015
Medicare and Medicare-assigned plans	56%	55%	56%
Medicaid and Managed Medicaid plans	7	5	6
Other government-based programs	4	4	4
Total government-based programs	67	64	66
Commercial (including hospital dialysis services)	33	36	34
Total U.S. dialysis and related lab services revenues	100%	100%	100%

Approximately 67% of our total U.S. dialysis services revenues for the year ended December 31, 2017 were from government-based programs, principally Medicare, Medicaid, Medicare-assigned and Managed Medicaid plans, representing approximately 89.5% of our total patients. Over the last year we have seen a decline in our commercial patients, which have been outpaced by the growth of our government-based patients. Less than 1% of our U.S. 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 U.S. dialysis and related lab services revenues for the year ended December 31, 2017.

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 net patient service 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 shift from the commercial insurance plan rates to Medicare payment rates, which on average 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 U.S. 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 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 business, results of operations and financial condition.

Operating expenses and charges

Patient care costs. U.S. 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. U.S. dialysis and related lab services patient care costs on a per treatment basis were $224 and $226 for 2017 and 2016, respectively. The $2 decrease in per treatment costs in 2017 as compared to 2016 was primarily attributable to a decrease in pharmaceutical unit costs due to a net price reduction as well as a decrease in profit sharing expense. These decreases were partially offset by an increase in labor and benefit costs due to an increase in teammates and clinical labor rates, and an increase in other direct operating expenses associated with our dialysis centers, including the impact of the hurricanes during the third quarter of 2017.

U.S. 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.

General and administrative expenses. U.S. dialysis and related lab services general and administrative expenses in 2017 increased by approximately $9 million as compared to 2016. This increase was primarily due to an increase in our labor and benefit costs, and occupancy costs, partially offset by a decrease in long-term incentive compensation, profit sharing and travel expenses.

U.S. dialysis and related lab services general and administrative expenses in 2016 increased by approximately $42 million as compared to 2015. This 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 incentive compensation expense.

Depreciation and amortization. U.S. dialysis and related lab services depreciation and amortization expenses for 2017 increased by approximately $38 million as compared to 2016 and increased by $45 million in 2016 as compared to 2015. The increases were primarily due to both growth through new dialysis center developments and acquisitions as well as additional informational technology initiatives.

Gain on settlement, net. During the first quarter of 2017, we reached an agreement with the government for amounts owed to us for dialysis services provided from 2005 through 2011 to patients covered by the Department of Veterans Affairs (VA). As a result of this settlement we recognized a one-time net gain of $527 million as well as equity investment income of $3 million for our share of the settlement recognized by our nonconsolidated joint ventures. As such, the total effect of this settlement on our operating income was an increase of $530 million.

Provision for uncollectible accounts receivable. The provision for uncollectible accounts receivable for our U.S. dialysis and related lab services business was 4.9% for 2017 and 4.5% for both 2016 and 2015. We continue to experience higher amounts of accounts receivable write-offs due to uninsured and underinsured patients. We assess our level of provision for uncollectible accounts based upon our historical cash collection experience and trends, and have and will continue to adjust the provision as necessary as a result of changes in expectations based on our cash collections.

Equity investment income. Equity investment income was approximately $25 million, $18 million and $15 million in 2017, 2016 and 2015, respectively. The increases in equity investment income over the last three years were primarily due to the increase in the number of our nonconsolidated dialysis joint ventures and an increase in profitability at some of these joint ventures.

Segment operating income

U.S. dialysis and related lab services operating income for 2017, which includes a net gain on the VA settlement of $530 million, increased by approximately $520 million as compared to 2016. Excluding this item from 2017, U.S. dialysis and related lab services adjusted operating income decreased by approximately $9 million from 2016. This decrease in adjusted operating income was primarily due to a decrease in the average dialysis net patient service revenue per treatment of approximately $5, one less treatment day, partially offset by treatment growth, as described above. Adjusted operating income also decreased due to an increase in general and administrative expenses, partially offset by lower patient care costs, as described above.

U.S. 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, U.S. dialysis and related lab services adjusted operating income 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 net patient service revenue per treatment of approximately $4, as described above. Adjusted operating income also increased due to a decrease in long-term incentive compensation expense, partially offset by higher patient care costs and an increase in general and administrative expenses, as described above.

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, 2017, these consisted primarily of pharmacy services, disease management services, vascular access services, clinical research programs, physician services, direct primary care, ESRD seamless care organizations, and comprehensive care as well as our international operations.

Our ancillary services and strategic initiatives, including our pharmacy services and international operations among others, generated approximately $1.6 billion of net revenues in 2017, representing approximately 14% of our consolidated net revenues. We expect to add additional service offerings to our business and pursue additional strategic initiatives in the future as circumstances warrant, which could include healthcare services not related to dialysis. In addition, in connection with our

previously announced capital allocation strategy, in 2018 we plan to continue our evaluation of strategic alternatives for various assets in our portfolio. 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 our strategic initiatives. If any of our ancillary services or strategic initiatives, including our pharmacy services and our international operations, are unsuccessful, it would have a negative impact on our business, results of operations and financial condition, and we may determine to exit the line of business. We could incur significant termination costs if we were to exit certain of these lines of business. In addition, we may incur a material write-off or an impairment of our investment, including goodwill, in one or more of our ancillary services or strategic initiatives. In that regard, we have taken, and may in the future take, impairment charges related to our ancillary services and strategic initiatives, including in our international and pharmacy businesses.

As of December 31, 2017, our international dialysis operations provided dialysis and administrative services to a total of 237 outpatient dialysis centers located in 11 countries outside of the U.S. The total net revenues generated from our international operations, as reflected below, were approximately 3% of our 2017 consolidated net revenues.

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

	Year ended December 31,		
	2017	2016	2015
	(dollars in millions)		
U.S. revenues			
Other revenues	$ 1,268	$ 1,413	$ 1,242
Total	1,268	1,413	1,242
International revenues			
Net dialysis patient service revenues	323	202	134
Other revenues	5	6	6
Total	328	208	140
Total net revenues	$ 1,596	$ 1,621	$ 1,382
Operating expenses and charges:			
Operating and other general expenses	$ 1,711	$ 1,686	$ 1,482
Goodwill impairment	36	28	4
Impairment of investment	295	15	—
Gain from APAC JV ownership changes	(6)	(374)	—
Total operating expenses and charges	2,036	1,355	1,486
Total ancillary services and strategic initiatives operating (loss) income	$ (439)	$ 267	$ (104)
U.S. operating loss	$ (110)	$ (65)	$ (45)
Reconciliation of non-GAAP:			
Goodwill impairment	35	28	—
Impairment of assets	15	—	—
Accruals for legal matters	—	16	22
Adjusted operating loss[1]	$ (60)	$ (21)	$ (23)
International operating (loss) income	$ (329)	$ 332	$ (59)
Reconciliation of non-GAAP:			
Goodwill impairment	—	—	4
Equity investment loss related to APAC JV goodwill impairment	6	—	—
Impairment of investment	280	15	—
Restructuring charges	2	—	—
Equity investment loss related to restructuring charges	1	—	—
Gain from APAC JV ownership changes	(6)	(374)	—
Adjusted operating loss[1]	$ (46)	$ (27)	$ (55)
Total adjusted ancillary services and strategic initiatives operating loss[1]	$ (107)	$ (48)	$ (78)

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

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

Net revenues

Ancillary services and strategic initiatives net revenues for 2017 decreased by approximately $25 million, or 1.5%, as compared to 2016. This decrease was primarily related to a decrease in volume in our pharmaceutical business, partially offset by an increase in pharmaceutical rates, an increase in VillageHealth special needs plan revenues, an increase in shared savings revenue recognized by our ESCO joint ventures and an increase in net revenues from expansions in our international business and other strategic initiatives.

Ancillary services and strategic initiatives net revenues for 2016 increased by approximately $239 million, or 17.3%, as compared to 2015. This 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 expansions in our international business and other strategic initiatives. These increases were partially offset by a decrease in our pharmacy services volume.

Operating and general expenses

Ancillary services and strategic initiatives operating and general expenses for 2017, which includes restructuring charges related to our international business of $3 million, increased by approximately $25 million from 2016, which included an estimated accrual for certain legal matters of $16 million. Excluding these items from their respective periods, ancillary services and strategic initiatives adjusted operating expenses increased by $38 million. This increase in adjusted operating and general expenses was primarily related to an increase in medical costs at VillageHealth, an increase in labor and benefits costs and additional expenses associated with our international dialysis expansion, including losses from adverse changes in foreign exchange rates included in equity investment income, partially offset by a decrease in pharmaceutical costs due to decreased volume in our pharmacy services business.

Ancillary services and strategic initiatives operating and general expenses for 2016, which includes an estimated accrual for certain legal matters of $16 million, increased by approximately $203 million from 2015, which included an estimated accrual for certain legal matters of $22 million. Excluding these items from their respective periods, ancillary services and strategic initiatives adjusted operating expenses increased by $209 million. This increase in adjusted operating and general 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, long-term incentive compensation expense and foreign currency gains.

Investment and other asset impairments

During the year ended December 31, 2017, we recognized a non-cash other-than-temporary impairment charge of $280 million on our investment in the APAC JV. This charge resulted from changes in our expectations for the joint venture based on continuing market research and assessments by both us and the DaVita Care Pte. Ltd. (the APAC JV) concerning the size of the addressable market available to the joint venture at attractive risk-adjusted returns. We estimated the fair value of our retained interest in the APAC JV with the assistance of an independent third party valuation firm based on information available to management as of December 31, 2017. After this charge, our investment in the APAC JV was carried at $160 million as of December 31, 2017.

During the year ended December 31, 2017, we also recognized other asset impairment charges of $15 million related to a restructuring of our pharmacy business.

During the year ended December 31, 2016, we recognized an impairment of $15 million related to an investment in one of our international reporting units.

Goodwill impairment charges

During the year ended December 31, 2016, we recognized a goodwill impairment charge of $28 million related to our vascular access reporting unit as a result of changes in future governmental reimbursement rates for this business 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.

During the year ended December 31, 2017, we recognized an additional goodwill impairment charge of $35 million at our vascular access reporting unit. This charge resulted primarily from continuing changes in our outlook for this business unit as our partners and operators continued to evaluate and make decisions concerning changes in operations, including termination

of their management services agreements and center closures as a result of the changes in reimbursement structure discussed above. As of December 31, 2017, there was no goodwill remaining at our vascular access reporting unit.

We also recognized a goodwill impairment charge of $2 million at one of our international reporting units during the year ended December 31, 2017 and $4 million at another international reporting unit during the year ended December 31, 2015.

Restructuring charges

During the year ended December 31, 2017, we recognized total restructuring charges related to our international business of $2 million and recognized equity investment losses of $1 million related to restructuring charges at our APAC JV. These restructuring charges were related to a reorganization of our international general and administrative infrastructure at the global, regional and county levels in order to improve efficiency.

Gain on changes in ownership interests in APAC JV

As a result of our agreement with Khazanah Nasional Berhad (Khazanah) and Mitsui and Co., Ltd (Mitsui) concerning the APAC JV, we recorded an additional $6 million non-cash gain during the year ended December 31, 2017 related to a change in estimate of pending post-closing adjustments for the 2016 formation of this joint venture.

In 2016 we deconsolidated our Asia Pacific dialysis business and recognized an initial non-cash non-taxable estimated 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 (loss) income

Ancillary services and strategic initiatives operating results for 2017, which include goodwill impairment charges of $35 million at our vascular access reporting unit, an impairment of $280 million on our investment in the APAC JV, an asset impairment of $15 million related to the restructuring of our pharmacy business, equity investment losses of $6 million related to goodwill impairments at our APAC JV, restructuring charges related to our international business of $3 million and an adjustment to the gain on the 2016 ownership change of our APAC JV of $6 million, decreased by approximately $706 million from the same period in 2016, which included an estimated gain on the ownership change of our APAC JV of $374 million, a goodwill impairment charge of $28 million at our vascular access reporting unit, an estimated accrual for certain legal matters of $16 million and an investment impairment of $15 million. Excluding these items from their respective periods, adjusted operating losses increased by $59 million, primarily due to a decrease in revenues in our pharmacy services business, an increase in medical costs, higher labor and benefits costs, and additional expenses associated with our international operations, partially offset by an increase in VillageHealth special needs plan revenues, an increase in shared savings revenue recognized by our ESCO joint ventures, an increase in net revenues from expansion in our international business, and a decrease in pharmaceutical costs due to decreased volume in our pharmacy services business.

Ancillary services and strategic initiatives operating results for 2016, which includes an estimated gain on the ownership change of our APAC JV of $374 million, a goodwill impairment charge of $28 million at our vascular access reporting unit, an estimated accrual for certain legal matters of $16 million and an investment impairment of $15 million, increased by approximately $372 million from 2015, which included an estimated accrual for certain legal matters 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 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.

Corporate level charges

Debt expense. Debt expense for 2017, 2016, and 2015 consisted of interest expense of approximately $407 million, $394 million and $390 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 $24 million, $20 million, and $18 million, respectively. The increase in debt expense in 2017 as compared to 2016 was primarily due to an increase in our average interest rate, partially offset by a decrease in our average outstanding balance. Our overall weighted average effective interest rate in 2017 was 4.70% as compared to 4.43% in 2016.

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.

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

Corporate administrative support costs were approximately $45 million in 2017 and $14 million 2016. Corporate administrative support costs increased $31 million due to a decrease in internal management fees charged to our ancillary lines of business and increases in long-term incentive compensation and labor and benefits expenses, partially offset by decreases in professional fees and other general and administrative expenses.

Corporate administrative support costs were approximately $14 million in 2016 and $19 million in 2015. Corporate administrative support costs decreased $5 million primarily attributable to a decrease in long-term incentive compensation expense, primarily due to reductions in ultimate expected pay-outs as well as the departure of a senior executive, partially offset by increases in labor and benefits, professional fees, and other general and administrative expenses.

Other income. Other income was approximately $18 million in 2017 and $8 million in both 2016 and 2015, and consisted principally of interest income. Other income in 2017 as compared to 2016 increased approximately $10 million, primarily due to a decrease in foreign currency transaction losses. 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.

Provision for income taxes. The provision for income taxes for 2017, 2016 and 2015 represented an effective annualized tax rate of 23.1%, 26.6% and 30.1% of income from continuing operations, respectively. The effective tax rate in 2017 was lower primarily due to the enactment of new U.S. federal tax reform legislation known as the Tax Cuts and Jobs Act (the 2017 Tax Act) as signed into law on December 22, 2017. The 2017 Tax Act, among other changes, reduces the federal corporate income tax rate from 35% to 21%, effective January 1, 2018, resulting in a net income net tax benefit of $252 million in 2017 primarily related to a remeasurement of our net deferred tax liability. Excluding this item, our effective tax rate from continuing operations for 2017 was 41.1%. The effective tax rate in 2016 was lower primarily due to the gain on the APAC JV ownership changes, offset by goodwill impairment charges. See Note 12 to the consolidated financial statements for further information.

Noncontrolling interests

Net income attributable to noncontrolling interests for 2017, 2016 and 2015 was approximately $167 million, $153 million and $158 million, respectively. The increase in noncontrolling interests in 2017 was primarily due to additional income to noncontrolling interests related to the net gain on the settlement with the VA of $24 million, partially offset by the impairment of our vascular access reporting unit, which reduced income to noncontrolling interests by $2 million year over year.

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 income to noncontrolling interest of $8 million. The percentage of net U.S. dialysis and related lab services revenues generated from dialysis-related joint ventures was approximately 24% in 2017, and 23% in both 2016 and 2015.

Accounts receivable

Our consolidated accounts receivable balances at December 31, 2017 and December 31, 2016 were $1.715 billion and $1.504 billion, respectively, representing approximately 57 days and 52 days of revenue, respectively, net of the allowance for uncollectible accounts. The increase in consolidated DSO was primarily related to our U.S. dialysis and related lab services business and was due to changes we made in our collection policies and procedures to improve overall collections. We expect DSO to decline two to three days over the next few quarters as we continue to adjust and refine our collection operations for these new protocols. Our DSO calculation is based on the current quarter's average revenues per day. There were no significant changes during 2017 from 2016 in the amount of unreserved accounts receivable over one year old or the amounts pending approval from third-party payors.

As of December 31, 2017 and 2016, our net patient services accounts receivable balances more than six months old represents approximately 21% and 16% of our dialysis accounts receivable balances, respectively. The increase was primarily

due to changes we made in our collection policies and procedures to improve overall collections. There were no significant unreserved balances over one year old. Approximately 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, 2017 and 2016, other than the standard monthly billing, consisted of approximately $104 million and $105 million, respectively, and are 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, payments received from Medicare are subject to adjustment based upon the actual results of these audits. Such audits typically occur one to four years after the claims are filed.

Liquidity and capital resources

Available liquidity. As of December 31, 2017, our cash balance was $508 million and we also had approximately $44 million in short-term investments. We had $300 million drawn on our $1.0 billion revolving line of credit under our senior secured credit facilities, in addition to the approximately $14 million committed for outstanding letters of credit. We also have approximately $90 million of additional outstanding letters of credit related to Kidney Care and $0.2 million of committed outstanding letters of credit related to DMG, which is backed 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.

Consolidated cash flows from operations during 2017 was $1.9 billion, of which $1.6 billion was from continuing operations, compared with consolidated cash flows from operations of $2.0 billion for 2016, of which $1.7 billion was from continuing operations. Consolidated cash flows declined due to an increase in DSO and the timing of other working capital items, partially offset by the payment received from the settlement with the VA, net of associated tax payments. Cash flows from operations in 2017 included cash interest payments of approximately $425 million and cash tax payments of $387 million. Cash flows from operations in 2016 included cash interest payments of approximately $407 million and cash tax payments of $339 million.

Non-operating cash outflows in 2017 included $905 million for capital asset expenditures, including $559 million for new center developments and relocations and $346 million for maintenance and information technology. We also spent an additional $804 million for acquisitions. In addition, during 2017 we received $21 million associated with stock award exercises and other share issuances. We also made distributions to noncontrolling interests of $211 million, which included $24 million related to the noncontrolling interest portion of the VA settlement gain, and received contributions from noncontrolling interests of $75 million associated with new or existing joint ventures. We also repurchased a total of 12,966,672 shares of our common stock for $811 million, or an average price of $62.54 per share, of which $8 million was unsettled at December 31, 2017.

Consolidated cash flows from operations during 2016 was $2.0 billion, of which $1.7 billion was from continuing operations, compared with cash flows from operations of $1.6 billion for 2015, of which $1.2 billion was from continuing operations. 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 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 flows from operations in 2016 included cash interest payments of approximately $407 million and cash tax payments of $339 million. Cash flows 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 or existing joint ventures. We also repurchased a total of 16,649,090 shares of our common stock for $1.1 billion, or an average price of $64.41 per share. In addition, we settled $25 million in share repurchases related to 2015.

During 2017, in the U.S. we opened 121 dialysis centers, acquired 66 dialysis centers, including dialysis centers from the Renal Ventures acquisition, closed and merged ten dialysis centers, closed nine dialysis centers, divested six dialysis centers, deconsolidated seven dialysis centers which we continue to operate under management services agreements, and terminated two management services agreements. In addition, our international dialysis operations acquired 68 dialysis centers,

opened eight dialysis centers, and closed one dialysis center. In addition, our APAC JV acquired two dialysis centers, opened nine dialysis centers and closed three dialysis centers.

During 2017, our DMG business acquired four primary care physician practices, including the acquisition of Magan, seven private medical practices, and one independent physician association.

On December 5, 2017, we entered into an equity purchase agreement to sell our DMG division to Optum, a subsidiary of UnitedHealth Group Inc., for $4.9 billion in cash, subject to net working capital and other customary adjustments. The transaction is expected to close in 2018 and is subject to regulatory approval and other customary closing conditions.

During 2016, in the U.S. we opened 100 new dialysis centers, acquired a total of eight dialysis centers, closed and 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 12 new dialysis and hospital operated centers. In addition, our APAC JV acquired three 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 the year ended December 31, 2017, we made mandatory principal payments under our senior secured credit facilities totaling $88 million on Term Loan A and $35 million on Term Loan B. 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.

Interest rate cap agreements

As of December 31, 2017, we maintain several currently effective interest rate cap agreements that were entered into in November 2014 with notional amounts totaling $3.5 billion. These cap agreements became effective September 30, 2016 and have the economic effect of capping the LIBOR variable component of our interest rate at a maximum of 3.50% on an equivalent amount of our debt. These cap agreements expire on June 30, 2018. As of December 31, 2017, these cap agreements had an immaterial fair value. During the year ended December 31, 2017, we recognized debt expense of $8.3 million from these caps. During the year ended December 31, 2017, we recorded a loss of $0.1 million in other comprehensive income due to a decrease in the unrealized fair value of these cap agreements.

As of December 31, 2017, we also 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 its debt. These cap agreements expire on June 30, 2020. As of December 31, 2017, the total fair value of these cap agreements was an asset of approximately $1.0 million. During the year ended December 31, 2017, we recorded a loss of $8.8 million in other comprehensive income due to a decrease in the unrealized fair value of these cap agreements.

Other items

As of December 31, 2017, our Term Loan B debt bears interest at LIBOR plus an interest rate margin of 2.75%. Term Loan B is subject to interest rate caps if LIBOR should rise above 3.50%. Term Loan A bears interest at LIBOR plus an interest rate margin of 2.00%. The capped portion of Term Loan A is $122.5 million. In addition, the uncapped portion of Term Loan A, which is subject to the variability of LIBOR, is $652.5 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 4.45%, based on the current margins in effect of 2.00% for Term Loan A and the Revolver and 2.75% for Term Loan B, as of December 31, 2017.

As of December 31, 2017, our interest rates are fixed on approximately 52% of our total debt.

Our overall weighted average effective interest rate during the year ended December 31, 2017 was 4.70% and as of December 31, 2017 was 4.88%.

As of December 31, 2017, we had $300 million drawn on our $1.0 billion revolving line of credit under our senior secured credit facilities, in addition to approximately $14.4 million committed for outstanding letters of credit. We also have approximately $90.1 million of additional outstanding letters of credit related to Kidney Care and $0.2 million of committed outstanding letters of credit related to DMG, which is backed by a certificate of deposit.

We believe that we will generate significant operating cash flows and will have sufficient liquidity to fund our scheduled debt service and other obligations for the foreseeable future, including the next 12 months, under the terms of our debt agreements. However, our primary sources of liquidity are cash from operations and cash from borrowings, including general, economic, financial, competitive, regulatory and other factors that are beyond our control, as described in the risk factor in Item IA Risk Factors under the heading "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 and for other intended purposes depends on many factors beyond our control."

Goodwill

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

During the year ended December 31, 2016, we recognized a goodwill impairment charge of $28 million related to our vascular access reporting unit as a result of changes in future governmental reimbursement rates for this business 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.

During the year ended December 31, 2017, we recognized an additional goodwill impairment charge of $35 million at our vascular access reporting unit. This charge resulted primarily from continuing changes in our outlook for this business unit as our partners and operators continued to evaluate and make decisions concerning changes in operations, including termination of their management services agreements and center closures, as a result of the changes in reimbursement structure discussed above. As of December 31, 2017, there was no goodwill remaining at our vascular access reporting unit.

During the year ended December 31, 2017, we also performed annual impairment assessments for various other reporting units. As a result of these assessments, we also recognized a goodwill impairment charge of $2 million at one of our international reporting units during the year ended December 31, 2017. During the year ended December 31, 2015, we recognized a goodwill impairment charge of $4 million in another international reporting unit.

Based on our most recent assessments, we determined that reductions in reimbursement rates, changes in actual or expected growth rates, or other significant adverse changes in expected future cash flows or valuation assumptions could result in goodwill impairment charges in the future for the following reporting units, which remain at risk of goodwill impairment as of December 31, 2017:

Reporting unit	Goodwill balance as of December 31, 2017	Carrying amount coverage[1]	Sensitivities	
			Operating income[2]	Discount rate[3]
	(in millions)			
Kidney Care Germany	$ 316	13.7%	(1.6)%	(11.1)%
Kidney Care Portugal	$ 47	16.9%	(1.9)%	(6.0)%
Kidney Care Poland	$ 47	11.8%	(1.9)%	(6.0)%

(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 through December 31, 2017.

Except as described above, none of our various other reporting units was considered at risk of significant goodwill impairment as of December 31, 2017. 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 values of any of our reporting units would be less than their respective carrying amounts as of December 31, 2017.

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, 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 2017, we granted approximately 1,692,154 stock-settled stock appreciation rights (SSARs) with an aggregate grant-date fair value of $24.5 million and a weighted-average expected life of approximately 4.2 years and approximately 528,968 stock units with an aggregate grant-date fair value of $34.8 million and a weighted-average expected life of approximately 3.4 years. We also granted 15,000 cash-settled stock-based awards with an aggregate grant-date fair value of $0.3 million.

For the years ended December 31, 2017 and 2016, long-term incentive compensation expense of $62.0 million and $65.0 million decreased by approximately $3.0 million and $59.0 million as compared to 2016 and 2015, respectively. This decrease in long-term incentive compensation expense was primarily due to 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.

As of December 31, 2017, there was $98.0 million in total estimated but unrecognized long-term incentive compensation expense for LTIP awards outstanding, including $61.2 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 1.1 years 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, 2017, 2016 and 2015, we received $13.5 million, $28.4 million and $45.7 million, respectively, in actual tax benefits upon the exercise of stock awards. Since we issue stock-settled stock appreciation rights rather than stock options, we did not receive cash proceeds from stock option exercises during the years ended December 31, 2017, 2016 and 2015.

Stock repurchases

We repurchased a total of 12,966,672 shares for $811 million, or an average price of $62.54 during the year ended December 31, 2017. We also repurchased a total of 16,649,090 shares for $1.1 billion, or an average price of $64.41 during the year ended December 31, 2016 and a total of 7,779,958 shares for $575 million, or an average price of $73.96 during the year ended December 31, 2015. Subsequent to December 31, 2017, we have repurchased 1,237,800 additional shares of our common stock for $93 million, or an average price of $74.96 per share, through February 22, 2018.

On October 10, 2017, our Board of Directors approved an additional share repurchase authorization in the amount of $1.3 billion. This share repurchase authorization was in addition to the $247 million remaining at that time under our Board of Directors' prior share repurchase authorization announced in July 2016. Accordingly, as of February 22, 2018, we have a total of $1.0 billion available under the current Board repurchase authorizations for additional share repurchases. Although these share repurchase authorizations do not have expiration dates, we remain subject to share repurchase limitations under the terms of our senior secured credit facilities and the indentures governing our senior notes.

Off-balance sheet arrangements and aggregate contractual obligations

In addition to the debt obligations reflected on our balance sheet, we have commitments associated with operating leases and letters of credit, as well as potential obligations associated with our equity investments in nonconsolidated businesses and to dialysis centers that are wholly-owned by third parties. Substantially all of our U.S. dialysis facilities are leased. We have potential obligations to purchase the noncontrolling interests held by third parties in several of our majority-owned joint ventures and other nonconsolidated entities. These obligations are in the form of put provisions that 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 flows 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 noncontrolling interests subject to put provisions are 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 17 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.

The following is a summary of these contractual obligations and commitments as of December 31, 2017:

	Less than 1 year	1-3 years	4-5 years	After 5 years	Total
	(dollars in millions)				
Scheduled payments under contractual obligations:					
Long-term debt	$ 158	$ 1,078	$ 4,549	$ 3,318	$ 9,103
Interest payments on the senior notes	237	473	473	367	1,550
Interest payments on Term Loan B[1]	148	290	71	—	509
Interest payments on Term Loan A[2]	27	12	—	—	39
Kidney Care capital lease obligations	20	44	43	190	297
Kidney Care operating leases	447	807	665	1,304	3,223
DMG capital lease obligations	37	—	—	—	37
DMG operating leases	85	152	108	283	628
	$ 1,159	$ 2,856	$ 5,909	$ 5,462	$ 15,386
Potential cash requirements under other commitments:					
Letters of credit	105	$ —	$ —	$ —	$ 105
Noncontrolling interests subject to put provisions	613	211	96	91	1,011
Non-owned and minority owned put provisions	27	—	28	—	55
Operating capital advances	1	1	1	2	5
Purchase commitments	447	644	497	—	1,588
	$ 1,193	$ 856	$ 622	$ 93	$ 2,764

(1) Based upon current LIBOR-based interest rates in effect at December 31, 2017 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, 2017 plus an interest rate margin of 2.00% for Term Loan A.

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. In January 2018, we entered into a new agreement extending this agreement with FMC through December 31, 2020. 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.

We are party to agreements with Baxter Healthcare Corporation (Baxter) that commit us to purchase a certain amount of hemodialysis non-equipment product supplies, such as dialyzers, at fixed prices through 2018. In addition, in February 2018 we amended our agreement with Baxter related to certain peritoneal dialysis supplies. Under this new contract with Baxter we have committed to purchase a certain amount of peritoneal dialysis supplies at fixed prices (as set forth in the contract for each year) through 2022.

In January 2017, we entered into a Sourcing and Supply Agreement with Amgen USA Inc. (Amgen) that expires on December 31, 2022. Under the terms of the agreement, we will purchase EPO in amounts necessary to meet no less than 90% of our requirements for ESAs through the expiration of the contract. 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 $33 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, including those within our DMG business, which 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, 2017, if these physician groups were not consolidated in our financial statements, our consolidated assets would have been approximately $18.522 billion and our consolidated other liabilities would have been approximately $3.342 billion. Our consolidated indebtedness would have remained approximately $9.400 billion due to these physician groups being classified as held for sale. For the year ended December 31, 2017, if these physician groups were not consolidated in our financial statements, our consolidated net income would have been reduced by approximately $21 million. Our consolidated total net revenues and consolidated operating income would have remained approximately $10.877 billion and $1.813 billion, respectively, due to these physician groups being reported as discontinued operations.

In addition, our DMG business owns 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. DMG's 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 within net loss from discontinued operations.

For the year ended December 31, 2017, excluding DMG's equity investment income attributable to CMGI, our consolidated net income would be decreased by approximately $19 thousand. See Note 29 to the consolidated financial statements for further details.

Contingencies

The information in Note 16 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 and investments, accounting for income taxes, quarterly and annual variable compensation accruals, consolidation of variable interest entities, and fair value estimates 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.

U.S. dialysis and related lab services revenue recognition and accounts receivable. There are significant estimating risks associated with the amount of U.S. 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 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 single bundled payment rate system, our revenue recognition is 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 197,800 U.S. dialysis patients at any point in time, together with the changes in patient coverages 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 the range of our U.S. dialysis and related lab services revenues estimating risk to be within 1% of its revenue, which can represent as much as approximately 5% of U.S. 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.

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

Impairments of goodwill and investments. We account for impairments of goodwill and equity method and other investments in accordance with the provisions of applicable accounting guidance. Goodwill is not amortized, but is assessed for impairment when changes in 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 estimated fair value. Equity method and other investments are assessed for other-than-temporary impairment when changes in circumstances warrant. An other-than-temporary impairment charge is recorded when the fair value of an investment has fallen below its carrying amount and the shortfall is expected to be indefinitely or permanently unrecoverable.

Such changes can include, among others, changes in the legal environment, addressable market, business strategy, development or business plans, reimbursement structure, operating performance, future prospects, relationships with partners, and/or market value indications for the subject business. We use a variety of factors to assess changes in the financial condition, future prospects and other circumstances concerning the subject businesses and to estimate their fair value when applicable. Any change in the factors, assessments or assumptions involved could impact a determination of whether and when to assess goodwill or an investment for impairment as well as the outcome of such an assessment. These assessments and the related valuations can involve significant uncertainties and require significant judgment on various matters, some of which could be subject to reasonable disagreement.

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, and changes in tax laws or regulations may be proposed or enacted that could adversely affect our overall tax liability. The actual impact of any such laws or regulations, including the 2017 Tax Act, could be materially different from our current estimates.

Significant judgments and estimates are required in determining our 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 federal, state, and foreign pre-tax operating income adjusted for items that do not have tax consequences. The assumptions about future taxable income require significant judgments 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.

Fair value estimates. We rely on fair value measurements and estimates for purposes that require the recording, reassessment, or adjustment of the carrying amounts of certain assets, liabilities and noncontrolling interest subject to put provisions (temporary equity). These purposes can include the accounting for business combination transactions, impairment assessments for goodwill, investments, or other long-lived assets, and stock-based compensation, among others. The criticality of a particular fair value estimate to our consolidated financial statements depends upon the nature and size of the item being measured and the extent of uncertainties involved and the nature and magnitude or potential effect of assumptions and judgments required. Critical fair value estimates can involve significant uncertainties and require significant judgment on various matters, some of which could be subject to reasonable disagreement.

The FASB defines fair value as the amount at which an asset (or liability) could be bought (or incurred) or sold (or settled) between willing parties, that is, other than in a forced or liquidation sale. Critical fair value estimates can be required for measurement of goodwill and equity method and other investment impairments, as discussed previously. Fair value estimates can also be critical in accounting for major acquisitions or business combination transactions of significant size involving businesses or industries in which we and/or our professional valuation advisors do not have significant experience. In these cases, the nature and size of the item being measured and the extent of uncertainties involved, as well as the nature and magnitude or potential effect of assumptions and judgments required, can make the fair value estimate a critical accounting estimate.

Significant new accounting standards

See Note 1 to the consolidated financial statements included in this report for information regarding certain recent financial 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, 2017. The variable rates presented reflect the weighted average LIBOR rates in effect for all debt tranches plus interest rate margins in effect as of December 31, 2017. The Term Loan A margin in effect at December 31, 2017 is 2.00%, 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
	2018	2019	2020	2021	2022				
	(dollars in millions)								
Long term debt:									
Fixed rate	$ 36	$ 28	$ 27	$ 26	$ 1,276	$ 3,501	$ 4,894	5.28%	$ 4,961
Variable rate	$ 142	$ 1,021	$ 46	$ 3,282	$ 8	$ 7	$ 4,506	4.45%	$ 4,549

	Notional amount	Contract maturity date					Receive variable	Fair value
		2018	2019	2020	2021	2022		
		(dollars in millions)						
Cap agreements	$ 7,000	$ 3,500	$ —	$ 3,500	$ —	$ —	LIBOR above 3.5%	$ 1.0

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, 2017, our Term Loan A bears interest at LIBOR plus an interest rate margin of 2.00% and our Term Loan B debt bears interest at LIBOR plus an interest rate margin of 2.75%. LIBOR was 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, 2017. The LIBOR-based interest component is effectively limited to a maximum LIBOR rate of 3.50% on the outstanding principal debt on Term Loan B and on $122.5 million of Term Loan A as a result of the interest rate cap agreements, as described below. In addition, the uncapped portion of Term Loan A, which is subject to the variability of LIBOR, is $652.5 million. Interest rates on our senior notes are fixed by their terms.

As of December 31, 2017, we maintain several currently effective interest rate cap agreements that were entered into in November 2014 with notional amounts totaling $3.5 billion. These cap agreements became effective September 30, 2016 and have the economic effect of capping the LIBOR variable component of our interest rate at a maximum of 3.50% on an equivalent amount of our debt. These cap agreements expire on June 30, 2018. As of December 31, 2017, these cap agreements had an immaterial fair value. During the year ended December 31, 2017, we recognized debt expense of $8.3 million from these caps. During the year ended December 31, 2017, we recorded a loss of $0.1 million in other comprehensive income due to a decrease in the unrealized fair value of these cap agreements.

As of December 31, 2017, we also 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 its debt. These cap agreements expire on June 30, 2020. As of December 31, 2017, the total fair value of these cap agreements was an asset of approximately $1.0 million. During the year ended December 31, 2017, we recorded a loss of $8.8 million in other comprehensive income due to a decrease in the unrealized fair value of these cap agreements.

Our overall weighted average effective interest rate on the senior secured credit facilities was 4.45%, based on the current margins in effect of 2.00% for Term Loan A and the Revolver and 2.75% for Term Loan B, as of December 31, 2017.

Our overall weighted average effective interest rate during the year ended December 31, 2017 was 4.70% and as of December 31, 2017 was 4.88%.

As of December 31, 2017, we had $300 million drawn on our $1.0 billion revolving line of credit under our senior secured credit facilities, in addition to approximately $14.4 million committed for outstanding letters of credit. We also have approximately $90.1 million of additional outstanding letters of credit related to Kidney Care and $0.2 million of committed outstanding letters of credit related to DMG, which is backed by a certificate of deposit.

We believe that we will generate significant operating cash flows and will have sufficient liquidity to fund our scheduled debt service and other obligations 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 means 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 $27.6 million, $11.6 million, and $9.3 million, net of tax, for the years ended December 31, 2017, 2016, and 2015, 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 average exchange rates during 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 2017, our international operations remained fairly small relative to the size of our consolidated financial statements, constituting less than 6% of our consolidated assets as of December 31, 2017 and approximately 3% of our consolidated net revenues for the year ended December 31, 2017. In addition, our foreign currency translation gains (losses) were less than approximately 6%, (2)%, and (3)% of our consolidated operating income for the years ended December 31, 2017, 2016 and 2015.

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, 2017 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, officers and directors, 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 2018 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 2018 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 2018 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, 2017, which consist of our 2011 Incentive Award Plan and our Employee Stock Purchase Plan. The material terms of these plans are described in Note 18 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	8,034,080[1]	67.92[2]	34,493,542	42,527,622
Equity compensation plans not requiring shareholder approval	—	—	—	—
Total	8,034,080	$ 67.92	34,493,542	42,527,622

(1) Includes 752,029 shares of common stock reserved for issuance in connection with performance share units and performance stock appreciation rights at the maximum number of shares issuable thereunder.

(2) This weighted-average includes performance stock appreciation rights at 100% of target amount and excludes full value awards such as restricted stock units and performance share units.

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 2018 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 2018 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 2018 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, 2017, 2016, and 2015	F-4
Consolidated Statements of Comprehensive Income for the years ended December 31, 2017, 2016, and 2015	F-5
Consolidated Balance Sheets as of December 31, 2017, and 2016	F-6
Consolidated Statements of Cash Flow for the years ended December 31, 2017, 2016, and 2015	F-7
Consolidated Statements of Equity for the years ended December 31, 2017, 2016, and 2015	F-8
Notes to Consolidated Financial Statements	F-9

(2) Index to Financial Statement Schedules:

Schedule II—Valuation and Qualifying Accounts	S-3

(3) Exhibits

The information required by this Item is set forth in the Exhibit Index that precedes the signature pages of this Annual Report on Form 10-K.

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, 2017.

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

To the Stockholders and Board of Directors
DaVita Inc.:

Opinion on the Consolidated Financial Statements

We have audited the accompanying consolidated balance sheets of DaVita Inc. and subsidiaries (the Company) as of December 31, 2017 and 2016, the related consolidated statements of income, comprehensive income, equity, and cash flow for each of the years in the three-year period ended December 31, 2017, and the related notes and financial statement Schedule II - Valuation and Qualifying Accounts (collectively, the consolidated financial statements). In our opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the Company as of December 31, 2017 and 2016, and the results of its operations and its cash flows for each of the years in the three-year period ended December 31, 2017, 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) (PCAOB), the Company's internal control over financial reporting as of December 31, 2017, based on criteria established in *Internal Control - Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission, and our report dated February 23, 2018 expressed an unqualified opinion on the effectiveness of the Company's internal control over financial reporting.

Basis for Opinion

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 are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the consolidated financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements. We believe that our audits provide a reasonable basis for our opinion.

/s/ KPMG LLP

We have served as the Company's auditor since 2000.

Seattle, Washington
February 23, 2018

Report of Independent Registered Public Accounting Firm

To the Stockholders and Board of Directors
DaVita Inc.:

Opinion on Internal Control Over Financial Reporting

We have audited DaVita Inc. and subsidiaries' (the Company) internal control over financial reporting as of December 31, 2017, based on criteria established in *Internal Control - Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission. In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2017, based on criteria established in *Internal Control - Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the consolidated balance sheets of the Company as of December 31, 2017 and 2016, the related consolidated statements of income, comprehensive income, equity, and cash flow for each of the years in the three-year period ended December 31, 2017, and the related notes and financial statement Schedule II - Valuation and Qualifying Accounts (collectively, the consolidated financial statements), and our report dated February 23, 2018 expressed an unqualified opinion on those consolidated financial statements.

Basis for Opinion

The Company'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 are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audit in accordance with the standards of the PCAOB. 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 of internal control over financial reporting 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.

Definition and Limitations of Internal Control Over Financial Reporting

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.

/s/ KPMG LLP

Seattle, Washington
February 23, 2018

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

	Year ended December 31,		
	2017	**2016**	**2015**
Dialysis and related lab patient service revenues	$ 10,093,670	$ 9,727,360	$ 9,155,447
Less: Provision for uncollectible accounts	(485,398)	(431,308)	(412,905)
Net dialysis and related lab patient service revenues	9,608,272	9,296,052	8,742,542
Other revenues	1,268,362	1,411,415	1,239,703
Total net revenues	10,876,634	10,707,467	9,982,245
Operating expenses and charges:			
Patient care costs and other costs	7,640,005	7,431,582	6,856,062
General and administrative	1,064,026	1,072,841	1,031,125
Depreciation and amortization	559,911	509,497	463,905
Provision for uncollectible accounts	(7,033)	11,677	9,240
Equity investment loss (income)	8,640	(16,874)	(13,919)
Investment and other asset impairments	295,234	14,993	—
Goodwill impairment charges	36,196	28,415	4,066
Gain on changes in ownership interests	(6,273)	(374,374)	—
(Gain) loss on settlements, net	(526,827)	—	495,000
Total operating expenses and charges	9,063,879	8,677,757	8,845,479
Operating income	1,812,755	2,029,710	1,136,766
Debt expense	(430,634)	(414,116)	(408,380)
Debt redemption charges	—	—	(48,072)
Other income, net	17,665	7,511	8,073
Income from continuing operations before income taxes	1,399,786	1,623,105	688,387
Income tax expense	323,859	431,761	207,510
Net income from continuing operations	1,075,927	1,191,344	480,877
Net loss from discontinued operations, net of tax	(245,372)	(158,262)	(53,467)
Net income	830,555	1,033,082	427,410
Less: Net income attributable to noncontrolling interests	(166,937)	(153,208)	(157,678)
Net income attributable to DaVita Inc.	$ 663,618	$ 879,874	$ 269,732
Earnings per share:			
Basic net income from continuing operations per share attributable to DaVita Inc.	$ 4.78	$ 5.12	$ 1.53
Basic net income per share attributable to DaVita Inc.	$ 3.52	$ 4.36	$ 1.27
Diluted net income from continuing operations per share attributable to DaVita Inc.	$ 4.71	$ 5.04	$ 1.49
Diluted net income per share attributable to DaVita Inc.	$ 3.47	$ 4.29	$ 1.25
Weighted average shares for earnings per share:			
Basic	188,625,559	201,641,173	211,867,714
Diluted	191,348,533	204,904,656	216,251,807
Amounts attributable to DaVita Inc.:			
Net income from continuing operations	$ 901,277	$ 1,032,373	$ 323,199
Net loss from discontinued operations	(237,659)	(152,499)	(53,467)
Net income attributable to DaVita Inc.	$ 663,618	$ 879,874	$ 269,732

See notes to consolidated financial statements.

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

	Year ended December 31,		
	2017	2016	2015
Net income	$ 830,555	$ 1,033,082	$ 427,410
Other comprehensive income (loss):			
Unrealized losses on interest rate cap and swap agreements:			
Unrealized losses on interest rate cap and swap agreements	(5,437)	(3,670)	(12,241)
Reclassifications of net cap and swap agreements realized losses into net income	5,058	2,566	3,111
Unrealized gains (losses) on investments:			
Unrealized gains (losses) on investments	3,705	1,427	(1,413)
Reclassification of net investment realized losses (gains) into net income	(220)	(423)	(377)
Foreign currency translation adjustments:			
Foreign currency translation adjustments	99,770	(39,614)	(23,889)
Reclassification of foreign currency translation into net income	—	10,087	—
Other comprehensive income (loss)	102,876	(29,627)	(34,809)
Total comprehensive income	933,431	1,003,455	392,601
Less: Comprehensive income attributable to noncontrolling interests	(166,935)	(153,398)	(157,678)
Comprehensive income attributable to DaVita Inc.	$ 766,496	$ 850,057	$ 234,923

See notes to consolidated financial statements.

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

	December 31, 2017	December 31, 2016
ASSETS		
Cash and cash equivalents	$ 508,234	$ 674,776
Short-term investments	43,516	306,981
Accounts receivable, less allowance of $218,399 and $238,897	1,714,750	1,503,950
Inventories	181,799	160,419
Other receivables	372,919	288,156
Income tax receivable	49,440	—
Prepaid and other current assets	112,058	99,510
Current assets held for sale	5,761,642	960,956
Total current assets	8,744,358	3,994,748
Property and equipment, net	3,149,213	2,864,121
Intangible assets, net	113,827	73,504
Equity method and other investments	245,534	492,039
Long-term investments	37,695	29,997
Other long-term assets	47,287	33,857
Goodwill	6,610,279	6,015,375
Long-term assets held for sale	—	5,252,135
	$ 18,948,193	$ 18,755,776
LIABILITIES AND EQUITY		
Accounts payable	$ 509,116	$ 456,619
Other liabilities	552,662	578,892
Accrued compensation and benefits	616,116	706,564
Current portion of long-term debt	178,213	160,262
Income tax payable	—	1,394
Current liabilities held for sale	1,185,070	807,233
Total current liabilities	3,041,177	2,710,964
Long-term debt	9,158,018	8,944,676
Other long-term liabilities	365,325	317,383
Deferred income taxes	486,247	530,869
Long-term liabilities held for sale	—	428,885
Total liabilities	13,050,767	12,932,777
Commitments and contingencies		
Noncontrolling interests subject to put provisions	1,011,360	973,258
Equity:		
Preferred stock ($0.001 par value, 5,000,000 shares authorized; none issued)		
Common stock ($0.001 par value, 450,000,000 shares authorized; 182,462,278 and 194,554,491 shares issued and outstanding, respectively)	182	195
Additional paid-in capital	1,042,899	1,027,182
Retained earnings	3,633,713	3,710,313
Accumulated other comprehensive income (loss)	13,235	(89,643)
Total DaVita Inc. shareholders' equity	4,690,029	4,648,047
Noncontrolling interests not subject to put provisions	196,037	201,694
Total equity	4,886,066	4,849,741
	$ 18,948,193	$ 18,755,776

See notes to consolidated financial statements.

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

	Year ended December 31,		
	2017	**2016**	**2015**
Cash flows from operating activities:			
Net income	$ 830,555	$ 1,033,082	$ 427,410
Adjustments to reconcile net income to net cash provided by operating activities:			
(Gain) loss on settlements, net	(526,827)	—	495,000
Depreciation and amortization	777,485	720,252	638,024
Impairment charges	981,589	296,408	210,234
Debt redemption charges	—	—	48,072
Stock-based compensation expense	35,092	38,338	56,664
Deferred income taxes	(395,217)	52,010	61,744
Equity investment income, net	28,925	17,766	9,293
Gain on sales of business interests, net	(23,402)	(404,165)	—
Other non-cash charges, net	66,925	(7,338)	44,691
Changes in operating assets and liabilities, net of effect of acquisitions and divestitures:			
Accounts receivable	(156,305)	(152,240)	(202,867)
Inventories	(18,625)	22,920	(48,313)
Other receivables and other current assets	(117,154)	(54,038)	32,761
Other long-term assets	(11,945)	35,893	3,723
Accounts payable	26,876	11,897	30,998
Accrued compensation and benefits	(78,239)	68,272	54,950
Other current liabilities	1,908	176,494	113,470
Settlement receipts (payments)	526,827	—	(493,775)
Income taxes	(52,176)	77,376	41,767
Other long-term liabilities	11,157	30,517	33,354
Net cash provided by operating activities	1,907,449	1,963,444	1,557,200
Cash flows from investing activities:			
Additions of property and equipment	(905,250)	(829,095)	(707,998)
Acquisitions	(803,879)	(563,856)	(96,469)
Proceeds from asset and business sales	92,336	64,725	19,715
Purchase of investments available for sale	(13,117)	(13,539)	(8,783)
Purchase of investments held-to-maturity	(230,989)	(1,133,192)	(1,709,883)
Proceeds from sale of investments available for sale	6,408	18,963	2,058
Proceeds from investments held-to-maturity	492,470	1,240,502	1,637,358
Purchase of equity investments	(4,816)	(27,096)	(17,911)
Proceeds from sale of equity investments	—	40,920	—
Distributions received on equity investments	106	—	129
Net cash used in investing activities	(1,366,731)	(1,201,668)	(881,784)

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

	Year ended December 31,		
	2017	**2016**	**2015**
Cash flows from financing activities:			
Borrowings	50,991,960	51,991,490	54,541,988
Payments on long-term debt and other financing costs	(50,837,112)	(52,116,120)	(53,998,962)
Purchase of treasury stock	(802,949)	(1,097,822)	(549,935)
Distributions to noncontrolling interests	(211,467)	(192,401)	(174,635)
Stock award exercises and other share issuances, net	21,252	23,543	26,155
Excess tax benefits from stock award exercises	—	13,251	28,157
Contributions from noncontrolling interests	74,552	47,590	54,644
Proceeds from sales of additional noncontrolling interests	2,864	—	—

Purchases of noncontrolling interests	(5,357)	(21,512)	(66,382)
Net cash used in financing activities	(766,257)	(1,351,981)	(138,970)
Effect of exchange rate changes on cash and cash equivalents	254	4,276	(2,571)
Net (decrease) increase in cash and cash equivalents	(225,285)	(585,929)	533,875
Less: Net (decrease) increase in cash and cash equivalents from discontinued operations	(58,743)	(15,788)	25,855
Net (decrease) increase in cash and cash equivalents from continuing operations	(166,542)	(570,141)	508,020
Cash and cash equivalents of continuing operations at beginning of the year	674,776	1,244,917	736,897
Cash and cash equivalents of continuing operations at end of the year	$ 508,234	$ 674,776	$ 1,244,917

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		Additional paid-in capital	Retained earnings	Treasury stock		Accumulated other comprehensive income (loss)	Total	
		Shares	Amount			Shares	Amount			
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	
Changes in non-controlling interests from:										
Distributions	(103,355)									(71,280)
Contributions	25,795									28,849
Acquisitions and divestitures	10,654									6,875
Partial purchases	(8,538)			(55,826)					(55,826)	(2,018)
Fair value remeasurement	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
Comprehensive income:										
Net income	99,834				879,874				879,874	53,374
Other comprehensive loss								(29,817)	(29,817)	190
Stock purchase shares issued		438	1	23,902					23,903	
Stock unit shares issued		4	—	(19,815)		276	19,815			
Stock-settled SAR shares issued		218	—	(36,685)		513	36,685			
Stock-settled stock-based compensation expense				37,970					37,970	
Excess tax benefits from stock awards exercised				13,251					13,251	
Changes in non-controlling interests from:										
Distributions	(111,092)									(81,309)
Contributions	33,517									14,073
Acquisitions and divestitures	28,874			3,423					3,423	2,585
Partial purchases	(6,660)			(13,105)					(13,105)	(1,747)
Fair value remeasurement	65,855			(65,855)					(65,855)	
Reclassifications and expirations of puts	(1,136)									1,136
Purchase of treasury stock						(16,649)	(1,072,377)		(1,072,377)	
Retirement of treasury stock		(23,226)	(23)	(34,230)	(1,526,396)	23,226	1,560,649			
Balance at December 31, 2016	$ 973,258	194,554	$ 195	$ 1,027,182	$ 3,710,313	—	$ —	$ (89,643)	$ 4,648,047	$ 201,694

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

	Non-controlling interests	DaVita Inc. Shareholders' Equity						Non-controlling interests not subject to
		Common stock		Additional	Treasury stock		Accumulated other	

	subject to put provisions	Shares	Amount	paid-in capital	Retained earnings	Shares	Amount	comprehensive income (loss)	Total	put provisions
Comprehensive income:										
Net income	103,641				663,618				663,618	63,296
Other comprehensive income								102,878	102,878	(2)
Stock purchase shares issued		360		22,131					22,131	
Stock unit shares issued		117		(101)					(101)	
Stock-settled SAR shares issued		398		—					—	
Stock-settled stock-based compensation expense				34,981					34,981	
Excess tax benefits from stock awards exercised										
Changes in noncontrolling interest from:										
Distributions	(128,853)									(82,614)
Contributions	52,911									21,641
Acquisitions and divestitures	43,799			(823)					(823)	(5,770)
Partial purchases	(397)			(2,752)					(2,752)	(2,208)
Fair value remeasurements	(32,999)			32,999					32,999	
Purchase of treasury stock						(12,967)	(810,949)		(810,949)	
Retirement of treasury stock		(12,967)	(13)	(70,718)	(740,218)	12,967	810,949			
Balance at December 31, 2017	$ 1,011,360	182,462	$ 182	$ 1,042,899	$ 3,633,713	—	$ —	$ 13,235	$ 4,690,029	$ 196,037

See notes to consolidated financial statements.

1. Organization and summary of significant accounting policies

Organization

DaVita Inc. (the Company) has consisted of 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, 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, 2017, the Company operated or provided administrative services through a network of 2,510 U.S. outpatient dialysis centers in 46 states and the District of Columbia, serving a total of approximately 197,800 patients. In addition, as of December 31, 2017, the Company operated or provided administrative services to a total of 237 outpatient dialysis centers serving approximately 22,900 patients located in 11 countries outside of the U.S.

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. On December 5, 2017, the Company entered into an equity purchase agreement to sell its DMG division to Collaborative Care Holdings, LLC (Optum), a subsidiary of UnitedHealth Group Inc. The transaction is expected to close in 2018 and is subject to regulatory approval and other customary closing conditions. As a result of this pending transaction, the DMG business has been reclassified as held for sale and its results of operations are reported as discontinued operations for all periods presented in these consolidated financial statements. For financial information about the DMG business, see Note 21.

The Company's U.S. dialysis and related lab services business qualifies as a separately reportable segment 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 goodwill and investments, accounting for income taxes, long-term variable compensation accruals, consolidation of variable interest entities, and certain fair value estimates. 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

U.S. dialysis 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 U.S. 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 revenues

Other revenues consist of the 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, and administrative and management support services to certain other non-dialysis joint ventures in which the Company owns a noncontrolling interest. Revenues associated with pharmacy services are recognized as prescriptions are filled and shipped to patients. Revenues associated with disease management services, medical consulting services, clinical research programs, physician services, ESRD seamless care organizations, and comprehensive care are recognized in the period services are provided. Revenues associated with direct primary care are recognized over the membership period. 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.

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 and cash-equivalents and short- and long-term investments, other non-operating gains from investment transactions, and 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.

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.

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.

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 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: 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.

Indefinite-lived intangibles

Indefinite-lived intangible assets include international licenses and accreditations that allow the Company to be reimbursed for providing dialysis services to patients, each of which has an indefinite useful life.

Equity method and other investments

Equity investments that do not have readily determinable fair values are carried on the cost or equity method, as applicable, net of any other-than-temporary impairment. The Company classifies its cost and equity method investments as "Equity method and other investments" on its balance sheet. See Note 9 to these consolidated financial statements for further details.

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 by individual reporting unit for impairment as circumstances warrant and at least annually. An impairment charge is recorded when a reporting unit's carrying amount is determined to exceed its fair value. The Company operates multiple reporting units. See Note 10 to these consolidated financial statements for further details.

Impairment of equity method and other investments

Equity method and other investments are assessed for other-than-temporary impairment when significant events or changes in circumstances indicate that an other-than-temporary impairment may have occurred. An other-than-temporary impairment charge is recorded when the fair value of an investment has fallen below its carrying amount and the shortfall is expected to be indefinitely or permanently unrecoverable.

Impairment of other long-lived assets

Other long-lived assets, including property and equipment and intangible assets, are reviewed for possible impairment whenever significant events or changes in circumstances indicate that an impairment may have occurred. Such changes can include changes in the Company's business strategy and plans, changes in the quality or structure of its relationships with its partners or deteriorating performance of individual outpatient dialysis centers or other business units. An impairment of an amortizable or depreciable asset is indicated when the sum of the expected future undiscounted net cash flows identifiable to the related asset group is less than its carrying amount. Impairment losses are measured based on the difference between the estimated fair value and the carrying amount of the subject asset group and are included in operating expenses.

Indefinite-lived intangible assets are reviewed for possible impairment at least annually and whenever significant events or changes in circumstances indicate that an impairment may have occurred.

Self-insurance

The Company is predominantly self-insured with respect to professional and general liability and workers' compensation risks through wholly-owned captive insurance companies, with excess or reinsurance coverage for additional risk. The Company is also predominantly self-insured with respect to employee medical and other health benefits. The Company records insurance liabilities for the professional and general liability, workers' compensation, and employee health benefit risks that it retains and estimates its liability for those risks using third party actuarial calculations that are based upon historical claims experience and expectations for future claims.

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 cap and swap agreements

The Company often carries a combination of currently effective 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 13 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, 2017, third parties held noncontrolling equity interests in 589 consolidated legal entities, including 586 legal entities classified as continuing operations.

Fair value estimates

The Company relies on fair value measurements and estimates for purposes that require the recording, reassessment, or adjustment of the carrying amounts of certain assets, liabilities and noncontrolling interests subject to put provisions (temporary equity). These purposes can include the accounting for business combination transactions, impairment assessments for goodwill, investments, or other long-lived assets, and stock-based compensation, as well as recurring valuations of available for sale securities, noncontrolling interests in temporary equity, derivative instruments, and/or contingent consideration, as applicable. 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 these consolidated financial statements for further details.

New accounting standards

On May 28, 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 2015 and 2016, the FASB issued ASU 2015-14, ASU2016-08, 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. These ASUs will replace most existing revenue recognition guidance in U.S. GAAP.

The Company will adopt these ASUs beginning January 1, 2018 using the cumulative effect method and will apply these ASUs only to those contracts that are not completed contracts as of that date with no cumulative effect adjustment. In preparation for the adoption of these ASUs, the Company has concluded that this guidance will result in a change to the presentation of its revenues, provision for uncollectible accounts and allowance for doubtful accounts, which will result in the Company's provision for uncollectible accounts being recorded as a reduction to revenue. The guidance will also require additional disaggregated revenue disclosures. The guidance will not have a material impact on the Company's consolidated financial position, results of operations, equity or cash flows. The Company expects to benefit from certain policy elections related to its adoption of these standards of approximately $30,000 in the first half of 2018.

In January 2016, the FASB issued ASU No. 2016-01, *Financial Instruments - 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 Company is still evaluating certain aspects of this ASU as well as the related impacts it may have on its consolidated financial statements when adopted on January 1, 2018.

In February 2016, the FASB issued ASU No. 2016-02, *Leases (Topic 842)*. The amendments in this ASU revise the accounting related to lessee accounting. Under the new guidance, lessees will be required to recognize a lease liability and a right-of-use asset for substantially all leases with lease terms in excess of twelve months. The new lease guidance also simplifies the accounting for sale and leaseback transactions primarily because lessees must recognize lease assets and lease liabilities. The amendments in this ASU are effective for the Company beginning on January 1, 2019 and are to be applied through a modified retrospective transition approach for leases existing at, or entered into after, the beginning of the earliest comparative period presented in the financial statements. Early adoption is permitted. The Company has assembled an internal lease task force that meets regularly to discuss and evaluate the overall impact of this guidance on its consolidated financial statements and related disclosures, as well as the expected timing of adoption. The Company is currently gathering information from its existing leases and 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 expects to adopt this ASU on January 1, 2019, and continues to evaluate the effect that the implementation of this ASU will have on its consolidated financial statements, related disclosures and controls.

In March 2016, the FASB issued ASU No. 2016-07, *Investments - Equity Method and Joint Ventures (Topic 323): Simplifying the Transition to the Equity Method of Accounting.* The amendments in this ASU eliminate the requirement that when an investment qualifies for use of the equity method as a result of an increase in the level of ownership interest or degree of influence, an investor must adjust the investment, results of operations, and retained earnings retroactively on a step-by-step basis as if the equity method had been in effect during all previous periods that the investment had been held. The amendments in this ASU were effective for the Company beginning on January 1, 2017 and were applied prospectively. The adoption of this ASU did not 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, classification on the statement of cash flow, and an election on estimating forfeitures. The amendments in this ASU were effective for the Company beginning January 1, 2017. The method of adoption differs for each of the topics covered by the ASU. The primary effect of this ASU for the Company is the presentation of excess tax benefits or deficiencies as a component of income tax expense within the Company's consolidated statements of income rather than within additional paid-in capital on its consolidated balance sheet. In addition, these excess tax benefits or deficiencies are presented as an operating activity rather than as a financing activity on the consolidated statements of cash flow.

The Company elected to apply the presentation requirements for cash flows related to excess tax benefits prospectively. Additionally, the Company has elected to continue to estimate forfeitures expected to occur in determining the amount of compensation expense to be recognized each period. While this new standard may cause volatility in the Company's effective tax rates and diluted earnings per share due to tax effects of stock awards being recorded within the Company's consolidated statements of operations, adoption of this standard did not have a material impact on the Company's consolidated financial statements for the year ended December 31, 2017.

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 is to be applied retrospectively to all periods presented. The adoption of this ASU is not expected to have a material impact on the Company's consolidated financial statements when adopted on January 1, 2018.

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 adoption of this ASU is not expected to have a material impact on the Company's consolidated financial statements when adopted on January 1, 2018.

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 goodwill impairment assessments. The Company early adopted this ASU as of January 1, 2017.

In August 2017, the FASB issued ASU No. 2017-12, *Derivatives and Hedging (Topic 815): Targeted Improvements to Accounting for Hedging Activities.* The amendments in this ASU better align an entity's risk management activities and

financial reporting for hedging relationships through changes to both the designation and measurement guidance for qualifying hedging relationships and the presentation of hedge results. The amendments in the new ASU are effective for the Company on January 1, 2019 and are to be applied prospectively. The adoption of this ASU is not expected to have a material impact on the Company's consolidated financial statements when adopted on January 1, 2018.

In February 2018, the FASB issued ASU No. 2018-2, *Income Statement - Reporting Comprehensive Income (Topic 220), Reclassification of Certain Tax Effects from Accumulated Other Comprehensive Income*, which allows for the reclassification of certain income tax effects related to the Tax Cuts and Jobs Act between "Accumulated other comprehensive income" and "Retained earnings." This ASU relates to the requirement that adjustments to deferred tax liabilities and assets related to a change in tax laws or rates to be included in "Income from continuing operations", even in situations where the related items were originally recognized in "Other comprehensive income" (rather than in "Income from continuing operations"). The amendments in this ASU are effective for all entities for fiscal years beginning after December 15, 2018, and interim periods within those fiscal years, with early adoption permitted. Adoption of this ASU is to be applied either in the period of adoption or retrospectively to each period in which the effect of the change in the tax laws or rates were recognized. The Company is still evaluating certain aspects of this ASU as well as the related impacts it may have on the Company's consolidated financial statements.

2. Earnings per share

Basic earnings 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 earnings per share includes the dilutive effect of outstanding stock-settled stock appreciation rights (SSARs) 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,		
	2017	2016	2015
	(shares in thousands)		
Numerators:			
Net income from continuing operations attributable to DaVita Inc.	$ 901,277	$ 1,032,373	$ 323,199
Net loss from discontinued operations attributable to DaVita Inc.	(237,659)	(152,499)	(53,467)
Net income attributable to DaVita Inc. for basic earnings per share calculation	$ 663,618	$ 879,874	$ 269,732
Basic:			
Weighted average shares outstanding during the period	190,820	203,835	214,062
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	188,626	201,641	211,868
Basic net income from continuing operations per share attributable to DaVita Inc.	$ 4.78	$ 5.12	$ 1.53
Basic net loss from discontinued operations per share attributable to DaVita Inc.	(1.26)	(0.76)	(0.26)
Basic net income per share attributable to DaVita Inc.	$ 3.52	$ 4.36	$ 1.27
Diluted:			
Weighted average shares outstanding during the period	190,820	203,835	214,062
Assumed incremental shares from stock plans	529	1,070	2,190
Weighted average shares for diluted earnings per share calculation	191,349	204,905	216,252
Diluted net income from continuing operations per share attributable to DaVita Inc.	$ 4.71	$ 5.04	$ 1.49
Diluted net loss from discontinued operations per share attributable to DaVita Inc.	(1.24)	(0.75)	(0.24)
Diluted net income per share attributable to DaVita Inc.	$ 3.47	$ 4.29	$ 1.25
Anti-dilutive stock-settled awards excluded from calculation[(1)]	4,350	2,523	1,365

(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. 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 these securities and certain other financial instruments consist of the following:

	December 31, 2017			December 31, 2016		
	Held to maturity	Available for sale	Total	Held to maturity	Available for sale	Total
Certificates of deposit, commercial paper and money market funds due within one year	$ 42,316	$ —	$ 42,316	$ 255,781	$ —	$ 255,781
Investments in mutual funds and common stock	—	38,895	38,895	50,000	31,197	81,197
	$ 42,316	$ 38,895	$ 81,211	$ 305,781	$ 31,197	$ 336,978
Short-term investments	$ 42,316	$ 1,200	$ 43,516	$ 305,781	$ 1,200	$ 306,981
Long-term investments	—	37,695	37,695	—	29,997	29,997
	$ 42,316	$ 38,895	$ 81,211	$ 305,781	$ 31,197	$ 336,978

The cost of certificates of deposit, commercial paper and money market funds at December 31, 2017 and 2016 approximate their fair value. As of December 31, 2017 and 2016, available for sale investments included $8,416 and $3,701, respectively, of gross pre-tax unrealized gains. During 2017 and 2016 the Company recorded gross pre-tax unrealized gains of $5,075 and $1,802, respectively, in other comprehensive income associated with changes in the fair value of these investments. During 2017, the Company sold investments in mutual funds and common stock for net proceeds of $6,408, and recognized a pre-tax gain of $360, or $220 after tax, that was previously recorded in other comprehensive income. 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.

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.

4. Accounts receivable

Approximately 21% and 16% of the Company's net patient services accounts receivable balances as of December 31, 2017 and 2016, respectively, were more than six months old. The increase was primarily due to changes the Company made in its collection policies and procedures to improve overall collections. 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 U.S. 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.

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.

During the year ended December 31, 2017, the Company's allowance for doubtful accounts decreased by $20,498. The decrease in 2017 was primarily due to an increase in write-offs of aged balances from an increase in uninsured and underinsured uncollectible patient balances related to the U.S. dialysis and related lab business. During the year ended December 31, 2016, the Company's allowance for doubtful accounts decreased by $12,837. 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.

5. Other receivables

Other receivables were comprised of the following:

	December 31,	
	2017	2016
Supplier rebates and non-trade receivables	$ 268,949	$ 183,498
Medicare bad debt claims	103,970	104,658
	$ 372,919	$ 288,156

6. Prepaid and other current assets

Other current assets were comprised of the following:

	December 31,	
	2017	2016
Prepaid expenses	$ 104,727	$ 96,818
Other	7,331	2,692
	$ 112,058	$ 99,510

7. Property and equipment

Property and equipment were comprised of the following:

	December 31,	
	2017	2016
Land	$ 33,814	$ 26,339
Buildings	473,489	429,039
Leasehold improvements	2,816,675	2,495,070
Equipment and information systems, including internally developed software	2,352,246	2,182,912
New center and capital asset projects in progress	576,651	429,037
	6,252,875	5,562,397
Less accumulated depreciation	(3,103,662)	(2,698,276)
	$ 3,149,213	$ 2,864,121

Depreciation expense on property and equipment was $544,129, $494,945, and $444,720 for 2017, 2016 and 2015, respectively.

In addition, during the first quarter of 2017, the Company recognized an asset impairment charge of $15,168 related to the restructuring of its pharmacy business.

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 $19,176, $12,990 and $9,723 for 2017, 2016 and 2015, respectively.

8. Intangibles

Intangible assets other than goodwill were comprised of the following:

	December 31,	
	2017	2016
Noncompetition and other agreements	$ 429,140	$ 407,220
Lease agreements	7,623	7,244
Indefinite-lived assets	33,255	1,125
Other	583	583
	470,601	416,172
Less accumulated amortization	(356,774)	(342,668)
	$ 113,827	$ 73,504

Amortization expense from amortizable intangible assets, other than lease agreements, was $15,782, $14,552, and $19,185 for 2017, 2016 and 2015, respectively. Lease agreement intangible assets and liabilities were amortized to rent expense in the amounts of $(203), $(232) and $(331) for 2017, 2016 and 2015, respectively.

During the years ended December 31, 2017, 2016 and 2015, the Company recognized no impairment charges on any intangible assets other than goodwill.

Amortizable intangible liabilities as of December 31, 2017 and 2016 were comprised of lease agreements of $5,447 and $6,011, respectively, which were net of accumulated amortization of $3,508 and $3,618, respectively.

There was no amortization benefit recognized from the alliance and product supply agreement in 2017 and 2016 as it expired in September 2015. Amortization benefit related to this agreement was $3,997 for 2015.

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, 2017 were as follows:

	Noncompetition and other agreements	Lease liabilities	Other
2018	$ 15,581	$ (849)	$ 102
2019	14,051	(658)	87
2020	12,629	(628)	44
2021	9,929	(602)	—
2022	6,808	(553)	—
Thereafter	21,341	(2,157)	—
Total	$ 80,339	$ (5,447)	$ 233

9. Equity method and other investments

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

As described in Note 20, effective as of August 1, 2016, the Company deconsolidated its Asia Pacific dialysis business held by DaVita Care Pte. Ltd. (the APAC JV), adjusted its retained investment in the APAC JV to estimated fair value at that time, and has accounted for this retained investment on the equity method since that time.

During the year ended December 31, 2017, the Company recognized a non-cash other-than-temporary impairment charge of $280,066 on its investment in the APAC JV. This charge resulted from changes in its expectations for the joint venture based on continuing market research and assessments by both the Company and the APAC JV concerning the size of the addressable market available to the joint venture at attractive risk-adjusted returns. The Company estimated the fair value of its retained interest in the APAC JV with the assistance of an independent third party valuation firm based on information available to management as of December 31, 2017. After this charge, the Company’s investment in the APAC JV was carried at $160,481 as of December 31, 2017.

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

Total equity method and other investments in nonconsolidated businesses were $245,534 and $492,039 at December 31, 2017 and 2016, respectively. The decrease in these equity investments was primarily due to the impairment of the Company's investment in the APAC JV. During 2017, 2016 and 2015, the Company recognized equity investment (loss) income of $(8,640), $16,874 and $13,919, respectively, from its equity method investments in nonconsolidated businesses.

10. Goodwill

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

	U.S. dialysis and related lab services	Other ancillary services and strategic initiatives	Consolidated total
Balance at January 1, 2016	$ 5,629,183	$ 267,032	$ 5,896,215
Acquisitions	75,295	123,632	198,927
Divestitures	(12,891)	(29,645)	(42,536)
Goodwill impairment charges	—	(28,415)	(28,415)
Foreign currency and other adjustments	—	(8,816)	(8,816)
Balance at December 31, 2016	$ 5,691,587	$ 323,788	$ 6,015,375
Acquisitions	485,434	131,598	617,032
Divestitures	(32,260)	(126)	(32,386)
Goodwill impairment charges	—	(36,196)	(36,196)
Foreign currency and other adjustments	—	46,454	46,454
Balance at December 31, 2017	$ 6,144,761	$ 465,518	$ 6,610,279
Goodwill	$ 6,144,761	$ 536,038	$ 6,680,799
Accumulated impairment charges	—	(70,520)	(70,520)
	$ 6,144,761	$ 465,518	$ 6,610,279

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

Each of the Company's operating segments described in Note 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 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 year ended December 31, 2016, the Company recognized a goodwill impairment charge of $28,415 related to the Company's vascular access reporting unit as a result of changes in future governmental reimbursement rates for this business 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 Rule which reflected significant changes in reimbursement structure for this business unit.

During the year ended December 31, 2017, the Company recognized an additional goodwill impairment charge of $34,696 at its vascular access reporting unit. This charge resulted primarily from continuing changes in the Company's outlook for this business unit as the Company's partners and operators continued to evaluate and make decisions concerning changes in operations, including termination of their management services agreements and center closures, as a result of the changes in reimbursement structure discussed above. As of December 31, 2017, there was no goodwill remaining at the Company's vascular access reporting unit.

During the year ended December 31, 2017, the Company also performed annual impairment assessments for various other reporting units. As a result of these assessments, the Company also recognized a goodwill impairment charge of $1,500 at one of its international reporting units during the year ended December 31, 2017. During the year ended December 31, 2015, the Company also recognized a goodwill impairment charge of $4,066 at another international reporting unit.

Based on the most recent assessments, the Company determined that reductions in reimbursement rates, changes in actual or expected growth rates, or other significant adverse changes in expected future cash flows or valuation assumptions could result in goodwill impairment charges in the future for the following reporting units, which remain at risk of goodwill impairment as of December 31, 2017:

Reporting unit	Goodwill balance as of December 31, 2017	Carrying amount coverage[1]	Sensitivities	
			Operating income[2]	Discount rate[3]
Kidney Care Germany	$ 316,369	13.7%	(1.6)%	(11.1)%
Kidney Care Portugal	$ 46,713	16.9%	(1.9)%	(6.0)%
Kidney Care Poland	$ 46,610	11.8%	(1.9)%	(6.0)%

(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 through December 31, 2017.

Except as described above, none of the Company's other reporting units were considered at risk of significant goodwill impairment as of December 31, 2017. 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 values of any of the Company's reporting units would be less than their respective carrying amounts as of December 31, 2017.

11. Other liabilities

Other liabilities were comprised of the following:

	December 31,	
	2017	2016
Payor refunds and retractions	$ 292,370	$ 270,298
Insurance and self-insurance accruals	64,924	76,857
Accrued interest	83,362	82,234
Accrued non-income tax liabilities	28,317	23,643
Other	83,689	125,860
	$ 552,662	$ 578,892

12. 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 statement 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 from continuing operations consisted of the following:

	Year ended December 31,		
	2017	2016	2015
Domestic	$ 1,725,822	$ 1,278,754	$ 730,249
International	(326,036)	344,351	(41,862)
	$ 1,399,786	$ 1,623,105	$ 688,387

Income tax expense (benefit) for continuing operations consisted of the following:

	Year ended December 31,		
	2017	2016	2015
Current:			
Federal	$ 330,191	$ 322,940	$ 124,503
State	47,228	44,525	20,442
International	3,422	1,928	856
Total current income tax	380,841	369,393	145,801
Deferred:			
Federal	(98,760)	88,412	71,016
State	37,347	(28,530)	(9,737)
International	4,431	2,486	430
Total deferred income tax	(56,982)	62,368	61,709
	$ 323,859	$ 431,761	$ 207,510

Income taxes are allocated between continuing and discontinued operations as follows:

	Year ended December 31,		
	2017	2016	2015
Continuing operations	$ 323,859	$ 431,761	$ 207,510
Discontinued operations	(364,856)	24,052	88,216
	$ (40,997)	$ 455,813	$ 295,726

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

	Year ended December 31,		
	2017	2016	2015
Federal income tax rate	35.0 %	35.0 %	35.0 %
State income taxes, net of federal benefit	3.7	2.6	1.7
Gain on APAC JV ownership changes	(0.2)	(9.9)	—
APAC investment impairment	6.4	—	—
Impact of 2017 Tax Act	(20.5)	—	—
Other	2.0	1.8	2.3
Impact of noncontrolling interests primarily attributable to non-tax paying entities	(3.3)	(2.9)	(8.9)
Effective tax rate	23.1 %	26.6 %	30.1 %

On December 22, 2017, the President signed into law the tax legislation known as the Tax Cuts and Jobs Act (the 2017 Tax Act). The 2017 Tax Act includes a number of changes to existing U.S. tax laws that impact the Company, most notably a reduction in the U.S. corporate income tax rate from 35.0% to 21.0% effective January 1, 2018. The 2017 Tax Act also provides for full expensing of qualified assets placed into service after September 27, 2017, as well as prospective changes beginning in 2018, imposes a one-time transition tax on certain foreign subsidiaries, and changes how foreign earnings are subject to U.S. tax prospectively.

The Company recognized the income tax effects of the 2017 Tax Act in its 2017 financial statements in accordance with Staff Accounting Bulletin No. 118, which provides SEC staff guidance for the application of ASC Topic 740, *Income Taxes*, in the reporting period in which the 2017 Tax Act was signed into law. As such, the Company's financial results reflect the income tax effects of the 2017 Tax Act for which accounting under ASC Topic 740 is complete and provisional amounts, primarily as it relates to the full expensing provisions of the 2017 Tax Act, for those specific income tax effects for which the accounting is incomplete but a reasonable estimate could be determined.

The Company has completed the accounting for income taxes with respect to the mandatory one-time tax on accumulated earnings of its foreign subsidiaries and has determined that there is no mandatory repatriation and therefore no income tax liability associated with this one-time tax.

The Company measures deferred tax assets and liabilities using enacted tax rates that will apply in the years in which the temporary differences are expected to be recovered or paid. Accordingly, the Company's deferred tax assets and liabilities were remeasured to reflect a reasonable estimate of the reduction in the U.S. corporate income tax rate from 35.0% to 21.0%, resulting in a provisional $251,510 net tax benefit.

While the Company has substantially completed its provisional analysis of the income tax effects of the 2017 Tax Act and recorded a reasonable estimate of such effects, the net one-time benefit related to the 2017 Tax Act may differ, possibly materially, due to, among other things, further refinement of the underlying calculations, changes in interpretations and assumptions that the Company has made, additional guidance that may be issued by the U.S. Government, and actions and related accounting policy decisions the Company may take as a result of the 2017 Tax Act. The Company will complete its analysis over a one-year measurement period ending December 22, 2018, and any adjustments during this measurement period will be included in net earnings from continuing operations as an adjustment to income tax expense in the reporting period in which such adjustments are determined.

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

	December 31,	
	2017	2016
Receivables	$ 19,705	$ 25,197
Accrued liabilities	96,537	224,712
Net operating loss carryforwards	108,429	128,813
Other	37,794	73,525
Deferred tax assets	262,465	452,247
Valuation allowance	(61,282)	(56,016)
Net deferred tax assets	201,183	396,231
Intangible assets	(501,763)	(676,781)
Property and equipment	(100,376)	(141,919)
Investments in partnerships	(61,529)	(95,936)
Other	(23,762)	(12,464)
Deferred tax liabilities	(687,430)	(927,100)
Net deferred tax liabilities	$ (486,247)	$ (530,869)

At December 31, 2017, the Company had federal net operating loss carryforwards of approximately $137,852 that expire through 2036, although a substantial amount expire by 2028. The Company also had state net operating loss carryforwards of $445,554 that expire through 2036 and international net operating loss carryforwards of $138,717, 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 net increase of $5,266 in the valuation allowance is primarily due to newly created net operating loss carryforwards in state and foreign jurisdictions that the Company does not anticipate being able to utilize.

The 2017 Tax Act includes a mandatory one-time tax on accumulated earnings of foreign subsidiaries, and as a result, all previously unremitted earnings for which no U.S. deferred tax liability had been accrued would now be subject to U.S. tax. Irrespective of the fact that the Company will not experience any one-time tax under this provision of the 2017 Tax Act, it

intends to continue to indefinitely reinvest these earnings, as well as capital invested and future earnings from its foreign subsidiaries to fund its international operations. In addition, the Company expects future U.S. cash generation will be sufficient to meet future U.S. cash needs. Determination of the amount of any applicable deferred taxes on the earnings is not practical since the computation would depend on a number of factors that cannot be known unless a decision is made to repatriate the earnings.

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 is as follows:

	Year ended December 31,	
	2017	2016
Beginning balance	$ 24,066	$ 39,011
Additions for tax positions related to current year	7,606	9,714
Additions for tax positions related to prior years	804	—
Reductions related to lapse of applicable statute	(1,380)	(1,277)
Impact of 2017 Tax Act	3,731	—
Reductions related to settlements with taxing authorities	(2,051)	(23,382)
Ending balance	$ 32,776	$ 24,066

As of December 31, 2017, the Company's total liability for unrecognized tax benefits relating to tax positions that do not meet the more-likely-than-not threshold is $32,776, all of which would impact the Company's effective tax rate if recognized. This balance represents an increase of $8,710 from the December 31, 2016 balance of $24,066, primarily due to additions for tax positions related to the current year.

The Company recognizes accrued interest and penalties related to unrecognized tax benefits in its income tax expense. At December 31, 2017 and 2016, the Company had approximately $4,195 and $2,595, 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 foreign 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.

13. Long-term debt

Long-term debt was comprised of the following:

	December 31,	
	2017	2016
Senior Secured Credit Facilities:		
Term Loan A	$ 775,000	$ 862,500
Term Loan B	3,377,500	3,412,500
Revolver	300,000	—
Senior notes	4,500,000	4,500,000
Acquisition obligations and other notes payable	150,512	117,547
Capital lease obligations	297,170	292,252
Total debt principal outstanding	9,400,182	9,184,799
Discount and deferred financing costs	(63,951)	(79,861)
	9,336,231	9,104,938
Less current portion	(178,213)	(160,262)
	$ 9,158,018	$ 8,944,676

Scheduled maturities of long-term debt at December 31, 2017 were as follows:

2018	178,213
2019	1,049,091
2020	73,362
2021	3,307,507
2022	1,283,671
Thereafter	3,508,338

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) 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, 2017, 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 2.00%. At December 31, 2017, 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, 2017. 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 $652,500 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, 2017, the Company made mandatory principal payments under its senior secured credit facilities totaling $87,500 on Term Loan A and $35,000 on Term Loan B.

Revolving lines of credit

The Company has $300,000 drawn on its $1,000,000 revolving line of credit under its senior secured credit facilities, in addition to approximately $14,383 committed for outstanding letters of credit. The Company also has approximately $90,085 of additional outstanding letters of credit related to Kidney Care and $211 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, 2017 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.

Interest rate cap and swap agreements

During the year ended December 31, 2017 the Company had several currently effective and forward interest rate cap 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 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 cap agreements do not contain credit-risk contingent features.

As of December 31, 2017, the Company maintains several currently effective interest rate cap agreements that were entered into in November 2014 with notional amounts totaling $3,500,000. These cap agreements became effective September 30, 2016 and have the economic effect of capping the LIBOR variable component of the Company's interest rate at a maximum of 3.50% on an equivalent amount of the Company's debt. These cap agreements expire on June 30, 2018. As of December 31, 2017, these cap agreements had an immaterial fair value. During the year ended December 31, 2017, the Company recognized debt expense of $8,278 from these caps. During the year ended December 31, 2017, the Company recorded a loss of $115 in other comprehensive income due to a decrease in the unrealized fair value of these cap agreements.

As of December 31, 2017, the Company also maintains several forward interest rate cap agreements that were entered into in October 2015 with notional amounts totaling $3,500,000. These forward cap agreements will become effective June 29, 2018 and will have the economic effect of capping the LIBOR variable component of the Company's interest rate at a maximum of 3.50% on an equivalent amount of its debt. These cap agreements expire on June 30, 2020. As of December 31, 2017, the total fair value of these cap agreements was an asset of approximately $1,032. During the year ended December 31, 2017, the Company recorded a loss of $8,782 in other comprehensive income due to a decrease in the unrealized fair value of these cap agreements.

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

		Fair value	
Derivatives designated as hedging instruments	**Balance sheet location**	**December 31, 2017**	**December 31, 2016**
Interest rate cap agreements	Other long-term assets	$ 1,032	$ 9,929

The following table summarizes the effects of the Company's interest rate cap and swap agreements for the years ended December 31, 2017, 2016 and 2015:

	Amount of unrealized losses in OCI on interest rate cap and swap agreements			Location of losses reclassified from accumulated OCI into income	Amount of losses reclassified from accumulated OCI into income		
	Year ended December 31,				Year ended December 31,		
Derivatives designated as cash flow hedges	**2017**	**2016**	**2015**		**2017**	**2016**	**2015**
Interest rate cap agreements	$ (8,897)	$ (5,198)	$ (16,114)	Debt expense	$ 8,278	$ 3,899	$ 2,439
Interest rate swap agreements	—	(815)	(3,971)	Debt expense	—	299	2,664
Tax benefit	3,460	2,343	7,844	Tax expense	(3,220)	(1,632)	(1,992)
Total	$ (5,437)	$ (3,670)	$ (12,241)		$ 5,058	$ 2,566	$ 3,111

As of December 31, 2017, 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 2.00%. The capped portion of Term Loan A is $122,500. In addition, the uncapped portion of Term Loan A, which is subject to the variability of LIBOR, is $652,500. 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 4.45%, based upon the current margins in effect of 2.00% for Term Loan A and the Revolver and 2.75% for Term Loan B, as of December 31, 2017.

The Company's overall weighted average effective interest rate during the year ended December 31, 2017 was 4.70% and as of December 31, 2017 was 4.88%.

Debt expense

Debt expense consisted of interest expense of $406,341, $394,013 and $389,755 and the amortization and accretion of debt discounts and premiums, amortization of deferred financing costs and the amortization of interest rate cap agreements of $24,293, $20,103 and $18,625 for 2017, 2016 and 2015, respectively. The interest expense amounts are net of capitalized interest.

14. Leases

The majority of the Company's facilities are leased under non-cancellable 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 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-cancellable operating and capital leases are as follows:

	Operating leases	Capital leases
2018	$ 446,935	$ 35,258
2019	422,245	36,038
2020	384,764	36,689
2021	351,962	32,578
2022	313,005	33,004
Thereafter	1,303,594	234,094
	$ 3,222,505	407,661
Less portion representing interest		(110,491)
Total capital lease obligations, including current portion		$ 297,170

Rent expense under all operating leases for 2017, 2016, and 2015 was $530,748, $478,531 and $440,601, 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 $257,772 and $263,438 at December 31, 2017 and 2016, respectively. Capital lease obligations are included in long-term debt. See Note 13 to these consolidated financial statements.

15. Employee benefit plans

The Company has a savings plan for substantially all of its Kidney Care 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 has not provided any matching contributions for its Kidney Care employees through December 31, 2017.

Beginning in 2018, the Company has implemented a 401(k) matching program under which the Company will match 50% of the employee's contribution up to 6% of the employee's salary, subject to certain limitations. The matching contributions will be subject to certain eligibility and vesting conditions.

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 2017, 2016 and 2015 were $4,497, $5,344 and $4,234, 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 2017, 2016 and 2015 the Company distributed $1,731, $916 and $1,270, 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, 2017 and 2016, the total fair value of assets held in this plan's trust were $38,816 and $30,192, respectively.

The Company also maintains a legacy 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 2017, 2016 and 2015 the Company distributed $1,058 and $149, $25 respectively, to participants in this plan. As of December 31, 2017 and 2016, the total fair value of assets held under this plan's trust was $79 and $1,005, respectively.

The fair value of all of the assets held in plan trusts as of December 31, 2017, and 2016 totaled $38,895 and $31,197, respectively. The assets of these plans are available for sale and as such are recorded at fair value with changes in the fair market values being recorded in other comprehensive income. Any fair value changes to the corresponding liability balance are recorded as compensation expense. See Note 3 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, 2017, these cash bonuses would total approximately $520,778 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, 2017, 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.

16. 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, *qui tam* suits, governmental investigations and audits (including investigations resulting from its obligation to self-report suspected violations of law) and other legal proceedings. The Company records accruals for certain legal proceedings and regulatory matters to the extent that the Company determines an unfavorable outcome is probable and the amount of the loss can be reasonably estimated. As of December 31, 2017 and December 31, 2016, the Company's total recorded accruals, including DMG, with respect to legal proceedings and regulatory matters, net of anticipated third party recoveries, were approximately $6,000 and $69,000, respectively. While these accruals reflect the Company's best estimate of the probable loss for those matters as of the dates of those accruals, the recorded amounts may differ materially from the actual amount of the losses for those matters, and any anticipated third party recoveries for any such losses may not ultimately be recoverable. Additionally, in some cases, no estimate of the possible loss or range of loss in excess of amounts accrued, if any, can be made because of the inherently unpredictable nature of legal proceedings and regulatory matters, which also may be impacted 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

2015 U.S. Office of Inspector General (OIG) Medicare Advantage Civil Investigation: In March 2015, JSA HealthCare Corporation (JSA), a subsidiary of DMG, received a subpoena from the Office of Inspector General (OIG) for the U.S. Department of Health and Human Services (HHS) requesting documents and information for the period from January 1, 2008 through December 31, 2013, for certain MA plans for which JSA provided services. It also requests information regarding JSA's communications about patient diagnoses as they relate to certain MA plans generally, and more specifically as related to two

Florida physicians with whom JSA previously contracted. The Company is producing the requested information and is cooperating with the government's investigation.

In addition to the subpoena described above, in June 2015, the Company received a civil subpoena from the OIG covering the period from January 1, 2008 through the present and seeking production of a wide range of documents relating to the Company's and its subsidiaries' (including DMG's and its subsidiary JSA's) provision of services to MA plans and related patient diagnosis coding and risk adjustment submissions and payments. The Company believes that the request is part of a broader industry investigation into MA patient diagnosis coding and risk adjustment practices and potential overpayments by the government. The information requested includes information relating to patient diagnosis coding practices for a number of conditions, including potentially improper historical DMG coding for a particular condition. With respect to that condition, the guidance related to that coding issue was discontinued following the Company's November 1, 2012 acquisition of HealthCare Partners (now known as the Company's DMG business), 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, some of which were the subject of the *Swoben Private Civil Suit,* and is in discussions with the DOJ relating to those practices. The Company is cooperating with the government. 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 Company's acquisition of DMG in 2012, the Company has certain indemnification rights against the sellers and an escrow was established as security for the indemnification. The Company has submitted an indemnification claim against the sellers secured by the escrow for any and all liabilities incurred relating to these matters and intends to pursue recovery from the escrow. However, the Company can make no assurances that the indemnification and escrow will cover the full amount of the Company's potential losses related to these matters.

2016 U.S. Attorney Prescription Drug Investigation: In early February 2016, the Company announced that its pharmacy services' wholly-owned subsidiary, DaVita Rx, received a Civil Investigative Demand (CID) from the U.S. Attorney's Office for the Northern District of Texas. The government is conducting a federal False Claims Act (FCA) investigation concerning allegations that DaVita Rx presented or caused to be presented false claims for payment to the government for prescription medications, as well as into the Company's relationship with pharmaceutical manufacturers. The CID covers the period from January 1, 2006 through the present. In the spring of 2015, the Company initiated an internal compliance review of DaVita Rx during which it identified potential billing and operational issues, including potential write-offs and discounts of patient co-payment obligations, and credits to payors for returns of prescription drugs related to DaVita Rx. The Company notified the government in September 2015 that it was conducting this review of DaVita Rx and began providing regular updates of its review. Upon completion of its review, the Company filed a self-disclosure with the OIG in February 2016 and has been working to address and update the practices it identified in the self-disclosure, some of which overlap with information requested by the U.S. Attorney's Office. The OIG informed the Company in February 2016 that its submission was not accepted. They indicated that the OIG is not expressing an opinion regarding the conduct disclosed or the Company's legal positions. In connection with the Company's ongoing efforts working with the government the Company learned that a *qui tam* complaint had been filed covering some of the issues in the CID and the Company's self-disclosure. In December 2017, the Company finalized and executed a settlement agreement with the government and relators in the *qui tam* matter and that included total monetary consideration of $63,700, as previously announced, of which $41,500 was an incremental cash payment and $22,200 was for amounts previously refunded, and all of which was previously accrued. The government's investigation into the Company's relationship with pharmaceutical manufacturers is ongoing and the Company is continuing to cooperate with the government in this investigation.

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

* * *

Although the Company cannot predict whether or when proceedings might be initiated or when these matters may be resolved (other than as described above), it is not unusual for inquiries such as these to continue for a considerable period of time through the various phases of document and witness requests and on-going discussions with regulators. In addition to the inquiries and proceedings specifically identified above, the Company is frequently subject to other inquiries by state or federal government agencies and/or private civil *qui tam* complaints filed by relators. Negative findings or terms and conditions that the Company might agree to accept as part of a negotiated resolution of pending or future government inquiries or relator

proceedings could result in, among other things, substantial financial penalties or awards against the Company, substantial payments made by the Company, harm to the Company's reputation, required changes to the Company's business practices, exclusion from future participation in the Medicare, Medicaid and other federal health care programs and, if criminal proceedings were initiated against the Company, possible criminal penalties, any of which could have a material adverse effect on the Company.

Shareholder Claims

Peace Officers' Annuity and Benefit Fund of Georgia Securities Class Action Civil Suit: On February 1, 2017, the Peace Officers' Annuity and Benefit Fund of Georgia filed a putative federal securities class action complaint in the U.S. District Court for the District of Colorado against the Company and certain executives. The complaint covers the time period of August 2015 to October 2016 and alleges, generally, that the Company and its executives violated federal securities laws concerning the Company's financial results and revenue derived from patients who received charitable premium assistance from an industry-funded non-profit organization. The complaint further alleges that the process by which patients obtained commercial insurance and received charitable premium assistance was improper and "created a false impression of DaVita's business and operational status and future growth prospects." In November 2017, the court appointed the lead plaintiff and an amended complaint was filed on January 12, 2018. The Company's response is due March 13, 2018. The Company disputes these allegations and intends to defend this action accordingly.

In re DaVita Inc. Stockholder Derivative Litigation: On August 15, 2017, the U.S. District Court for the District of Delaware consolidated the three previously disclosed shareholder derivative lawsuits: the Blackburn Shareholder action filed on February 10, 2017, the Gabilondo Shareholder action filed on May 30, 2017, and the City of Warren Police and Fire Retirement System Shareholder action filed on June 9, 2017. The complaint covers the time period from 2015 to present and alleges, generally, breach of fiduciary duty, unjust enrichment, abuse of control, gross mismanagement, corporate waste, and misrepresentations and/or failures to disclose certain information in violation of the federal securities laws in connection with an alleged practice to direct patients with government-subsidized health insurance into private health insurance plans to maximize the Company's profits. An amended complaint was filed in September 2017, and on December 18, 2017 the Company filed a motion to dismiss and a motion to stay proceedings in the alternative. 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, demands, 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 also initiates litigation or other legal proceedings as a plaintiff arising out of contracts or other matters.

Resolved Matters

Swoben Private Civil Suit: On July 13, 2009, pursuant to the *qui tam* provisions of the 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. In April 2013, HealthCare Partners (HCP), now known as the Company's DMG subsidiary, was one of several defendants served with a civil complaint filed by a former employee of SCAN Health Plan (SCAN), an HMO. The allegations in the complaint relate to alleged overpayments received from government healthcare programs, including allegations of violations of the federal FCA and the California False Claims Act and allegations against HCP relating to patient diagnosis coding. The complaint sought monetary damages and civil penalties as well as costs and expenses. On October 18, 2017, the relator filed a Notice of Dismissal of the action as to HCP, and the government consented to the dismissal, as a result of which the suit is now dismissed, without prejudice.

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

agreement. In October 2017, the Company finalized and executed a settlement agreement with the OIG including payment of an immaterial amount.

2011 Suit against the U.S. Department of Veterans Affairs: As previously disclosed, the Company had a pending lawsuit in the U.S. Court of Federal Claims against the federal government which was originally filed in May 2011. The lawsuit related to the U.S. Department of Veterans Affairs (VA) underpayment of dialysis services the Company provided from 2005 through 2011 to veterans pursuant to VA regulations. In the first quarter of 2017, the Company received a payment of $538,000 related to the settlement with the VA. The Company's consolidated entities recognized a net gain of $527,000 on this settlement. The Company's nonconsolidated and managed entities recognized a gain of $9,000, of which the Company's equity investment share was $3,000. The net effect was a net increase of $530,000 to the Company's operating income.

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

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

* * *

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 16, or the timing of their resolution or the ultimate losses or impact of developments in those matters, which could have a material adverse effect on the Company's revenues, earnings and cash flows. Further, any legal proceedings or regulatory matters involving the Company, whether meritorious or not, are time consuming, and often require management's attention and result in significant legal expense, and may result in the diversion of significant operational resources, or otherwise harm the Company's business, financial results or reputation.

17. 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 that 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 flows 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 noncontrolling interests subject to put provisions are 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.

The Company has certain other potential commitments to provide operating capital to a number of dialysis centers that are wholly-owned by third parties or businesses in which the Company 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 $5,385.

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

Other commitments

In January 2017, the Company entered into a 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 the terms of the agreement, the Company will purchase EPO in amounts necessary to meet no less than 90% of its requirements for erythropoiesis-stimulating agents (ESAs) through the expiration of the contract 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, 2020. During 2017, 2016 and 2015, the Company purchased $176,212, $164,766 and $154,566, 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 2017, 2016 and 2015, the Company purchased $166,764, $162,109 and $112,931 of hemodialysis product supplies from Baxter under this agreement.

Other than operating leases disclosed in Note 14 to the consolidated financial statements, the letters of credit disclosed in Note 13 to the consolidated financial statements, and the arrangements as described above, the Company has no off balance sheet financing arrangements as of December 31, 2017.

18. 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, corporate administrative support, and the ancillary services and strategic initiatives.

In March 2016, the FASB issued ASU No. 2016-09, *Compensation - Stock Compensation (Topic 718): Improvements to Employee Share-Based Payment Accounting*. The changes required by this ASU involve several aspects of the accounting for

share-based payment transactions, including income tax consequences, classification of awards as either equity or liabilities, classification on the statement of cash flows, and an election on estimating forfeitures. The amendments in this ASU were effective for the Company beginning January 1, 2017. See the *New accounting standards* section in Note 1 for further details.

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 authorized but unissued 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 qualified as performance-based compensation under Section 162(m) of the Internal Revenue Code for tax years 2017 and prior. 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, 2017, there were 6,648,199 stock-settled stock appreciation rights, 1,075,572 stock-settled stock units, 23,000 cash-settled stock appreciation rights and 1,600 cash-settled stock units outstanding, and 27,369,515 shares available for future grants, under the 2011 Plan.

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 (SSARs) and stock-settled stock unit awards is as follows:

	Year ended December 31, 2017				
	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	7,337,266	$ 64.90		785,553	
Granted	1,692,154	65.29		528,968	
Exercised	(2,022,418)	54.27		(119,000)	
Canceled	(358,803)	70.61		(119,949)	
Outstanding at end of period	6,648,199	$ 67.92	2.3	1,075,572	2.0
Exercisable at end of period	2,628,008	$ 62.78	0.6	—	0.0
Weighted-average fair value of grants					
2017	$ 14.51			$ 65.73	
2016	$ 13.74			$ 70.99	
2015	$ 17.97			$ 80.25	

Range of SSARs base prices	Awards Outstanding	Weighted average exercise price	Awards exercisable	Weighted average exercise price
$50.01–$60.00	1,856,145	59.05	1,712,675	59.15
$60.01–$70.00	2,715,542	66.70	632,849	67.47
$70.01–$80.00	1,443,749	74.77	243,041	73.16
$80.01–$90.00	632,763	83.59	39,443	81.51
Total	6,648,199	$ 67.92	2,628,008	$ 62.78

The Company granted 15,000 cash-settled stock-based awards during 2017. Liability-classified stock-based awards contributed $114, $376 and $(236) to stock-based compensation expense for the years ended December 31, 2017, 2016 and 2015, respectively. As of December 31, 2017 the Company had 24,600 liability-classified stock-based awards outstanding, none of which were vested, and a total stock-based compensation liability balance of $99.

For the years ended December 31, 2017, 2016, and 2015, the aggregate intrinsic value of stock-based awards exercised was $34,895, $73,944 and $117,260, respectively. At December 31, 2017, the aggregate intrinsic value of stock-based awards outstanding was $117,722 and the aggregate intrinsic value of stock awards exercisable was $25,609.

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 expense 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 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,		
	2017	2016	2015
Expected term	4.2	4.2	4.1
Expected volatility	23.9%	21.0%	24.6%
Expected dividend yield	—%	—%	—%
Risk-free interest rate	1.7%	1.0%	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 its fair market value on the first day of the purchase right period or 85% of its 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 2017, 2016 and 2015 participation periods were $22,131, $23,902 and $24,523, respectively. Shares purchased pursuant to the plan's 2017, 2016 and 2015 participation periods were 360,368, 438,002 and 413,859, respectively. At December 31, 2017, there were 7,124,027 shares remaining available for future grants under this plan, after an additional 7,500,000 shares were approved to the plan by stockholders on June 20, 2016.

The fair value of participants' 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 2017, 2016 and 2015, respectively: expected volatility of 23%, 22% and 26%; risk-free interest rate of 1.3%, 0.8% and 0.2%, and no dividends. Using these assumptions, the weighted average estimated fair value of these purchase rights was $15.19, $16.73 and $18.76 for 2017, 2016 and 2015, respectively.

Long-term incentive compensation expense and proceeds

For the years ended December 31, 2017, 2016 and 2015, the Company recognized $61,978, $64,956 and $123,957, respectively, in total long-term incentive program (LTIP) expense, of which $34,431, $34,530 and $52,665, 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 2017, 2016 and 2015 were $7,717, $12,731 and $19,689, respectively. As of December 31, 2017, there was $98,015 total estimated unrecognized compensation expense for outstanding LTIP awards, including $61,166 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 this LTIP expense over a weighted average remaining period of 1.1 years and the stock-based component of this LTIP expense over a weighted average remaining period of 1.4 years.

For the years ended December 31, 2017, 2016 and 2015, the Company received $13,473, $28,397 and $45,749, respectively, in actual tax benefits upon the exercise of stock awards. Since the Company issues stock-settled stock appreciation

rights rather than stock options, there have been no cash proceeds from stock option exercises during the years ended December 31, 2017, 2016 and 2015.

Stock repurchases

During the years ended December 31, 2017 and 2016, the Company repurchased a total of 12,966,672 shares and 16,649,090 shares of its common stock for $810,949 and $1,072,377, or an average price of $62.54 and $64.41 per share, respectively, pursuant to previously announced authorizations by the Board of Directors. The Company also repurchased 1,237,800 shares of its common stock for $92,790, or an average price of $74.96 per share, subsequent to December 31, 2017 through February 22, 2018.

On October 10, 2017, the Company's Board of Directors approved an additional share repurchase authorization in the amount of $1,252,961. This share repurchase authorization was in addition to the $247,039 remaining at that time under the Company's Board of Directors' prior share repurchase authorization announced in July 2016. Accordingly, as of February 22, 2018, the Company has a total of $1,026,326 available under the current Board repurchase authorizations for additional share repurchases. Although these share repurchase authorizations do not have expiration dates, the Company remains subject to share repurchase limitations under the terms of its senior secured credit facilities and the indentures governing its senior notes.

The Company retired all shares held in its treasury effective as of December 31, 2017 and 2016.

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 in consolidated subsidiaries on the Company's equity are as follows:

	Year ended December 31,		
	2017	2016	2015
Net income attributable to DaVita Inc.	$ 663,618	$ 879,874	$ 269,732
Changes in paid-in-capital for:			
Sales of noncontrolling interest	(114)	—	—
Purchase of noncontrolling interests	(2,752)	(13,105)	(55,826)
Net transfer in noncontrolling interests	(2,866)	(13,105)	(55,826)
Net income attributable to DaVita Inc. net of transfers in noncontrolling interests	$ 660,752	$ 866,769	$ 213,906

The Company acquired additional ownership interests in several existing majority-owned joint ventures for $5,357, $21,512, and $66,382 in 2017, 2016, and 2015, respectively.

19. Other comprehensive (loss) income

Charges and credits to other comprehensive (loss) income have been as follows:

	Interest rate cap and swap agreements	Investment securities	Foreign currency translation adjustments	Accumulated other comprehensive (loss) income
Balance at January 1, 2015	$ (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)
Unrealized (losses) gains	(8,897)	5,075	99,770	95,948
Related income tax	3,460	(1,368)	—	2,092
	(5,437)	3,707	99,770	98,040
Reclassification from accumulated other comprehensive losses (income) into net income	8,278	(360)	—	7,918
Related income tax	(3,220)	140	—	(3,080)
	5,058	(220)	—	4,838
Balance at December 31, 2017	$ (12,408)	$ 5,662	$ 19,981	$ 13,235

The reclassification of net cap and swap realized losses into income are recorded as debt expense in the corresponding consolidated statements of income. See Note 13 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 3 to these consolidated financial statements for further details.

20. Acquisitions and divestitures

Acquisition of Renal Ventures

On May 1, 2017, the Company completed its acquisition of 100% of the equity of Colorado-based Renal Ventures Management, LLC (Renal Ventures) for approximately $359,913 in net cash. Renal Ventures operated 36 dialysis centers, one uncertified dialysis center and one home program, that provided services to approximately 2,600 patients in six states. As a part of this transaction, the Company was required to divest three Renal Ventures outpatient dialysis centers, and three outpatient dialysis centers and one uncertified dialysis center of the Company for approximately $21,219 in net cash. The Company also incurred approximately $11,950 in transaction and integration costs during the year ended December 31, 2017 associated with this acquisition that are included in general and administrative expenses.

The initial purchase price allocation for the Renal Ventures acquisition is recorded at estimated fair values based upon the best information available to management and will be finalized when certain information arranged to be obtained has been

received. In particular, certain working capital items, income tax amounts and the fair value of intangibles and fixed assets are pending final audit, issuance of final tax returns and valuation reports.

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

Current assets, net of cash acquired	$	22,739
Property and equipment		36,295
Amortizable intangible and other long-term assets		11,547
Goodwill		298,200
Current liabilities		(8,389)
Long-term liabilities		(479)
	$	359,913

Amortizable intangible assets acquired, primarily related to non-compete agreements, had weighted-average estimated useful lives of five years. The total estimated amount of goodwill deductible for tax purposes associated with this acquisition was approximately $298,200.

Other routine acquisitions

During 2017, the Company also acquired 30 dialysis centers in the U.S. and 68 dialysis centers outside the U.S. for a total of $308,550 in net cash, earn-outs of $2,692, and deferred purchase price and liabilities assumed of $23,748. During 2016, the Company acquired eight dialysis centers in the U.S. and 21 dialysis centers outside the U.S. for a total of $165,108 in net cash, earn-outs of $1,511, and deferred purchase price of $17,963. During 2015, the Company acquired six dialysis centers in the U.S. and 21 dialysis centers outside the U.S. for a total of $54,551 in net cash and deferred purchase price of $7,452. The assets and liabilities for all acquisitions were recorded at their estimated fair values at the dates of the acquisitions and are included in the Company's financial statements and operating results from the effective dates of the acquisitions. For several of the 2017 acquisitions, certain income tax amounts are pending final evaluation and quantification of any pre-acquisition tax contingencies. In addition, valuation of intangibles 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 noncontrolling interests assumed in these transactions:

	Year ended December 31,		
	2017	2016	2015
Current assets	$ 14,366	$ 3,996	$ 2,647
Property and equipment	18,192	8,840	4,466
Amortizable intangible and other long-term assets	11,663	5,876	8,924
Non-amortizable intangibles	32,296	—	—
Goodwill	318,832	198,927	67,183
Deferred income taxes	(210)	597	(717)
Noncontrolling interests assumed	(44,303)	(30,337)	(18,905)
Liabilities assumed	(15,846)	(3,317)	(1,595)
Aggregate purchase cost	$ 334,990	$ 184,582	$ 62,003

Amortizable intangible assets acquired, primarily related to non-compete agreements, during 2017, 2016 and 2015 had weighted-average estimated useful lives of seven, seven and eleven years, respectively. The total amount of goodwill deductible for tax purposes associated with these acquisitions for 2017, 2016, and 2015 was approximately $237,363, $169,379 and $43,823, respectively.

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 made initial investments of $50,000 each on August 1, 2016 as well as additional subscribed contributions of $50,000 each on August 1, 2017. Subsequent to those contributions, the Company now holds a 60% voting interest and a 73.3% current economic interest in the APAC JV.

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 of 2016 and recognized an initial non-cash non-taxable estimated 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 Mitsui investment and adjusted for certain time value of money and uncertainty discounts. The Company then recognized an additional $6,293 gain in the first quarter of 2017 upon resolution of certain post-closing adjustments related to this transaction.

The Company's non-cash gain on its retained investment in the APAC JV in the third quarter of 2016 was computed with the assistance of an independent third party valuation firm and was based upon the best information available to management at that time. Subsequent to its deconsolidation on August 1 2016, the Company's retained interest in the APAC JV has been accounted for under the equity method. See Note 9 for further details on the accounting for this retained investment and a subsequent other-than-temporary impairment thereof recognized in 2017.

Pro forma financial information (unaudited)

The following summary, prepared on a pro forma basis, combines the results of operations as if all acquisitions within continuing operations in 2017 and 2016 had been consummated as of the beginning of 2016, including the impact of certain adjustments such as amortization of intangibles, interest expense on acquisition financing and income tax effects.

	Year ended December 31,	
	2017	2016
	(unaudited)	
Pro forma net revenues	$ 11,005,330	$ 11,076,750
Pro forma net income from continuing operations	907,443	1,052,700
Pro forma basic net income per share from continuing operations attributable to DaVita Inc.	4.81	5.22
Pro forma diluted net income per share from continuing operations attributable to DaVita Inc.	4.74	5.14

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 $11,466 if certain EBITDA, operating income performance targets or quality margins are met over the next two to six 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 recognized in earnings. See Note 24 to these consolidated financial statements for further details. As of December 31, 2017, the Company estimated the fair value of these contingent earn-out obligations to be $6,388, of which a total of $216 is included in other liabilities, and the remaining $6,172 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, 2017:

Beginning balance January 1, 2017	$	2,950
Contingent earn-out obligations associated with acquisitions		2,692
Remeasurement of fair value		746
	$	6,388

21. Held for sale and discontinued operations

DaVita Medical Group (DMG)

On December 5, 2017, we entered into an equity purchase agreement to sell our DMG division to Optum, a subsidiary of UnitedHealth Group Inc., for $4,900,000 in cash, subject to net working capital and other customary adjustments. The transaction is expected to close in 2018 and is subject to regulatory approval and other customary closing conditions. As a result of this pending transaction, the DMG business has been reclassified as held for sale and its results of operations are reported as discontinued operations for all periods presented.

The following table presents the financial results of discontinued operations related to DMG:

	Year ended December 31,		
	2017	2016	2015
Net revenues	$ 4,676,213	$ 4,113,414	$ 3,837,260
Expenses	4,634,782	3,994,624	3,596,342
Goodwill and other asset impairment charges	651,659	253,000	206,169
(Loss) income from discontinued operations before taxes	(610,228)	(134,210)	34,749
Income tax benefit (expense)	364,856	(24,052)	(88,216)
Net loss from discontinued operations, net of tax	$ (245,372)	$ (158,262)	$ (53,467)

As previously disclosed, the Company's DMG business has continued to experience declining operating results in recent years, and prior to being reclassified as held for sale the Company recorded goodwill and other asset impairment charges for the DMG business of $651,659, $253,000 and $206,169 in 2017, 2016 and 2015, respectively. These charges resulted from continuing developments in the Company's DMG business, including recent annual updates to Medicare Advantage benchmark reimbursement rates, changes in expectations concerning future government reimbursement rates and the Company's expected ability to mitigate them, medical cost and utilization trends, commercial pricing pressures, underperformance of certain DMG business units and other market factors.

The following table presents the financial position of discontinued operations related to DMG:

	December 31, 2017	December 31, 2016
Assets		
Cash and cash equivalents	$ 179,668	$ 238,411
Other current assets	888,697	722,545
Property and equipment, net	379,945	311,246
Intangible assets, net	1,316,550	1,454,263
Other long-term assets	116,805	94,684
Goodwill	2,879,977	3,391,942
Total assets held for sale	$ 5,761,642	$ 6,213,091
Total current assets held for sale	$ 5,761,642	$ 960,956
Total long-term assets held for sale	$ —	$ 5,252,135
Liabilities		
Other liabilities	$ 505,734	$ 460,458
Medical payables	457,040	349,506
Current portion of long-term debt	2,845	4,779
Long-term debt	35,003	2,652
Other long-term liabilities	184,448	418,723
Total liabilities held for sale	$ 1,185,070	$ 1,236,118
Total current liabilities held for sale	$ 1,185,070	$ 807,233
Total long-term liabilities held for sale	$ —	$ 428,885

The following table presents cash flows of discontinued operations related to DMG:

	Year ended December 31,		
	2017	2016	2015
Net cash provided by operating activities from discontinued operations	$ 351,557	$ 287,049	$ 365,138
Net cash used in investing activities from discontinued operations	$ (232,329)	$ (430,917)	$ (121,893)

DMG acquisitions

During 2017, the Company's DMG business acquired other medical businesses for a total of $135,416 in net cash, deferred purchase price of $1,038, and liabilities assumed of $10,145. During 2016, the Company acquired other medical businesses for a total of $398,748 in net cash and deferred purchase price and liabilities assumed of $7,694. During 2015, the Company acquired other medical businesses for a total of $41,918 in net cash and deferred purchase price of $944. For several of the 2017 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 assets and liabilities for all acquisitions were recorded at their estimated fair values at the dates of the acquisitions and are included in the Company’s current held for sale assets and liabilities.

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. A number of these VIEs are within the Company's DMG business, which has been reclassified as held for sale and as a discontinued operation in these 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, 2017, these consolidated financial statements include total assets of VIEs of $870,314 and total liabilities and noncontrolling interests of VIEs to third parties of $475,143, including assets of $595,670 and liabilities and noncontrolling interests of $319,777 related to the Company's DMG business which is classified as held for sale.

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 15 to these consolidated financial statements for disclosures on the assets of these consolidated non-qualified deferred compensation plans.

23. Concentrations

Approximately 67%, 64% and 66% of total U.S. dialysis services revenues in 2017, 2016 and 2015, 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 Managed Medicaid plans, were approximately $869,083 and $831,445, as of December 31, 2017 and 2016, respectively.

There is no single commercial payor that accounted for more than 10% of total consolidated accounts receivable or consolidated net revenues at December 31, 2017 and 2016.

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 the 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, 2017 and 2016:

December 31, 2017	Total	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Assets				
Available for sale securities	$ 38,895	$ 38,895	$ —	$ —
Interest rate cap agreements	$ 1,032	$ —	$ 1,032	$ —
Liabilities				
Contingent earn-out obligations	$ 6,388	$ —	$ —	$ 6,388
Temporary equity				
Noncontrolling interests subject to put provisions	$ 1,011,360	$ —	$ —	$ 1,011,360
December 31, 2016				
Assets				
Available for sale securities	$ 31,197	$ 31,197	$ —	$ —
Interest rate cap agreements	$ 9,929	$ —	$ 9,929	$ —
Liabilities				
Contingent earn-out obligations	$ 2,950	$ —	$ —	$ 2,950
Temporary equity				
Noncontrolling interests subject to put provisions	$ 973,258	$ —	$ —	$ 973,258

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 redemption prices reported by each mutual fund. See Note 3 to these consolidated financial statements for further discussion.

The interest rate cap agreements are recorded at fair value estimated from valuation models utilizing the income approach and commonly accepted valuation techniques that use inputs from closing prices for similar assets and liabilities in active markets as well as other relevant observable market inputs at quoted intervals such as current interest rates, forward yield curves, implied volatility and credit default swap pricing. The Company does not believe the ultimate amount that could be realized upon settlement of these interest rate cap agreements would be materially different from the fair value estimates currently reported. See Note 13 to these consolidated financial statements for further discussion.

The estimated fair value measurements of contingent earn-out obligations are primarily based on unobservable inputs, including projected EBITDA. The estimated fair value of these contingent earn-out obligations is 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 17 to these consolidated financial statements for a discussion of the Company's methodology for estimating the fair values 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 non-debt financial instruments are presented in the consolidated financial statements at December 31, 2017 and 2016 at their approximate fair values due to the short-term nature of their settlements. The carrying amount of the Company's senior secured credit facilities totaled $4,428,376 as of December 31, 2017, and their fair value was approximately $4,495,649 based upon quoted market prices. The carrying amount of the Company's Senior Notes was approximately $4,460,176 at December 31, 2017 and their fair value was approximately $4,566,175 at December 31, 2017 based upon quoted market prices.

25. Segment reporting

The Company has consisted of 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 ancillary services and strategic initiatives consist primarily of pharmacy services, disease management services, vascular access services, clinical research programs, physician services, direct primary care, ESRD seamless care organizations and comprehensive care as well as the Company's international operations.

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. On December 5, 2017, the Company entered into an equity purchase agreement to sell its DMG division to Optum, a subsidiary of UnitedHealth Group Inc. The transaction is expected to close in 2018 and is subject to regulatory approval and other customary closing conditions. As a result of this pending transaction, the DMG business has been reclassified as held for sale and its results of operations are reported as discontinued operations for all periods presented in these consolidated financial statements.

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, each of its ancillary services and strategic initiatives, its consolidated international kidney care operations in each country and under the Saudi Ministry of Health charter, its equity method investment in the Asia Pacific joint venture, and its other health operations in Europe. The U.S. dialysis and related lab services business qualifies as a separately reportable segment, 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 Company's operating segments. For internal management reporting, segment operations include direct segment operating expenses but generally exclude corporate administrative support costs, which consist primarily of indirect labor, benefits and long-term incentive-based compensation expenses of certain departments which provide support to all of the Company's various operating lines of business, except to the extent that such costs are charged to and borne by certain ancillary services and strategic initiatives via internal management fees. These corporate administrative support costs are reduced by internal management fees received from the Company's ancillary lines of business.

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,		
	2017	2016	2015
Segment revenues:			
U.S. dialysis and related lab services			
Patient service revenues:			
External sources	$ 9,767,123	$ 9,524,067	$ 9,014,577
Intersegment revenues	55,175	27,355	19,414
Total U.S. dialysis and related lab services revenues	9,822,298	9,551,422	9,033,991
Less: Provision for uncollectible accounts	(482,007)	(429,882)	(406,530)
Net U.S. dialysis and related lab services patient service revenues	9,340,291	9,121,540	8,627,461
Other revenues[1]	19,774	16,649	13,971
Total net U.S. dialysis and related lab services revenues	9,360,065	9,138,189	8,641,432
Other - Ancillary services and strategic initiatives			
Net patient service revenues	323,156	201,867	134,496
Other external sources	1,248,588	1,394,766	1,225,731
Intersegment revenues	24,603	24,739	22,204
Total ancillary services and strategic initiatives revenues	1,596,347	1,621,372	1,382,431
Total net segment revenues	10,956,412	10,759,561	10,023,863
Elimination of intersegment revenues	(79,778)	(52,094)	(41,618)
Consolidated net revenues	$ 10,876,634	$ 10,707,467	$ 9,982,245
Segment operating margin (loss):			
U.S. dialysis and related lab services	$ 2,297,198	$ 1,777,014	$ 1,259,632
Other—Ancillary services and strategic initiatives	(439,477)	266,324	(103,901)
Total segment margin	1,857,721	2,043,338	1,155,731
Reconciliation of segment operating margin to consolidated income from continuing operations before income taxes:			
Corporate administrative support	(44,966)	(13,628)	(18,965)
Consolidated operating income	1,812,755	2,029,710	1,136,766
Debt expense	(430,634)	(414,116)	(408,380)
Debt redemption charges	—	—	(48,072)
Other income	17,665	7,511	8,073
Consolidated income from continuing operations before income taxes	$ 1,399,786	$ 1,623,105	$ 688,387

(1) Includes management fee revenues from providing management and administrative services to dialysis ventures in which the Company owns a noncontrolling interest or which are wholly-owned by third parties.

Depreciation and amortization expense by segment is as follows:

	Year ended December 31,		
	2017	2016	2015
U.S. dialysis and related lab services	$ 520,965	$ 482,768	$ 438,238
Other - Ancillary services and strategic initiatives	38,946	26,729	25,667
	$ 559,911	$ 509,497	$ 463,905

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

Summary of assets by segment is as follows:

	Year ended December 31,	
	2017	2016
Segment assets		
U.S. dialysis and related lab services (including equity investments of $84,866 and $66,924, respectively)	$ 11,776,042	$ 11,108,386
Other - Ancillary services and strategic initiatives[(1)] (including equity investments of $160,668 and $425,115, respectively)	1,410,509	1,434,299
DMG - Held for sale (including equity investments of $10,321 and $10,350, respectively)	5,761,642	6,213,091
Consolidated assets	$ 18,948,193	$ 18,755,776

(1) Includes approximately $125,932 and $96,396 in 2017 and 2016, respectively, of net property and equipment related to the Company's international operations.

Expenditures for property and equipment by segment is as follows:

	Year ended December 31,		
	2017	2016	2015
U.S. dialysis and related lab services	$ 759,218	$ 675,994	$ 584,513
Other - Ancillary services and strategic initiatives	50,891	68,702	56,685
DMG - Held for sale	95,141	84,399	66,800
	$ 905,250	$ 829,095	$ 707,998

26. Supplemental cash flow information

The table below provides supplemental cash flow information:

	Year ended December 31,		
	2017	2016	2015
Cash paid:			
Income taxes	$ 387,159	$ 339,411	$ 156,075
Interest	424,547	406,987	405,120
Non-cash investing and financing activities:			
Fixed assets under capital lease obligations	48,378	28,127	74,035

27. Selected quarterly financial data (unaudited)

	2017				2016			
	December 31	September 30	June 30	March 31	December 31	September 30	June 30	March 31
Net revenues	$ 2,780,913	$ 2,765,071	$ 2,699,399	$ 2,631,251	$ 2,699,419	$ 2,725,407	$ 2,675,474	$ 2,607,167
Operating income	$ 150,337	$ 395,294	$ 391,196	$ 875,928	$ 363,445	$ 813,103	$ 431,129	$ 422,033
Net income from continuing operations, before taxes	$ 46,825	$ 289,384	$ 288,060	$ 775,517	$ 259,669	$ 710,246	$ 331,231	$ 321,959
Net income (loss) from discontinued operations, net of income taxes	$ 143,587	$ (370,872)	$ (24,520)	$ 6,433	$ 11,772	$ 20,213	$ (118,443)	$ (71,804)
Net income (loss) attributable to DaVita Inc.	$ 303,396	$ (214,476)	$ 127,001	$ 447,697	$ 157,726	$ 571,332	$ 53,382	$ 97,434
Basic net income from continuing operations per share attributable to DaVita Inc.	$ 0.86	$ 0.81	$ 0.79	$ 2.29	$ 0.74	$ 2.69	$ 0.84	$ 0.83
Basic net income (loss) from discontinued operations per share attributable to DaVita Inc.	$ 0.80	$ (1.95)	$ (0.13)	$ 0.04	$ 0.07	$ 0.11	$ (0.58)	$ (0.35)
Basic net income (loss) per share attributable to DaVita Inc.	$ 1.66	$ (1.14)	$ 0.66	$ 2.33	$ 0.81	$ 2.80	$ 0.26	$ 0.48
Diluted net income from continuing operations per share attributable to DaVita Inc.	$ 0.85	$ 0.80	$ 0.78	$ 2.26	$ 0.73	$ 2.65	$ 0.82	$ 0.81
Diluted net income (loss) from discontinued operations per share attributable to DaVita Inc.	$ 0.79	$ (1.92)	$ (0.13)	$ 0.03	$ 0.07	$ 0.11	$ (0.56)	$ (0.34)
Diluted net income (loss) per share attributable to DaVita Inc.	$ 1.64	$ (1.12)	$ 0.65	$ 2.29	$ 0.80	$ 2.76	$ 0.26	$ 0.47

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 twelve months ended December 31, 2017					
Dialysis and related lab patient service revenues	$ —	$ 6,884,750	$ 3,393,026	$ (184,106)	$ 10,093,670
Less: Provision for uncollectible accounts	—	(340,586)	(151,982)	7,170	(485,398)
Net dialysis and related lab patient service revenues	—	6,544,164	3,241,044	(176,936)	9,608,272
Other revenues	793,751	1,204,501	68,322	(798,212)	1,268,362
Total net revenues	793,751	7,748,665	3,309,366	(975,148)	10,876,634
Operating expenses and charges	527,942	6,475,550	3,035,535	(975,148)	9,063,879
Operating income	265,809	1,273,115	273,831	—	1,812,755
Debt expense	(426,149)	(209,612)	(34,831)	239,958	(430,634)
Other income, net	411,731	11,169	18,467	(423,702)	17,665
Income tax expense	65,965	237,670	20,224	—	323,859
Equity earnings in subsidiaries	478,192	74,375	—	(552,567)	—
Net income from continuing operations	663,618	911,377	237,243	(736,311)	1,075,927
Net (loss) income from discontinued operations, net of tax	—	(433,185)	4,069	183,744	(245,372)
Net income	663,618	478,192	241,312	(552,567)	830,555
Less: Net income attributable to noncontrolling interests	—	—	—	(166,937)	(166,937)
Net income attributable to DaVita Inc.	$ 663,618	$ 478,192	$ 241,312	$ (719,504)	$ 663,618
For twelve months ended December 31, 2016					
Dialysis and related lab patient service revenues	$ —	$ 6,665,601	$ 3,215,085	$ (153,326)	$ 9,727,360
Less: Provision for uncollectible accounts	—	(272,430)	(158,878)	—	(431,308)
Net dialysis and related lab patient service revenues	—	6,393,171	3,056,207	(153,326)	9,296,052
Other revenues	767,791	1,378,956	30,184	(765,516)	1,411,415
Total net revenues	767,791	7,772,127	3,086,391	(918,842)	10,707,467
Operating expenses and charges	493,175	6,907,469	2,195,955	(918,842)	8,677,757
Operating income	274,616	864,658	890,436	—	2,029,710
Debt expense	(407,925)	(191,083)	(40,434)	225,326	(414,116)
Other income, net	396,797	3,726	7,694	(400,706)	7,511
Income tax expense	77,334	238,446	115,981	—	431,761
Equity earnings in subsidiaries	693,720	667,278	—	(1,360,998)	—
Net income from continuing operations	879,874	1,106,133	741,715	(1,536,378)	1,191,344
Net (loss) income from discontinued operations, net of tax	—	(412,413)	78,771	175,380	(158,262)
Net income	879,874	693,720	820,486	(1,360,998)	1,033,082
Less: Net income attributable to noncontrolling interests	—	—	—	(153,208)	(153,208)
Net income attributable to DaVita Inc.	$ 879,874	$ 693,720	$ 820,486	$ (1,514,206)	$ 879,874

Consolidating Statements of Income - (continued)

	DaVita Inc.	Guarantor Subsidiaries	Non-Guarantor Subsidiaries	Consolidating Adjustments	Consolidated Total
For twelve months ended December 31, 2015					
Dialysis and related lab patient service revenues	$ —	$ 6,471,702	$ 2,814,909	$ (131,164)	$ 9,155,447
Less: Provision for uncollectible accounts	—	(281,976)	(130,929)	—	(412,905)
Net dialysis and related lab patient service revenues	—	6,189,726	2,683,980	(131,164)	8,742,542
Other revenues	727,887	1,208,607	24,013	(720,804)	1,239,703
Total net revenues	727,887	7,398,333	2,707,993	(851,968)	9,982,245
Operating expenses and charges	488,595	6,925,234	2,283,618	(851,968)	8,845,479
Operating income	239,292	473,099	424,375	—	1,136,766
Debt (expense) and refinancing charges	(449,598)	(178,389)	(32,450)	203,985	(456,452)
Other income, net	365,752	1,261	6,921	(365,861)	8,073
Income tax expense (benefit)	60,671	163,401	(16,562)	—	207,510
Equity earnings in subsidiaries	174,957	322,022	—	(496,979)	—
Net income from continuing operations	269,732	454,592	415,408	(658,855)	480,877
Net (loss) income from discontinued operations, net of tax	—	(279,635)	64,292	161,876	(53,467)
Net income	269,732	174,957	479,700	(496,979)	427,410
Less: Net income attributable to noncontrolling interests	—	—	—	(157,678)	(157,678)
Net income attributable to DaVita Inc.	$ 269,732	$ 174,957	$ 479,700	$ (654,657)	$ 269,732

Consolidating Statements of Comprehensive Income

	DaVita Inc.	Guarantor Subsidiaries	Non-Guarantor Subsidiaries	Consolidating Adjustments	Consolidated Total
For the year ended December 31, 2017					
Net income	$ 663,618	$ 478,192	$ 241,312	$ (552,567)	$ 830,555
Other comprehensive income	3,106	—	99,770	—	102,876
Total comprehensive income	666,724	478,192	341,082	(552,567)	933,431
Less: Comprehensive income attributable to noncontrolling interest	—	—	—	(166,935)	(166,935)
Comprehensive income attributable to DaVita Inc.	$ 666,724	$ 478,192	$ 341,082	$ (719,502)	$ 766,496
For the year ended December 31, 2016					
Net income	$ 879,874	$ 693,720	$ 820,486	$ (1,360,998)	$ 1,033,082
Other comprehensive loss	(290)	—	(29,337)	—	(29,627)
Total comprehensive income	879,584	693,720	791,149	(1,360,998)	1,003,455
Less: Comprehensive income attributable to noncontrolling interest	—	—	—	(153,398)	(153,398)
Comprehensive income attributable to DaVita Inc.	$ 879,584	$ 693,720	$ 791,149	$ (1,514,396)	$ 850,057
For the year ended December 31, 2015					
Net income	$ 269,732	$ 174,957	$ 479,700	$ (496,979)	$ 427,410
Other comprehensive loss	(10,920)	—	(23,889)	—	(34,809)
Total comprehensive income	258,812	174,957	455,811	(496,979)	392,601
Less: Comprehensive income attributable to noncontrolling interest	—	—	—	(157,678)	(157,678)
Comprehensive income attributable to DaVita Inc.	$ 258,812	$ 174,957	$ 455,811	$ (654,657)	$ 234,923

Consolidating Balance Sheets

	DaVita Inc.	Guarantor Subsidiaries	Non-Guarantor Subsidiaries	Consolidating Adjustments	Consolidated Total
As of December 31, 2017					
Cash and cash equivalents	$ 149,305	$ —	$ 358,929	$ —	$ 508,234
Accounts receivable, net	—	1,208,715	506,035	—	1,714,750
Other current assets	68,027	604,450	87,255	—	759,732
Current assets held for sale	—	4,992,067	769,575	—	5,761,642
Total current assets	217,332	6,805,232	1,721,794	—	8,744,358
Property and equipment, net	408,010	1,560,390	1,180,813	—	3,149,213
Intangible assets, net	250	50,971	62,606	—	113,827
Investments in subsidiaries	10,009,874	3,085,722	—	(13,095,596)	—
Intercompany receivables	3,677,947	—	1,313,213	(4,991,160)	—
Other long-term assets and investments	47,297	68,344	214,875	—	330,516
Goodwill	—	4,732,320	1,877,959	—	6,610,279
Total assets	$ 14,360,710	$ 16,302,979	$ 6,371,260	$ (18,086,756)	$ 18,948,193
Current liabilities	$ 238,706	$ 1,181,139	$ 436,262	$ —	$ 1,856,107
Current liabilities held for sale	—	739,294	445,776	—	1,185,070
Total current liabilities	238,706	1,920,433	882,038	—	3,041,177
Intercompany payables	—	3,690,042	1,301,118	(4,991,160)	—
Long-term debt and other long-term liabilities	8,857,373	682,630	469,587	—	10,009,590
Noncontrolling interests subject to put provisions	574,602	—	—	436,758	1,011,360
Total DaVita Inc. shareholders' equity	4,690,029	10,009,874	3,085,722	(13,095,596)	4,690,029
Noncontrolling interests not subject to put provisions	—	—	632,795	(436,758)	196,037
Total equity	4,690,029	10,009,874	3,718,517	(13,532,354)	4,886,066
Total liabilities and equity	$ 14,360,710	$ 16,302,979	$ 6,371,260	$ (18,086,756)	$ 18,948,193

Consolidating Balance Sheets - (continued)

	DaVita Inc.	Guarantor Subsidiaries	Non-Guarantor Subsidiaries	Consolidating Adjustments	Consolidated Total
As of December 31, 2016					
Cash and cash equivalents	$ 549,921	$ —	$ 124,855	$ —	$ 674,776
Accounts receivable, net	—	1,048,580	455,370	—	1,503,950
Other current assets	277,911	462,684	114,471	—	855,066
Current assets held for sale	—	514,407	446,549	—	960,956
Total current assets	827,832	2,025,671	1,141,245	—	3,994,748
Property and equipment, net	337,200	1,444,248	1,082,673	—	2,864,121
Intangible assets, net	487	42,037	30,980	—	73,504
Investments in subsidiaries	9,717,728	2,021,062	—	(11,738,790)	—
Intercompany receivables	3,250,692	—	866,955	(4,117,647)	—
Other long-term assets and investments	39,994	73,466	442,433	—	555,893
Goodwill	—	4,480,344	1,535,031	—	6,015,375
Long-term assets held for sale	—	5,066,453	185,682	—	5,252,135
Total assets	$ 14,173,933	$ 15,153,281	$ 5,284,999	$ (15,856,437)	$ 18,755,776
Current liabilities	$ 303,840	$ 1,343,748	$ 256,143	$ —	$ 1,903,731
Current liabilities held for sale	—	533,250	273,983	—	807,233
Total current liabilities	303,840	1,876,998	530,126	—	2,710,964
Intercompany payables	—	2,382,428	1,735,219	(4,117,647)	—
Long-term debt and other long-term liabilities	8,614,445	835,845	342,638	—	9,792,928
Long-term liabilities held for sale	—	340,282	88,603	—	428,885
Noncontrolling interests subject to put provisions	607,601	—	—	365,657	973,258
Total DaVita Inc. shareholders' equity	4,648,047	9,717,728	2,021,062	(11,738,790)	4,648,047
Noncontrolling interests not subject to put provisions	—	—	567,351	(365,657)	201,694
Total equity	4,648,047	9,717,728	2,588,413	(12,104,447)	4,849,741
Total liabilities and equity	$ 14,173,933	$ 15,153,281	$ 5,284,999	$ (15,856,437)	$ 18,755,776

Consolidating Statements of Cash Flow

	DaVita Inc.	Guarantor Subsidiaries	Non-Guarantor Subsidiaries	Consolidating Adjustments	Consolidated Total
For the year ended December 31, 2017					
Cash flows from operating activities:					
Net income	$ 663,618	$ 478,192	$ 241,312	$ (552,567)	$ 830,555
Changes in operating assets and liabilities and non-cash items included in net income	(534,302)	366,947	691,682	552,567	1,076,894
Net cash provided by operating activities	129,316	845,139	932,994	—	1,907,449
Cash flows from investing activities:					
Additions of property and equipment, net	(155,972)	(490,800)	(258,478)	—	(905,250)
Acquisitions	—	(693,522)	(110,357)	—	(803,879)
Proceeds from asset sales, net of cash divested	—	90,340	1,996	—	92,336
Investments and other items	211,619	(9,003)	47,446	—	250,062
Net cash provided by (used in) investing activities	55,647	(1,102,985)	(319,393)	—	(1,366,731)
Cash flows from financing activities:					
Long-term debt and related financing costs, net	173,529	(12,662)	(6,019)	—	154,848
Intercompany borrowing	22,589	218,980	(241,569)	—	—
Other items	(781,697)	(2,493)	(136,915)	—	(921,105)
Net cash (used in) provided by financing activities	(585,579)	203,825	(384,503)	—	(766,257)
Effect of exchange rate changes on cash	—	—	254	—	254
Net (decrease) increase in cash and cash equivalents	(400,616)	(54,021)	229,352	—	(225,285)
Less: Net decrease in cash and cash equivalents from discontinued operations	—	(54,021)	(4,722)	—	(58,743)
Net (decrease) increase in cash and cash equivalents from continuing operations	(400,616)	—	234,074	—	(166,542)
Cash and cash equivalents of continuing operations at beginning of the year	549,921	—	124,855	—	674,776
Cash and cash equivalents of continuing operations at end of the year	$ 149,305	$ —	$ 358,929	$ —	$ 508,234

Consolidating Statements of Cash Flow - (continued)

	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	$ 693,720	$ 820,486	$ (1,360,998)	$ 1,033,082
Changes in operating assets and liabilities and non-cash items included in net income	(612,706)	350,684	(168,614)	1,360,998	930,362
Net cash provided by operating activities	267,168	1,044,404	651,872	—	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 and business 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	236,052	(231,800)	(4,252)	—	—
Other items	(1,061,203)	(21,525)	(144,811)	—	(1,227,539)
Net cash used in financing activities	(917,611)	(281,155)	(153,215)	—	(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)
Less: Net (decrease) increase in cash and cash equivalents from discontinued operations	—	(50,165)	34,377	—	(15,788)
Net (decrease) increase in cash and cash equivalents from continuing operations	(636,715)	—	66,574	—	(570,141)
Cash and cash equivalents of continuing operations at beginning of the year	1,186,636	—	58,281	—	1,244,917
Cash and cash equivalents of continuing operations at end of the year	$ 549,921	$ —	$ 124,855	$ —	$ 674,776

Consolidating Statements of Cash Flow - (continued)

	DaVita Inc.	Guarantor Subsidiaries	Non-Guarantor Subsidiaries	Consolidating Adjustments	Consolidated Total
For the year ended December 31, 2015					
Cash flows from operating activities:					
Net income	$ 269,732	$ 174,957	$ 479,700	$ (496,979)	$ 427,410
Changes in operating assets and liabilities and non-cash items included in net income	(125,981)	684,760	74,032	496,979	1,129,790
Net cash provided by operating activities	143,751	859,717	553,732	—	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	466,038	(370,839)	(95,199)	—	—
Other items	(572,295)	(66,382)	(119,991)	—	(758,668)
Net cash provided by (used in) financing activities	533,752	(449,174)	(223,548)	—	(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
Less: Net increase (decrease) in cash and cash equivalents from discontinued operations	—	31,436	(5,581)	—	25,855
Net increase in cash and cash equivalents from continuing operations	487,760	—	20,260	—	508,020
Cash and cash equivalents of continuing operations at beginning of the year	698,876	—	38,021	—	736,897
Cash and cash equivalents of continuing operations at end of the year	$ 1,186,636	$ —	$ 58,281	$ —	$ 1,244,917

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, 2017				
Dialysis and related lab patient service revenues	$ 10,093,670	$ —	$ —	$ 10,093,670
Less: Provision for uncollectible accounts	(485,398)	—	—	(485,398)
Net dialysis and related lab patient service revenues	9,608,272	—	—	9,608,272
Other revenues	1,268,362	—	—	1,268,362
Total net revenues	10,876,634	—	—	10,876,634
Operating expenses and charges	9,063,879	—	—	9,063,879
Operating income	1,812,755	—	—	1,812,755
Debt expense	(430,634)	—	—	(430,634)
Other income, net	17,665	—	—	17,665
Income tax expense	323,859	—	—	323,859
Net income from continuing operations	1,075,927	—	—	1,075,927
Net (loss) income from discontinued operations, net of tax	(245,372)	13,611	19	(259,002)
Net income	830,555	13,611	19	816,925
Less: Net income attributable to noncontrolling interests	(166,937)	7,183	—	(174,120)
Net income attributable to DaVita Inc.	$ 663,618	$ 20,794	$ 19	$ 642,805

Condensed Consolidating Statements of Comprehensive Income

	Consolidated Total	Physician Groups	Unrestricted Subsidiaries	Company and Restricted Subsidiaries(1)
For the year ended December 31, 2017				
Net income	$ 830,555	$ 13,611	$ 19	$ 816,925
Other comprehensive income	102,876	—	—	102,876
Total comprehensive income	933,431	13,611	19	919,801
Less: Comprehensive income attributable to noncontrolling interest	(166,935)	7,183	—	(174,118)
Comprehensive income attributable to DaVita Inc.	$ 766,496	$ 20,794	$ 19	$ 745,683

(1) After the elimination of the unrestricted subsidiaries and the physician groups

Condensed Consolidating Balance Sheets

	Consolidated Total	Physician Groups	Unrestricted Subsidiaries	Company and Restricted Subsidiaries[1]
As of December 31, 2017				
Cash and cash equivalents	$ 508,234	$ —	$ —	$ 508,234
Accounts receivable, net	1,714,750	—	—	1,714,750
Other current assets	759,732	3,033	—	756,699
Other current assets held for sale	5,761,642	423,205	2,733	5,335,704
Total current assets	8,744,358	426,238	2,733	8,315,387
Property and equipment, net	3,149,213	—	—	3,149,213
Amortizable intangibles, net	113,827	—	—	113,827
Other long-term assets	330,516	—	—	330,516
Goodwill	6,610,279	—	—	6,610,279
Total assets	$ 18,948,193	$ 426,238	$ 2,733	$ 18,519,222
Current liabilities	$ 1,856,107	$ —	$ —	$ 1,856,107
Current liabilities held for sale	1,185,070	308,884	—	876,186
Total current liabilities	3,041,177	308,884	—	2,732,293
Payables to parent	—	—	2,733	(2,733)
Long-term debt and other long-term liabilities	10,009,590	—	—	10,009,590
Noncontrolling interests subject to put provisions	1,011,360	—	—	1,011,360
Total DaVita Inc. shareholders' equity	4,690,029	117,354	—	4,572,675
Noncontrolling interests not subject to put provisions	196,037	—	—	196,037
Shareholders' equity	4,886,066	117,354	—	4,768,712
Total liabilities and shareholders' equity	$ 18,948,193	$ 426,238	$ 2,733	$ 18,519,222

Condensed Consolidating Statements of Cash Flow

	Consolidated Total	Physician Groups	Unrestricted Subsidiaries	Company and Restricted Subsidiaries[1]
For the year ended December 31, 2017				
Cash flows from operating activities:				
Net income	$ 830,555	$ 13,611	$ 19	$ 816,925
Changes in operating and intercompany assets and liabilities and non-cash items included in net income	1,076,894	27,312	(19)	1,049,601
Net cash provided by operating activities	1,907,449	40,923	—	1,866,526
Cash flows from investing activities:				
Additions of property and equipment	(905,250)	(5,406)	—	(899,844)
Acquisitions and divestitures, net	(803,879)	—	—	(803,879)
Proceeds from asset sales	92,336	—	—	92,336
Investments and other items, net	250,062	(3,800)	—	253,862
Net cash used in investing activities	(1,366,731)	(9,206)	—	(1,357,525)
Cash flows from financing activities:				
Long-term debt and related financing costs, net	154,848	—	—	154,848
Intercompany	—	(36,220)	—	36,220
Other items	(921,105)	—	—	(921,105)
Net cash used in financing activities	(766,257)	(36,220)	—	(730,037)
Effect of exchange rate changes on cash	254	—	—	254
Net decrease in cash and cash equivalents	(225,285)	(4,503)	—	(220,782)
Less: Net decrease in cash and cash equivalents from discontinued operations	(58,743)	(4,503)	—	(54,240)
Net decrease in cash and cash equivalents from continuing operations	(166,542)	—	—	(166,542)
Cash and cash equivalents of continuing operations at beginning of the year	674,776	—	—	674,776
Cash and cash equivalents of continuing operations at end of the year	$ 508,234	$ —	$ —	$ 508,234

(1) After the elimination of the unrestricted subsidiaries and the physician groups

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.(25)
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	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.(4)
4.2	Form of 5.750% Senior Notes due 2022 and related Guarantee (included in Exhibit 4.1).(4)
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.(26)
4.4	Form of 5.125% Senior Notes due 2024 and related Guarantee (included in Exhibit 4.3).(26)
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.(21)
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, effective September 22, 2005, by and between DaVita Inc. and James Hilger.(8)*
10.2	Amendment to Mr. Hilger's Employment Agreement, effective December 12, 2008.(18)*
10.3	Second Amendment to Mr. Hilger's Employment Agreement, effective December 27, 2012.(23)*
10.4	Employment Agreement, effective July 25, 2008, between DaVita Inc. and Kent J. Thiry.(15)*
10.5	Employment Agreement, effective August 1, 2008, between DaVita Inc. and Allen Nissenson.(16)*
10.6	Employment Agreement, effective March 17, 2010, by and between DaVita Inc. and Javier Rodriguez.(20)*
10.7	Employment Agreement, effective April 27, 2016, by and between DaVita HealthCare Partners Inc. and Kathleen A. Waters.(6)*
10.8	Consulting Agreement, effective June 15, 2017, by and between DaVita Inc. and Roger J. Valine.(3)*
10.9	Amendment to Stock Appreciation Rights Agreements, effective June 15, 2017, by and between DaVita Inc. and Roger J. Valine. (3)*
10.10	Employment Agreement, effective November 1, 2016, by and between DaVita Inc. and Charles G. Berg.(9)*

10.11	Amendment to Employment Agreement, effective October 13, 2017, by and among DaVita Inc., Charles G. Berg and DaVita Medical Management, LLC.(3)*
10.12	Employment Agreement, effective February 21, 2017, by and between DaVita Inc. and Joel Ackerman.(9)*
10.13	Sourcing and Supply Agreement between DaVita Inc. and Amgen USA Inc. effective as of January 6, 2017.(6)**
10.14	Equity Purchase Agreement, dated as of December 5, 2017, by and among DaVita Inc., Collaborative Care Holdings, LLC, and solely with respect to Section 9.3 and Section 9.18 thereto, UnitedHealth Group Incorporated.(2)
10.15	Form of Indemnity Agreement.(12)*
10.16	Form of Indemnity Agreement.(7)*
10.17	DaVita Deferred Compensation Plan.(9)*
10.18	Executive Incentive Plan (as Amended and Restated effective January 1, 2009).(19)*
10.19	Executive Retirement Plan.(18)*
10.20	DaVita Voluntary Deferral Plan.(5)*
10.21	Deferred Bonus Plan (Prosperity Plan).(17)*
10.22	Amendment No. 1 to Deferred Bonus Plan (Prosperity Plan).(18)*
10.23	Amended and Restated Employee Stock Purchase Plan.(13)*
10.24	Amended and Restated DaVita Inc. Severance Plan.(23)*
10.25	Change in Control Bonus Program.(18)*
10.26	DaVita Inc. Non-Employee Director Compensation Policy.(14)*
10.27	DaVita Inc. Non-Employee Director Compensation Policy. *✓
10.28	Form of Restricted Stock Units Agreement—Board members (DaVita Inc. 2011 Incentive Award Plan). (24)*
10.29	Form of Stock Appreciation Rights Agreement—Executives (DaVita Inc. 2011 Incentive Award Plan).(24)*
10.30	Form of Restricted Stock Units Agreement—Executives (DaVita Inc. 2011 Incentive Award Plan).(24)*
10.31	Form of Restricted Stock Units Agreement (DaVita Inc. 2011 Incentive Award Plan).(23)*
10.32	Form of Stock Appreciation Rights Agreement (DaVita Inc. 2011 Incentive Award Plan).(23)*
10.33	Form of Long-Term Incentive Program Award Agreement (For 162(m) designated teammates) (DaVita Inc. 2011 Incentive Award Plan).(23)*
10.34	Form of Long-Term Incentive Program Award Agreement (DaVita Inc. 2011 Incentive Award Plan).(23)*

10.35	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. (21)
10.36	Amended and Restated DaVita Inc. 2011 Incentive Award Plan.(11)*
10.37	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)
10.38	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)
10.39	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.(4)
10.40	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).(10) * **
10.41	Form of 2014 Long Term Incentive Program Cash Performance Award Agreement under the DaVita Inc. 2011 Incentive Award Plan and Long-Term Incentive Program.(10)* **
10.42	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).(10) * **
10.43	Form of 2014 Long Term Incentive Program Restricted Stock Units Agreement under the DaVita Inc. 2011 Incentive Award Plan and Long-Term Incentive Program.(10)*
10.44	Form of 2014 Long Term Incentive Program Stock Appreciation Rights Agreement under the DaVita Inc. 2011 Incentive Award Plan and Long-Term Incentive Program.(10)*
10.45	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.✓
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 S-1).
31.1	Certification of the Chief Executive Officer, dated February 23, 2018, 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 23, 2018, 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 23, 2018, 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 23, 2018, 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 December 6, 2017 as an exhibit to the Company's Current Report on Form 8-K.
(3) Filed on November 7, 2017 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2017.
(4) Filed on August 28, 2012 as an exhibit to the Company's Current Report on Form 8-K.
(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 May 2, 2017 as an exhibit to the Company's Quarterly Report on 10-Q for the quarter ended March 31, 2017.
(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 February 24, 2017 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 2016.
(10) 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.
(11) Filed on April 28, 2014 as Appendix A to the Company's Definitive Proxy Statement on Schedule 14A.
(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 August 1, 2014 as an exhibit to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2014.
(22) Filed on April 17, 2015 as an exhibit to the Company's Current Report on Form 8-K.
(23) Filed on March 1, 2013 as an exhibit to the Company's Annual Report on Form 10-K for the year ended December 31, 2012.
(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 July 9, 2012 as an exhibit to the Company's Current Report on Form 8-K.
(26) Filed on June 16, 2014 as an exhibit to the Company's current Report on Form 8-K.
(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.

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 23, 2018.

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, Joel Ackerman, 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 23, 2018
/S/ JOEL ACKERMAN Joel Ackerman	Chief Financial Officer (Principal Financial Officer)	February 23, 2018
/S/ JAMES K. HILGER James K. Hilger	Chief Accounting Officer (Principal Accounting Officer)	February 23, 2018
/S/ PAMELA M. ARWAY Pamela M. Arway	Director	February 23, 2018
/S/ CHARLES G. BERG Charles G. Berg	Director	February 23, 2018
/S/ CAROL A. DAVIDSON Carol A. Davidson	Director	February 23, 2018
/S/ BARBARA J. DESOER Barbara J. Desoer	Director	February 23, 2018
/S/ PASCAL DESROCHES Pascal Desroches	Director	February 23, 2018
/S/ PAUL J. DIAZ Paul J. Diaz	Director	February 23, 2018
/S/ PETER T. GRAUER Peter T. Grauer	Director	February 23, 2018
/S/ JOHN M. NEHRA John M. Nehra	Director	February 23, 2018
/S/ WILLIAM L. ROPER William L. Roper	Director	February 23, 2018
/S/ PHYLLIS R. YALE Phyllis R. Yale	Director	February 23, 2018

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, 2017	$ 238,897	$ —	$ 478,365	$ 498,863	$ 218,399
Year ended December 31, 2016	$ 251,734	$ —	$ 442,985	$ 455,822	$ 238,897
Year ended December 31, 2015	$ 229,802	$ —	$ 422,145	$ 400,213	$ 251,734

DAVITA INC.
NON-EMPLOYEE DIRECTOR COMPENSATION POLICY

ARTICLE I

PURPOSE

The primary purposes of the DaVita Inc. (the "Company") Non-Employee Director Compensation and Reimbursement Policy (this "Policy") are as follows:

- to pay differentially higher compensation for higher levels of work, responsibility and performance;
- to provide a compensation structure that will attract highly competent candidates; and
- to provide a significant portion of compensation in the form of equity-based awards to align non-employee director compensation with increases in long-term shareholder value.

All references to "Director" in this Policy shall mean a member of the Company's Board of Directors (the "Board") who is not employed by the Company.

ARTICLE II

BASE ANNUAL RETAINER

Each Director shall receive a base annual retainer (the "Base Annual Retainer") of up to Two Hundred Seventy Thousand Dollars (*$270,000) per fiscal year as follows:

2.1 Cash: Eighty Thousand Dollars ($80,000) to be paid in quarterly installments made within five business days of the last calendar day of each fiscal quarter;

2.2 Stock Settled Stock Appreciation Rights: Ninety-Five Thousand Dollars ($95,000) to be paid in the form of stock-settled stock appreciation rights ("SSARs"). The SSARs shall be subject to the following terms and conditions (the "SSAR Grant Terms"):

2.2.1 Grant Date: The SSARs shall be granted on the date of the Company's annual meeting of stockholders.

2.2.2 Amount: The number of SSARs to be granted shall be the nearest whole number of shares determined by dividing $95,000 by twenty percent (20%) of the closing market price of the Company's common stock as listed on the New York Stock Exchange on the Grant Date.

2.2.3 Vesting: The SSARs shall vest one hundred percent (100%) on the one year anniversary following the Grant Date.

2.2.4 Expiration: The SSARs shall expire five years following the Grant Date.

2.3 Direct Stock Issuances: Ninety-Five Thousand Dollars ($95,000) to be paid in the form of direct stock issuances ("DSIs") granted quarterly. The DSIs shall be subject to the following terms and conditions (the "DSI Grant Terms"):

2.3.1 Grant Date: The DSIs shall be granted on the last day of each fiscal quarter.

2.3.2 Amount: The number of DSIs to be granted shall be the nearest whole number of shares as determined by dividing $23,750 by the closing market price of the Company's common stock as listed on the New York Stock Exchange on the last trading day of each fiscal quarter.

2.4 Proration: The Base Annual Retainer shall be prorated, as applicable, based on the days of service on the Board within a fiscal quarter. SSARs granted on a prorated basis shall be granted and priced as of the close of market on the first day of service on the Board, which date shall be determined by the Board upon such individual's appointment as a Director.

ARTICLE III

ANNUAL RETAINER PREMIUM – LEAD INDEPENDENT DIRECTOR

A Director serving as the Lead Independent Director of the Board shall be paid a premium (the "Lead Director Premium") of up to One Hundred Twenty-Five Thousand Dollars ($125,000) per fiscal year as follows:

3.1 Cash: Thirty-Seven Thousand Five Hundred Dollars ($37,500) to be paid in quarterly installments made within five business days of the last calendar day of each fiscal quarter.

3.2 Stock Settled Stock Appreciation Rights: Forty-Three Thousand Seven Hundred Fifty Dollars ($43,750) to be paid in the form of SSARs, subject to the SSAR Grant Terms provided in Section 2.2 above.

3.3 Direct Share Issuances: Forty-Three Thousand Seven Hundred Fifty Dollars ($43,750) to be paid in the form of DSIs to be granted quarterly, subject to the DSI Grant Terms provided in Section 2.3 above.

3.4 Proration: The Lead Director Premium shall be prorated, as applicable, based on the days of service on the Board within a fiscal quarter. SSARs granted on a prorated basis shall be granted and priced as of the close of market as listed on the New York Stock Exchange on the first day of service, which date shall be determined by the Board upon such Director's appointment as the Lead Independent Director.

ARTICLE IV

ANNUAL RETAINER PREMIUM – COMMITTEE CHAIRS

A Director serving as a Chair of a committee ("Committee") of the Board shall be paid a cash premium (the "Chair Premium") per fiscal year as follows:

4.1 Chairs of the Audit, Compensation and Compliance Committees: Fifty-Thousand Dollars ($50,000) to be paid each in quarterly installments made within five business days of the last calendar day of each fiscal quarter.

4.2 Chairs of the Public Policy and Clinical Performance Committees: Twenty-Five Thousand Dollars ($25,000) to be paid each in quarterly installments made within five business days of the last calendar day of each fiscal quarter.

4.3 Chair of the Nominating and Governance Committee: No Chair Premium will be paid for services provided as Chair of the Nominating and Governance Committee.

4.4 Proration: A Chair Premium shall be prorated, as applicable, based on the days of service as a Chair of a Committee within a fiscal quarter.

ARTICLE V

MEETING FEES

A Director shall be paid the following fees for his or her in person or telephonic attendance of Board and Committee meetings as follows:

5.1 Board: Two Thousand Five Hundred Dollars ($2,500) cash for attendance of: (1) special Board meetings held in person, irrespective of length, and (2) special Board meetings held telephonically that last approximately one hour. No additional compensation shall be provided for attendance of regular Board meetings.

5.2 Committees/Sub-Committees: Two Thousand Five Hundred Dollars ($2,500) cash for attendance of the following Committee meetings, provided that the Director is a member of such Committee: (1) regular or special Committee meetings held in person, and (2) regular or special Committee meetings held telephonically that last approximately one hour. Notwithstanding the foregoing, each member of the Audit Committee shall be paid Two Thousand Five Hundred Dollars ($2,500) in cash for his or her in person or telephonic attendance to each Audit Committee meeting related to quarterly earnings releases, regardless of the duration of such meeting.

5.2.1 Notwithstanding anything herein to the contrary, a Director shall be paid $2,500 in cash for attendance to a regular or

special meeting of a Committee of which such Director is not a member, provided that such Director's attendance was made at the request of the Committee's chair and provided further that such payment is made in accordance with this Section 5.2.

5.2.2 New Committee Members: A Director attending a Committee meeting held earlier on the same day of his or her appointment by the Board to such Committee, will be eligible to receive Committee meeting fees as described under this Section 5.2.

ARTICLE VI

EXPENSE REIMBURSEMENT AND COMPENSATION FOR ADDITIONAL TIME EXPENDED

6.1 Expense Reimbursement. Each Director shall be reimbursed for his or her reasonable out-of-pocket business expenses incurred in connection with attending meetings of the Board or its Committees or in connection with other Board related business.

6.2 Compensation for Additional Time. Each Director shall be compensated in cash on a "per diem," hourly or other basis at a rate that is reasonable and fair to the Company as determined in the discretion of the Lead Independent Director (or, should the matter be referred to them, the Board or the Compensation Committee), for significant time spent outside of Board or Committee meetings for meetings or activities outside the scope of normal Board duties, including director training, meeting with Company management or external auditors, interviewing director candidates or other activities deemed necessary by the Chairman of the Board, the Lead Independent Director, or the entire Board. Any dollar amounts set for a particular unit of time shall be paid on a pro rata basis for time expended that is less than the full unit of time for which a rate was set. The Lead Independent Director shall oversee requests for compensation under this Article VI.

Exhibit 12.1

DAVITA 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,				
	2017	**2016**	**2015**	**2014**	**2013**
Earnings adjusted for fixed charges:					
Income from continuing operations before income taxes	$ 1,399,786	$ 1,623,105	$ 688,387	$ 1,094,322	$ 692,438
Add:					
Debt expense	430,634	414,116	408,380	410,223	429,938
Interest portion of rent expense	171,842	154,901	143,311	130,640	120,398
Less: Noncontrolling interests	(175,176)	(159,404)	(158,304)	(140,949)	(124,438)
	427,300	409,613	393,387	399,914	425,898
	$ 1,827,086	$ 2,032,718	$ 1,081,774	$ 1,494,236	$ 1,118,336
Fixed charges:					
Debt expense	$ 430,634	$ 414,116	$ 408,380	$ 410,223	$ 429,938
Interest portion of rent expense	171,842	154,901	143,311	130,640	120,398
Capitalized interest	19,176	12,990	9,723	7,888	6,408
	$ 621,652	$ 582,007	$ 561,414	$ 548,751	$ 556,744
Ratio of earnings to fixed charges	2.94	3.49	1.93	2.72	2.01

Exhibit 21.1

SUBSIDIARIES OF THE COMPANY
as of December 31, 2017

Name	Jurisdiction of Organization
DaVita Kidney Care:	
Aberdeen Dialysis, LLC	Delaware
Alamosa Dialysis, LLC	Delaware
American Fork Dialysis, LLC	Delaware
American Medical Insurance, Inc.	Arizona
Animas Dialysis, LLC	Delaware
Arcadia Gardens Dialysis, LLC	Delaware
Astro, Hobby, West Mt. Renal Care Limited Partnership	Delaware
Athio Dialysis, LLC	Delaware
Atlantic Dialysis, LLC	Delaware
Austin Dialysis Centers, L.P.	Delaware
Bainbridge Dialysis, LLC	Delaware
Bannon Dialysis, LLC	Delaware
Barnell Dialysis, LLC	Delaware
Barton Dialysis, LLC	Delaware
Basin Dialysis, LLC	Delaware
Bastrop Dialysis, LLC	Delaware
Beachside Dialysis, LLC	Delaware
Beacon Dialysis, LLC	Delaware
Bear Creek Dialysis Center, L.P.	Delaware
Beck Dialysis, LLC	Delaware
Bellevue Dialysis, LLC	Delaware
Beverly Dialysis, LLC	Delaware
Beverly Hills Dialysis Partnership	California
Birch Dialysis, LLC	Ohio
Bladon Dialysis, LLC	Delaware
Blake Dialysis, LLC	Delaware
Blanco Dialysis, LLC	Delaware
Bliss Dialysis, LLC	Delaware
Bluegrass Dialysis, LLC	Delaware
Bogachiel Dialysis, LLC	Delaware
Bohama Dialysis, LLC	Delaware
Borrego Dialysis, LLC	Delaware
Bottle Dialysis, LLC	Delaware
Brache Dialysis, LLC	Delaware
Braden Dialysis, LLC	Delaware
Bridges Dialysis, LLC	Delaware
Brighton Dialysis Center, LLC	Delaware
Brook Dialysis, LLC	Delaware
Brownsville Kidney Center, Ltd.	Texas
Brownwood Dialysis, LLC	Delaware
Bruno Dialysis, LLC	Delaware

Buford Dialysis, LLC	Delaware
Bullards Dialysis, LLC	Delaware
Butano Dialysis, LLC	Delaware
Canyon Springs Dialysis, LLC	Delaware
Capes Dialysis, LLC	Delaware
Capital Dialysis Partnership	California
Carroll County Dialysis Facility Limited Partnership	Maryland
Carroll County Dialysis Facility, Inc.	Maryland
Cascades Dialysis, LLC	Delaware
Caverns Dialysis, LLC	Delaware
Cedar Dialysis, LLC	Delaware
Centennial LV, LLC	Delaware
Central Carolina Dialysis Centers, LLC	Delaware
Central Georgia Dialysis, LLC	Delaware
Central Iowa Dialysis Partners, LLC	Delaware
Central Kentucky Dialysis Centers, LLC	Delaware
Centrum Dializa II Sp. z o.o.	Poland
Chadron Dialysis, LLC	Delaware
Channel Dialysis, LLC	Delaware
Cheraw Dialysis, LLC	Delaware
Chicago Heights Dialysis, LLC	Delaware
Chipeta Dialysis, LLC	Delaware
Chouteau Dialysis, LLC	Delaware
Churchill Dialysis, LLC	Delaware
Cinco Rios Dialysis, LLC	Delaware
Clark Dialysis, LLC	Delaware
Clayton Dialysis, LLC	Delaware
Cleburne Dialysis, LLC	Delaware
Clinica Central do Bonfim S.A.	Portugal
Clinica Medica DaVita Londrina Servicos de Nefrologia Ltda.	Brazil
Clinton Township Dialysis, LLC	Delaware
Clover Dialysis, LLC	Delaware
Clyfee Dialysis, LLC	Delaware
Cobbles Dialysis, LLC	Delaware
Columbus-RNA-DaVita, LLC	Delaware
Conconully Dialysis, LLC	Delaware
Continental Dialysis Center of Springfield-Fairfax, Inc.	Virginia
Continental Dialysis Center, Inc.	Virginia
Coral Dialysis, LLC	Delaware
Couer Dialysis, LLC	Delaware
Cowell Dialysis, LLC	Delaware
Crystals Dialysis, LLC	Delaware
Cuivre Dialysis, LLC	Delaware
Dallas-Fort Worth Nephrology, L.P.	Delaware
Damon Dialysis, LLC	Delaware
DaVita - Riverside II, 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 Brasil Servicos de Nefrologia Uber Ltda.	Brazil
DaVita Care (Saudi Arabia)	Saudi Arabia
DaVita Dakota Dialysis Center, LLC	Delaware
DaVita Deutschland AG	Germany
DaVita Deutschland Beteiligungs GmbH & Co. KG	Germany
DaVita DPC Holding Co., LLC	Delaware
DaVita EL Paso East, L.P.	Delaware
DaVita Germany GmbH	Germany
DaVita Health Solutions, LLC	Delaware
DaVita of New York, Inc.	New York
DaVita Rx, LLC	Delaware
DaVita S.A.S.	Colombia
DaVita Servicos de Nefrologia Botafogo Ltda.	Brazil
DaVita Servicos de Nefrologia de Araraquara Ltda.	Brazil
DaVita Servicos de Nefrologia Jardim das Imbuias Ltda.	Brazil
DaVita Servicos de Nefrologia Joao Dias Ltda.	Brazil
DaVita Servicos de Nefrologia Penha Ltda.	Brazil
DaVita Servicos de Nefrologia Recife Ltda.	Brazil
DaVita Servicos de Nefrologia Santos Ltda.	Brazil
DaVita Sp. z o.o.	Poland
DaVita Tidewater - Virginia Beach, LLC	Delaware
DaVita VillageHealth, Inc.	Delaware
DC Healthcare International, Inc.	Delaware
Dialysis Holdings, Inc.	Delaware
Dialysis of Des Moines, LLC	Delaware
Dialysis of Northern Illinois, LLC	Delaware
Dialysis Specialists of Dallas, Inc.	Texas
DNP Management Company, LLC	Delaware
Dolores Dialysis, LLC	Delaware
Dome Dialysis, LLC	Delaware
Doves Dialysis, LLC	Delaware
Downriver Centers, Inc.	Michigan
Downtown Houston Dialysis Center, L.P.	Delaware
DV Care Netherlands B.V.	Netherlands
DV Care Netherlands C.V.	Netherlands
DVA Healthcare - Southwest Ohio, LLC	Tennessee
DVA Healthcare of Maryland, LLC	Maryland
DVA Healthcare of Massachusetts, Inc.	Massachusetts
DVA Healthcare of New London, LLC	Tennessee
DVA Healthcare of Norwich, LLC	Tennessee
DVA Healthcare of Pennsylvania, LLC	Pennsylvania
DVA Healthcare of Tuscaloosa, LLC	Tennessee
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
East Ft. Lauderdale, LLC	Delaware
East Houston Kidney Center, L.P.	Delaware
Ebrea Dialysis, LLC	Delaware
Edisto Dialysis, LLC	Delaware
Elberton Dialysis Facility, Inc.	Georgia
Eldrist Dialysis, LLC	Delaware
Elgin Dialysis, LLC	Delaware
Elk Grove Dialysis Center, LLC	Delaware
Empire State DC, Inc.	New York
Etowah Dialysis, LLC	Delaware
Eufaula Dialysis, LLC	Delaware
EURODIAL - Centro de Nefrologia e Dialise de Leiria S.A.	Portugal
Falcon, LLC	Delaware
Fanthorp Dialysis, LLC	Delaware
Farragut Dialysis, LLC	Delaware
Federal Way Assurance, Inc.	Colorado
Fields Dialysis, LLC	Delaware
Five Star Dialysis, LLC	Delaware
Flagler Dialysis, LLC	Delaware
Flamingo Park Kidney Center, Inc.	Florida
Flor Dialysis, LLC	Delaware
Forester Dialysis, LLC	Delaware
Fort Dialysis, LLC	Delaware
Freehold Artificial Kidney Center, L.L.C.	New Jersey
Fremont Dialysis, LLC	Delaware
Fullerton Dialysis Center, LLC	Delaware
Ganois Dialysis, LLC	Delaware
Garner Dialysis, LLC	Delaware
Garrett Dialysis, LLC	Delaware
Gaviota Dialysis, LLC	Delaware
GDC International, LLC	Delaware
Genesis KC Development, LLC	Delaware
Geyser Dialysis, LLC	Delaware
GiveLife Dialysis, LLC	Delaware
Glacier Dialysis, LLC	Delaware
Glassland Dialysis, LLC	Delaware
Glosser Dialysis, LLC	Delaware
Golden ASC, LLC	Delaware
Goliad Dialysis, LLC	Delaware
Great Dialysis, LLC	Delaware
Greater Las Vegas Dialysis, LLC	Delaware

Greater Los Angeles Dialysis Centers, LLC	Delaware
Green Country Dialysis, LLC	Delaware
Green Desert Dialysis, LLC	Delaware
Griffin Dialysis, LLC	Delaware
Harmony Dialysis, LLC	Delaware
Hart Dialysis, LLC	Delaware
Hawn Dialysis, LLC	Delaware
Hazelton Dialysis, LLC	Delaware
Hills Dialysis, LLC	Delaware
Honey Dialysis, LLC	Delaware
Honeyman Dialysis, LLC	Delaware
Houston Kidney Center/Total Renal Care Integrated Service Network Limited Partnership	Delaware
Hunter Dialysis, LLC	Delaware
Huntington Artificial Kidney Center, Ltd.	New York
Huntington Park Dialysis, LLC	Delaware
Hyde Dialysis, LLC	Delaware
IDC -International Dialysis Centers, Lda	Portugal
Indian River Dialysis Center, LLC	Delaware
Iroquois Dialysis, LLC	Delaware
ISD Bartlett, LLC	Delaware
ISD Corpus Christi, LLC	Delaware
ISD I Holding Company, Inc.	Delaware
ISD II Holding Company, Inc.	Delaware
ISD Las Vegas, LLC	Delaware
ISD Lees Summit, LLC	Delaware
ISD Renal, Inc.	Delaware
ISD Schaumburg, LLC	Delaware
ISD Spring Valley, LLC	Delaware
ISD Summit Renal Care, LLC	Ohio
Jacinto Dialysis, LLC	Delaware
Kamiah Dialysis, LLC	Delaware
Kavett Dialysis, LLC	Delaware
Kenai Dialysis, LLC	Delaware
Kidney Care Services, LLC	Delaware
Kidney Center South LLC	Delaware
Kidney HOME Center, LLC	Delaware
Kimball Dialysis, LLC	Delaware
Kingston Dialysis, LLC	Delaware
Knickerbocker Dialysis, Inc.	New York
Lakeshore Dialysis, LLC	Delaware
Landing Dialysis, LLC	Delaware
Lassen Dialysis, LLC	Delaware
Latrobe Dialysis, LLC	Delaware
Leasburg Dialysis, LLC	Delaware
Leawood 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
Lifeline Vascular Center-Orlando, LLC	Delaware
Limon Dialysis, LLC	Delaware
Lincoln Park Dialysis Services, Inc.	Illinois
Little Rock Dialysis Centers, LLC	Delaware
Livingston Dialysis, LLC	Delaware
Llano Dialysis, LLC	Delaware
Lockhart Dialysis, LLC	Delaware
Lofield Dialysis, LLC	Delaware
Lone Dialysis, LLC	Delaware
Long Beach Dialysis Center, LLC	Delaware
Lord Baltimore Dialysis, LLC	Delaware
Lory Dialysis, LLC	Delaware
Loup Dialysis, LLC	Delaware
Lourdes Dialysis, LLC	Delaware
Magoffin Dialysis, LLC	Delaware
Mammoth Dialysis, LLC	Delaware
Manzano Dialysis, LLC	Delaware
Maple Grove Dialysis, LLC	Delaware
Marlton Dialysis Center, LLC	Delaware
Mason-Dixon Dialysis Facilities, Inc.	Maryland
Mazonia Dialysis, LLC	Delaware
Memorial Dialysis Center, L.P.	Delaware
Meridian Dialysis, LLC	Delaware
Mermet Dialysis, LLC	Delaware
Mesilla Dialysis, LLC	Delaware
Middlesex Dialysis Center, LLC	Delaware
Milo Dialysis, LLC	Delaware
Minam Dialysis, LLC	Delaware
Mountain West Dialysis Services, LLC	Delaware
Mulgee Dialysis, LLC	Delaware
MVZ DaVita Alzey GmbH	Germany
MVZ DaVita Aurich GmbH	Germany
MVZ DaVita Bad Duben GmbH	Germany
MVZ DaVita Cardio Centrum Dusseldorf GmbH	Germany
MVZ DaVita Dormagen GmbH	Germany
MVZ DaVita Dresden GmbH	Germany
MVZ DaVita Duisburg GmbH	Germany
MVZ DaVita Elsterland GmbH	Germany
MVZ DaVita Emden GmbH	Germany
MVZ DaVita Geilenkirchen GmbH	Germany
MVZ DaVita Gera GmbH	Germany
MVZ DaVita Iserlohn GmbH	Germany
MVZ DaVita Monchengladbach GmbH	Germany

MVZ DaVita Neuss GmbH	Germany
MVZ DaVita Niederrhein GmbH	Germany
MVZ DaVita Nierenzentrum Berlin-Britz GmbH	Germany
MVZ DaVita Rhein-Ahr GmbH	Germany
MVZ DaVita Rhein-Ruhr GmbH	Germany
MVZ DaVita Salzgitter-Seesen GmbH	Germany
MVZ DaVita Sud-Niedersachsen GmbH	Germany
MVZ DaVita Viersen GmbH	Germany
Nansen Dialysis, LLC	Delaware
Natomas Dialysis, LLC	Delaware
Navarro Dialysis, LLC	Delaware
Nephrology Medical Associates of Georgia, LLC	Georgia
Nephrology Practice Solutions, LLC	Delaware
Neptune Artificial Kidney Center, L.L.C.	New Jersey
New Bay Dialysis, LLC	Delaware
New Springs Dialysis, LLC	Delaware
Norbert Dialysis, LLC	Delaware
North Atlanta Dialysis Center, LLC	Delaware
North Colorado Springs Dialysis, LLC	Delaware
Ohio River Dialysis, LLC	Delaware
Okanogan Dialysis, LLC	Delaware
Open Access Lifeline, LLC	Delaware
Orange Dialysis, LLC	California
Ordust Dialysis, LLC	Delaware
Owyhee Dialysis, LLC	Delaware
Palo Dialysis, LLC	Delaware
Palomar Dialysis, LLC	Delaware
Panther Dialysis, LLC	Delaware
Parkside Dialysis, LLC	Delaware
Patient Pathways, LLC	Delaware
PDI Holdings, Inc.	Delaware
Pearl Dialysis, LLC	Delaware
Pershing Dialysis, LLC	Delaware
Pfeiffer Dialysis, LLC	Delaware
Philadelphia-Camden Integrated Kidney Care, 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
Pittsburgh Dialysis Partners, LLC	Delaware
Piute Dialysis, LLC	Delaware
Plaine Dialysis, LLC	Delaware
Platte Dialysis, LLC	Delaware

Pluribus Dialise, S.A.	Portugal
Pokagon Dialysis, LLC	Delaware
Portola Dialysis, LLC	Delaware
Prineville Dialysis, LLC	Delaware
Prings Dialysis, LLC	Delaware
Rayburn Dialysis, LLC	Delaware
Red Willow Dialysis, LLC	Delaware
Redcliff Dialysis, LLC	Delaware
Refuge Dialysis, LLC	Delaware
Renal Center of Beaumont, LLC	Delaware
Renal Center of Hamilton, LLC	Delaware
Renal Center of Lewisville, LLC	Delaware
Renal Center of Morristown, LLC	Delaware
Renal Center of North Denton, L.L.L.P.	Delaware
Renal Center of Port Arthur, LLC	Delaware
Renal Center of West Beaumont, LLC	Delaware
Renal Clinic of Houston, 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
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
Renal Ventures Management, LLC	Delaware
RenalServ LLC	Delaware
Riddle Dialysis, LLC	Delaware
Rio Dialysis, LLC	Delaware
River Valley Dialysis, LLC	Delaware
RMS Lifeline Inc.	Delaware
RNA - DaVita Dialysis, LLC	Delaware
Rochester Dialysis Center, LLC	Delaware
Rocky Mountain Dialysis Services, LLC	Delaware
Roose Dialysis, LLC	Delaware
Roushe Dialysis, LLC	Delaware
Royale Dialysis, LLC	Delaware
RTC TN, Inc.	Delaware
Rusk Dialysis, LLC	Delaware
Russell Dialysis, LLC	Delaware
SafeHarbor Dialysis, LLC	Delaware
Sahara Dialysis, LLC	Delaware
SAKDC-DaVita Dialysis Partners, L.P.	Delaware
San Marcos Dialysis, LLC	Delaware
Sands Dialysis, LLC	Delaware
Santa Fe Springs Dialysis, LLC	Delaware

Santiam Dialysis, LLC	Delaware
Sapelo Dialysis, LLC	Delaware
Seabay Dialysis, LLC	Delaware
Seneca Dialysis, LLC	Delaware
Shadow Dialysis, LLC	Delaware
Shayano Dialysis, LLC	Delaware
Shelby Dialysis, LLC	Delaware
Shelling Dialysis, LLC	Delaware
Sherman Dialysis, LLC	Delaware
Shining Star Dialysis, Inc.	New Jersey
Shone Dialysis, LLC	Delaware
Shoshone Dialysis, LLC	Delaware
Siena Dialysis Center, LLC	Delaware
Sierra Rose Dialysis Center, LLC	Delaware
Simeon Dialysis, LLC	Delaware
Skagit Dialysis, LLC	Delaware
Soledad Dialysis Center, LLC	Delaware
Somerville Dialysis Center, LLC	Delaware
South Central Florida Dialysis Partners, LLC	Delaware
South Florida Integrated Kidney Care, LLC	Delaware
South Fork Dialysis, LLC	Delaware
Southcrest Dialysis, LLC	Delaware
Southern Hills Dialysis Center, LLC	Delaware
Southlake Dialysis, LLC	Delaware
Southwest Atlanta Dialysis Centers, LLC	Delaware
Sprague Dialysis, LLC	Delaware
St. Luke's Dialysis, LLC	Delaware
Star Dialysis, LLC	Delaware
Stewart Dialysis, LLC	Delaware
Stines Dialysis, LLC	Delaware
Storrie Dialysis, LLC	Delaware
Sugarloaf Dialysis, LLC	Delaware
Sun City Dialysis Center, L.L.C.	Delaware
Sun City West Dialysis Center, LLC	Delaware
Sunapee Dialysis, LLC	Delaware
Sunset Dialysis, LLC	Delaware
Talimena Dialysis, LLC	Delaware
The DaVita Collection, Inc.	California
The Woodlands Dialysis Center, LP	Delaware
Tortugas Dialysis, LLC	Delaware
Total Acute Kidney Care, Inc.	Florida
Total Renal Care Of North Carolina, LLC	Delaware
Total Renal Care Texas Limited Partnership	Delaware
Total Renal Care, Inc.	California
Total Renal Care/Eaton Canyon Dialysis Center Partnership	California
Total Renal Laboratories, Inc.	Florida
Total Renal Research, Inc.	Delaware

Transmountain Dialysis, L.P.	Delaware
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
Tugman Dialysis, LLC	Delaware
Tunnel Dialysis, LLC	Delaware
Turlock Dialysis Center, LLC	Delaware
Tustin Dialysis Center, LLC	Delaware
Tyler Dialysis, LLC	Delaware
Ukiah Dialysis, LLC	Delaware
Unicoi Dialysis, LLC	Delaware
University Dialysis Center, LLC	Delaware
Upper Valley Dialysis, L.P.	Delaware
USC-DaVita Dialysis Center, LLC	California
Valley Springs Dialysis, LLC	Delaware
Victory Dialysis, LLC	Delaware
VillageHealth DM, LLC	Delaware
Villanueva Dialysis, LLC	Delaware
Vogel Dialysis, LLC	Delaware
Wakoni Dialysis, LLC	Delaware
Walker Dialysis, LLC	Delaware
Walton Dialysis, LLC	Delaware
Weldon Dialysis, LLC	California
West Elk Grove Dialysis, LLC	Delaware
West Sacramento Dialysis, LLC	Delaware
Weston Dialysis Center, LLC	Delaware
Whitney Dialysis, LLC	Delaware
Wilder Dialysis, LLC	Delaware
Willowbrook Dialysis Center, L.P.	Delaware
Winds Dialysis, LLC	Delaware
Wood Dialysis, LLC	Delaware
Woodford Dialysis, LLC	Delaware
Wyandotte Central Dialysis, LLC	Delaware
Yargol Dialysis, LLC	Delaware
Ybor City Dialysis, LLC	Delaware
Zephyrhills Dialysis Center, LLC	Delaware
DaVita Medical Group:	
Colorado Innovative Physician Solutions, Inc.	Colorado
DaVita Clinical Trials, LLC	Delaware
DaVita Health Plan of California, Inc.	Delaware
DaVita Health Plan of Nevada, Inc.	Nevada

DaVita Magan Management, Inc.	California
DaVita Medical ACO California, LLC	California
DaVita Medical ASC Colorado, LLC	Colorado
DaVita Medical ASC-LB California, LLC	California
DaVita Medical Colorado ASC, LLC	Colorado
DaVita Medical Colorado, LLC	Colorado
DaVita Medical Endoscopy Center New Mexico, LLC	New Mexico
DaVita Medical Explorer, LLC	Delaware
DaVita Medical Florida, Inc.	Delaware
DaVita Medical Group Colorado Springs, LLC	Colorado
DaVita Medical Group New Mexico, LLC	Delaware
DaVita Medical Group South Florida, LLC	Florida
DaVita Medical Holding Company, New Mexico, LLC	New Mexico
DaVita Medical Holdings Colorado, LLC	Colorado
DaVita Medical Holdings Florida, Inc.	Delaware
DaVita Medical Holdings, LLC	California
DaVita Medical IPA Nevada, LLC	Nevada
DaVita Medical LV, LLC	Nevada
DaVita Medical Management Services California, LLC	Delaware
DaVita Medical Management Services Nevada, LLC	Nevada
DaVita Medical Management, LLC	California
DaVita Medical Nevada, LLC	Nevada
DaVita Medical RE, LLC	Delaware
DaVita Pharmacy Colorado, LLC	Colorado
Everett MSO, Inc.	Washington
Mountain View Medical Group, LLC	Colorado
North Puget Sound Oncology Equipment Leasing Company, LLC	Washington

Exhibit 23.1

Consent of Independent Registered Public Accounting Firm

The Board of Directors
DaVita 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 (No. 333-203394, No. 333-196630, No. 333-183285, and No. 333-169690) of DaVita Inc. of our reports dated February 23, 2018, with respect to the consolidated balance sheets of DaVita Inc. as of December 31, 2017 and 2016, and the related consolidated statements of income, comprehensive income, equity, and cash flow for each of the years in the three-year period ended December 31, 2017, and the related notes and financial statement Schedule II - Valuation and Qualifying Accounts (collectively, the consolidated financial statements), and the effectiveness of internal control over financial reporting as of December 31, 2017, which reports appear in the December 31, 2017 annual report on Form 10-K of DaVita Inc.

/s/ KPMG LLP

Seattle, Washington
February 23, 2018

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 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 23, 2018

Exhibit 31.2

SECTION 302 CERTIFICATION

I, Joel Ackerman, certify that:

1. I have reviewed this annual report on Form 10-K of DaVita Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and 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/ JOEL ACKERMAN

Joel Ackerman
Chief Financial Officer

Date: February 23, 2018

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 Inc. (the "Company") on Form 10-K for the year ending December 31, 2017 as filed with the Securities and Exchange Commission on the date hereof (the "Periodic Report"), I, Kent J. Thiry, Chief Executive Officer of the Company, certify, pursuant to 18.U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, that:

1 The Periodic Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

2 The information contained in the Periodic Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/S/ KENT J. THIRY

Kent J. Thiry
Chief Executive Officer

February 23, 2018

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 Inc. (the "Company") on Form 10-K for the year ending December 31, 2017 as filed with the Securities and Exchange Commission on the date hereof (the "Periodic Report"), I, Joel Ackerman, Chief Financial Officer of the Company, certify, pursuant to 18.U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, that:

1 The Periodic Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

2 The information contained in the Periodic Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/S/ JOEL ACKERMAN

Joel Ackerman
Chief Accounting Officer

February 23, 2018

Appendix 11

Ancillary and Support Agreements and Vendors

Appendix 11

DaVita Auburn Valley Dialysis Center

Proposed Ancillary and Support Agreements & Services

Agreements & Services
Extensive Facility Maintenance
Patient Transfer
Janitorial
Waste Disposal
Medical Waste Disposal
Alarm Monitoring
Information Management
Mutual Emergency Backup Dialysis
Laboratory Services
Stat Laboratory Services
Student Training
Renal Network Membership
Nursing Home Dialysis Services
Pest Control

The above list is representative of those agreements and services to be established and is not represented to be an exhaustive list of every support and ancillary agreement relationship into which the facility may enter.

Appendix 12

Patient Transfer Agreement

FOR COMPANY USE ONLY:
Clinic #:

PATIENT TRANSFER AGREEMENT

This **PATIENT TRANSFER AGREEMENT** (the "Agreement") is made as of the last date of signature hereto (the "Effective Date"), by and between **[**INSERT HOSPITAL NAME**]** (hereinafter "Hospital") and **[**INSERT NAME OF DAVITA/DVA ENTITY**]**, a subsidiary of DaVita Inc. ("Company").

RECITALS

WHEREAS, the parties hereto desire to enter into this Agreement governing the transfer of patients between Hospital and the following free-standing dialysis clinic owned and operated by Company:

_____ ***Dialysis***
Street Address
City, State Zip Code

WHEREAS, the parties hereto desire to enter into this Agreement in order to specify the rights and duties of each of the parties and to specify the procedure for ensuring the timely transfer of patients between the facilities;

WHEREAS, the parties wish to facilitate the continuity of care and the timely transfer of patients and records between the facilities; and

WHEREAS, only a patient's attending physician (not Company or the Hospital) can refer such patient to Company for dialysis treatments.

NOW THEREFORE, in consideration of the premises herein contained and for other good and valuable consideration, the receipt and legal sufficiency of which are hereby acknowledged, the parties agree as follows:

1. HOSPITAL OBLIGATIONS. In accordance with the policies and procedures as hereinafter provided, and upon the recommendation of an attending physician, a patient of Company may be transferred to Hospital.

(a) Hospital agrees to exercise its best efforts to provide for prompt admission of patients provided that all usual, reasonable conditions of admission are met. All transfers between the facilities shall be made in accordance with applicable federal and state laws and regulations, the standards of The Joint Commission ("TJC") and any other applicable accrediting bodies, and reasonable policies and procedures of the facilities. Transfer record forms shall be completed in detail and signed by the physician or nurse in charge at Company and must accompany the patient to the receiving institution.

(b) Neither the decision to transfer a patient nor the decision to not accept a request to transfer a patient shall be predicated upon arbitrary, capricious or unreasonable discrimination or based upon the patient's inability to pay for services rendered by either facility.

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2. COMPANY OBLIGATIONS.

(a) Upon transfer of a patient to Hospital, Company agrees:

i. That it shall transfer any needed personal effects of the patient, and information relating to the same, and shall be responsible therefore until signed for by a representative of Hospital;

ii. Original medical records kept by each of the parties shall remain the property of that institution; and

iii. That transfer procedures shall be made known to the patient care personnel of each of the parties.

(b) Company agrees to transmit with each patient at the time of transfer, or in case of an emergency, as promptly as possible thereafter, an abstract of pertinent medical and other records necessary to continue the patient's treatment without interruption and to provide identifying and other information, to include:

i. current medical findings;

ii. diagnosis;

iii. rehabilitation potential;

iv. discharge summary;

v. a brief summary of the course of treatment followed;

vi. nursing and dietary information;

vii. ambulating status; and

viii. administrative and pertinent social information.

(c) Company agrees to readmit to its facilities patients who have been transferred to Hospital for medical care as clinic capacity allows. Hospital agrees to keep the administrator or designee of Company advised of the condition of the patients that will affect the anticipated date of transfer back to Company and to provide as much notice of the transfer date as possible. Company shall assign readmission priority for its patients who have been treated at Hospital and who are ready to transfer back to Company.

3. BILLING, PAYMENT, AND FEES. Hospital and Company each shall be responsible for billing the appropriate payor for the services it provides, respectively, hereunder. Company shall not act as guarantor for any charges incurred while the patient is a patient in Hospital.

4. HIPAA. Hospital and Company agree to comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Hospital and Company

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acknowledge and agree that from time to time, HIPAA may require modification to this Agreement for compliance purposes. Hospital and Company further acknowledge and agree to comply with requests by the other party hereto related to HIPAA.

5. STATUS AS INDEPENDENT CONTRACTORS. The parties acknowledge and agree that their relationship is solely that of independent contractors. Governing bodies of Hospital and Company shall have exclusive control of the policies, management, assets, and affairs of their respective facilities. Nothing in this Agreement shall be construed as limiting the right of either to affiliate or contract with any other Hospital or facility on either a limited or general basis while this Agreement is in effect. Neither party shall use the name of the other in any promotional or advertising material unless review and approval of the intended use shall be obtained from the party whose name is to be used and its legal counsel.

6. INSURANCE. Each party shall secure and maintain, or cause to be secured and maintained during the term of this Agreement, commercial general liability, property damage, and workers compensation insurance in amounts generally acceptable in the industry, and professional liability insurance providing minimum limits of liability of $1,000,000 per occurrence and $3,000,000 in aggregate. Each party shall deliver to the other party certificate(s) of insurance evidencing such insurance coverage upon execution of this Agreement, and annually thereafter upon the request of the other party. Each party shall provide the other party with not less than thirty (30) days prior written notice of any change in or cancellation of any of such insurance policies. Said insurance shall survive the termination of this Agreement.

7. INDEMNIFICATION.

(a) Hospital Indemnity. Hospital hereby agrees to defend, indemnify and hold harmless Company and its shareholders, affiliates, officers, directors, employees, and agents for, from and against any claim, loss, liability, cost and expense (including, without limitation, costs of investigation and reasonable attorney's fees), directly or indirectly relating to, resulting from or arising out of any action or failure to act arising out of this Agreement by Hospital and its staff regardless of whether or not it is caused in part by Company or its officers, directors, agents, representatives, employees, successors and assigns. This indemnification provision shall not be effective as to any loss attributable exclusively to the negligence or willful act or omission of Company.

(b) Company Indemnity. Company hereby agrees to defend, indemnify and hold harmless Hospital and its shareholders, affiliates, officers, directors, employees, and agents for, from and against any claim, loss, liability, cost and expense (including, without limitation, costs of investigation and reasonable attorney's fees), directly or indirectly relating to, resulting from or arising out of any action or failure to act arising out of this Agreement by Company and its staff regardless of whether or not it is caused in part by or its officers, directors, agents, representatives, employees, successors and assigns. This indemnification provision shall not be effective as to any loss attributable exclusively to the negligence or willful act or omission of Hospital.

(c) Survival. The indemnification obligations of the parties shall continue in full force and effect notwithstanding the expiration or termination of this Agreement with respect to any

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such expenses, costs, damages, claims and liabilities which arise out of or are attributable to the performance of this Agreement prior to its expiration or termination.

8. DISPUTE RESOLUTION. Any dispute which may arise under this Agreement shall first be discussed directly with representatives of the departments of the parties that are directly involved. If the dispute cannot be resolved at this level, it shall be referred to administrative representatives of the parties for discussion and resolution.

(a) Informal Resolution. Should any dispute between the parties arise under this Agreement, written notice of such dispute shall be delivered from one party to the other party and thereafter, the parties, through appropriate representatives, shall first meet and attempt to resolve the dispute in face-to-face negotiations. This meeting shall occur within thirty (30) days of the date on which the written notice of such dispute is received by the other party.

(b) Resolution Through Mediation. If no resolution is reached through informal resolution, pursuant to Section 8(a) above, the parties shall, within forty-five (45) days of the first meeting referred to in Section 8(a) above, attempt to settle the dispute by formal mediation. If the parties cannot otherwise agree upon a mediator and the place of the mediation within such forty-five (45) day period, the American Arbitration Association ("AAA") in the **[**DRAFTER'S NOTE: INSERT STATE OR COMMONWEALTH**]** of **[**INSERT STATE IN WHICH FACILITY IS LOCATED**]** shall administer the mediation. Such mediation shall occur no later than ninety (90) days after the dispute arises. All findings of fact and results of such mediation shall be in written form prepared by such mediator and provided to each party to such mediation. In the event that the parties are unable to resolve the dispute through formal mediation pursuant to this Section 8(b), the parties shall be entitled to seek any and all available legal remedies.

9. TERM AND TERMINATION. This Agreement shall be effective for an initial period of one (1) year from the Effective Date and shall continue in effect indefinitely after such initial term, except that either party may terminate by giving at least sixty (60) days notice in writing to the other party of its intention to terminate this Agreement. If this Agreement is terminated for any reason within one (1) year of the Effective Date of this Agreement, then the parties hereto shall not enter into a similar agreement with each other for the services covered hereunder before the first anniversary of the Effective Date. Termination shall be effective at the expiration of the sixty (60) day notice period. However, if either party shall have its license to operate its facility revoked by the State or become ineligible as a provider of service under Medicare or Medicaid laws, this Agreement shall automatically terminate on the date such revocation or ineligibility becomes effective.

10. AMENDMENT. This Agreement may be modified or amended from time to time by mutual written agreement of the parties, signed by authorized representatives thereof, and any such modification or amendment shall be attached to and become part of this Agreement. No oral agreement or modification shall be binding unless reduced to writing and signed by both parties.

11. ENFORCEABILITY/SEVERABILITY. The provisions of this Agreement are severable. The invalidity or unenforceability of any term or provisions hereto in any jurisdiction

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shall in no way affect the validity or enforceability of any other terms or provisions in that jurisdiction, or of this entire Agreement in any other jurisdiction.

12. COMPLIANCE RELATED MATTERS. The parties agree and certify that this Agreement is not intended to generate referrals for services or supplies for which payment maybe made in whole or in part under any federal health care program. The parties will comply with statutes, rules, and regulations as promulgated by federal and state regulatory agencies or legislative authorities having jurisdiction over the parties.

13. EXCLUDED PROVIDER. Each party represents that neither that party nor any entity owning or controlling that party has ever been excluded from any federal health care program including the Medicare/Medicaid program or from any state health care program. Each party further represents that it is eligible for Medicare/Medicaid participation. Each party agrees to disclose immediately any material federal, state, or local sanctions of any kind, imposed subsequent to the date of this Agreement, or any investigation which commences subsequent to the date of this Agreement, that would materially adversely impact Company's ability to perform its obligations hereunder.

14. NOTICES. All notices, requests, and other communications to any party hereto shall be in writing and shall be addressed to the receiving party's address set forth below or to any other address as a party may designate by notice hereunder, and shall either be (a) delivered by hand, (b) sent by recognized overnight courier, or (c) by certified mail, return receipt requested, postage prepaid.

If to Hospital: _____
_____
_____
Attention: _____

If to Company: _____
C/o: DaVita Inc.
_____
_____
Attention: _____

With copies to: _____
C/o: DaVita Inc.
601 Hawaii Street
El Segundo, CA 90245
Attention: Senior Corporate Counsel

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DaVita Inc.
2000 16th Street
Denver, Colorado 80202
Attention: General Counsel

All notices, requests, and other communication hereunder shall be deemed effective (a) if by hand, at the time of the delivery thereof to the receiving party at the address of such party set forth above, (b) if sent by overnight courier, on the next business day following the day such notice is delivered to the courier service, or (c) if sent by certified mail, five (5) business days following the day such mailing is made.

15. ASSIGNMENT. This Agreement shall not be assigned in whole or in part by either party hereto without the express written consent of the other party, except that Company may assign this Agreement to one of its affiliates or subsidiaries without the consent of Hospital.

16. COUNTERPARTS. This Agreement may be executed simultaneously 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. Copies of signatures sent by facsimile shall be deemed to be originals.

17. NON-DISCRIMINATION. All services provided by Hospital hereunder shall be in compliance with all federal and state laws prohibiting discrimination on the basis of race, color religion, sex national origin, handicap, or veteran status.

18. WAIVER. The failure of any party to insist in any one or more instances upon performance of any terms or conditions of this Agreement shall not be construed as a waiver of future performance of any such term, covenant, or condition, and the obligations of such party with respect thereto shall continue in full force and effect.

19. GOVERNING LAW. The laws of the state of **[**INSERT STATE WHERE CLINIC IS LOCATED**]** shall govern this Agreement.

20. HEADINGS. The headings appearing in this Agreement are for convenience and reference only, and are not intended to, and shall not, define or limit the scope of the provisions to which they relate.

21. ENTIRE AGREEMENT. This Agreement constitutes the entire agreement between the parties with respect to the subject matter hereof and supersedes any and all other agreements, either oral or written, between the parties (including, without limitation, any prior agreement between Hospital and Company or any of its subsidiaries or affiliates) with respect to the subject matter hereof.

22. APPROVAL BY DAVITA INC. ("DAVITA") 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 hereof.

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[SIGNATURES APPEAR ON THE FOLLOWING PAGE.]

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IN WITNESS WHEREOF, the parties hereto have executed this Agreement the day and year first above written.

Hospital:	**Company:**
By:	**By:**
Its:	**Its:**
Date:	**Date:**
	Approved as to Form for DaVita Inc.:
	By: Doyna V. Ballew
	Its: Senior Corporate Counsel

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Appendix 13

State Regulatory Agencies

State Regulatory Agencies
January 2017

AGENCY NAME	AGENCY NAME 2	ADDRESS	ADDRESS 2	CITY	STATE	ZIP CODE
ACS New Mexico Medicaid	NM Medicaid Provider Enrollment	P O Box 27460		Albuquerque	NM	87125-7460
Agency for Health Care Administration	Certification	2727 Mahan Drive	Mail Stop 32	Tallahassee	FL	32308
Agency for Health Care Administration	Certification	2727 Mahan Drive	Mail Stop 32	Tallahassee	FL	32308
Agency for Health Care Administration	CLIA State	2727 Mahan Drive	Mail Stop 32	Tallahassee	FL	32308
AHCCCS	Provider Registration Unit	801 East Jefferson Street		Phoenix	AZ	85034
Alabama Department of Public Health	Survey	The RSA Tower	201 Monroe St	Montgomery	AL	36104-3735
Alabama Medicaid Program	HP Provider Enrollment	301 Techna Center Drive		Montgomery	AL	36117-6008
Alachua Field Office - Region 3	State Survey Field Office-Alachua	14101 N.W. Hwy. 441	Suite 800	Alachua	FL	32615-5669
Alachua Field Office - Region 3	State Survey Field Office-Bradford	14101 N.W. Hwy. 441	Suite 800	Alachua	FL	32615-5669
Alachua Field Office - Region 3	State Survey Field Office-Citrus	14101 N.W. Hwy. 441	Suite 800	Alachua	FL	32615-5669
Alachua Field Office - Region 3	State Survey Field Office-Columbia	14101 N.W. Hwy. 441	Suite 800	Alachua	FL	32615-5669
Alachua Field Office - Region 3	State Survey Field Office-Dixie	14101 N.W. Hwy. 441	Suite 800	Alachua	FL	32615-5669
Alachua Field Office - Region 3	State Survey Field Office-Gilchrist	14101 N.W. Hwy. 441	Suite 800	Alachua	FL	32615-5669
Alachua Field Office - Region 3	State Survey Field Office-Hamilton	14101 N.W. Hwy. 441	Suite 800	Alachua	FL	32615-5669
Alachua Field Office - Region 3	State Survey Field Office-Hernando	14101 N.W. Hwy. 441	Suite 800	Alachua	FL	32615-5669
Alachua Field Office - Region 3	State Survey Field Office-Lafayette	14101 N.W. Hwy. 441	Suite 800	Alachua	FL	32615-5669
Alachua Field Office - Region 3	State Survey Field Office-Lake	14101 N.W. Hwy. 441	Suite 800	Alachua	FL	32615-5669
Alachua Field Office - Region 3	State Survey Field Office-Levy	14101 N.W. Hwy. 441	Suite 800	Alachua	FL	32615-5669
Alachua Field Office - Region 3	State Survey Field Office-Marion	14101 N.W. Hwy. 441	Suite 800	Alachua	FL	32615-5669
Alachua Field Office - Region 3	State Survey Field Office-Putnam	14101 N.W. Hwy. 441	Suite 800	Alachua	FL	32615-5669
Alachua Field Office - Region 3	State Survey Field Office-Sumter	14101 N.W. Hwy. 441	Suite 800	Alachua	FL	32615-5669
Alachua Field Office - Region 3	State Survey Field Office-Suwannee	14101 N.W. Hwy. 441	Suite 800	Alachua	FL	32615-5669
Alachua Field Office - Region 3	State Survey Field Office-Union	14101 N.W. Hwy. 441	Suite 800	Alachua	FL	32615-5669
AR Medicaid/HP Enterprise Services - Provider Enrollment		PO Box 8105		Little Rock	AR	72203-8105
AR Medicaid/HP Enterprise Services - Provider Enrollment		PO Box 8105		Little Rock	AR	72203-8105
Arizona Division of Assurance & Licensing Services		150 North 18th Avenue, Ste 450		Phoenix	AZ	85007
Atlanta Regional Office - Region 4	R.O. 4 Div. of Survey and Certification Ops	61 Forsyth Street, SW	Ste 4T20	Atlanta	GA	30303-8909
Boston Regional Office - Region 1	R.O. 1 Div. of Survey and Certification Ops	JFK Federal Building, Government Center	Room 2275	Boston	MA	2203
CA Department of Health Care Services	Provider Enrollment Division	P O Box 997413	MS 4704	Sacramento	CA	95899-7413
Cabinet for Health Services	KY Licensing Dept	Health Services Bldg.	275 East Main Street - 5 East	Frankfort	KY	40621
Cahaba GBA - AL (J10)	AL (J10) Provider Enrollment	PO Box 1537		Birmingham	AL	35201-1537
Cahaba GBA - GA (J10)	GA (J10)Provider Enrollment	PO Box 1537		Birmingham	AL	35201-1537
Cahaba GBA - TN (J10)	TN (J10) Provider Enrollment	PO Box 1537		Birmingham	AL	35201-1537
California Dept of Public Health	Bakersfield District Office	4540 California Ave., Ste 200	Licensing & Certification	Bakersfield	CA	93309
California Dept of Public Health	San Diego North District Office	7575 Metropolitan Dr., Suite 104	Licensing & Certification	San Diego	CA	92108-4402
California Dept of Public Health	San Bernardino District office	464 W 4th St., Suite 529	Licensing & Certification	San Bernardino	CA	92401-
California Dept of Public Health	Los Angeles District Office	3400 Aerojet Ave Ste 323	Licensing & Certification	El Monte	CA	91731
California Dept of Public Health	East Bay District Office	850 Marina Bay Parkway, Bldg P, 1st Floor	Licensing & Certification	Richmond	CA	94804-6403
California Dept of Public Health	Fresno District Office	285 W Bullard Ave Suite 101	Licensing & Certification	Fresno	CA	93704
California Dept of Public Health	Chico District Office	126 Mission Ranch Blvd	Licensing & Certification	Chico	CA	95926
California Dept of Public Health	Orange County District Office	681 S Parker St Ste 200	Licensing & Certification	Orange	CA	92868
California Dept of Public Health	Redwood Coast/Santa Rosa District Office	2170 Northpoint Pkwy	Licensing & Certification	Santa Rosa	CA	95407
California Dept of Public Health	Riverside District Office	625 E Carnegie Dr Ste 280	Licensing & Certification	San Bernardino	CA	92408
California Dept of Public Health	Sacramento District Office	3901 Lennane Dr Ste 210	Licensing & Certification	Sacramento	CA	95834
California Dept of Public Health	San Francisco District Office	150 North Hill Dr Ste 22	Licensing & Certification	Brisbane	CA	94005
California Dept of Public Health	San Jose District Office	100 Paseo de San Antonio Ste 235	Licensing & Certification	San Jose	CA	95113
California Dept of Public Health	Ventura District Office	1889 N Rice Ave Ste 200	Licensing & Certification	Oxnard	CA	93030
CGS (J15)	(J15) Provider Enrollment	PO Box 20004		Nashville	TN	37202
Chicago Regional Office - Region 5	R.O. 5 Div. of Survey and Certification Ops	233 North Michigan Avenue	Ste 600	Chicago	IL	60601-5519
CLIA Programs, DHH		P.O. Box 3767		Baton Rouge	LA	70821-3767
Colorado Department of Public Health & Environment		4300 Cherry Creek Drive South		Denver	CO	80246-1530
Colorado Medical Assistance Program	CO Medicaid Provider Enrollment	PO Box 1100		Denver	CO	80201-1100
CT Medicaid/HP	CT Provider Enrollment Unit	PO Box 5007		Hartford	CT	6104
Dallas Regional Office - Region 6	R.O. 6 Div. of Survey and Certification Ops	1301 Young Street	Room 827	Dallas	TX	75202

State Regulatory Agencies
January 2017

AGENCY NAME	AGENCY NAME 2	ADDRESS	ADDRESS 2	CITY	STATE	ZIP CODE
DC Dept of Health Regulation Administration		899 North Capitol Street NE	Second Floor	Washington	DC	20002
DC Medicaid/Xerox State Healthcare Solutions	DC Medicaid Provider Enrollment	750 1st Street, NE	Ste. 1020	Washington	DC	20002
DE Medicaid/HP Enterprise Services, LLC	DE Medicaid Provider Enrollment	PO Box 909		New Castle	DE	19720
Delaware Dept. of Health Services		1901 N Dupont Hwy		New Castle	DE	19720
Delray Beach Field Office - Region 9 & 10	State Survey Field Office-Broward	5150 Linton Boulevard	Suite 500	Delray Beach	FL	33484
Delray Beach Field Office - Region 9 & 10	State Survey Field Office-Indian River	5150 Linton Boulevard	Suite 500	Delray Beach	FL	33484
Delray Beach Field Office - Region 9 & 10	State Survey Field Office-Martin	5150 Linton Boulevard	Suite 500	Delray Beach	FL	33484
Delray Beach Field Office - Region 9 & 10	State Survey Field Office-Okeechobee	5150 Linton Boulevard	Suite 500	Delray Beach	FL	33484
Delray Beach Field Office - Region 9 & 10	State Survey Field Office-Palm Beach	5150 Linton Boulevard	Suite 500	Delray Beach	FL	33484
Delray Beach Field Office - Region 9 & 10	State Survey Field Office-St. Lucie	5150 Linton Boulevard	Suite 500	Delray Beach	FL	33484
Denver Regional Office - Region 8	R.O. 8 Div. of Survey and Certification Ops	1600 Broadway	Ste 700	Denver	CO	80202
Department of Health	Division of Home Health Services	132 Kline Plaze, Suite A		Harrisburg	PA	17104-
Department of Public Health		Div of Health Systems Reg.	410 Capitol Ave., MS #12FLIS	Hartford	CT	06134-0308
Dept of Health, HSQA		111 Israel Road SE		Tumwater	WA	98501
Dept of Health, HSQA		PO Box 47874		Olympia	WA	98504
Dept. of Health and Human Services		1205 Umstead Dr.	Licensure & Certification Section	Raleigh	NC	27603
Director, Division of Health Provider	Bureau of Certification/Health Regulation	SC DHEC	301 Gervais St	Columbia	SC	29201-
First Coast Service Options - FL (J9)	FL (J9) Provider Enrollment	532 Riverside Avenue		Jacksonville	FL	32202-4914
FL Dept of Health	Brevard County Environmental Health	2725 Judge Fran Way	Ste A116	Viera	FL	32940-6605
FL Dept of Health	Alachua County Environmental Health	224 SE 24th St		Gainesville	FL	32641-3405
FL Dept of Health in Bay County	Biomedical Waste	597 W 11th St		Panama City	FL	32401
FL Dept of Health in Broward County	Biomedical Waste	780 SW 24 Street	Building OPS	Ft Lauderdale	FL	33315
FL Dept of Health in Charlotte County	Biomedical Waste	18500 Murdock Cir	Ste 203	Port Charlotte	FL	33948
FL Dept of Health in Clay County	Biomedical Waste	PO Box 578		Green Cove Springs	FL	32043
FL Dept of Health in Collier County	Biomedical Waste	PO Box 429		Naples	FL	34106-0429
FL Dept of Health in Dade County	Biomedical Waste	1725 167th St		Miami Gardens	FL	33056
FL Dept of Health in DeSoto County	Biomedical Waste	34 South Baldwin Avenue		Arcadia	FL	34266
FL Dept of Health in Duval County	Biomedical Waste-Duval	900 University Blvd N	Ste 300, MC-45	Jacksonville	FL	32211
FL Dept of Health in Duval County	Biomedical Waste-St. Johns	900 University Blvd N	Ste 300, MC-45	Jacksonville	FL	32211
FL Dept of Health in Escambia County	Biomedical Waste-Escambia	1300 W Gregory Street		Pensacola	FL	32502
FL Dept of Health in Escambia County	Biomedical Waste-Okaloosa	1300 W Gregory Street		Pensacola	FL	32502
FL Dept of Health in Escambia County	Biomedical Waste-Santa Rosa	1300 W Gregory Street		Pensacola	FL	32502
FL Dept of Health in Flagler County	Biomedical Waste	PO Box 847		Bunnell	FL	32110
FL Dept of Health in Hernando County	Biomedical Waste	7551 Forest Oaks Blvd		Spring Hill	FL	34606
FL Dept of Health in Hillsborough County	Biomedical Waste	PO Box 5135		Tampa	FL	33675
FL Dept of Health in Indian River County	Biomedical Waste	1900 27th Street		Vero Beach	FL	32960
FL Dept of Health in Jackson County	Biomedical Waste	PO Box 310		Marianna	FL	32447
FL Dept of Health in Lake County	Biomedical Waste	315 W Main Street		Tavares	FL	32778
FL Dept of Health in Lee County	Biomedical Waste	2295 Victoria Ave		Fort Myers	FL	33901
FL Dept of Health in Leon County	Biomedical Waste	PO Box 2745		Tallahassee	FL	32316
FL Dept of Health in Manatee County	Biomedical Waste	410 Sixth Ave E		Bradenton	FL	34208
FL Dept of Health in Marion County	Biomedical Waste-Marion	PO Box 2408		Ocala	FL	34478
FL Dept of Health in Monroe County	Biomedical Waste	PO Box 6193		Key West	FL	33040
FL Dept of Health in Nassau County	Biomedical Waste	PO Box 15100		Fernandina Beach	FL	32035
FL Dept of Health in Orange County	Biomedical Waste	800 N Mercy Drive	Ste 1	Orlando	FL	32808
FL Dept of Health in Osceola County	Biomedical Waste	1 Courthouse Square	Ste 1200	Kissimmee	FL	34741
FL Dept of Health in Palm Beach County	Biomedical Waste	PO Box 29 - Fiscal Office		West Palm Beach	FL	33402
FL Dept of Health in Pasco County	Biomedical Waste	11611 Denton Avenue		Hudson	FL	34667
FL Dept of Health in Pinellas County	Biomedical Waste	8751 Ulmerton Road	Suite 2000	Largo	FL	33771
FL Dept of Health in Sarasota County	Biomedical Waste	1001 Sarasota Center Blvd		Sarasota	FL	34240
FL Dept of Health in Seminole County	Biomedical Waste	400 W Airport Blvd		Sanford	FL	32773
FL Dept of Health in St. Lucie County	Biomedical Waste	5150 NW Milner Dr		Port St. Lucie	FL	34983
FL Dept of Health in Sumter County	Biomedical Waste	PO Box 98		Bushnell	FL	33513
FL Dept of Health in Taylor County	Biomedical Waste	1215 N Peacock Avenue		Perry	FL	32347

State Regulatory Agencies
January 2017

AGENCY NAME	AGENCY NAME 2	ADDRESS	ADDRESS 2	CITY	STATE	ZIP CODE
FL Dept of Health in Volusia County	Biomedical Waste	PO Box 9190		Daytona Beach	FL	32120
FL Dept of Health in Washington County	Biomedical Waste	PO Box 648		Chipley	FL	32428
FL Medicaid/Agency for Health Care Administration		2727 Mahan Drive,	MS-4	Tallahassee	FL	32308
Florida Board of Pharmacy	Pharmacy	4052 Bald Cypress Way	Bin C-04	Tallahassee	FL	32399
Florida Board of Pharmacy	Pharmacy	4052 Bald Cypress Way	Bin C-04	Tallahassee	FL	32399
Fort Myers Field Office - Region 8	State Survey Field Office-Charlotte	2295 Victoria Ave.	Room 340	Ft. Myers	FL	33901
Fort Myers Field Office - Region 8	State Survey Field Office-Collier	2295 Victoria Ave.	Room 340	Ft. Myers	FL	33901
Fort Myers Field Office - Region 8	State Survey Field Office-DeSoto	2295 Victoria Ave.	Room 340	Ft. Myers	FL	33901
Fort Myers Field Office - Region 8	State Survey Field Office-Glades	2295 Victoria Ave.	Room 340	Ft. Myers	FL	33901
Fort Myers Field Office - Region 8	State Survey Field Office-Hendry	2295 Victoria Ave.	Room 340	Ft. Myers	FL	33901
Fort Myers Field Office - Region 8	State Survey Field Office-Lee	2295 Victoria Ave.	Room 340	Ft. Myers	FL	33901
Fort Myers Field Office - Region 8	State Survey Field Office-Monroe	2295 Victoria Ave.	Room 340	Ft. Myers	FL	33901
Fort Myers Field Office - Region 8	State Survey Field Office-Sarasota	2295 Victoria Ave.	Room 340	Ft. Myers	FL	33901
GA Dept of Community Health	Certification	2 Peachtree St; Suite 31.477	Specialized Care Unit	Atlanta	GA	30303-3167
GA Dept of Community Health	Licensure	2 Peachtree St; Suite 31.477	Licensure & Certification Section	Atlanta	GA	30303-3167
GA Medicaid/HP Enterprise Services	GA Medicaid Provider Enrollment	100 Crescent Center Pkwy	Ste# 1100	Atlanta	GA	30084
Gadsden County Health Dept	Biomedical Waste	PO Box 1000		Quincy	FL	32353
Gulf County Health Dept	Biomedical Waste	2475 Garrison Ave		Port St. Joe	FL	32456
HP Enterprise Services	FL Medicaid MS Medicaid Provider Enrollment	2671 Executive Center Circle	Ste 100	Tallahassee	FL	32301
IA Dept. of Inspections & Appeals	Certification	321 East 12th Street	Lucas State Office Bldg.	Des Monies	IA	50319-0083
ID Dept. of Health & Welfare		3232 Elder street	P.O. Box 83720	Boise	ID	83720-0036
Idaho Dept of Health	Division of Medicaid	PO Box 70082		Boise	ID	83707
IL Department of Health	Certification	525 W. Jefferson St.	Licensing & Certification	Springfield	IL	62761-
IL Dept of Public Health	IL CLIA PROGRAM	525 W Jefferson St	4th Fl	Springfield	IL	62761
Illinois Department of Public Aid	IL Medicaid Provider Enrollment	607 E Adams St		Springfield	IL	62739
IME - Iowa Medicaid Enterprise	IA Medicaid Provider Enrollment	100 Army Post Road		Des Moines	IA	50315-6241
IN Dept of Health Acute Care Services	Indiana CLIA Program	2 N Meridian St	Room 4 A	Indianapolis	IN	46204
Indiana Dept. of Health Services	Certification	2 N. Meridian Street, Section 4A	Licensing & Certification	Indianapolis	IN	46204-
Indiana Medicaid Program	IN Medicaid Provider Enrollment	950 North Meridian Street	Suite 1150	Indianapolis	IN	46204
Jacksonville Field Office - Region 4	State Survey Field Office-Baker	921 N. Davis St.	Bldg A, Ste 115	Jacksonville	FL	32209
Jacksonville Field Office - Region 4	State Survey Field Office-Clay	921 N. Davis St.	Bldg A, Ste 115	Jacksonville	FL	32209
Jacksonville Field Office - Region 4	State Survey Field Office-Duval	921 N. Davis St.	Bldg A, Ste 115	Jacksonville	FL	32209
Jacksonville Field Office - Region 4	State Survey Field Office-Flagler	921 N. Davis St.	Bldg A, Ste 115	Jacksonville	FL	32209
Jacksonville Field Office - Region 4	State Survey Field Office-Nassau	921 N. Davis St.	Bldg A, Ste 115	Jacksonville	FL	32209
Jacksonville Field Office - Region 4	State Survey Field Office-St. Johns	921 N. Davis St.	Bldg A, Ste 115	Jacksonville	FL	32209
Jacksonville Field Office - Region 4	State Survey Field Office-Volusia	921 N. Davis St.	Bldg A, Ste 115	Jacksonville	FL	32209
Kansas Bureau of Health & Environment		1000 SW Jackson St., Suite 200		Topeka	KS	66612-1274
Kansas City Regional Office - Region 7	R.O. 7 Div. of Survey and Certification Ops	601 East 12th Street	Room 355	Kansas City	MO	64106
Kansas Medical Assistance Program	KMAP Provider Enrollment Unit	6700 SW Topeka Blvd	Ste. 283-J	Topeka	KS	66601
Kentucky Dept. of Health Services		275 East Main Street - 5 East		Frankfort	KY	40621-
Kidney Health Care	State Kidney Program	PO Box 149347	Mail Code 1938	Austin	TX	78714-9347
KY Medicaid Program	KY Provider Enrollment Unit	275 E Main St		Frankfort	KY	40621
Louisiana Medicaid-Molina Medicaid Solutions	LA Medicaid Provider Enrollment	PO Box 80159		Baton Rouge	LA	70898-0159
Madison County Health Department	Madison County Environmental Health	801 SW Smith St		Madison	FL	32340
Maryland Kidney Program	MD Medicaid Provider Enrollment	PO Box 17030		Baltimore	MD	21203
Maryland Medicaid		201 West Preston Street		Baltimore	MD	21201
Massachusetts Department of Health		10 West Street, 5th Floor		Boston	MA	2111
MassHealth	MA Medicaid Provider Enrollment	55 Summer St.	8th Floor	Boston	MA	2110
MD Commission on Kidney Disease					MD	
ME Medicaid/Molina	ME Medicaid Provider Enrollment	189 Water St		Augusta	ME	4330
Miami Field Office - Region 11	State Survey Field Office-Miami-Dade	8333 N.W. 53rd St	Suite 300	Miami	FL	33166
Michigan Dept of Community Health		611 W. Ottawa St.	1st Floor, Ottawa Building	Lansing	MI	48933-1070
Michigan Dept. of Community Health		320 South Walnut St.		Lansing	MI	48933-2014
Minnesota Dept. of Human Services	MN Medicaid Provider Enrollment	540 Cedar St		St. Paul	MN	55101

State Regulatory Agencies
January 2017

AGENCY NAME	AGENCY NAME 2	ADDRESS	ADDRESS 2	CITY	STATE	ZIP CODE
Missouri Dept of Social Services	MO Medicaid Provider Enrollment	615 Howerton Ct		Jefferson City	MO	65109
Montana Medicaid - Xerox	MT Medicaid FL Medicaid Provider Enrollment	PO Box 4936		Helena	MT	59604
MS Division of Medicaid	Provider Enrollment	550 High St	Ste 1000	Jackson	MS	39201
MT Dept of Public Health and Human Services		Quality Assurance Div - License Bureau	2401 Colonial Dr	Helena	MT	59620-2953
N.C. Medicaid Provider Enrollment	CSC	2610 Wycliff Road	Suite 102	Raleigh	NC	27607-3073
National Government Services - IL (J6)	IL (J6) Provider Enrollment	P.O. Box 6474		Indianapolis	IN	46206-6474
National Government Services - MA (JK)	MA (JK) Provider Enrollment	P.O. Box 7149		Indianapolis	IN	46207-7149
National Government Services - NH (JK)	NH (JK) Provider Enrollment	P.O. Box 7149		Indianapolis	IN	46207-7149
National Government Services - RI (JK)	RI (JK) Provider Enrollment	P.O. Box 7149		Indianapolis	IN	46207-7149
National Government Services - WI (J6)	WI (J6) Provider Enrollment	P.O. Box 6474		Indianapolis	IN	46206-6474
National Government Services- ME (JK)	ME (JK) Provider Enrollment	P.O. Box 7149		Indianapolis	IN	46207-7149
National Government Services MN (J6)	MN (J6) Provider Enrollment	P.O. Box 6474		Indianapolis	IN	46206-6474
National Government Services, Inc. - NY (JK)	NY (JK) Provider Enrollment	P.O. Box 7149		Indianapolis	IN	46207-7149
National Government Services, LLC - CT (JK)	CT (JK) Provider Enrollment	P.O. Box 7149		Indianapolis	IN	46207-7149
ND Dept of Human Services	Attn: Provider Enrollment	600 E Blvd Ave	Dept 325	Bismarck	ND	58505
ND Dept. of Health		600 East Blvd. Avenue Dept 301		Bismarck	ND	58505-0200
Nebraska Dept. of Health & Human Serv.	Medicaid Provider Enrollment	301 Centennial Mall South		Lincoln	NE	68509
Nebraska Health & Human Services System		301 Centennial Mall South		Lincoln	NE	68509-5007
Nebraska Health & Human Services System	Licensure Unit	301 Centennial Mall South		Lincoln	NE	68509-5007
Nevada Department of Health	Bureau of Licensure & Certification	727 Fairveiw Dr	Ste E	Carson City	NV	89701
Nevada Medicaid Program	NV Medicaid Provider Enrollment	P O Box 30042		Reno	NV	89520-3042
Nevada State Treasurer	Nevada State Lab	727 Fairview Dr	Ste E	Carson City	NV	89701
New Mexico Board of Pharmacy Office	New Mexico Pharmacy	5500 Oakland NE	Ste C	Albuquerque	NM	87109
New Mexico Department of Health		2040 South Pacheco St	2nd Floor Room 202	Santa Fe	NM	87505
New York Dept. of Health		Hedley Park Place	433 River Street, 6th Floor	Troy	NY	12180-
New York Regional Office - Region 2	R.O. 2Div. of Survey and Certification Ops	26 Federal Plaza	Room 37-130	New York	NY	10278-0063
New York State Department of Health		150 Broadway	Suite 6E	Albany	NY	12204
NH Department of Health & Human Services		129 Pleasant St.		Concord	NH	03301-3857
NH Medicaid/Xerox	NH Medicaid Provider Enrollment	2 Pillsbury St.,	Suite 200	Concord	NH	3301
NJ Dept. of Health & Senior Services		171 Jersey St.	Bldg. 5, 1st Floor	Trenton	NJ	8611
NJ Medicaid/Molina	NJ Medicaid Provider Enrollment	P.O. Box 4804		Trenton	NJ	8650
Noridian - AZ (JF)	AZ (JF) Provider Enrollment	900 42nd St S		Fargo	ND	58103
Noridian - CA (JE)	CA (JE) Provider Enrollment	901 42nd St S		Fargo	ND	58103
Noridian - ID (JF)	ID (JF) Provider Enrollment	903 42nd St S		Fargo	ND	58103
Noridian - MT (JF)	MT (JF) Provider Enrollment	904 42nd St S		Fargo	ND	58103
Noridian - ND (JF)	ND (JF) Provider Enrollment	905 42nd St S		Fargo	ND	58103
Noridian - NV (JE)	NV (JE) Provider Enrollment	906 42nd St S		Fargo	ND	58103
Noridian - OR (JF)	OR (JF) Provider Enrollment	900 42nd St S		Fargo	ND	58103
Noridian - SD (JF)	SD (JF) Provider Enrollment	900 42nd St S		Fargo	ND	58103
Noridian - UT (JF)	UT (JF) Provider Enrollment	902 42nd St S		Fargo	ND	58103
Noridian - WA (JF)	WA (JF) Provider Enrollment	900 42nd St S		Fargo	ND	58103
Novitas (AR - JH)	AR (JH) Provider Enrollment	P.O. Box 3095		Mechanicsburg	PA	17055-1813
Novitas (CO - JH)	CO (JH) Provider Enrollment	P.O. Box 3095		Mechanicsburg	PA	17055-1813
Novitas (D.C. - JL)	DC (JL) Provider Enrollment	PO Box 3157		Mechanicsburg	PA	17055-1836
Novitas (DE - JL)	DE (JL) Provider Enrollment	PO Box 3157		Mechanicsburg	PA	17055-1836
Novitas (LA - JH)	LA (JH) Provider Enrollment	P.O. Box 3095		Mechanicsburg	PA	17055-1813
Novitas (MD - JL)	MD (JL) Provider Enrollment	PO Box 3157		Mechanicsburg	PA	17055-1836
Novitas (MS - JH)	MS (JH) Provider Enrollment	P.O. Box 3095		Mechanicsburg	PA	17055-1813
Novitas (NJ - JL)	NJ (JL) Provider Enrollment	PO Box 3157		Mechanicsburg	PA	17055-1836
Novitas (NM - JH)	NM (JH) Provider Enrollment	P.O. Box 3095		Mechanicsburg	PA	17055-1813
Novitas (OK - JH)	OK (JH) Provider Enrollment	P.O. Box 3095		Mechanicsburg	PA	17055-1813
Novitas (PA - JL)	PA (JL) Provider Enrollment	PO Box 3157		Mechanicsburg	PA	17055-1836
Novitas (TX - JH)	TX (JH) Provider Enrollment	P.O. Box 3095		Mechanicsburg	PA	17055-1813
Office of Health Care Quality		Spring Grove Center	55 Wade Avenue, Bland Bryant Bldg	Catonsville	MD	21228-

State Regulatory Agencies
January 2017

AGENCY NAME	AGENCY NAME 2	ADDRESS	ADDRESS 2	CITY	STATE	ZIP CODE
Office of Health Facility	Licensure and Certification	1 Davis Square	Suite 101	Charleston	WV	25301-
Office of Health Regulation		MS Dept of Health 570 E Woodrow Wilson Ave		Jackson	MS	39216
Office of Inspector General	KENTUCKY CLIA PROGRAM	275 East Main Street	5E - A	Frankfort	KY	40621
Ohio Department of Health	DQA / BIOS (Certification)	246 N High St		Columbus	OH	43216-2412
Ohio Department of Health	Non Long Term Care Unit (Survey)	246 N High St		Columbus	OH	43216-2412
Ohio Department of Health	DQA / BIOS (Licensure)	246 N High St		Columbus	OH	43216-2412
Ohio Medicaid Program	OH Medicaid Provider Enrollment	255 East Main Street	2nd Floor	Columbus	OH	43215-5222
Ohio State Board of Pharmacy	Pharmacy	77 South High St	17th Floor	Columbus	OH	43266
Oklahoma Health Care Authority	OK Medicaid Provider Enrollment	4545 North Lincoln Blvd	Suite 124	Oklahoma City	OK	73107
Oregon Department of Human Services	Health Care Licensure and Certification	800 NE Oregon Street	#21, Suite 640	Portland	OR	97232-
Oregon Health Authority	DMAP Provider Enrollment	500 Summer St NE	E44	Salem	OR	97301
Oregon State Public Health Division	Laboratory Compliance Program	3150 NW 29th Avenue	Ste 100	Hillsboro	OR	97124
Orlando Field Office - Region 7	State Survey Field Office-Brevard	400 W. Robinson St.	Hurston South Tower, Suite S309	Orlando	FL	32801
Orlando Field Office - Region 7	State Survey Field Office-Orange	400 W. Robinson St.	Hurston South Tower, Suite S309	Orlando	FL	32801
Orlando Field Office - Region 7	State Survey Field Office-Osceola	400 W. Robinson St.	Hurston South Tower, Suite S309	Orlando	FL	32801
Orlando Field Office - Region 7	State Survey Field Office-Seminole	400 W. Robinson St.	Hurston South Tower, Suite S309	Orlando	FL	32801
PA Dept of Health	Chronic Renal Disease Program	625 Forster St	7th Fl East	Harrisburg	PA	17120
PA Medicaid/Bureau of Fee For Service Programs	PA Medicaid Provider Enrollment	PO Box 8045		Harrisburg	PA	17110
Palmetto GBA - NC (J11)	NC (J11) Provider Enrollment	PO Box 100238		Columbia	SC	29202-3238
Palmetto GBA - SC (J11)	SC (J11) Provider Enrollment	PO Box 100238		Columbia	SC	29202-3238
Palmetto GBA - VA (J11)	VA (J11) Provider Enrollment	PO Box 100238		Columbia	SC	29202-3238
Palmetto GBA - WV (J11)	WV (J11) Provider Enrollment	PO Box 100238		Columbia	SC	29202-3238
Philadelphia Regional Office - Region 3	R.O. 3 Div. of Survey and Certification Ops	150 S. Independence Mall, West		Philadelphia	PA	19106-3413
Program Assurance Unit, Lic. & Certification Program		P.O. Box 64900		St. Paul	MN	55164-0900
Rhode Island Dept of Health	Office of Health Systems Development - CON	Three Capitol Hill	Room 410	Providence	RI	02908-5097
Rhode Island Dept of Health	Office of Health Systems Development	Three Capitol Hill	Room 404	Providence	RI	02908-5097
RI Medicaid/HP	MT Medicaid Provider Enrollment	PO Box 2010		Warwick	RI	2887
San Francisco Regional Office - Region 9	R.O. 9 Div. of Survey and Certification Ops	90 7th Street	Ste 5-300	San Francisco	CA	94103-6707
Seattle Regional Office - Region 10	R.O. 10 Div. of Survey and Certification Ops	701 Fifth Avenue	Ste 1600	Seattle	WA	98104
South Dakota Department of Health	Office of Licensure & Certification	615 East 4th Street		Pierre	SD	57501
South Dakota Dept. of Social Serv.	SD Medicaid Provider Enrollment	700 Governors Drive		Pierre	SD	57501-2291
St. Petersburg Field Office - Regions 5 & 6	State Survey Field Office-Hardee	525 Mirror Lake Drive North	Sebring Building, Suite 410A	St. Petersburg	FL	33701
St. Petersburg Field Office - Regions 5 & 6	State Survey Field Office-Highlands	525 Mirror Lake Drive North	Sebring Building, Suite 410A	St. Petersburg	FL	33701
St. Petersburg Field Office - Regions 5 & 6	State Survey Field Office-Hillsborough	525 Mirror Lake Drive North	Sebring Building, Suite 410A	St. Petersburg	FL	33701
St. Petersburg Field Office - Regions 5 & 6	State Survey Field Office-Manatee	525 Mirror Lake Drive North	Sebring Building, Suite 410A	St. Petersburg	FL	33701
St. Petersburg Field Office - Regions 5 & 6	State Survey Field Office-Pasco	525 Mirror Lake Drive North	Sebring Building, Suite 410A	St. Petersburg	FL	33701
St. Petersburg Field Office - Regions 5 & 6	State Survey Field Office-Pinellas	525 Mirror Lake Drive North	Sebring Building, Suite 410A	St. Petersburg	FL	33701
St. Petersburg Field Office - Regions 5 & 6	State Survey Field Office-Polk	525 Mirror Lake Drive North	Sebring Building, Suite 410A	St. Petersburg	FL	33701
State Hygienic Laboratory	Iowa CLIA Laboratory Program	2490 Crosspark Road	Ste E	Coralville	IA	52241
State of Louisiana Dept of Health & Hospitals		P.O Box 3767		Baton Rouge	LA	70821-3767
State of Oklahoma Health Dept.		1000 N. E. Tenth Street	Room 1114	Oklahoma City	OK	73117-1299
Tallahassee Field Office - Regions 1 & 2	State Survey Field Office-Bay	2727 Mahan Drive	Mail Stop 46	Tallahassee	FL	32308
Tallahassee Field Office - Regions 1 & 2	State Survey Field Office-Calhoun	2727 Mahan Drive	Mail Stop 46	Tallahassee	FL	32308
Tallahassee Field Office - Regions 1 & 2	State Survey Field Office-Escambia	2727 Mahan Drive	Mail Stop 46	Tallahassee	FL	32308
Tallahassee Field Office - Regions 1 & 2	State Survey Field Office-Franklin	2727 Mahan Drive	Mail Stop 46	Tallahassee	FL	32308
Tallahassee Field Office - Regions 1 & 2	State Survey Field Office-Gadsden	2727 Mahan Drive	Mail Stop 46	Tallahassee	FL	32308
Tallahassee Field Office - Regions 1 & 2	State Survey Field Office-Gulf	2727 Mahan Drive	Mail Stop 46	Tallahassee	FL	32308
Tallahassee Field Office - Regions 1 & 2	State Survey Field Office-Holmes	2727 Mahan Drive	Mail Stop 46	Tallahassee	FL	32308
Tallahassee Field Office - Regions 1 & 2	State Survey Field Office-Jackson	2727 Mahan Drive	Mail Stop 46	Tallahassee	FL	32308
Tallahassee Field Office - Regions 1 & 2	State Survey Field Office-Jefferson	2727 Mahan Drive	Mail Stop 46	Tallahassee	FL	32308
Tallahassee Field Office - Regions 1 & 2	State Survey Field Office-Liberty	2727 Mahan Drive	Mail Stop 46	Tallahassee	FL	32308
Tallahassee Field Office - Regions 1 & 2	State Survey Field Office-Leon	2727 Mahan Drive	Mail Stop 46	Tallahassee	FL	32308
Tallahassee Field Office - Regions 1 & 2	State Survey Field Office-Madison	2727 Mahan Drive	Mail Stop 46	Tallahassee	FL	32308
Tallahassee Field Office - Regions 1 & 2	State Survey Field Office-Okaloosa	2727 Mahan Drive	Mail Stop 46	Tallahassee	FL	32308

State Regulatory Agencies
January 2017

AGENCY NAME	AGENCY NAME 2	ADDRESS	ADDRESS 2	CITY	STATE	ZIP CODE
Tallahassee Field Office - Regions 1 & 2	State Survey Field Office-Santa Rosa	2727 Mahan Drive	Mail Stop 46	Tallahassee	FL	32308
Tallahassee Field Office - Regions 1 & 2	State Survey Field Office-Taylor	2727 Mahan Drive	Mail Stop 46	Tallahassee	FL	32308
Tallahassee Field Office - Regions 1 & 2	State Survey Field Office-Wakulla	2727 Mahan Drive	Mail Stop 46	Tallahassee	FL	32308
Tallahassee Field Office - Regions 1 & 2	State Survey Field Office-Walton	2727 Mahan Drive	Mail Stop 46	Tallahassee	FL	32308
Tallahassee Field Office - Regions 1 & 2	State Survey Field Office-Washington	2727 Mahan Drive	Mail Stop 46	Tallahassee	FL	32308
Tennessee Department of Health	Division of Health Care Facilites (Licensure)	227 French Landing, STE 501	665 Mainstream Dr 2nd Fl	Nashville	TN	37243
Texas Department of State Health Services	Zone I	8407 Wall St	8407 Wall Street	Austin	TX	78754
Texas Department of State Health Services	Zone II	1301 South Bowen	1301 South Bowen, Ste 200	Arlington	TX	76013
Texas Department of State Health Services	Zone III	2303 SE Military Dr	2303 Military Drive, Bldg 514	San Antonio	TX	78223-3597
Texas Department of State Health Services	Zone IV	5425 Polk Ave	5425 Polk Ave, Ste J	Houston	TX	77023-1497
Texas Department of State Health Services	Zone V	1517 West Front St	2521 West Front St	Tyler	TX	75702
TN Bureau of TennCare	TN Provider Enrollment Unit	310 Great Circle Road	2W	Nashville	TN	37243
Tricare North	TriCare North Provider Enrollment	P. O. Box 870141		Surfside Beach	SC	29587-9741
Tricare South	Provider Data Management	P.O. Box 7032	Provider Data Management	Camden	SC	29021-7032
Tricare West	TriCare West Provider Enrollment	P.O. Box 7065		Camden	SC	29021-7065
TX Medicaid and Healthcare Partnership	TX Medicaid Provider Enrollment	12357 B. Riata Trace Pkwy.		Austin	TX	78727-6474
UT Medicaid/Bureau of Medicaid Operations	UT Medicaid Provider Enrollment	PO Box 143106		Salt Lake City	UT	84114
Utah Department of Health	Manager, Facility Licensing	P.O. Box 144103	288 North 1460 West	Salt Lake City	UT	84114-4103
Utah Department of Health	Manager, Facility Licensing	P.O. Box 144103	288 North 1460 West	Salt Lake City	UT	84114-4103
VA Department of Health Services		9960 Mayland Drive	STE 401	Henrico	VA	23233
VA Department of Health Services		9960 Mayland Drive	STE 401	Henrico	VA	23233
VA Medicaid/Xerox	Virginia Medicaid Provider Enrollment Services	PO Box 26803		Richmond	VA	23261
WA Health Care Authority Legal Services & Admi	State Kidney Program	PO Box 42702		Olympia	WA	98504
Washington State Healthcare Authority	WA Medicaid Provider Enrollment	PO Box 45562		Olympia	WA	98504
WI Bureau of Quality Assurance		1 West Wilson Street	P.O. Box 2969	Madison	WI	53703-3445
Wisconsin Chronic Disease Program	WCDP Provider Enrollment	313 Blettner Blvd		Madison	WI	53784
Wisconsin Medicaid Program	Provider Enrollment Dept	313 Blettner Blvd		Madison	WI	53784
Wisconsin Physician Services - IA (J5)	IA (J5) Provider Enrollment	P.O. Box 8248		Madison	WI	53708-8248
Wisconsin Physician Services - IN (J8)	IN (J8) Provider Enrollment	P.O. Box 8248		Madison	WI	53708-8248
Wisconsin Physician Services - MI (J8)	MI (J8) Provider Enrollment	P.O. Box 8248		Madison	WI	53708-8248
Wisconsin Physician Services - NE (J5)	NE (J5) Provider Enrollment	P.O. Box 8248		Madison	WI	53708-8248
Wisconsin Physicians Services - KS (J5)	KS (J5) Provider Enrollment	P.O. Box 8248		Madison	WI	53708-8248
Wisconsin Physicians Services - MO (J5)	MO (J5) Provider Enrollment	P.O. Box 8248		Madison	WI	53708-8248
WV Medicaid/Molina	WV Medicaid Provider Enrollment	1600 Pennsylvania Avenue		Charleston	WV	25302
Wyoming Department of Health		2020 Carey Ave. - 8th floor		Cheyenne	WY	82002-

Appendix 14

Accepting Patients for Treatment
Indigent Care Policy
Involuntary Transfer Procedure
Patients Rights Policy

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

TITLE: ACCEPTING END STAGE RENAL DISEASE PATIENTS FOR TREATMENT

PURPOSE: To establish requirements for admitting End Stage Renal Disease (ESRD) patients to a DaVita dialysis facility and to allow DaVita to obtain necessary information from the patient/personal representative and to enter the correct information into the appropriate information system prior to providing dialysis treatment to a patient at a DaVita dialysis facility.

DEFINITION(S):

Visiting patient: A patient who is visiting a facility and plans to return to his/her home facility within 30 days. A visiting patient refers to patients visiting from a non-DaVita facility to a DaVita facility as well as visiting from a DaVita facility to another DaVita facility.

Medical Evidence Report Form (CMS 2728): Required by Medicare to determine if an individual is medically entitled to Medicare under the ESRD provisions of the law and to register patients with the United States Renal Data System. The 2728 form is used as the primary source in determining the COB for patient's insurance. Physicians have a 45 day grace period to sign the 2728 form when the patients are new to dialysis. A patient is generally only required to complete the 2728 form once, not for every facility visit or transfer (Refer to *Completion of Centers for Medicare & Medicaid Services (CMS) 2728,* available on the Clinical P&P website in Vol. 3. on the VillageWeb).

Medicare Secondary Payor Form (MSP): Determines if a commercial Employer Group Health Plan (EGHP) (or other insurance carrier) will be primary payer. This form is completed online in the Registration System and must be completed for all patients who have Medicare coverage when they start treatment at DaVita.

Patient Authorization and Financial Responsibility Form (PAFR): Document that informs patients of their financial obligations regarding services provided to them by DaVita. The form must be signed and witnessed prior to the start of the first dialysis treatment By signing the PAFR, the patient/personal representative is assigning the payment for services provided by DaVita, directly to DaVita from insurance companies. The PAFR form must be signed each year at each DaVita facility where the patient receives treatments.

Note: California facilities: For all Medi Cal patients (Medicaid program for California), a new form must be signed the first full week in January regardless of dialysis start date. Example: First date of DaVita Dialysis 12-31-2011, need PAFR for December and one for January 2012.

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Origination Date: September 2006
Revision Date: March 2008, September 2008, December 2008, April 2009, September 2009, October 2010, September 2011, September 2012, March 2013, September 2013, March 2014, September 2014, March 2015, September 2015, March 2016, December 2016

Permanent patient: A patient who has selected a DaVita dialysis facility as his/her home facility.

Personal Representative: An individual who is legally appointed, designated and/or authorized pursuant to state law to: (a) make health care decisions on behalf of a patient, or (b) act on behalf of a deceased individual or a deceased individual's estate. Reference: *Personal Representatives of Patients* (available on the HIPAA website on the VillageWeb).

Transfer patient: An existing dialysis patient who is permanently relocating from any dialysis facility to a DaVita dialysis facility. Once the transfer is complete, the patient will become a "permanent patient."

POLICY:

1. DaVita will accept and dialyze patients with renal failure needing a regular course of dialysis without regard to race, color, national origin, gender, sexual orientation, age, religion, or disability if:

    a. The admitting physician or Medical Director must provide the appropriate diagnosis of Acute Kidney Injury (AKI) or End Stage Renal Disease (ESRD) in the treatment orders prior to a patient's first treatment.

    b. If the Nephrologist determines patient renal status of AKI and decides to admit, follow the policy: *Accepting Patients with Acute Kidney Injury for Treatment.*

    c. If the Nephrologist determines patient renal status of ESRD, follow the policy outlined below for admission.

    d. Final decision on whether or not the candidate patient will be admitted rests with the Medical Director. The Medical Director's determination is based on assessment of the facility's ability to safely dialyze the candidate patient without adversely affecting the quality and safety of all patients.

    e. Should the patient not have an admitting physician, refer to: *Patients without an Admitting Physician* policy (available on the Team Quest website on the VillageWeb).

    f. The patient's care can be managed in an outpatient dialysis facility according to individual modality.

    g. The patient is under the care of a nephrologist who is credentialed in the DaVita facility.

h. There is adequate treatment space, equipment and appropriately trained staff available to provide appropriate care to the patient.

i. The patient (a) has been verified as Medicare or Medicaid eligible and/or has private insurance coverage issued by an Insurance Provider licensed and operating in the United States or United States Territories which has been verified, and from which an authorization for treatment has been received by DaVita as required, (b) accepts financial responsibility for care by signing the *Patient Authorization & Financial Responsibility* (PAFR) Form.

   i. Patients who are uninsured must be authorized at the facility level with written approval by the facility's Divisional Vice President (DVP), or their designee, prior to treatment. (*Cash Payment Fee Schedule for Patients with no Insurance Coverage Policy* (available on the ROPS website on the VillageWeb).

   ii. Patients who have an out-of-state Medicaid plan that will not pay for treatment(s) cannot be requested to pay for these services, either as primary or secondary to Medicare. Admittance to the facility must be authorized at the facility level with written approval by the facility's DVP, or their designee, prior to treatment.

   iii. Patients who are out-of-network and have no out of network benefits must be authorized at the facility level with written approval by the facility's DVP, or their designee, prior to treatment.

2. Patients without adequate medical insurance coverage will be responsible to pay their portion of the cost prior to actual treatment.

3. All visiting patients, including patients visiting a non-contracted facility, will be responsible to sign a new PAFR Form specific to the visiting facility.

4. The facility will obtain height and weight on all visiting patients, including patients visiting a non-contracted facility. This information will be recorded in Snappy on the first treatment in the visiting facility.

5. A Purchase Order for services and treatments outside of their area is required prior to treatment for patients who have Indian Health Services coverage.

6. Any new patient who is uninsured must be approved for treatment by the facility's DVP, or their designee, prior to treatment.

7. DaVita dialysis facility will transmit the required information to the corresponding Corporate Business Office (CBO) ROPS registration teammate upon notification of a new or visiting patient.

8. ROPS registration teammate will verify all insurances and obtain authorization if needed to complete the registration process.

9. Visiting patients must make payment for non-covered, and out of network services in the form of cashier's check, money order, travelers check, American Express, Visa, Discover or MasterCard prior to treatment. Please see *Money Received at Centers Policy* and *Credit Card Process Policy* (available on the ROPS website on the VillageWeb).

10. DaVita will bill using the name and number as it appears on the beneficiary Medicare card or other document confirming the patient's health care coverage through a third party, and as the patient's name is confirmed by two (2) additional forms of identification which has the patient's current legal name listed on it. Reference DaVita's *Patient Identification and Verification Policy Attachment A: Acceptable Forms of Personal Identification* (available on the eP&P site Dialysis Regulatory and Ancillary Policies & Procedures folder) for acceptable forms of personal identification. Reference DaVita's *Entering Patient's Name Policy* (available on the ROPS website on the VillageWeb) for guidance on entering patient name into DaVita systems.

11. If any information on the beneficiary Medicare card is incorrect, DaVita will advise the beneficiary to contact their local servicing Social Security Office to obtain a new Medicare card.

12. If information contained on the insurance card is incorrect, DaVita will advise the policyholder to contact their insurance company to obtain a new insurance card. All insurance cards should match the patient's identification. The patient must produce evidence that a change was initiated with the appropriate insurance carrier within 90 days of the noted discrepancy.

13. There are four (4) mandatory data elements for any patient to be registered in Registration System. These fields must be completed accurately prior to treatment. Required Registration System fields are:

    a. First and last name;

    b. DOB (date of birth);

    c. Anticipated start date at DaVita; and

d. An ICD-9/ICD-10 code(s), representing the condition (ESRD) as specified by the admitting physician (may also consult the hospital discharge/pre-discharge summary).

14. Listed below are the following documents that are required for in-center dialysis patients and home dialysis patients prior to first treatment at a DaVita Dialysis facility, unless otherwise required by applicable state regulation:

a. Patient demographics and insurance information;
b. Copy of History and Physical (within the last year – must be legible);
c. Hepatitis and TB Testing Results: For Hepatitis and TB testing requirements, refer to policies: *Hepatitis Surveillance, Vaccination and Infection Control Measures* and *Tuberculosis Infection Control Policy* (available on the eP&P site Incenter Hemodialysis Policies & Procedures, Peritoneal Dialysis and Home Hemodialysis folders); Note: Hepatitis C testing is strongly recommended, but not required;
d. Copy of current hemodialysis orders for treatment;
e. Two (2) forms of personal identification, in addition to the patient's insurance card, verifying the patient's legal name and current legal residence, one of which is a picture ID. Reference DaVita's *Patient Identification and Verification Policy Attachment A: Acceptable Forms of Personal Identification* (available on the eP&P site Regulatory and Ancillary Policies and Procedures folder) for acceptable forms of personal identification;
f. All copies of patient's current insurance cards-front and back;
g. Initiation of CMS 2728. Once completed, within the 45-day guideline, it should include the patient's and nephrologists' signature and date. This is the official document of the patient's first date of dialysis ever, first dialysis modality, and provides transplant information, if applicable; *Patient Authorization & Financial Responsibility Form* (PAFR). Must be signed and witnessed prior to the start of the first dialysis treatment. This form allows DaVita to receive payment from insurance companies and informs the patient of the financial responsibilities regarding treatment provided to them. Without a signed PAFR Form, DaVita may not be reimbursed for services provided to the patient;
h. Medicare Secondary Payor Form (MSP). Determines if a commercial Employer Group Health Plan (EGHP) will be primary payor. Must be completed for all patients who have Medicare coverage when they start treatment at DaVita;
i. DaVita's *Notice of Privacy Practices.* Each patient/personal representative will be provided with the notice.

Facilities may elect to require documents a. through h. listed above prior to admission to a DaVita Dialysis facility.

For patients who have dialyzed before* (permanent transfers or visiting patients) the following will also be required:

a. Copy of most recent Plan of Care including: Nursing, Dietary and Social Work Assessments;
b. Copies of three (3) flowsheets within two (2) weeks of requested treatment(s);
c. Monthly labs within 30 days prior to first treatment date including hematocrit, hemoglobin, URR, electrolytes.
d. Current list of medications being administered to patient in-center and at home (recommended for patient to bring in current medications at time of first treatment);
e. Allergies;
f. Access Information;
g. Hospitalization Discharge information; and
h. Advance Directives, if patient has executed an Advance Directive and confirmed with patient as current.

*For patients displaced by disaster/emergency event, please see policy: *Facility Emergency and Disaster Plan.*

15. The following document is to be requested (but not required) for a safe transition of care for in-center dialysis patients and home dialysis patients prior to admission to a DaVita Dialysis facility:

    a. Consultations (Hematology, GI, Cardiology).

16. Unless otherwise provided for under this policy, prior to the first treatment at the facility, all patients, including Transfer, Guest, and Permanent Patients will be given the following documents to read and sign:

    a. Patient Rights;

    b. Patient Responsibilities;

    c. Patient Authorization and Financial Responsibility Form (PAFR);

    d. Patient Standards of Conduct;

    e. Patient Grievance Procedure;

    f. Authorization for and Verification of Consent to Hemodialysis/Peritoneal Dialysis;

    g. HIPAA Permission to Discuss;

h. HIPAA Notice Acknowledgement form; and

i. Affidavit of Patient Identification form (Note: This form is only given if the patient or Personal Representative on behalf of the patient is not able to produce the requested two (2) forms of personal identification verifying the patient's legal name and current legal residence upon admission or within seven (7) days of admission).

17. The patient/personal representative will agree to follow the *Patient's Rights and Responsibilities, Patient's Standards of Conduct and the Patient Grievance Procedure.* (Refer to *Patient's Standards of Conduct; Patient Grievance Procedure; Patient Rights and Responsibilities* available on the eP&P site Dialysis Regulatory and Ancillary Policies & Procedures folder).

18. Visiting patients are only required to sign the *Patient's Rights and Responsibilities, Patient's Standards of Conduct and the Patient Grievance Procedure* one time for each DaVita facility they visit, as long as these forms are visibly posted at the facility, unless there are changes made to any of those forms/policies, or state specifications require otherwise.

19. If the patient, or Personal Representative on behalf of the patient, is not able to produce the requested two (2) forms of personal identification verifying the patient's legal name and current legal residence, the teammate admitting the patient should follow the procedures set forth in the *Patient Identification and Verification Policy* (available on the eP&P site Dialysis Regulatory and Ancillary Policies & Procedures folders), and any other relevant policies based on the situation at hand.

20. Any conflict with the criteria established or refusal to sign appropriate consents and authorization to bill would constitute a need for prior written authorization by the facility's DVP or designee.

21. Other than a PAFR which is always required, a permanent DaVita patient may be treated at a DaVita facility other than his /her home facility without completing the required documentation,when:

a. The attending nephrologist has privileges at both the facilities in question (the patient's home facility and the anticipated visiting facility);

b. A visiting record is generated by the home facility at least one hour before the scheduled treatment;

c. The Facility Administrator (FA) at the visiting facility agrees to treat the patient; and

d. The visiting facility has the space and resources to treat the patient.

22. All other exceptions to this policy are subject to approval by the DVP for the region/division.

23. Clinical documentation: add all to ESRD

    a. Use ICD-9/ICD-10 code(s) as specified by admitting physician for justification in the dialysis treatment order

24. Use ICD-9/ICD-10 code(s) as specified by admitting physician for justification in all medication and laboratory orders

ATTACHMENTS:

Attachment A: Procedures for Accepting Patients for Treatment

Teammates are expected to report possible violations of this policy and procedure. You may make your report to an appropriate DaVita manager, to the Corporate Compliance Hotline (1-888-458-5848 or DaVitaComplianceHotline.com.) DaVita has a Non-Retaliation policy and will not tolerate any form of retaliation against anyone who files a Compliance report in good faith. Reports can be made anonymously or you may request confidentiality. Questions regarding this policy should be directed to policies&procedures@davita.com.

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Printed copies are for reference only. Please refer to the electronic copy for the latest version.

TITLE: PATIENT BEHAVIOR AGREEMENTS, 30 DAY DISCHARGE, INVOLUNTARY DISCHARGE OR INVOLUNTARY TRANSFER

PURPOSE: To provide guidance on Patient Behavior Agreements, 30 Day Discharge, Involuntary Discharge or Involuntary Transfer. These may become necessary when a patient does not conform to the *Patient's Standards of Conduct* and/or *Patient's Rights, Responsibilities and Facility Rules.* When a facility is considering involuntary discharge, the patient is automatically designated as "unstable" and therefore requires an assessment. The Interdisciplinary Team (IDT) must assess the patient with an intent to identify any potential action or plan that could prevent the need to discharge or transfer the patient involuntarily.

POLICY:

Disruptive, Non-Threatening Behavior:

1. If the patient's behavior is disruptive to the facility, but is non-threatening, a comprehensive patient assessment will be completed by the Interdisciplinary Team (IDT) in order to identify any potential action or plan of correction required. The assessment must focus on identifying the root causes of the disruptive behavior and result in a plan of care aimed at addressing those causes and resolving disruptive behavior. This assessment may require a change in health status to unstable.

2. At the completion of the assessment, a Patient Care Conference (PCC) is required. The IDT should meet with the patient in a conference setting. The PCC will specifically address patient behavior and any patient concerns. The PCC and assessment will be documented in the medical record.

3. If the patient's behavior continues to be disruptive to the facility, but is non-threatening to others, the patient should receive a First Letter of Concern. This letter will be written in collaboration with your Risk Manager and will provide specific details of the patient's behavior and concerns the facility has regarding the patient's behavior.

Threatening Behavior/Behavior Agreements:

4. If at any time teammates or other patients feel an immediate severe threat or safety is a concern, the police should be notified immediately via 911. (See **Immediate Severe Threat** below).

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5. If a patient's behavior in the dialysis facility is threatening, either verbally or physically, the treatment that day will be terminated and the patient will be asked to leave the facility. The facility will immediately notify the Medical Director, the patient's physician, the Regional Operations Director (ROD), the ESRD Network and the Risk Manager.

6. In collaboration with the ESRD Network, the facility and Risk Manager will make a determination of whether the patient should be immediately discharged from the facility due to the nature of the threatening behavior or placed on a Behavior Agreement. The collaboration with the ESRD Network will be documented in the medical record.

7. If it is determined that a Behavior Agreement is appropriate, the Behavior Agreement will be drafted in collaboration with the Risk Manager and address the behavior exhibited. The Medical Director, patient's physician, ROD, Divisional Vice President (DVP) and ESRD Network will be notified. A PCC will be scheduled with the patient and IDT to discuss the Behavior Agreement. The Behavior Agreement will also be mailed to patient via certified mail, return receipt requested.

8. Behavior Agreements will not be used for non-adherence or for patients who choose to sign off Against Medical Advice (AMA).

30 Day Discharge, Involuntary Transfer and Involuntary Discharge:

9. Lost to Follow-Up is defined as a patient who has not dialyzed for 30 days at the facility and the dialysis facility is unable to located the patient. In the event that a patient is considered Lost to Follow-Up and at risk for involuntary discharge, dialysis facilities are to notify their ESRD Network. Notify the Risk Manager for further guidance.

10. If the patient acts in violation of the Behavior Agreement, your Risk Manager is to be notified for further direction. The facility and Risk Manager will consult with the ESRD Network regarding 30 day discharge or involuntary discharge or transfer to another facility.

11. The patient's physician and facility Medical Director must be notified of the pending involuntary transfer or discharge and provide a signed order. This notification and order will be documented in the patient's medical record.

12. The ROD, DVP, State agency and ESRD Network must be notified of the involuntary discharge. If a 30 day notice is given, the effective date is the day the notice is written. This notification will be documented in the medical record.

13. The patient has the right to choose and to change physician and/or treatment facility provided that the new physician and/or facility can reasonably accommodate the patient. The patient is advised to confirm that the facility under consideration has been certified by Medicare.

14. Social Worker/designee will provide the patient with a list of area dialysis facilities (DaVita and non DaVita) that may be able to accept the patient, and the patient will be allowed to provide input as to facility preference. The patient will be advised to consult with his or her treating physician about alternative treatment options and to confirm the physician has privileges at selected dialysis facilities.

15. Good faith efforts should be made to place the patient at the patient's preferred facility and/or find the closest facility to the patient's residence that will accept the patient in transfer. The patient will be informed that DaVita cannot guarantee the transfer to the identified facility. The applicable patient's medical record must include evidence of those placement efforts.

16. The goal of contacting another dialysis facility is for continuity of care and the HIPAA privacy rules do not require patient consent to contact another dialysis facility. The HIPAA privacy rule does limit sharing of protected health information to medical records requested by the other provider and prohibits sharing information obtained through hearsay.

Immediate Severe Threat:

17. If it is determined that a patient will be immediately discharged due to the nature of the threatening behavior ("immediate, severe threat"), 30 day patient notice is not required. An immediate severe threat is considered to be a threat of physical harm. For example, if a patient has a gun or a knife or is making credible threats of physical harm, this would be considered an "immediate severe threat". An angry verbal outburst or verbal abuse is not considered to be an immediate severe threat.

18. In instances of an immediate severe threat, facility teammates may utilize "abbreviated" involuntary discharge or transfer procedures. These abbreviated procedures may include taking immediate protective action such as calling "911" and asking for police assistance. In this scenario, there may not be time or opportunity for re-assessment, intervention, or contact with another facility for possible transfer.

19. After the emergency is addressed and teammates and other patients are safe, teammates must notify the Medical Director, patient's physician, Risk Manager, ROD and DVP, State agency and ESRD Network of the involuntary discharge. Document this notification and the exact nature of the "immediate severe threat" in the patient's medical

record. The Risk Manager may recommend onsite security for a period of time after the discharge of the patient (mutually agreed upon by Operations and Risk Manager).

Discharge for Lack of Physician Coverage:

20. If the reason for discharge is the physician's determination to no longer care for a particular patient and there is no other physician available that is willing to accept the patient, generally the state practice boards for physicians require the patient be given some notice to avoid a charge of patient abandonment. The facility will need to follow this regulation as to reassessment, 30 day notice of discharge, attempts for placement, etc. during the physician's period of notice to the patient. The Facility Administrator/designee should follow state law requirements regarding notice.

TITLE: **Patient Financial Evaluation Policy**

PURPOSE:
To establish policies and procedures for the individualized determination of patient financial need for services provided by DaVita.

DEFINITIONS:
Obligation – The amount a patient must pay for dialysis and related services after all other third party payers (Medicare, Medicaid, commercial insurers, etc.) have paid DaVita, including copayments, coinsurance, deductibles, noncovered services and self-pay amounts.

PFE – Patient Financial Evaluation form (Addendum A) utilized to determine a patient's individual financial status and ability to pay the patient's Obligation.

Patient Assistance – The amount by which the patient's Obligation is reduced as a result of the PFE. Patient Assistance may be a full or partial reduction of the patient's Obligation.

Patient Assistance Scale – Sliding scale based on the Federal Poverty Guidelines used to determine the level of Patient Assistance for which the patient is eligible. (Addendum B)

Household Size – All persons residing in the same household as determined by this Policy.

Household Income – income of all persons identified in Household Size. Visitor – A patient who is at the facility for less than 30 consecutive days.

POLICY:
DaVita may provide Patient Assistance related to Patient Obligations based on an individualized determination of a patient's financial need. Any approval for Patient Assistance will be based on current facts and the agreement of the patient to maintain current coverage. Any amounts paid by an insurance company directly to the patient for services furnished by DaVita must be paid to DaVita and are not included in the patient Obligation amounts eligible for Patient Assistance.

Patients with previously approved PFEs will continue to receive Patient Assistance under the prior agreement until the first of any of the following events occurs:

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TITLE: **Patient Financial Evaluation Policy**

- Current PFE expires
- Insurance coverage changes
- Patient notifies DaVita of a change in household size or income and requests an updated PFE

PROCEDURE:

A Patient Financial Evaluation (Addendum A) may be offered for patients who have a patient Obligation and have indicated some financial need to a DaVita Teammate. If the patient refuses and/or declines offer of a PFE, the Social Worker must inform the patient that he/she is responsible for the full amount of the patient Obligation.

For patients within the state of Rhode Island, if a Community Health Center, listed on Attachment C, refers a patient and notifies the center that the patient has NO insurance and a household income up to the 200% of the Federal Poverty Limits (Full Waiver level on the PFE Scale), the center will require no further documentation from that patient and the patient will qualify for a full waiver PFE.

The PFE applies equally to all patients, without regard to the source of payment. Prior to applying for Patient Assistance, the patient must make a good faith effort to obtain insurance and exhaust all coverage options that will improve the patient's insurance coverage. All patients must have a current signed PAFR on file in order to apply for a PFE; California patients must have a PAFR signed within the current calendar year.

Patient Assistance is based on household financial status and the ability to pay after all other options for third party coverage and payment has been exhausted. The Social Worker (SW) or center designee is required to document these efforts to obtain any and all third party coverage in the patient's account record.

All patients must apply for Medicaid programs and any other available state financial assistance programs prior to applying for a PFE and provide copy of denial/approval with PFE application. If an uninsured patient is not able to apply for Medicaid, the Social Worker must document the reason. Note that patients with Medicare coverage MUST seek apply for Medicaid.

This policy is not available to patients who have had lapses in insurance coverage that the patient could control or other forms of patient non-compliance with obtaining or maintaining insurance coverage, including but not limited to; the failure to pay premiums or provide documentation necessary. If a patient is being discharged from a hospital, the patient must first attempt to secure a Single Patient Agreement (SPA) prior to utilizing the PFE Policy. Should the patient fail or refuse to provide the required PFE documentation, the patient will be discharged according to the procedures outlined in the Non-Payment Discharge Policy.

TITLE: **Patient Financial Evaluation Policy**

This policy is not applicable when superseded by state law. Patients who have a Cash Pay Agreement with the center do not qualify. DaVita reserves the right to deny or revoke patient assistance at its full discretion.

An existing PFE applies to all DaVita centers, even when the patient is a Visitor. PFEs cannot be used for visiting charges only.

With regard to any state law regarding patient "share of cost" or spend-down obligations for Medicaid, the patient shall be considered to have (1) incurred expenses for medical services and (2) assumed legal responsibility for medical services expenses, as of the date that medical services having a cost or charge equal to or greater than the amount of the patient's share of cost or spend- down obligations actually were rendered to the patient. This is the date the patient Obligation is created, notwithstanding any later application of Patient Assistance to the patient Obligation amount.

The patient is required to provide proof of Household Size and Personal Income to determine eligibility for Patient Assistance to the Social Worker or designee.

Household Size - at least one of the following documents showing proof of the household size:

- Federal Tax Return – No later than previous tax year and signed.
- State Assistance Program letters which name household members.
  - Social Security Letters which name all parties in one letter.

If the patient is unable to produce the above documents and is not otherwise covered by a government health plan, the following documents may be used to support household size:

- School records that identify an address for the children stated as part of the household that matches a lease agreement or address on a utility bill in the name of the patient
- Copy of an official marriage license
- Copy of Official birth certificate
- Court records for legal guardianship
- Adoption records
- Proof of domestic partnership

*If we do not have evidence that the patient's household size is different, we will default to one person.

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TITLE: **Patient Financial Evaluation Policy**

Income – The patient ***must*** provide at least one (1) of the following documents listed in Column A showing proof of income. If the patient is not able to provide any of the documentation listed in Column A, patient ***may*** provide at least two (2) of the documents listed in Column B, ***or*** at least three (3) of the documents listed in Column C.

*Please note, if patient is currently a financial need patient of DaVita Healthcare Partners Inc., the patient must provide an item of documentation from Column A. Additionally, any patient that is eligible for a government health plan (e.g., Medicare, Medicaid) must submit documentation from Column A.

If patient is not able to provide the **required** income verification documentation listed in Columns A, B and C, patient must provide a signed document explaining his/her situation that prevents the patient from furnishing the required documentation.. If the patient is able to provide the required income verification documentation listed in Columns A, B and C but refuses to do so, the patient is not eligible for Patient Assistance under this Policy.

OR

If patient is not able to provide the **required** income verification documentation listed in Columns A, B and C, patient may complete a W-7 Form to file for an IRS Individual Taxpayer Identification Number (ITIN). Once the patient has received an ITIN, the patient may either file a federal income tax return and submit a copy as stated in Column A or sign an affidavit explaining why the patient is not required to file a federal income tax return.

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TITLE: **Patient Financial Evaluation Policy**

Income Verification

Column A	Column B	Column C
✓ Federal Income Tax Return from no later than the previous year ✓ W2-form or 1099 from no later than the previous year ✓ Social Security Statement of Earnings (cannot be older than the previous tax year) ✓ One (1) consecutive month of paycheck stubs (within 60 days of PFE application) ✓ Retirement Income (Annuity, Pension, Dividends Paid Out, Veteran's Benefits) ✓ Copy of Medicaid Application (including Emergency Medicaid) along with Approval/Denial Letter	✓ Credit Check Report ✓ Document of Assets ✓ Bank Statements (last 3 months) ✓ Worker's Compensation income statements ✓ Unemployment Compensation Determination Letter ✓ Statement from Employer of employment and salary ✓ Documentation of Homeless Shelter Use	✓ *Living Expenses (i.e. rent, utility bills, cell phone carrier bill, grocery receipts, etc) along with copies of checks paid or money order receipts paying such expenses ✓ Food Stamp Benefit Information ✓ Proof of Participation in other Government Assistance Programs ✓ Court Documentation of Bankrupt Condition ✓ Proof of Residence in Area of High Poverty ✓ Proof that family is eligible for free or reduced-fare school lunch ✓ Children's School Records ✓ Strike Benefits from Union Funds ✓ Alimony ✓ Child Support ✓ PFE from another institution ✓ Other Documents of Sources of Income *Living Expenses shall not be used to offset income or determine actual expenses; rather, Living Expenses shall be used as a proxy for income that cannot otherwise be proved.

Any change in family size or insurance coverage will require a new application to be submitted. A change in insurance coverage will cause any current PFE to terminate.

The patient must sign the PFE stating that all information provided is accurate. A PFE lacking proof of income and/or family size will be denied.

TITLE: **Patient Financial Evaluation Policy**

Determination for awarding Patient assistance will be based on the attached Patient Assistance Scale (Addendum B).

1. Household income and household size of patient compared to a % of the federal poverty guidelines per the Patient Assistance Scale (Addendum B).
2. If the patient qualifies for 100% assistance, deeming him/her indigent, the patient will not be billed for any patient Obligations.
3. If the patient qualifies for partial Patient Assistance, he/she will be billed for the lesser of the remaining patient Obligation for the month of services or the Patient Assistance rate.
4. If the patient does not qualify for Patient Assistance, he/she will be billed for the remaining patient Obligation for the month of services.

The status of the PFE and the level of Patient Assistance which has been approved will be communicated to the patient, Social Worker and IMT.

The PFE and related documentation will be maintained in the patient's account record. The billing office designee will enter the PFE approval or denial into the patient record and patient bills will be calculated based on this information.

An approved PFE is valid for one year from the month of the submission and can retro up to twelve months, if necessary. Any payments made by the patient for Patient Obligations that are within the approval range of the PFE will not be refunded. The PFE is reviewed on an annual basis.

This policy applies equally to all patient types, including patients who are DaVita Teammates.

Teammates are expected to report possible violations of this policy and procedure. You may make your report to an appropriate DaVita manager, to the Corporate Compliance Hotline (1-888-458-5848 or DaVitaComplianceHotline.com). DaVita has a Non-Retaliation policy and will not tolerate any form of retaliation against anyone who files a Compliance report in good faith. Reports can be made anonymously or you may request confidentiality.

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TITLE: PATIENT'S RIGHTS

YOUR RIGHTS AS A PATIENT:

As a DaVita patient I understand I am entitled to the following:

1. To be fully informed of my rights (including privacy rights), responsibilities and all rules governing conduct related to patient care, services and financial policies/responsibilities.
2. To be accepted for admission without regard to national origin or sponsor, race, age, sex, religion, disability, payer, sexual orientation, marital status, or other factors unrelated to the provision of appropriate medical care.
3. To be treated with (i) respect, dignity, and recognition of my individuality, choices, strengths, abilities, cultural values, religious beliefs and personal needs, to the extent possible during treatment;, and (ii) sensitivity to my psychological needs and ability to cope with ESRD.
4. The right to privacy and confidentiality in all aspects of treatment. The dialysis facility will make accommodations to provide for patient privacy when patients are examined or body exposure is required, for example privacy screens or curtains.
5. To be free from abuse, neglect, exploitation, coercion, manipulation, sexual abuse, sexual assault, seclusion, or restraint (if not necessary to prevent harm to myself or others), or misappropriation of my personal property by the facility's teammates.
6. To receive adequate, safe, sanitary, and efficient dialysis treatment and respectful care by competent personnel in a comfortable environment.
7. To receive all information in a way that I can understand.
8. To receive assistance from a family member, representative or other individual in understanding, protecting and/or exercising my rights.
9. To be fully informed of all services available in the facility and charges not covered under Medicare or other health insurance, as applicable.
10. Upon request, to receive any information which the facility has available relative to financial assistance and free health care.
11. To be fully informed of my right to execute an advance directive and of DaVita's policy that properly executed and documented advance directives will be honored and carried out in DaVita facilities.
12. The right to choose and to change physician and/or treatment facility provided that the new physician and/or facility can reasonably accommodate me. I am advised to confirm that the facility under consideration has been certified by Medicare.
13. To know who my primary physician is, and to participate with my primary physician in planning my care.
14. To know the names, professional status, and experience of the staff who are providing and coordinating my care and treatment.
15. Upon request, to obtain an explanation as to the relationship, if any, of the facility to any other health care facility or educational institutions insofar as that relationship relates to my care or treatment.

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16. To receive a full explanation by my physician/allied health professional of the nature of my medical status and the necessity for recommended treatment/appointment(s), including the risks, side effects, expected outcomes, and other treatment/appointment options before giving consent to or refusing treatment/appointment.

17. To expect and receive appropriate assessment, management and treatment of pain as an integral component of my care.

18. To receive a full explanation of facility policies regarding patient care including, but not limited to, certain policies about infectious diseases that may require me to be dialyzed in a separate space from other patients and policies about visitors and socialization within the facility.

19. To be fully informed about all treatment modalities, including but not limited to, transplantation, home dialysis (home hemodialysis, intermittent peritoneal dialysis, continuous ambulatory peritoneal dialysis, continuous cycling peritoneal dialysis), in-facility hemodialysis, in-facility nocturnal hemodialysis, hospice, and the option of no treatment.

20. To receive resource information for dialysis modalities not offered by the facility, including information about alternative scheduling options for working patients.

21. To be advised of research studies that affect my care and give my informed, written consent to participate in such research or refuse to participate.

22. To be informed about whether the facility is participating in any teaching programs and to refuse to allow their participation in my treatment.

23. To be transferred or discharged only for medical reasons, for my own welfare or that of other patients, or for nonpayment of fees. If I am discharged for these reasons, I will be given advance written notice of 30 days unless the reason involves issues of immediate safety to other patients or teammates. These actions may result in an immediate discharge. Reasons for involuntary discharge may include failure to comply with items in the *Patient's Standards of Conduct, Responsibilities and Facility Rules*, which are provided in the Patient Registration Packet.

24. To review my medical record with supervision by the Facility Administrator or designee and at a time mutually agreed upon by me and the Facility Administrator or designee in advance.

25. To receive a copy of my medical records. All requests for medical records will be put in writing. Based on individual state requirements for accessing medical records, there may be a fee charged for copying the medical records. All records requests will be completed within 30 days of the request.

26. To receive necessary services or referrals as outlined in my individualized plan of care.

27. To know my medical records and the information contained will be considered private and confidential and only released in compliance with state and federal law.

28. To freely express comments, complaints or grievances verbally or in writing personally, anonymously, or through a representative of my choosing. My comments, complaints and grievances may be expressed to facility teammates, administration, DaVita's Corporate Compliance Department, the ESRD Network organization and appropriate regulatory agencies without fear of reprisal or denial of services, discrimination or retaliation. All comments, complaints and grievances will be resolved in a timely manner in accordance with the facility's grievance process. Information regarding the grievance process will be provided to me and the facility Social Worker will assist you if needed.

29. To have all reasonable requests responded to promptly and adequately within the capacity of the facility.

30. To be informed about and participate, if desired, in all aspects of my individualized plan of care and be informed of the right to refuse treatment and to be fully informed of the medical consequences of refusing treatment/appointment.

31. If I require hemodialysis and dialyzer reuse is practiced in the facility, I am entitled to the following:

- To give or refuse permission to participate in the reuse program and to request to change from one to the other at any time either verbally or in writing. Refusal to participate in reuse will still allow me to dialyze in this facility and receive other services, however, failure to agree to reuse will minimally restrict your choice of a dialyzer.
- To have questions about reuse answered in a complete and understandable way.

Please note, this version of the document is not intended for distribution to patients. The companion version of this document that is intended for distribution to patients (which is identical to this form, but includes a patient signature block) can be found electronically in the Reggie system.

PATIENT RIGHTS:

TEMPLATE FOR FACILITY INFORMATION

Name of Facility: _____

Phone Number of Facility: _____

Facility Address: _____

Facility Medical Director: _____

Attending Physician: _____

Facility Administrator: _____

Nurse Responsible for Clinical Care: _____

Social Worker: _____

Dietitian: _____

Facility Normal Hours of Operation: _____

Dialysis Schedule (days & time): _____

How to contact physician and obtain emergency assistance after facility normal hours of operation: _____

PATIENT RIGHTS:

TEMPLATE FOR FACILITY INFORMATION

Name of Facility: _____

Phone Number of Facility: _____

Facility Address: _____

Facility Medical Director: _____

Attending Physician: _____

Facility Administrator: _____

Nurse Responsible for Clinical Care: _____

Social Worker: _____

Dietitian: _____

Facility Normal Hours of Operation: _____

Dialysis Schedule (days & time): _____

How to contact physician and obtain emergency assistance after facility normal hours of operation: _____

Appendix 15

Lease Agreement
Zoning Documentation

Department of Assessments

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PARCEL

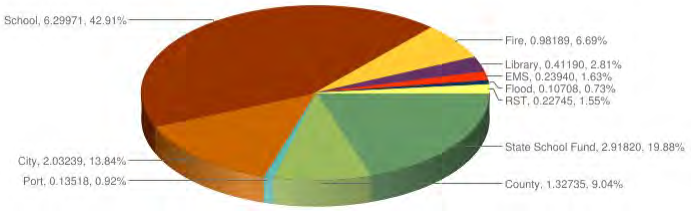
Parcel Number	030150-0090
Name	SOUTHERN FINANCIAL GRP LLC
Site Address	1700 O ST 98001
Legal	AUBURN 400 CORPORATE PARK DIV #1

BUILDING 1

Year Built	
Building Net Square Footage	
Construction Class	
Building Quality	
Lot Size	83457
Present Use	Vacant(Industrial)
Views	No
Waterfront	

TOTAL LEVY RATE DISTRIBUTION

Tax Year: 2018 **Levy Code:** 0133 **Total Levy Rate:** $14.68055 **Total Senior Rate:** $7.16161



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Click here to see levy distribution comparison by year.

TAX ROLL HISTORY

Valued Year	Tax Year	Appraised Land Value ($)	Appraised Imps Value ($)	Appraised Total ($)	Taxable Land Value ($)	Taxable Imps Value ($)	Taxable Total ($)
2017	2018	58,400	0	58,400	58,400	0	58,400
2016	2017	41,700	0	41,700	41,700	0	41,700
2015	2016	41,700	0	41,700	41,700	0	41,700
2014	2015	41,700	0	41,700	41,700	0	41,700
2013	2014	41,700	0	41,700	41,700	0	41,700
2012	2013	41,700	0	41,700	41,700	0	41,700
2011	2012	41,700	0	41,700	41,700	0	41,700
2010	2011	41,700	0	41,700	41,700	0	41,700
2009	2010	41,700	0	41,700	41,700	0	41,700
2008	2009	41,700	0	41,700	41,700	0	41,700
2007	2008	41,700	0	41,700	41,700	0	41,700
2006	2007	41,700	0	41,700	41,700	0	41,700
2005	2006	41,700	0	41,700	41,700	0	41,700
2004	2005	41,700	0	41,700	41,700	0	41,700
2003	2004	41,700	0	41,700	41,700	0	41,700
2002	2003	13,300	0	13,300	13,300	0	13,300
2001	2002	13,300	0	13,300	13,300	0	13,300
2000	2001	13,300	0	13,300	13,300	0	13,300
1999	2000	13,400	0	13,400	13,400	0	13,400
1998	1999	13,400	0	13,400	13,400	0	13,400
1997	1998	0	0	0	13,400	0	13,400
1996	1997	0	0	0	13,400	0	13,400
1994	1995	0	0	0	13,400	0	13,400
1992	1993	0	0	0	333,800	0	333,800
1990	1991	0	0	0	292,100	0	292,100

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Reference Links:

- King County Taxing Districts Codes and Levies (.PDF)
- King County Tax Links
- Property Tax Advisor
- Washington State Department of Revenue (External link)
- Washington State Board of Tax Appeals (External link)
- Board of Appeals/Equalization
- Districts Report
- iMap
- Recorder's Office

Scanned images of surveys and other map documents

Scanned images of plats

1988	1989	0	0	0	166,900	0	166,900
1986	1987	0	0	0	120,100	0	120,100
1985	1986	0	0	0	104,300	0	104,300

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FAX: 206-296-5107
TTY: 206-296-7888

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PARCEL

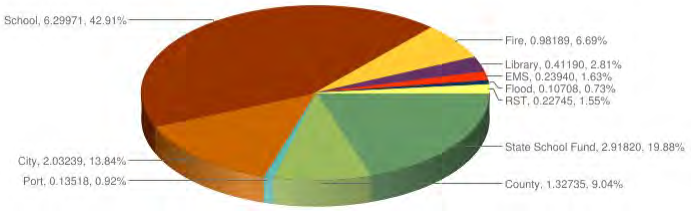
Parcel Number	030150-0110
Name	SOUTHERN FINANCIAL GRP LLC
Site Address	1700 O ST 98001
Legal	AUBURN 400 CORPORATE PARK DIV #1 LOTS 10 & 11 PER AU-LLA 0010-90 REC #9005081375

BUILDING 1

Year Built	
Building Net Square Footage	
Construction Class	
Building Quality	
Lot Size	93000
Present Use	Vacant(Industrial)
Views	No
Waterfront	

TOTAL LEVY RATE DISTRIBUTION

Tax Year: 2018 **Levy Code:** 0133 **Total Levy Rate:** $14.68055 **Total Senior Rate:** $7.16161



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Click here to see levy distribution comparison by year.

TAX ROLL HISTORY

Valued Year	Tax Year	Appraised Land Value ($)	Appraised Imps Value ($)	Appraised Total ($)	Taxable Land Value ($)	Taxable Imps Value ($)	Taxable Total ($)
2017	2018	65,100	0	65,100	65,100	0	65,100
2016	2017	46,500	0	46,500	46,500	0	46,500
2015	2016	46,500	0	46,500	46,500	0	46,500
2014	2015	46,500	0	46,500	46,500	0	46,500
2013	2014	46,500	0	46,500	46,500	0	46,500
2012	2013	46,500	0	46,500	46,500	0	46,500
2011	2012	46,500	0	46,500	46,500	0	46,500
2010	2011	46,500	0	46,500	46,500	0	46,500
2009	2010	46,500	0	46,500	46,500	0	46,500
2008	2009	46,500	0	46,500	46,500	0	46,500
2007	2008	46,500	0	46,500	46,500	0	46,500
2006	2007	46,500	0	46,500	46,500	0	46,500
2005	2006	46,500	0	46,500	46,500	0	46,500
2004	2005	46,500	0	46,500	46,500	0	46,500
2003	2004	46,500	0	46,500	46,500	0	46,500
2002	2003	14,800	0	14,800	14,800	0	14,800
2001	2002	14,800	0	14,800	14,800	0	14,800
2000	2001	14,800	0	14,800	14,800	0	14,800
1999	2000	15,000	0	15,000	15,000	0	15,000
1998	1999	15,000	0	15,000	15,000	0	15,000
1997	1998	0	0	0	15,000	0	15,000
1996	1997	0	0	0	15,000	0	15,000
1994	1995	0	0	0	15,000	0	15,000
1992	1993	0	0	0	372,000	0	372,000
1991	1992	0	0	0	325,500	0	325,500

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- Washington State Board of Tax Appeals (External link)
- Board of Appeals/Equalization
- Districts Report
- iMap
- Recorder's Office

Scanned images of surveys and other map documents

Scanned images of plats

1990	1991	0	0	0	325,400	0	325,400
1989	1990	0	0	0	186,000	0	186,000
1988	1989	0	0	0	93,000	0	93,000
1986	1987	0	0	0	66,900	0	66,900
1985	1986	0	0	0	58,100	0	58,100

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TTY: 206-296-7888

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PARCEL

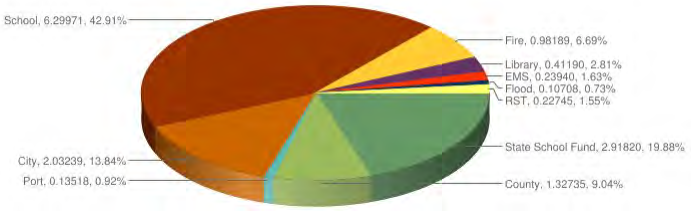
Parcel Number	030150-0280
Name	SOUTHERN FINANCIAL GRP LLC
Site Address	1450 15TH ST SW 98001
Legal	AUBURN 400 CORPORATE PARK DIV #1 POR LOTS 27 & 28 DAF - BEG NELY COR SD LOT 27 TH S 0-40-08 E ALG ELY LN THOF 263.19 FT TO TPOB TH S 89-19-52 W 209.86 FT TH S 56-24 -46 W 12.7 FT TH N 62-28-46 W 23.05 FT TH N 81-40-00 W 71.58 FT TH S 89-18-15 W 142.35 FT TH N 0- 40-08 W 111.71 FT TH N 89-19-52 E 23.89 FT TH N 0-37-14 W 126.36 FT TO SLY MGN OF 15TH ST SW TH S 89-19-52 W ALG SD SLY MGN 185.17 FT TAP OF CRV TH CONT ALG SD SLY MGN & ELY MGN OF "O" ST 39.23 FT ALG ARC OF TAN CRV TO LFT RAD 25 FT C/A OF 89-54-48 TAP OF TAN TH S 0-34-56 E ALG SD ELY MGN OF "O" ST 350.28 FT TO SWLY COR OF SD LOT 28 TH N 89-18-15 E ALG SLY LN OF SD LOT 28 640.58 FT TO SE COR OF LOT 27 TH N 0-40-08 W ALG ELY LN OF SD LOT 27 121.76 FT TO TPOB - AKA LOT A AU LLA 0012-91 REC #9107230386

BUILDING 1

Year Built	
Building Net Square Footage	
Construction Class	
Building Quality	
Lot Size	130913
Present Use	Vacant(Industrial)
Views	No
Waterfront	

TOTAL LEVY RATE DISTRIBUTION

Tax Year: 2018 **Levy Code:** 0133 **Total Levy Rate:** $14.68055 **Total Senior Rate:** $7.16161



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Click here to see levy distribution comparison by year.

TAX ROLL HISTORY

Valued Year	Tax Year	Appraised Land Value ($)	Appraised Imps Value ($)	Appraised Total ($)	Taxable Land Value ($)	Taxable Imps Value ($)	Taxable Total ($)
2017	2018	91,600	0	91,600	91,600	0	91,600
2016	2017	65,400	0	65,400	65,400	0	65,400
2015	2016	65,400	0	65,400	65,400	0	65,400
2014	2015	65,400	0	65,400	65,400	0	65,400
2013	2014	65,400	0	65,400	65,400	0	65,400
2012	2013	65,400	0	65,400	65,400	0	65,400
2011	2012	65,400	0	65,400	65,400	0	65,400
2010	2011	65,400	0	65,400	65,400	0	65,400
2009	2010	65,400	0	65,400	65,400	0	65,400
2008	2009	65,400	0	65,400	65,400	0	65,400
2007	2008	65,400	0	65,400	65,400	0	65,400
2006	2007	65,400	0	65,400	65,400	0	65,400
2005	2006	26,100	0	26,100	26,100	0	26,100
2004	2005	26,100	0	26,100	26,100	0	26,100
2003	2004	26,100	0	26,100	26,100	0	26,100
2002	2003	20,900	0	20,900	20,900	0	20,900
2001	2002	261,800	0	261,800	261,800	0	261,800
2000	2001	261,800	0	261,800	261,800	0	261,800

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Reference Links:

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- Washington State Department of Revenue (External link)
- Washington State Board of Tax Appeals (External link)
- Board of Appeals/Equalization
- Districts Report
- iMap
- Recorder's Office
- Scanned images of surveys and other map documents
- Scanned images of plats

1999	2000	244,100	0	244,100	244,100	0	244,100
1998	1999	244,100	0	244,100	244,100	0	244,100
1997	1998	0	0	0	244,100	0	244,100
1996	1997	0	0	0	244,100	0	244,100
1994	1995	0	0	0	244,100	0	244,100
1992	1993	0	0	0	21,000	0	21,000
1991	1992	0	0	0	457,300	0	457,300
1990	1991	0	0	0	457,300	0	457,300
1988	1989	0	0	0	251,300	0	251,300
1986	1987	0	0	0	180,800	0	180,800
1985	1986	0	0	0	157,000	0	157,000

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LEASE AGREEMENT

BY AND BETWEEN

GENESIS KC DEVELOPMENT, LLC ("LANDLORD")

AND

TOTAL RENAL CARE, INC. ("TENANT")

FOR SPACE AT

The intersection of O Street and 15th Street SW, King County Parcel ID #0301500090, #0301500280, and #0301500110, Auburn, Washington 98001

Dated: May 23, 2018

DATA SHEET

Landlord:	GENESIS KC DEVELOPMENT, LLC, a Delaware limited liability company
Address of Landlord:	c/o DaVita Inc. Attn: Real Estate Legal 2000 16th Street Denver, CO 80202 concurrently to: relegal@davita.com Subject: Spokane, WA DDP (Facility #TBD)
Address for Payment of Rent:	P.O. Box 1476, Tacoma, Washington 98401-1476 Attention: Rent Department concurrently to: rentdepartment@davita.com
Tenant:	TOTAL RENAL CARE, INC., a California corporation
Address of Tenant:	c/o DaVita Inc. Attn: Real Estate Legal 2000 16th Street Denver, CO 80202 concurrently to: relegal@davita.com Subject: Auburn, WA DDP (Facility #TBD)
Premises Address:	The intersection of O Street and 15th Street SW, King County Parcel ID #0301500090, #0301500280, and #0301500110, Auburn, Washington
Building Rentable Area:	approximately 11,500 rentable square feet

LEASE AGREEMENT

THIS LEASE AGREEMENT (this "Lease"), made and entered into as of the May 23, 2018 (the "Effective Date") by and between GENESIS KC DEVELOPMENT, LLC, a Delaware limited liability company ("Landlord"), and TOTAL RENAL CARE, INC., a California corporation ("Tenant").

W I T N E S S E T H:

WHEREAS, Tenant has entered into, or concurrently herewith will enter into, a ground lease (the "Ground Lease") with Southern Financial Group, LLC, a Washington limited liability company ("Ground Lessor") for that certain real property known as King County Parcel ID #0301500090, #0301500280, and #0301500110, located at the intersection of O Street and 15th Street SW in the City of Auburn (the "City"), County of King ("County"), State of Washington ("the State"), which property is more particularly described on the attached Exhibit A, together with all common areas, easements, declarations, parking areas, rights of way, and appurtenant rights thereto, including all improvements presently on the property (if any) (collectively, the "Property");

WHEREAS, Tenant intends to assign its interest in the Ground Lease to Landlord, and subject to such assignment (the "Assignment"), and Tenant's issuance of a Notice to Proceed (as defined below), Landlord desires to demise, lease and rent unto Tenant, and Tenant desires to rent and lease from Landlord, a to-be-constructed building (the "Building"), as generally shown on the attached Exhibit B, on the Property;

WHEREAS, Tenant shall lease and occupy the entire Property and Building (collectively, the "Premises") to consist of approximately 11,500 rentable square feet (the "Building Rentable Area") and including without limitation, all heating, venting, air conditioning, mechanical, electrical, elevator and plumbing systems, roofs, walls, foundations, fixtures, an overhead dock door and that certain number of non-exclusive parking spaces per rentable square foot of the Premises, including handicapped-striped spaces, as set forth in Section 23 and as may be required by applicable Laws (as defined in Section 12).

NOW, THEREFORE, for and in consideration of the mutual covenants, promises and agreements herein contained, Landlord does hereby demise, lease and rent unto Tenant and Tenant does hereby rent and lease from Landlord the Premises, under and pursuant to the following terms and conditions:

1. Demise; Premises. Landlord hereby leases to Tenant, and Tenant hereby hires from Landlord, the Premises and all easements and appurtenances related thereto, for the rents, covenants and conditions (including limitations, restrictions and reservations) hereinafter provided.

2. Term and Delivery of Premises.

2.1 **Term**. The term of this Lease shall be for 180 months (the "Term") and shall commence upon that date which is 30 days following the date that Tenant obtains the necessary certificate of occupancy from the applicable municipality for the Premises (the "Commencement Date"). The expiration date of the Term shall be the last day of the 180th month following the Commencement Date (the "Termination Date"), unless the Term is renewed in which event the Termination Date shall extend to the end of such exercised renewal period(s). Each 12 month period beginning on the Commencement Date shall hereinafter be called a "Lease Year", provided that in the event the Commencement Date does not fall on the first day of the month, the first Lease Year shall expire upon the last day of the month in which the first anniversary of the Commencement Date falls. Upon determination of the Commencement Date, Landlord shall complete, execute and forward a Commencement Date Memorandum in the form attached as Exhibit C to Tenant for Tenant's approval and execution.

2.2 **Notice to Proceed**. Notwithstanding anything to the contrary herein, all obligations of the parties hereto are contingent upon Tenant's issuance to Landlord of a written notice of its intent to commence the Lease (such notice is hereinafter referred to as the "Notice to Proceed") on or before the

date which is 24 months after the Effective Date (the "Termination Deadline"), and neither the Term nor the accrual of any obligation to pay Rent, Additional Rent, or other charges shall commence until Tenant has provided the Notice to Proceed. Tenant may terminate this Lease at any time prior to the Termination Deadline, and this Lease shall be of no further force or effect and the parties hereto shall be released from all liability under this Lease.

2.3 **Assignment of Ground Lease**. Upon issuance of the Notice to Proceed, Tenant shall assign to Landlord, and Landlord shall accept such assignment, all Tenant's rights and interest in the Ground Lease (the "Assignment"). Tenant shall provide Landlord with a reasonably acceptable Assignment and Assumption form which the parties will execute to effect the Assignment. Landlord and Tenant agree that, should any due diligence or entitlement required in connection with construction of the Premises be unsatisfactory, in Landlord's and Tenant's reasonable and mutual opinion, Landlord shall exercise its right to terminate the Ground Lease in accordance with the terms thereof. In such event, concurrently with termination of the Ground Lease, this Lease shall automatically terminate and be of no further force or effect.

2.4 **Possession Date; Delay in Delivery**. Landlord shall deliver possession of the Premises to Tenant upon substantial completion of the Landlord's Work, as defined in Section 9 below. The date on which Landlord delivers possession of the Premises to Tenant is the "Possession Date".

3. Rent. Beginning on the Commencement Date, Tenant shall pay as initial annual base rent ("Rent") $394,220.00, based on a $34.28 per rentable square foot amount for each square foot of Building Rentable Area. Tenant shall pay such Rent in monthly installments in the amount of $32,851.67, in advance, on the first day of each calendar month during the Term, such monthly installment and any Additional Rent or other charges to be prorated for any partial calendar month in which the Commencement Date or Termination Date occurs. On the fifth anniversary of the Commencement Date and each five years thereafter during the Term, the Rent shall be increased by 10% per rentable square foot over the Rent for the prior Lease Year. All amounts (unless otherwise provided herein) other than Rent and the adjustments thereto described in this Section and Section 4 below owed by Tenant to Landlord hereunder shall be deemed Additional Rent. As a condition to payment of Rent or Additional Rent, Landlord shall provide Tenant with a completed Form W-9 Request for Taxpayer Information and Certification and an executed Commencement Date Memorandum in the form attached as Exhibit C. Tenant shall have no obligation to pay Rent, Additional Rent or any other charge due under this Lease until it receives or mutually agrees upon a Commencement Date Memorandum executed by Landlord. Upon any assignment by Landlord of its rights, title and interest in and to this Lease, Landlord shall cause such successor landlord to deliver a completed Form W-9 to Tenant.

Actual rentable square footage for the Premises will be determined with all measurements computed in accordance with *Retail Buildings: Standard Method of Measurement* (ANSI/BOMA Z65.5-2010), as promulgated by The Building Owners and Managers Association International. Tenant may elect to have the space measured prior to the Commencement Date or during the first Lease Year. If the rentable square footage of the Premises is found to be greater or less than the rentable square footage shown in this Lease, then Rent and other provisions of this Lease which are based on the Building Rentable Area shall be adjusted accordingly.

Except as otherwise provided in this Lease, it is the intention of the parties that Landlord shall receive Rent, Additional Rent and all other sums payable by Tenant under this Lease free of all taxes, expenses, charges, damages and deductions of any nature whatsoever (except as otherwise provided herein). Tenant shall, however, be under no obligation to pay principal or interest on any mortgage on the fee of the Premises, penalties or interest for late or partial payment nor any income, franchise, margin, inheritance, estate,

transfer, excise, gift or capital gain taxes, that are or may be payable by Landlord or that may be imposed against Landlord or against the rents payable hereunder, or succession tax by reason of any present, future or retroactive law which may be enacted during the Term.

If Landlord does not receive any payment of Rent or Additional Rent on or before the fifth business day following the day it is due, then Tenant shall pay a late fee ("Late Fee") equal to 5% of the amount overdue, to compensate Landlord for the loss of the use of the amount not paid and the administrative costs caused by the delinquency. Notwithstanding the foregoing, Landlord will not impose a Late Fee as to the first late payment in any Lease Year, unless Tenant fails to pay the late payment to Landlord within five days after the delivery of a written notice from Landlord to Tenant demanding the late payment be paid. However, Landlord may impose a Late Fee without advance notice to Tenant on any subsequent late payment in the same Lease Year. Interest shall accrue on all sums not paid when due hereunder at the lesser of: (a) the highest rate allowed by law; or (b) an interest rate equal to the Prime Rate as published in The Wall Street Journal from time to time plus 2%, from the due date until paid; provided that interest shall not be assessed on any Late Fee.

Upon request from Tenant, Landlord shall provide to Tenant electronically, true and accurate records of items that constitute Additional Rent, including without limitation repair and replacement costs, insurance, taxes, and other "Impositions" (as defined in Section 8 below). Tenant or its duly authorized representative shall have the right to request and inspect such records from time to time for a period of two years after the close of each calendar year. If any audit of Landlord's submitted reports shall disclose an overcharge, Landlord shall promptly pay to Tenant, within 30 days, the amount of such overcharge, and if such audit discloses an overcharge of more than 5%, Landlord shall reimburse Tenant its actual costs incurred in connection with such audit. The provisions of this paragraph shall survive the termination or expiration of this Lease.

"Tenant's Proportionate Share" is 100%. In the event that new space which is not occupied by Tenant is added to the Building or additional buildings are constructed on the Property, then Tenant's Proportionate Share shall be adjusted so that it equals the quotient obtained by dividing the Building Rentable Area set forth herein by the total rentable area of the Building, including the new space and/or the total rentable area of any additional buildings constructed on the Property, as applicable (collectively, the "New Building Rentable Area") and such adjustments shall be set forth in an amendment to this Lease. The New Building Rentable Area will be determined without exclusions or reference to whether such area is actually leased, leasable, occupiable or occupied.

In addition, in the event any future development occurs on the Property ("Future Development") including, but not limited to, subdivision of the land on which the Premises are located and/or construction of new space in the Building or construction of additional buildings on the Property and the Project Costs were not prorated to exclude and/or proportionally reduce Project Costs related to any such anticipated Future Development, then upon commencement of such Future Development the parties shall enter into a mutually acceptable amendment to this Lease to reduce Rent (retroactive to the Commencement Date and through the remainder of the Term) to exclude or proportionately reduce, as applicable, Project Costs related to the Future Development. Landlord shall also enter into any amendment or other agreement necessary to ensure Tenant's continued use of and access to the Premises and to ensure Tenant's rights under this Lease are not impacted by the Future Development. Tenant shall not be responsible for any impositions related to Future Development property.

Should new space be constructed adjacent to the Premises and should Landlord lease space within the adjacent space to any tenant that materially impairs Tenant's ability to use the Premises for the Permitted Use, including but not limited to any business that involves loud noises, strong food or chemical odors, or is otherwise a nuisance, and the disruption continues for in excess of 30 days after notice to Landlord from Tenant, Tenant shall have the right to either (a) terminate this Lease, without any additional notice or cure period required under Section 17.2, upon 60 days' written notice specifying the effective date of Tenant's termination or (b) implement such control measures as it deems reasonable to isolate Tenant from such

noise, odors, or other nuisance, at Landlord's expense. Provided that if the control measures are not successful, Tenant shall again have the right to terminate this Lease. Upon such termination, Landlord shall reimburse Tenant's unamortized leasehold improvement costs and the parties shall be relieved of all further obligations under this Lease, except those that expressly survive such termination.

4. Renewals. Tenant shall have the right and option to renew this Lease for three additional periods of five years each, next immediately ensuing after the expiration of the initial Term and the subsequent renewal period by notifying Landlord in writing not more than 24 months and not less than seven months before the expiration of the immediately preceding initial Term or subsequent renewal Term of Tenant's intention to exercise its option to renew. In the event Tenant so elects to extend this Lease, then, for such extended period of the Term, all of the terms, covenants and conditions of this Lease shall continue to be, and shall be, in full force and effect during such extended period of the Term, except for the Rent. Rent for the renewal Term shall be an amount equal to 110% of the current Rent prior to such renewal.

5. Condition of Premises. Landlord warrants to Tenant, for a period of one year after the Commencement Date that the existing systems and equipment constituting will be in good order and condition (the "Warranty Period"). Tenant shall give written notice to Landlord within 60 days after expiration of the Warranty Period of any condition with the systems and equipment of the Premises which Tenant reasonably determines to be defective or other than as represented by Landlord herein. Landlord will, upon receipt of such notice from Tenant, promptly repair such defective condition, at Landlord's cost and expense. In addition, Landlord shall be responsible for repairing, at Landlord's sole cost and expense, any latent, patent or structural construction defects in the Premises that may be discovered at any time during the Term.

6. Use of Premises. Subject to the Ground Lease and all applicable Laws, Tenant may exclusively occupy and use the Premises during the Term for purposes of the operation of an outpatient renal dialysis clinic, renal dialysis home training, aphaeresis services and similar blood separation and cell collection procedures, general medical offices, clinical laboratory, including all incidental, related and necessary elements and functions of other recognized dialysis disciplines which may be necessary or desirable to render a complete program of treatment to patients of Tenant and related office and administrative uses or for any other lawful purposes not in conflict with any existing restrictions or covenants (the "Permitted Use"). Tenant may operate during such days and hours as Tenant may determine, without the imposition of minimum or maximum hours of operation by Landlord, and Tenant shall have exclusive use of and full-time access to the Premises, and may operate, up to 24 hours per day, seven days per week, year-round.

So long as no default by Tenant is continuing beyond any applicable notice and grace period, Landlord shall not sell, rent or permit any property owned, leased or controlled by Landlord or any affiliate of Landlord within a radius of five miles from the Premises to be occupied or used by a business that derives more than 10% of its revenues from renal dialysis, renal dialysis home training, any aphaeresis service(s) or similar blood separation or cell collection procedures, except services involving the collection of blood or blood components from volunteer donors. Landlord shall not display or permit to be displayed upon any such property within such radius any advertisement for any such business, other than Tenant's advertisement(s) for Tenant's business(es). Landlord further covenants that in any lease, sublease, license agreement or similar agreement hereafter executed by Landlord affecting any property owned, leased or controlled by Landlord within such radius, Landlord will insert a restrictive clause preventing such property from being used for any purposes herein prohibited. This paragraph shall survive for two years following the termination or expiration of this Lease.

7. Assignment/Subletting. Except for a Permitted Transfer (as defined below), Tenant shall not assign this Lease, or sublet the Premises, or any part thereof, without Landlord's prior written consent which consent shall not be unreasonably withheld, conditioned or delayed. Any denial by Landlord of such sublease or assignment by Tenant must be predicated upon a commercially reasonable basis for such

denial. In considering a proposed assignment or sublet and Landlord's consent thereto, it shall not be unreasonable for Landlord to consider: (i) the financial condition of the proposed assignee or subtenant as applicable, relative to the financial obligations under the Lease; (ii) the business reputation of the assignee or subtenant, as applicable; (iii) the proposed use of the Premises by the proposed assignee or subtenant, as applicable; and (iv) whether an event of default shall have occurred and be continuing as of the date on which Tenant shall request Landlord's consent to such assignment or subletting.

Except for a Permitted Transfer, prior to any sublease or assignment, Tenant shall first notify Landlord in writing of its election to sublease all or a portion of the Premises or to assign this Lease or any interest hereunder. At any time within 30 days after service of such notice, Landlord shall notify Tenant that it consents or refuses to consent to the sublease or assignment. If Landlord fails to respond within such 30 day period, Tenant shall deliver a second written notice, and a failure by Landlord to respond within ten days after such second notice shall be deemed to be a consent.

Notwithstanding the foregoing, no consent of Landlord is required for Tenant to assign, sublet or otherwise transfer (by operation of law or otherwise) this Lease or any of its rights hereunder to: (a) any person, corporation, partnership or other entity which acquires all or substantially all of the business or assets of Tenant or equity in Tenant; (b) any person, corporation, partnership or other entity which controls, is controlled by or is under common control with Tenant; (c) any affiliate (within the meaning of such term as set forth in Rule 501 of Regulation D under the Federal Securities Act of 1933, as amended) of Tenant; or (d) any physician, person, corporation, partnership or other entity subleasing a portion of the Premises for purposes consistent with Tenant's Permitted Use (each, a "Permitted Transfer").

No assignment, sublease or other transfer, in whole or in part, of any Tenant's rights or obligations under this Lease shall release Tenant hereunder and Tenant shall remain responsible for performing Tenant's obligations hereunder should Tenant's assignee, subtenant or transferee fail to perform any such obligations, unless specifically provided otherwise by Landlord in writing. Landlord shall have no right to recapture any sublease or assignment space.

8. Operating Expenses and Utilities.

8.1 Tenant shall promptly pay all real estate taxes, assessments, water and sewer charges and other governmental levies, and any applicable ownership association fees and Operating Expenses chargeable to the tenant under the Ground Lease ("Impositions") against the Premises. The amount to be paid by Tenant on account of taxes during the first and last calendar years in which any portion of the Term falls shall be prorated per diem so that Tenant is liable only for so much of such taxes as the portion of the Term which falls within such calendar year bears to a full calendar year. In case of special taxes which may be payable in installments, only the amount of each installment payable during a calendar year shall be included in taxes for that calendar year, and any one time (as opposed to on-going) special assessments for public improvements having a useful economic life exceeding the remaining term of this Lease shall be prorated between Landlord and Tenant using a straight-line method, based on the proportion of that economic life falling within the remaining Term. Taxes shall not include any penalties or interest for late or partial payment if not caused by Tenant nor any income, franchise, margin, inheritance, estate, transfer, excise, gift or capital gain taxes, that are or may be payable by Landlord or that may be imposed against Landlord or against the rents payable hereunder. Landlord shall provide to Tenant a copy of all final tax bill(s) for each calendar year within ten days after Landlord's receipt of such tax bill(s), and in any event at least 30 days before the same are due and payable.

8.2 Tenant shall pay the net cost (after applying any discounts or incentives) of all utilities and other services necessary in the operation of the Premises, including but not limited to, gas, fuel oil, electrical, telephone and other utility charges, janitorial services (if Tenant shall contract for such services) and grounds and easement maintenance (exclusive of repaving or repairs to paving). Tenant shall contract directly with all utility providers such that all utilities for the Premises shall be in Tenant's name.

8.3 Tenant may contest the amount or validity of any Imposition described in this Section by appropriate proceedings. However, Tenant shall promptly pay such Imposition unless such proceedings shall operate to prevent or stay the collection of the Imposition so contested. The Landlord, at Tenant's sole cost and expense, shall join in any such contestation proceedings if any Laws shall so require.

8.4 All sums (other than the Rent) which may be due and payable under this Lease shall be deemed to be "Additional Rent" hereunder and in the event that Rent shall be prorated or shall abate pursuant to the terms of this Lease then such Additional Rent shall be prorated or abate to the same extent and in the same manner, unless otherwise specifically provided for in this Lease.

8.5 Landlord appoints Tenant the attorney-in-fact of Landlord for the purpose of making all payments to be made by Tenant pursuant to any of the provisions of this Lease to persons other than Landlord. In case any person to whom any sum is directly payable by Tenant under any of the provisions of this Lease shall refuse to accept payment of such sum from Tenant, Tenant shall thereupon give written notice of such fact to Landlord and shall pay such sum directly to Landlord, who shall thereupon pay such sum to such person.

9. Landlord's Work. Landlord shall complete all of Landlord's Work, as described in Exhibit A-1. All Landlord's Work shall be done in a good and workmanlike manner and in compliance with all applicable Laws (as defined in Section 12), ordinances, building and safety codes, regulations and orders of the federal, state, county or other governmental authorities having jurisdiction thereof. Without in any way limiting any obligation of Landlord under this Lease, Landlord shall indemnify, defend and hold harmless Tenant from and against claims, damages, losses and expenses, including but not limited to attorneys' fees, arising out of or resulting from performance of Landlord's Work, which indemnity shall survive termination or expiration of this Lease.

10. Tenant Improvements/Signage. Tenant may construct its tenant improvements to the Premises (the "Tenant Improvements"). Landlord shall not charge Tenant a fee or other charges for the supervision and/or overhead associated with the construction of the Tenant Improvements, nor shall Landlord provide such services unless agreed to by Landlord and Tenant pursuant to a separate written agreement. Tenant Improvements shall not include the work involved with bringing electrical and water utilities to a point in the Premises designated by Tenant.

Tenant shall have the right to place a generator and biomedical waste container outside of and in close proximity to the Building at a location mutually agreed upon by Landlord and Tenant that complies with all legal requirements and minimizes expenses related thereto and if the location of the generator and biomedical waste container is known at the time of Lease execution it will be designated on the Building Site Plan attached as Exhibit B. In the event the generator is located within the Premises, Tenant, at Tenant's cost and expense, shall have the right to install exhaust venting for such generator from the interior of the Building to the outside of the Building and a transfer switch to service the generator.

To the maximum extent permitted by applicable Laws, Landlord hereby waives any rights which Landlord may have, as to any of Tenant's furniture, fixtures, equipment, personal property, tenant improvements and alterations in the nature of a landlord's lien, security interest or otherwise and further waives the right to enforce any such lien or security interest.

Tenant shall have the right to erect, affix and display such signage as Tenant may consider necessary or desirable on the exterior and interior walls, doors and windows of the Building (including directional and designated parking signage in parking areas) and a sign on the exterior of the Building and a monument sign at locations on the Building and/or related property as shall be agreed to by Landlord or at such locations as other tenants have signs located. All such signs shall comply with all applicable zoning Laws and shall be subject to applicable municipal permits. Tenant shall obtain Landlord's prior approval for signs on the exterior of the Building and each monument sign, which approval shall not be unreasonably withheld, conditioned or delayed, for the location and design of such signs.

11. Alterations. Tenant shall have the right to make such interior, non-structural alterations, additions and improvements to the Premises that it shall deem desirable for the operation of its business, without Landlord's consent, provided that any such alterations, additions or improvements shall not diminish the value of the Premises nor impair the structural integrity of the Premises or the Building ("Alterations"). Such Alterations, additions or improvements shall be in conformance to applicable governmental codes. All other Alterations shall require Landlord's prior written consent, such consent not to be unreasonably withheld, conditioned or delayed.

12. Environmental.

12.1 Tenant shall not cause or permit any hazardous or toxic substances, materials or waste, including, without limitation, medical waste and asbestos ("Hazardous Substances") to be used, generated, stored or disposed of in, on or under, or transported to or from, the Premises in violation of any applicable local, state, and federal laws, ordinances, statutes, rules, regulations, executive orders, judgments, decrees, case law and/or other determination of an arbitrator or a court or other governmental authority, in each case applicable to or binding upon such person or any of its property or to which such person or any of its property is subject (the "Laws"), whether now in existence or hereafter adopted, relating to Hazardous Substances or otherwise pertaining to the environment (the "Environmental Laws"). Tenant shall periodically cause to be removed from the Premises such Hazardous Substances placed thereon by Tenant or Tenant's agents, servants, employees, guests, invitees or independent contractors in accordance with good business practices, such removal to be performed by persons or entities duly qualified to handle and dispose of Hazardous Substances. Without limiting the generality of the foregoing, Landlord acknowledges that the following Hazardous Substances, among others, are required for Tenant's business operations: bleach, cidex, hibiclens, metricide, hydrogen peroxide and formaldehyde. Upon the expiration or earlier termination of this Lease, Tenant shall cause all Hazardous Substances placed on the Premises by Tenant to be removed from the Premises, at Tenant's cost and expense and disposed of in strict accordance with Environmental Laws.

12.2 Tenant shall indemnify, defend (by counsel reasonably acceptable to Landlord) and hold Landlord harmless, from and against any and all claims, liabilities, penalties, fines, judgment, forfeitures, losses, costs (including clean-up costs) or expenses (including reasonable attorney's fees, consultant's fees and expert's fees) for the death of or injury to any person or damage to any property whatsoever, arising from or caused in whole or in part, directly or indirectly, by (a) the presence after the Commencement Date in, on, under or about the Premises of any Hazardous Substances caused by Tenant or its agents, servants, employees, guests, invitees or independent contractors; (b) any discharge or release by Tenant or its agents, servants, employees, guests, invitees or independent contractors after the Commencement Date in or from the Premises of any Hazardous Substances; (c) Tenant's use, storage, transportation, generation, disposal, release or discharge after the Commencement Date of Hazardous Substances to, in, on, under, about or from the Premises; or (d) Tenant's failure after the Commencement Date to comply with any Environmental Law (other than to the extent caused by or related to Landlord's use, generation, storage or disposal of Hazardous Substances in, on or under the Premises). Tenant agrees to remediate at Tenant's expense immediately upon receipt of notice from Landlord any condition described in (a) through (d) of the previous sentence.

12.3 Landlord shall indemnify, defend (by counsel reasonably acceptable to Tenant) and hold Tenant harmless, from and against any and all claims, liabilities, penalties, fines, judgment, forfeitures, losses, costs (including clean-up costs) or expenses (including reasonable attorney's fees, consultant's fees and expert's fees) for the death of or injury to any person or damage to any property whatsoever, arising from or caused in whole or in part, directly or indirectly, by (a) the presence on or prior to the Commencement Date in, on, under or about the Premises, Building or the land on which the Building is located of any Hazardous Substances; (b) any discharge or release on or prior to the Commencement Date in or from the Premises or Building of any Hazardous Substances; (c) the use, storage, transportation, generation, disposal, release or discharge of Hazardous Substances by Landlord or its agents, servants, employees, guests, invitees, or independent contractors to, in, on, under, about or from the Premises,

Building or the land on which the Building is located; (d) Landlord's failure to comply with any Environmental Law (other than to the extent caused by or related to Tenant's use, generation, storage or disposal of Hazardous Substances in, on or under the Premises); or (e) any Hazardous Substances to the extent not due to any act or omission of Tenant or its agents, servants, employees, guests, invitees or independent contractors. Landlord agrees to remediate, at Landlord's cost and expense, immediately upon receipt of notice from Tenant any condition described in (a) through (e) of the previous sentence. The indemnities set forth in this Section 12 shall survive termination or expiration of this Lease.

12.4 Landlord represents and warrants to Tenant that (a) to the best of Landlord's knowledge, there are no Hazardous Substances in, on, under or about the Premises, Building or the land on which the Building is located, including without limitation asbestos or mold, and (b) Landlord has received no notice from any governmental or private entity relating to Hazardous Substances in, on, under or about the Premises, Building or the land on which the Building is located.

12.5 Tenant shall promptly deliver to Landlord copies of all notices made by Tenant to, or received by Tenant from, any state, county, municipal or other agency having authority to enforce any Environmental Law or from the United States Occupational Safety and Health Administration ("Enforcement Agency") concerning environmental matters or Hazardous Substances at the Premises, Building or the land on which the Building is located. Landlord shall promptly deliver to Tenant copies of all notices received by Landlord from any Enforcement Agency concerning environmental matters or Hazardous Substances at the Premises, Building or the land on which the Building is located.

13. Damage to Premises by Fire or Casualty. In the event the Premises shall be damaged by fire or other casualty during the Term, then:

13.1 if the damage to the Premises is so substantial that either: (a) the repair, restoration or rehabilitation of such damage cannot reasonably be expected to be substantially completed within 180 days from the date of such damage or (b) so much of the Premises is destroyed or rendered untenantable by such fire or other casualty as to make use of the Premises as a dialysis facility operating at least 50% of the dialysis stations operating prior to the fire or casualty impracticable, then Tenant may elect to terminate this Lease by giving written notice to Landlord within 30 days of the date of such fire or casualty; or

13.2 if (a) the damage to the Premises is so substantial that the estimated repair costs exceed $100,000.00 and such damage has occurred within the final 180 days of the then current Term and Tenant has not exercised its next available renewal option, if any or (b) the Building is damaged to the extent of 50% or more of the monetary value thereof, then Landlord may elect to terminate this Lease by giving written notice to Tenant within 30 days of the date of such fire or casualty.

If not so terminated, Landlord shall proceed with all due diligence to repair, restore or rehabilitate the Premises, to substantially its former condition immediately prior to such damage or destruction, at Landlord's cost and expense, in which latter event this Lease shall not terminate.

If the Premises are rendered untenantable by fire or other casualty, there shall be an abatement of Rent and Additional Rent due Landlord by Tenant for the period of time during which the Premises is untenantable. If the restoration is not substantially completed within 210 days of such damage, Tenant shall have the option to terminate this Lease by written notice to Landlord; provided, however, if the restoration is substantially completed prior to the date Tenant delivers any such termination notice, then the termination notice shall be null and void, and this Lease shall continue in effect. In the event of any termination of this Lease, Rent and Additional Rent shall be paid only to the date of such fire or casualty.

In the event that the Premises are partially but not substantially damaged by fire or other casualty, then Landlord shall immediately proceed with all due diligence to repair and restore the Premises and Rent and

Additional Rent shall abate in proportion to that portion of the Premises that is untenantable during the period of restoration.

Notwithstanding the foregoing provisions of this Section 13, in the event regulatory changes occurring on or after the Effective Date, applicable to Tenant's business, require changes to the Premises, including but not limited to the common areas and parking areas, or the Building in order for Tenant to continue operating its business, then if Landlord proceeds to repair the Premises, Landlord shall incorporate such changes into the repair and restoration of the Premises. Additionally, in the event that insurance proceeds applicable to Alterations or Tenant Improvements constructed by Tenant at its expense are made available to Tenant, Tenant shall be responsible for restoring such Alterations or Tenant Improvements; provided, however, that Rent and Additional Rent abatement shall continue during such period of restoration so long as Tenant is diligently pursuing the completion of such restoration, but in no event for a period longer than ten months following substantial completion of Landlord's repairs and restoration. In the event that Landlord does not restore the Premises, Tenant may retain all insurance proceeds applicable to Alterations and Tenant Improvements constructed by Tenant at its expense. Landlord shall be responsible for restoring improvements constructed by Landlord in all events and Tenant shall be responsible for restoring improvements constructed by Tenant in all events.

14. Eminent Domain.

14.1 **Taking**. If by any lawful authority through condemnation or under the power of eminent domain: (a) the whole of the Premises shall be permanently taken; (b) less than the entire Premises shall be permanently taken, but the remainder of the Premises are not, in Tenant's sole judgment, fit for Tenant to carry on the normal operation of Tenant's business therein; (c) Tenant determines, in its reasonable judgment, that after such taking adequate parking space will not be available near the Premises; (d) there is any substantial impairment of ingress or egress from or to or visibility of the Premises; or (e) all or any portion of the common areas shall be taken resulting in a material interference with the operations of or access to Tenant's business, then in any such event, Tenant may terminate this Lease by written notice, effective as of the date of such taking, and Rent and Additional Rent shall be prorated as of the date of such termination.

14.2 **Rent Adjustment**. Unless this Lease is terminated as provided in Section 14.1, commencing on the date possession is acquired by a condemning authority, Rent and Additional Rent shall be reduced by the then applicable per rentable square foot Rent and Additional Rent multiplied by the number of rentable square feet taken, and Landlord shall restore the Premises, including but not limited to the common areas and parking areas, at Landlord's cost and expense, to a complete architectural unit. During such period of restoration Rent and Additional Rent shall be abated to the extent the Premises are rendered untenantable.

14.3 **Awards**. Subject to the rights of Ground Lessor, if any, all compensation awarded or paid in any such eminent domain proceeding shall belong to and be the property of Landlord without any participation by Tenant, except that nothing contained herein shall preclude Tenant from prosecuting any claim directly against the condemning authority in such eminent domain proceeding for its relocation costs, its unamortized leasehold improvements and trade fixtures, loss of business and the like provided that any such award to Tenant shall not reduce the award otherwise payable to Landlord.

15. Right of Entry by Landlord. Subject to Landlord's obligations under Section 33, Landlord, or any of its agents, shall have the right to enter the Premises during all reasonable hours and upon at least 24 hours prior notice (except in cases of emergency) to perform its obligations under this Lease, examine the Premises or, in the six month period immediately preceding the Expiration Date, to exhibit the Premises to potential tenants. Any work done by Landlord to Premises shall be performed during hours that Tenant is not open for business (except in emergencies) unless Tenant, in the exercise of its reasonable discretion, otherwise agrees. Any restoration work or alteration work at the Premises which is necessitated by or results from Landlord's entry, including, without limitation, any work necessary to conceal any element

whose presence is permitted hereunder, shall be performed by Landlord at its expense or, at Tenant's election, by Tenant on Landlord's behalf and at Landlord's cost and expense. Landlord shall be liable for all loss, damage or injury to persons or property and shall indemnify and hold Tenant harmless from all claims, losses, costs, expenses and liability, including reasonable attorney's fees resulting from Landlord's entry except to the extent caused by the negligent or intentional act of Tenant or its contractors, agents, employees or licensees. In the exercise of Landlord's rights pursuant to this Section, Landlord shall make all reasonable efforts to minimize interference with Tenant's operations. If Landlord's entry into the Premises interferes with the conduct by Tenant of its business to such an extent that Tenant, in the exercise of its reasonable business judgment, must close the Premises or is unable to use 75% of the Premises for business for three or more days, then Rent and Additional Rent shall totally abate for each day or portion thereof that such interference continues.

Landlord acknowledges that Tenant is subject to the provisions of the Health Insurance Portability and Accountability Act of 1996 and related regulations ("HIPAA") and in order for Tenant to comply with HIPAA, Tenant must restrict access to the portions of the Premises where patient medical records are kept or stored. Landlord hereby agrees that, notwithstanding the rights granted to Landlord pursuant to this Lease including this Section, except when accompanied by an authorized representative of Tenant, neither Landlord nor its employees, agents, representatives or contractors shall be permitted to enter those areas of the Premises designated by Tenant as locations where patient medical records are kept and/or stored or where such entry is prohibited by applicable state or federal health care privacy Laws. Landlord further agrees to comply with the provisions of HIPAA and all applicable medical privacy Laws in connection with Landlord's entry into the Premises.

16. Indemnity. Tenant agrees to indemnify Landlord and save Landlord harmless from any and all liability, claims and loss for personal injury or property damage, or both, sustained or claimed to have been sustained by any person or persons, or property in, upon or about the Premises caused or brought about by the act or neglect of Tenant or its agents, servants or employees. Landlord agrees to indemnify Tenant and save Tenant harmless from any and all liability, claims and loss for personal injury or property damage, or both, sustained or claimed to have been sustained by any person or persons, or property in, upon or about the Premises caused or brought about by the act or neglect of Landlord or its agents, servants or employees. The indemnities set forth in this Section 16 shall survive termination or expiration of this Lease.

17. Default and Remedies.

17.1 **Tenant Default and Landlord Remedies**. In the event that (a) Tenant defaults in the payment of Rent or Additional Rent hereunder and such Rent or Additional Rent remains due and unpaid for five business days following written notice of such default from Landlord to Tenant; (b) Tenant defaults in the performance of any other provisions of this Lease and such default is not cured within 30 days following written notice from Landlord specifying such default (unless such default is not reasonably capable of being cured within such 30 day period and Tenant is diligently prosecuting such cure to completion); (c) a petition in bankruptcy is filed by or against Tenant (provided Tenant shall have 90 calendar days to stay any involuntary proceeding); (d) Tenant makes an assignment for the benefit of its creditors, or a receiver is appointed for Tenant and such receiver is not dismissed within 60 days of its appointment; (e) Tenant enters into an assignment or sublet in violation of Section 7; (f) Tenant fails to respond to Landlord's second written request for a subordination agreement in accordance with and subject to the terms of Section 24 below; or (g) Tenant fails to respond to Landlord's second written request for an estoppel certificate in accordance with and subject to the terms of Section 28 below, then, in any of these events, Landlord may, at its option (x) proceed for past due installments of Rent or Additional Rent, reserving its right to proceed later the remaining installments when due; or (y) declare the rights of Tenant under this Lease terminated and, thereafter, recover possession of the Premises through legal process. Notwithstanding the remedy Landlord may seek, the foregoing cure periods shall be applicable.

Upon and after termination of this Lease, Tenant shall pay to Landlord the Rent up to the time of such termination, in addition to any amounts payable by Tenant to Landlord pursuant to the immediately following paragraph. Landlord shall make a commercially reasonable effort to mitigate its damages and relet the Premises or any part thereof to any person, firm or corporation other than Tenant for such rent, for such time and upon such terms as Landlord in Landlord's reasonable discretion shall determine.

In the event of any such termination, Landlord may: (A) choose to have Tenant remain liable for, and pay on the days originally fixed for such payment hereunder, the full amount of all Rent and Additional Rent as if this Lease had not been terminated; provided, however, if Landlord relets the Premises there shall be credited against such obligation the amount actually received by Landlord as a result of such reletting after deducting all costs and expenses incurred by Landlord in connection with reletting the Premises including, without limitation, all repossession costs, brokerage commissions, legal expenses, reasonable attorneys' fees, alteration costs and expenses of preparation for such reletting; or (B) demand Tenant pay to Landlord on such demand, as and for liquidated and agreed damages for Tenant's default, the present value (based on a discount rate then established by the Federal Reserve closest to the Premises) of the amount by which the aggregate Rent that would have been payable under this Lease by Tenant from the date of such termination until what would have been the last day of the Term but for such termination exceeds the fair market rental value of the Premises for the same period.

17.2 **Landlord Default and Tenant Remedies**. Subject to the terms and provisions below, and in addition to any other remedy expressly available to Tenant pursuant to this Lease or at law or in equity, should Landlord fail to perform any term or covenant under this Lease (each and any such failure, a "Landlord Default") and if any such Landlord Default is not cured and continues for 30 days (unless a shorter notice and cure period is expressly provided herein, in which case such shorter period shall govern) following written notice by Tenant to Landlord (and to any "Mortgagee" (as defined in Section 24 below) that has delivered written notice to Landlord requesting notice of a Landlord Default and a right to cure) of such Landlord Default (unless a different period is expressly provided for in any other provision of this Lease or such default is not reasonably capable of being cured within such expressed period and Landlord or Mortgagee is diligently prosecuting such cure to completion, but in no event to extend beyond 90 days), then Tenant shall have the option, (at Tenant's sole discretion), of (a) remedying such Landlord Default and, in connection therewith, incurring expenses for the account of Landlord, and any and all such sums expended or obligations incurred by Tenant in connection therewith shall be paid by Landlord to Tenant upon demand, and if Landlord fails to immediately reimburse and pay same to Tenant, Tenant may, in addition to any other right or remedy that Tenant may have under this Lease, deduct such amount (together with interest thereon at the maximum rate permitted by applicable Law from the date of any such expenditure by Tenant until the date of repayment thereof by Landlord to Tenant) from subsequent installments of Rent and Additional Rent that from time to time become due and payable by Tenant to Landlord hereunder. In all events Tenant shall have the right to remedy any Landlord Default without prior notice in the event of an emergency (so long as Tenant gives notice within a reasonable period of time thereafter) and invoice Landlord and abate Rent and Additional Rent in the manner set forth in the preceding sentences of this Section 17.2.

If Landlord is or becomes a Referral Source, as defined in Section 31, and if this Lease is terminated for any reason before the first anniversary of the Commencement Date, then Landlord and Tenant shall not enter into any similar lease agreement with each other for the Premises or substantially similar space before the first anniversary of the Commencement Date.

18. Insurance.

18.1 **Landlord's Insurance**. During the Term, Landlord shall procure and maintain in full force and effect with respect to the Premises (a) a policy or policies of property insurance (including, to the extent required by Tenant, any holder of any fee or leasehold mortgage, or to the extent Landlord reasonably deems prudent, sprinkler leakage, vandalism, malicious mischief, earthquake, terrorism and flood insurance coverage) for full replacement value; and (b) a policy of commercial liability insurance in a

minimum amount of $1,000,000.00 per occurrence and $3,000,000.00 in the aggregate for both bodily injury and property damage insuring Landlord's activities with respect to the Premises and the Building for loss, damage or liability for personal injury or death of any person or loss or damage to property occurring in, upon or about the Premises or the Building. Tenant shall reimburse Landlord for the commercially reasonable cost of such insurance, not to exceed the cost of insurance premiums charged by third party commercial providers, as Additional Rent. Any additional insurance obtained by Tenant shall be at Tenant's sole cost and expense.

18.2 **Tenant's Insurance**. Tenant shall obtain and keep in force with respect to the Premises and Tenant's use thereof commercial general liability insurance in a minimum amount of $1,000,000.00 per occurrence and $3,000,000.00 in the aggregate for both bodily injury and property damage. Tenant covenants and agrees to keep Tenant Improvements and Tenant's contents in the Premises insured for full replacement value, under a Special Form 'All Risk' policy. In no event shall Tenant's insurance provide coverage or indemnity to Landlord for any claim, loss, suit, action or other legal proceeding in which Landlord or its agents, servants, employees, guests, invitees or independent contractors bear responsibility. Rather, it is the intent of this Section to provide general liability coverage to Landlord, as an additional insured, when it is made a party to a claim, loss, suit, action or other legal proceeding for which it bears no responsibility. In the event that both Landlord and Tenant bear responsibility for the claim, loss, suit, action or other legal proceeding, then each party will look to its own insurance for coverage. Tenant may carry any insurance required by this Lease under a blanket policy or under a policy containing a self-insured retention.

18.3 **General Requirements**. All policies of insurance required to be carried under this Lease by Landlord shall be written by companies rated A- VII or better in Best's Key Rating Guide. Upon request, Landlord and Tenant shall each furnish to the other party a certificate evidencing the insurance required to be maintained pursuant to this Lease. Tenant and Landlord shall endeavor to give to any party listed as an additional insured 30 days written notice prior to any cancellation of the policy. If Tenant fails to procure and maintain insurance as required by this Lease, Landlord may obtain that insurance and keep it in effect. If Landlord procures insurance on Tenant's behalf, then Tenant shall pay to Landlord the premium cost for that insurance, upon demand and as Additional Rent.

19. Subrogation. Each of the parties hereto hereby releases the other and the other's partners, agents and employees, to the extent of each party's property insurance coverage, from any and all liability for any loss or damage which may be inflicted upon the property of such party even if such loss or damage shall be brought about by the fault or negligence of the other party or its partners, agents or employees; provided, however, that this release shall be effective only with respect to loss or damage occurring during such time as the appropriate policy of insurance shall contain a clause to the effect that this release shall not affect said policy or the right of the insured to recover thereunder. If any policy does not permit such a waiver, and if the party to benefit therefrom requests that such a waiver be obtained, the other party agrees to obtain an endorsement to its insurance policies permitting such waiver of subrogation if it is commercially available and if such policies do not provide therefor. If an additional premium is charged for such waiver, the party benefiting from the waiver, if it desires to have the waiver, agrees to pay to the other the amount of such additional premium promptly upon being billed therefor.

20. Maintenance Responsibilities.

20.1 **Landlord Maintenance Responsibilities**. Landlord shall keep the roof and structural components of the Building in good order and repair at Landlord's sole cost and expense. Landlord shall make any replacements to the parking lot (and any components thereof), roof and HVAC system (collectively "Capital Items") if necessary, during the Term. Tenant shall reimburse Landlord the reasonable actual costs of the Capital Items on an amortized basis, as more fully described in Section 20.3 below.

If Landlord shall not commence the foregoing repairs within the 15 days following written notice from Tenant that such repairs are necessary, and if Tenant's use of the Premises is materially and adversely affected by the need for such repairs, then Tenant may, at its option, cause such Landlord's repairs to be made and shall furnish Landlord with a statement of the cost of such repairs upon substantial completion thereof. Landlord shall reimburse Tenant for the reasonable and actual cost of such repairs plus a service charge to cover Tenant's expenses in an amount equal to 10% of the cost of such repairs within ten days of the date of the statement from Tenant setting forth the amount due, provided, however, should Landlord fail to reimburse Tenant with said ten day period, then Tenant may, at its option, offset such amount against subsequent Rent and Additional Rent due under this Lease.

20.2 **Tenant Maintenance Responsibilities**. Except for Landlord's obligations set forth above and except for any damage caused by the acts of negligence by Landlord or its agents within the Premises, Tenant shall maintain said Premises, including the HVAC system serving the Premises, and parking areas, in good condition, order and repair as they are at the commencement of the Term, excepting therefrom ordinary wear and tear arising from the use thereof and damage by fire or other casualty. Tenant shall maintain a contract for the routine and periodic maintenance and regular inspection of such HVAC systems servicing the Premises, the replacement of filters as recommended and the performance of other recommended periodic servicing in accordance with applicable manufacturer's standards and recommendations.

20.3 **Amortized Basis**. "Amortized basis" shall mean allocation of the subject cost over the useful life of the capital item, as determined under GAAP, with a return on capital at the then current market rate per annum on the unamortized balance or at such lower rate as may have been actually paid by Landlord on funds borrowed for the purpose of making such repairs or replacements, and only the annual amortized amount shall be the amount Tenant is required to reimburse Landlord during each Lease Year. The "useful life" for purposes of replacements of the roof, roof membrane, or roof covering shall be 20 years, and for purposes of replacements of the Building's HVAC it shall be 15 years. The "useful life" for all other items shall be determined in accordance with generally accepted accounting principles consistently applied.

21. Emergency. If Landlord is unable or unwilling to take action which it is obligated to take hereunder where an emergency has occurred with respect to the Premises, then Tenant may take such action as is reasonably necessary to protect the Premises and persons or property in the Premises and Landlord shall, within 15 days after written notice thereof from Tenant reimburse Tenant for its reasonable out-of-pocket expenses incurred in curing such emergency; provided, however, should Landlord fail to reimburse Tenant within the 15 day period, then Tenant may, at its option, offset such amount against Rent and Additional Rent due under this Lease.

22. Title and Parking. Landlord hereby represents to Tenant that Landlord is (or will be as of the Possession Date) the owner in fee simple of the Premises, including the Building and all improvements thereon and has the right and authority to enter into this Lease. Landlord further represents that Landlord and those signatories executing this Lease on behalf of Landlord have full power and authority to execute this Lease.

Landlord agrees that Landlord shall not make any material modifications to the Premises (including, without limitation, the parking areas, driveways and walks) without Tenant's prior written consent, such consent not to be unreasonably withheld, conditioned or delayed. Tenant shall be entitled to the exclusive use of the parking stalls located within the Premises, and the non-exclusive use of the parking area within the Common Areas of the Center (as defined in the Ground Lease), in accordance with a parking ratio as may be required by local code, including handicapped parking spaces.

23. Compliance with Laws. Both parties shall comply with all applicable Laws throughout the Term. Landlord represents and warrants to Tenant that as of the Possession Date the Premises, the Building and the parking areas are in compliance with the Ground Lease and with all Laws, including, without limitation, applicable zoning Laws and with all applicable instruments affecting title to the Premises. Landlord further represents that it has received no notices or communications from any public authority having jurisdiction alleging violation of any Laws relating to the Premises, the Building, or the common areas and has received no notices alleging violation of any title instrument. Without limiting the generality of the foregoing, Landlord represents and warrants that as of the Commencement Date (a) the use of the Premises and the Building and improvements thereon for purposes of operation of a dialysis clinic and related medical and business offices is permitted by and will not violate private restrictions or applicable Laws, including without limitation zoning Laws, and does not constitute a "non-conforming use" thereunder, or if such use is a "non-conforming use" thereunder then such use is permitted pursuant to a conditional use permit or other variance issued by the appropriate governmental agency or authority, (b) the Premises, the Building, and the parking areas comply with all applicable Laws relating to handicapped accessibility, including, without limitation, the Americans with Disabilities Act (ADA) of 1990, as amended, 42 U.S.C. §§12101 *et seq.* (1990), and (c) the Building enjoys, and Landlord will provide for the Term, ingress and egress from the parking area to the adjoining public streets and highways.

If at any time or from time to time any alterations, including, without limitation, structural alterations, are required in order for the Premises or Building or parking areas to comply with any generally applicable Laws from time to time applicable to the Premises, Landlord shall immediately make such alterations at its sole cost and expense. If at any time or from time to time any alterations, including, without limitation, structural alterations, are required in order for the Premises to comply with any Laws specifically applicable to the Premises due to Tenant's use as a dialysis facility and not due to any act by Landlord, Tenant shall immediately make such alterations, at its sole cost and expense.

24. Tenant to Subordinate. Tenant shall, upon written request of the holder of a mortgage or deed of trust in the nature of a mortgage, which holder is a commercial or institutional lender, on the Premises ("Mortgagee") subordinate any interest which it has by virtue of this Lease, and any extensions and renewals thereof to any mortgages or deeds of trust placed upon the Premises by Landlord, if and only if such Mortgagee shall execute, deliver and record in the appropriate registry of deeds a recognition and non-disturbance agreement in form and content substantially similar to Exhibit D or such other commercially reasonable form as may be agreed upon by the parties. Tenant shall respond to any such requests within 15 business days following receipt of the Mortgagee's written request. If Tenant fails to respond within such initial 15 business day period, then Landlord may deliver a second written request, and if Tenant fails to respond within ten business days following receipt of the second written request, such failure shall be a default under this Lease, provided that Landlord's second notice states in bolded and capitalized font that a failure to respond within ten business days of receipt is the basis for a default under the Lease. Such agreements shall provide by their terms that notwithstanding any foreclosure of such mortgage or deed of trust Tenant may continue to occupy the Premises during the Term or any extensions or renewals thereof under the same terms, conditions and provisions of this Lease unless Tenant shall be in default beyond any applicable grace periods provided for herein. Landlord shall, at or prior to the Commencement Date, secure from Landlord's present Mortgagee of the Premises a non-disturbance agreement in a form reasonably acceptable to Tenant. Landlord shall also secure from any future Mortgagee or lienholders of Landlord non-disturbance agreements during the Term. If Landlord shall not obtain such non-disturbance agreement, then this Lease shall not be subordinate to any such future lien, mortgage, or refinancing.

25. Quiet Enjoyment. Tenant shall, upon payment of the Rent and Additional Rent, subject to all applicable notice and cure periods and subject to all of the terms and covenants of this Lease, on Tenant's part to be kept, observed and performed, shall quietly have and enjoy the Premises during the Term. Landlord agrees that Tenant shall have continuous, peaceful, uninterrupted and exclusive possession and quiet enjoyment of the Premises during the Term.

26. Memorandum of Lease. Landlord agrees to enter into and have recorded a recordable memorandum or notice of this Lease in the form attached as Exhibit F or in form otherwise reasonably satisfactory to Tenant upon Tenant's written request. Tenant shall be responsible for the preparation thereof, recording and the cost of recording the same.

27. Notices. All notices, demands and requests which may be or are required to be given by either party to the other shall be in writing and shall be either (a) sent by registered or certified mail, return receipt requested, postage prepaid, (b) delivered, by hand, or (c) sent by overnight courier such as Federal Express. All notices to Landlord should be addressed to Landlord at c/o DaVita Inc., Attention: Real Estate Legal, 2000 16th Street, Denver, CO 80202, Telephone: (303) 405-2100; concurrently to: relegal@davita.com, Subject: Spokane, WA DDP (Facility #TBD), or at such other place as Landlord may from time to time designate in written notice to Tenant. All notices to Tenant shall be addressed to Tenant c/o DaVita Inc., Attention: Real Estate Legal, 2000 16th Street, Denver, CO 80202, Telephone: (303) 405-2100, concurrently to: relegal@davita.com, Subject: AuburnWA DDP (Facility #TBD) or to any such other place as Tenant may from time to time designate in written notice to Landlord. In addition, all correspondence to Tenant related to Taxes, Insurance, Rent or Additional Rent shall be sent to P.O. Box 1476, Tacoma, WA 98401-1476; Attention: Rent Department, concurrently to: rentdepartment@davita.com. All notices, demands and requests which shall be served upon Landlord and Tenant in the manner aforesaid shall be deemed sufficiently served or given for all purposes hereunder. Notwithstanding anything contained in this Lease to the contrary, any written notice by either Landlord or Tenant to the other party may be transmitted by facsimile or electronic transmission, and that the facsimile or electronic copies of such party's signature shall have the same effect as if it were an original signature, provided that the party providing such notice obtains a confirmation page or delivery confirmation email and further provided that within three business days after the electronic transmission of any such notice, Landlord or Tenant shall execute and deliver to the other party an original copy of the notice via one of the methods provided in this Section.

28. Estoppel Certificate. Each of Landlord and Tenant agrees at any time and from time to time upon not less than 15 business days' prior written request by the other to execute, acknowledge and deliver to the other an estoppel certificate in the form attached as Exhibit E certifying that (a) this Lease is unmodified and in full force and effect (or if there have been modifications that the same is in full force and effect as modified and stating the modifications), (b) the dates to which Rent and other charges have been paid in advance, if any, (c) all of the defaults of Landlord or Tenant hereunder, if any, (and if there are no defaults a statement to that effect), and (d) any other information reasonably requested, it being intended that any such estoppel certificate delivered pursuant to this Section may be relied upon by any prospective purchaser of the Premises or any mortgagee or assignee of any mortgage upon the fee or leasehold of the Premises or by any prospective assignee of this Lease or subtenant of the whole or any portion of the Premises and/or by other party interested in the Premises or any part thereof. If either party fails to execute, acknowledge and deliver an estoppel certificate within 15 business days following its receipt of the initial written request, as required in this Section, the requesting party may send a second written request, and if the recipient party shall thereafter fail to execute, acknowledge and deliver the estoppel certificate within ten business days following receipt of the second request, such failure shall be a default under this Lease, provided that the second notice states in bolded and capitalized font that a failure to respond within ten business days of receipt is the basis for a default under the Lease.

29. Landlord's Sale of the Building. Landlord may, at any time, without the prior consent of Tenant, contract to and/or perform any of the following transactions with respect to an interest in Landlord, the Lease, the Premises, the realty underlying the Premises, and/or any portion of or interest in the realty or improvements owned or hereafter acquired by Landlord: sale, purchase, exchange, transfer, assignment, lease, conveyance (collectively referred to herein as "Sale"); and/or encumbrance, pledge, mortgage, deed of trust, hypothecation or sale and leaseback transaction (collectively referred to herein as "Mortgage"). Any "For Sale" sign placed by Landlord on the land outside the Building shall be a professionally made sign of a reasonable size that does not interfere with the visibility of any of Tenant's signage. From and after a Sale, Landlord shall be released from all liability to Tenant and Tenant's successors and assigns arising

from this Lease because of any act, occurrence or omission of Landlord occurring after such Sale, and Tenant shall look solely to Landlord's successor in connection with the same; provided, however, that Landlord shall not be released from liability to Tenant and Tenant's successors and assigns from this Lease because of any act, occurrence or omission of Landlord occurring prior to such Sale, unless such liability is expressly assumed by Landlord's successor-in-interest in the Building and Premises. Within 30 days following the effective date of a Sale, Landlord shall notify Tenant whether Landlord's successor-in-interest and assignee to this Lease would or would not be a Referral Source as described in Section 31. Upon any Sale entered into between Landlord and an unaffiliated third party, any lease or other arrangement entered into between Landlord's successor and a competitive business prior to the effective date of the Sale that would otherwise be a violation of the terms of Section 31 shall not be deemed a violation of the restrictions set forth therein if entered into prior to the effective date of the Sale.

30. Tenant's Satellite and Cable Rights. Tenant shall have the right to place a satellite dish on the roof and run appropriate electrical cabling from the Premises to such satellite dish and/or install cable service to the Premises at no additional fee, provided all such work shall be performed in accordance with all applicable Laws and so as not to invalidate any then effective roof warranty for the Building. Landlord shall reasonably cooperate with Tenant's satellite or cable provider to ensure there is no delay in acquiring such services. Tenant shall also have the right to run appropriate electrical cabling from the Premises to connect its electrical generator and associated transfer switch. Tenant shall be responsible for any damage to the roof caused by Tenant's installation or removal of any such satellite dish or cabling.

31. Regulatory Compliance. Landlord represents and warrants to Tenant that Landlord is not a "referring physician" or a "referral source" as to Tenant for services paid for by Medicare or other federal or state health care programs, as the terms are defined under any federal or state health care anti-referral or anti-kickback regulation, interpretation or opinion ("Referral Source"). Landlord covenants, during the Term, it will not transfer the Premises to any individual or entity who is a Referral Source as to Tenant without complying with all other provisions of this Lease.

Landlord represents and warrants that: (i) it is not currently excluded from participation in any federal health care program, as defined under 42 U.S.C. §§1320a-7b; (ii) it is not currently excluded, debarred, suspended or otherwise ineligible to participate in Federal procurement or non-procurement programs; and (iii) it has not been convicted of a criminal offense that falls within the scope of 42 U.S.C. §§ 1320a-7(a) (each of (i), (ii) and (iii), an "Exclusion"). Landlord will notify Tenant within two business days of learning of any Exclusion or any basis that may give rise to an Exclusion. In the event of an Exclusion, Tenant may immediately terminate this Lease without further liability. Tenant may screen Landlord against applicable Exclusion databases on an annual basis.

If Landlord or Landlord's successor becomes a Referral Source during the Term, the following Section 31.1 through 31.3 will apply, but will have no effect until that time:

31.1 **Lease Unrelated to Referrals**. It is not the purpose of this Lease to exert any influence over the reason or judgment of any party with respect to the referral of patients or other business between Landlord and Tenant. Rather, any referrals made between the parties will be based solely upon the medical judgment and discretion of the patient's physician.

Landlord and Tenant further agree and acknowledge that: (a) Base Rent is (i) set forth in advance; (ii) consistent with fair market value in an arms-length transaction; (iii) does not take into account the volume or value of any referrals or other business generated between the parties; and (iv) would be reasonable even if no referrals were made between the parties; (b) Tenant's Proportionate Share does not exceed Tenant's pro-rata share of expenses; and (c) the Premises Rentable Area does not exceed the reasonable square footage needed for the legitimate business plans of Tenant.

31.2 **Compliance with Law**. The parties enter into this Lease with the intent of conducting their relationship in full compliance with applicable laws, including the Anti-Kickback Statute, and agree and

certify that neither party will violate the Anti-Kickback Statute in performing under this Lease. Notwithstanding any unanticipated effect of any provisions of this Lease, neither party will intentionally conduct itself under the terms of this Lease in a manner that violates any such law. Landlord agrees not to request an advisory opinion related to the legality of this Lease without the approval of Tenant. If a change in applicable health care laws or reimbursement systems affects the legality of this Lease, Tenant may terminate this Lease. Landlord shall notify Tenant of, and cooperate with, any request from a duly authorized government representative (e.g., Secretary of HHS, Comptroller General) for access to books, documents and records related to this Lease. Landlord will indemnify Tenant from any liability arising out of Landlord's refusal to cooperate.

31.3 **Covered Person; Additional Requirements**. A "Covered Person" means any: (i) individual or entity who (a) provides patient care items or services on behalf of DaVita Dialysis, or (b) performs billing or coding functions on behalf of DaVita Dialysis; (ii) DaVita Dialysis domestic dialysis joint venture partner; or (iii) medical director for any domestic DaVita Dialysis clinic.

If Landlord, its members, partners, shareholders or trustees is or becomes a Covered Person during the Term, the following provisions will apply:

A. Tenant shall provide the Covered Person a copy of, or access to, Tenant's applicable code of conduct (the "Code of Conduct") and relevant policies and procedures (the "Policies and Procedures") designed to ensure compliance with this Section 31.3 and relevant Federal health care program requirements.

B. Upon notification by Tenant, the Covered Person shall: (i) participate in all Tenant-required compliance training, including online general compliance training, on an annual basis; (ii) complete all training within the timeframes required by Tenant; (iii) comply with the Policies and Procedures and Code of Conduct; and (iv) certify in writing or electronic form that the Covered Person read, understood and shall abide by the Code of Conduct and return the certification to Tenant within 30 days after receiving notice.

C. The Covered Person shall report immediately to Tenant any suspected or known violations of Tenant's policies and procedures or of any violation of applicable federal healthcare program laws and regulations.

32. Cooperation with Tenant's Cost Reporting Responsibilities. Landlord's full cooperation with applicable authorities in connection with cost reporting is essential for Tenant's continued operation of its business. Therefore, Landlord agrees to provide to Tenant, within 30 days of Tenant's request, any and all information that is reasonably necessary for Tenant to fulfill its cost reporting requirements to such applicable authorities.

33. Protected Health Information.

33.1 Landlord acknowledges and agrees that from time to time during the Term, Landlord and/or its employees, representatives or assigns may be exposed to, or have access to, Protected Health Information ("PHI"), as defined by HIPAA, 45 CFR Parts 160 and 164. Landlord agrees that it will not use or disclose, and Landlord shall cause its employees, or assigns not to use or disclose, PHI for any purpose unless required by a court of competent jurisdiction or by any governmental authority in accordance with the requirements of HIPAA and all other applicable medical privacy Laws.

33.2 Landlord shall preserve, and cause any of its employees, agents and representatives to preserve, any "Confidential Information" of or pertaining to Tenant and shall not, without first obtaining Tenant's prior written consent, disclose to any person or organization, or use for its own benefit, any Confidential Information of or pertaining to Tenant during and after the Term, unless such Confidential Information is required to be disclosed by a court of competent jurisdiction or by any

governmental authority. As used herein, the term "Confidential Information" shall mean any business, financial, personal or technical information relating to the business or other activities of Tenant that Landlord obtains in connection with the Lease.

34. Landlord's Consent. Unless otherwise expressly stated herein, whenever Landlord's consent is required under this Lease, such consent shall not be unreasonably withheld, conditioned or delayed, and Landlord's reasonable satisfaction shall be sufficient for any matters under this Lease.

35. Surrender of Premises. At the expiration of the Term, whether by expiration of time or otherwise, Tenant shall surrender the Premises to Landlord in broom clean condition free of debris and rubbish, excepting damage caused by ordinary wear and tear, fire, acts of God, Landlord, condemnation and/or other casualty or the elements. All Alterations which may be made by Tenant shall be the property of Tenant and Tenant shall be entitled to remove from the Premises during the Term all Tenant Improvements and any and all furniture, removable trade fixtures, equipment and personal property ("Fixtures") installed or located on or in the Premises provided that Tenant repair any and all damage caused by the removal of the foregoing. Any Tenant Improvements or Fixtures which Tenant does not elect to remove at or prior to the expiration of the Term shall be surrendered with the Premises at the termination of this Lease; provided that Tenant shall remove its signage and its reverse osmosis ("RO") tanks and bio-medical equipment and remove and cap all piping in the RO room and repair any and all damage done by the removal of the foregoing, at Tenant's sole cost and expense.

36. Holding Over. In the event Tenant remains in possession of the Premises after the expiration of the Term, or any extensions hereof without the written consent of Landlord, this Lease shall continue on a month-to-month basis, terminable by either party upon 30 days' prior written notice and Tenant shall be obligated to pay Rent at 115% the then current rate at the end of the Term (including all adjustments), with all other sums then payable hereunder prorated on a daily basis for each day that Landlord is kept out of possession of the Premises. Notwithstanding the foregoing, in the event that applicable Law, including without limitation applicable health care Law, limits the period of any such holdover, both parties shall comply with such applicable Law. Tenant shall during any such holdover period continue to pay any Additional Rent that would otherwise be payable under this Lease.

37. Binding Effect. All covenants, agreements, stipulations, provisions, conditions and obligations set forth herein shall extend to, bind and inure to the benefit of, as the case may require, the successors and assigns of Landlord and Tenant respectively, as fully as if any such successor or assign was referenced to wherever reference to Landlord or Tenant, as the case may be, occurs in this Lease.

38. Severability. If any term, covenant or condition of this Lease or the application thereof to any person or circumstance shall, to any extent, be invalid or unenforceable, the remainder of this Lease, or the application of such term, covenant or condition to persons or circumstances other than those as to which it is held invalid or unenforceable, shall not be affected thereby and each term, covenant or condition of this Lease shall be valid and be enforced to the fullest extent permitted by Law.

39. Applicable Law. The Laws of the State where the Premises are located shall govern the validity, performance and enforcement of this Lease, without regard to such State's conflict-of-law principles.

40. Force Majeure. Whenever a day is appointed herein on which, or a period of time is appointed within which, either party hereto is required to do or complete any act, matter or thing (excluding payments of amounts due hereunder), the time for the doing or completion thereof shall be extended by a period of time equal to the number of days on or during which such party is prevented from, or is interfered with, the doing or completion of such act, matter or thing because of strikes, lock-outs, embargoes, unavailability of labor or materials, wars, insurrections, rebellions, civil disorder, declaration of national emergencies, acts of God or other causes beyond such party's reasonable control, provided that no

extension of the time under this Section shall exceed 90 days unless otherwise agreed to in writing by the parties.

41. Complete Agreement. Any stipulations, representations, promises or agreements, oral or written, made prior to or contemporaneously with this agreement shall have no legal or equitable consequences and the only agreement made and binding upon the parties with respect to the leasing of the Premises is contained herein, and it is the complete and total integration of the intent and understanding of Landlord and Tenant with respect to the leasing of the Premises. No amendment or modification of this Lease shall be valid or binding unless reduced to writing and executed by the parties hereto in the same manner as the execution of this Lease.

42. Counterparts. This Lease may be executed in any number of counterparts via facsimile or electronic transmission or otherwise, each of which shall be deemed an original and all of which together shall constitute one and the same instrument.

43. Guaranty. In the event of an assignment of this Lease by original Landlord, Tenant shall cause DaVita Inc. to provide a Guaranty of this Lease to Landlord's assignee in the form attached hereto as Exhibit G.

44. Costs of Enforcement. If Landlord or Tenant defaults under this Lease or there is a dispute under this Lease, then the defaulting party or the party not prevailing in such dispute shall pay, on demand, the out-of-pocket costs and expenses incurred by the other party in enforcing or establishing its rights hereunder, including, without limitation, court costs and reasonable attorneys' fees.

45. Right of First Offer. If at any time during the Term, Landlord decides to market the Premises for sale (the "Offer to Sell"), Landlord grants Tenant the option to purchase the Premises on the same terms and conditions as provided in the Offer to Sell (the "Right of First Offer") provided, however, that the purchase price to Tenant shall be reduced by any real estate commissions Landlord would be obligated to pay by contract pursuant to a sale to a third party but which Landlord shall not be obligated to pay upon a sale to Tenant. Landlord shall give Tenant written notice in accordance with Section 27 of this Lease of the listing price and any other terms and conditions of the Offer to Sell, enclosing a copy of all other information and documentation reasonably necessary for Tenant's consideration of such offer (the "Offer Package"). In order to exercise this Right of First Offer, Tenant must provide Landlord with written notice of Tenant's interest in purchasing the Premises within thirty (30) days after Landlord's delivery to Tenant of the Offer Package (the "Acceptance Deadline"). Landlord shall promptly provide Tenant with any other information reasonably requested by Tenant prior to the Acceptance Deadline for Tenant's consideration of such offer and Tenant shall have until the later to occur of the Acceptance Deadline or five (5) days after Tenant's receipt of such additional information to exercise such option. If Tenant accepts the Right of First Offer, Landlord and Tenant shall execute a purchase agreement pursuant to the terms and conditions of the Offer Package or as otherwise agreed upon by the parties within thirty (30) days after Tenant's delivery to Landlord of Tenant's written notice of its exercise of the Right of First Offer. The failure of Tenant to exercise the Right of First Offer shall in no way release or relieve Landlord from Landlord's obligation to provide Tenant with notice of any future Offer to Sell or if the purchase price set forth in the original Offer Package delivered to Tenant is reduced. The parties hereby agree that if Tenant exercises its Right of First Offer and purchases the Premises, Landlord shall assign this Lease to the purchaser of the Premises. For purposes of this Section only, the term "Tenant" includes any person, corporation, partnership or other entity which controls, is controlled by or is under common control with Tenant. This Section shall not apply to any Offer to Sell promulgated by Genesis KC Development, LLC, the original Landlord under this Lease.

46. Incorporation of Exhibits and Schedule. This Lease is subject to the provisions of the attached exhibits, listed below, which exhibits are hereby made a part of this Lease.

EXHIBIT A	-	LEGAL DESCRIPTION
EXHIBIT A-1	-	LANDLORD'S WORK
EXHIBIT B	-	BUILDING SITE PLAN
EXHIBIT C	-	FORM OF COMMENCEMENT DATE MEMORANDUM
EXHIBIT D	-	FORM OF SUBORDINATION, NON-DISTURBANCE AND ATTORNMENT AGREEMENT
EXHIBIT E	-	FORM OF ESTOPPEL CERTIFICATE
EXHIBIT F		FORM OF MEMORANDUM OF LEASE
EXHIBIT G	-	FORM OF GUARANTY

[Signature pages follow]

IN TESTIMONY WHEREOF, Landlord and Tenant have caused this Lease to be executed as of the dates set forth below.

LANDLORD:

GENESIS KC DEVELOPMENT, LLC, a Delaware limited liability company

By: _____
Name: Peter Berkowitz
Title: VP – Real Estate and Center Development
Date: 5/22/18

FOR LANDLORD'S INTERNAL PURPOSES ONLY:

Approved: Arthur Richey

Digitally signed by Arthur Richey
DN: cn=Arthur Richey, o=Genesis, ou=Davita, email=arthur.richey@davita.com, c=US
Date: 2018.05.20 08:17:26 -07'00'

By: _____
Name: Arthur Richey
Title: Senior Director of Real Estate

Approved As To Form:

By: _____
Name: Amy M. DeColibus
Title: Assistant General Counsel

STATE OF COLORADO)
) SS
COUNTY OF DENVER)

I, MARIA GAUDIEL JAKES, a Notary Public in and for the County and State aforesaid, do hereby certify that PETER BERKOWITZ the VP-REAL ESTATE AND CENTER DEVELOPMENT of GENESIS KC DEVELOPMENT, LLC, who is personally known to me to be the same person whose name is subscribed to the foregoing instrument, appeared before me in person and acknowledged that he/she signed, sealed and delivered the said instrument as his/her own free and voluntary act and as the free and voluntary act of said VP-REAL ESTATE, for the uses and purposes therein set forth.

Given under my hand and notarial seal this 22 day of MAY, 2018.

_____
Notary Public

My Commission Expires: DECEMBER 1, 2018

MARIA GAUDIEL JAKES
NOTARY PUBLIC
STATE OF COLORADO
NOTARY ID 20144043028
MY COMMISSION EXPIRES DECEMBER 1, 2018

TENANT:

TOTAL RENAL CARE INC., a California corporation

By: _____
Name: Jennie Funk
Title: Division Vice President

Date: 5-21-18

Approved As To Form:

By: _____
Name: _____
Title: Assistant General Counsel

STATE OF _____)
) SS
COUNTY OF _____)

I, _____, a Notary Public in and for the County and State aforesaid, do hereby certify that _____ the _____ of _____ who is personally known to me to be the same person whose name is subscribed to the foregoing instrument, appeared before me in person and acknowledged that he/she signed, sealed and delivered the said instrument as his/her own free and voluntary act and as the free and voluntary act of said _____, for the uses and purposes therein set forth.

Given under my hand and notarial seal this _____ day of _____ 20__

_____
Notary Public

My Commission Expires: _____

EXHIBIT A

LEGAL DESCRIPTION

PARCEL A:

LOTS 10 AND 11 OF CITY OF AUBURN LOT LINE ADJUSTMENT NO. LLA-0010-09 RECORDED MAY 8, 1990 UNDER RECORDING NO. 9005081375, IN KING COUNTY, WASHINGTON.

PARCEL B:

LOT 9, AUBURN 400 CORPORATE PARK DIVISION NO. 1, ACCORDING TO THE PLAT THEREOF RECORDED IN VOLUME 128 OF PLATS, AT PAGES 97 THROUGH 99, IN KING COUNTY, WASHINGTON.

EXHIBIT A-1

LANDLORD'S WORK

MINIMUM BASE BUILDING IMPROVEMENT REQUIREMENTS

At a minimum, the Landlord shall provide the following Base Building and Site Development Improvements to meet Tenant's Building and Site Development specifications at Landlord's sole cost:

All MBBI work completed by the Landlord will need to be coordinated and approved by the Tenant and their Consultants prior to any work being completed, including shop drawings and submittal reviews.

1.0 - Building Codes & Design

All Minimum Base Building Improvements (MBBI) and Site Development are to be performed in accordance with all current local, state, and federal building codes including any related amendments, fire and life safety codes, barrier-free regulations, energy codes, State Department of Public Health, and other applicable and codes as it pertains to Dialysis. All Landlord's work will have Governmental Authorities Having Jurisdiction ("GAHJ") approved architectural and engineering (Mechanical, Plumbing, Electrical, Structural, Civil, Environmental) plans and specifications prepared by a licensed architect and engineer and must be coordinated with the Tenant Improvement plans and specifications.

Building design will follow DaVita Shell prototype design package – see attached exhibit.

2.0 - Zoning & Permitting

Building and premises must be zoned to perform services as a dialysis clinic without the need for special-use approval by the AHJ. Landlord to provide all permitting related to the base building and site improvements.

3.0 - Common Areas

Tenant will have access and use of all common areas i.e. Lobbies Hallways, Corridors, Restrooms, Stairwells, Utility Rooms, Roof Access, Emergency Access Points and Elevators. All common areas must be code and ADA compliant for Life Safety per current federal, state and local code requirements.

4.0 Foundation and Floor

The foundation and floor of the building shall be in accordance with local code requirements. The foundation and concrete slab shall be designed by the Landlord's engineer to accommodate site-specific Climate and soil conditions and recommendations

per Landlord's soil engineering and exploration report (To be reviewed and approved by Tenant's engineer).

Foundation to consist of formed concrete spread footing with horizontal reinforcing sized per geotechnical engineering report. Foundation wall, sized according to exterior wall systems used and to consist of formed and poured concrete with reinforcing bars or a running bond masonry block with proper horizontal and vertical reinforcing within courses and cells. Internal masonry cells to be concrete filled full depth entire building perimeter up to finish floor at a minimum. Foundation wall to receive poly board R-10 insulation on interior side of wall on entire building perimeter (if required by code). Provide proper foundation drainage.

The floor shall be concrete slab on grade and shall be a minimum of four-inch (4") (five-inch (5") at Water treatment room) thick with minimum concrete strength of 4,000-psi. It will include one of the following, wire mesh or fiber mesh, and/or rebar reinforcement over a 10 mil minimum vapor barrier and granular fill per Landlord's soils and/or structural engineering team based on soil conditions and report from the Soils Engineer. Finish floor elevation to be a minimum of 8" above finish grade. Include proper expansion control joints. Floor shall be level (1/8" with 10' of run), smooth, broom clean with no adhesive residues, in a condition that is acceptable to install floor coverings in accordance with the flooring manufacturer's specifications. Concrete floor shall be constructed so that no more 90% relative humidity is emitted per completed RH testing (ASTM F2170-11, 'Standard Test Method for Determining Relative Humidity in Concrete Floor Slabs Using in situ Probes') results after 28 day cure time. Relative humidity testing to be performed by Tenant at Tenant's sole cost. Means and methods to achieve this level will be responsibility of the Landlord and may preclude the requirement for Tenant's third party testing. Under slab plumbing shall be installed by Tenant's General Contractor in coordination with Landlord's General Contractor, inspected by municipality and Tenant for approval prior to pouring the building slab.

5.0 - Structural

Structural systems shall be designed to provide a minimum 13'-0" clearance (for 10'-0" finished ceiling height) to the underside of the lowest structural member from finished slab and meet building steel (Type II construction or better) erection requirements, standards and codes. Structural design to allow for ceiling heights (as indicated above) while accommodating all Mechanical, Plumbing, Electrical above ceiling. Structure to include all necessary members including, but not limited to, columns, beams, joists; load bearing walls, and demising walls. Coordinate column spacing and locations with Tenant's Architect. Provide necessary bridging, bracing, and reinforcing supports to accommodate all Mechanical systems (Typical for flat roofs - minimum of four (4) HVAC roof top openings, one (1) roof hatch opening, and four (4) exhaust fans openings). Treatment room shall be column free.

The floor and roof structure shall be fireproofed as needed to meet local building code and regulatory requirements.

Roof hatch shall be provided and equipped with ladders meeting all local, state and federal requirements.

6.0 - Exterior walls

Exterior walls to be fire rated if required by code requirements. If no fire rating is required, interior of walls shall be left as exposed and until Tenants completes any and all work within walls on the interior side of the exterior walls. Landlord shall be responsible for interior metal stud furring/framing, mold- and moisture-resistant glass mat board, mold- and moisture-resistant gypsum board, taping and finishing on the interior side of all exterior walls.

7.0 - Demising walls

All demising walls shall be a 1 or 2hr fire rated wall depending on local, state and/or regulatory (NFPA 101 – 2000) codes requirements whichever is more stringent. Walls will be installed per UL design and taped (Tenant shall be responsible for final finish preparation of gypsum board walls on Tenant side only). At Tenant's option and as agreed upon by Landlord, the interior drywall finish of demising walls shall not be installed until after Tenant's improvements are complete in the wall. Walls to be fire caulked in accordance with UL standards at floor and roof deck. Demising walls will have minimum 3-inch thick mineral wool sound attenuation batts from floor to underside of deck.

8.0 - Roof Covering

The roof system shall have a minimum of a twenty (20) year life span with full (no dollar limit - NDL) manufacturer's warrantee against leakage due to ordinary wear and tear. Roof system to include a minimum of R-30 insulation. Ice control measures mechanically or electrically controlled to be considered in climates subject to these conditions. Downspouts to be connected into controlled underground discharge for the rain leaders into the storm system for the site or as otherwise required meeting local storm water treatment requirements. Storm water will be discharged away from the building, sidewalks, and pavement. Roof and all related systems to be maintained by the Landlord for the duration of the lease. Landlord to provide Tenant copy of material and labor roof warranty for record.

9.0 – Parapet

Landlord to provide a parapet wall based on building designed/type and wall height should be from the highest roof line. HVAC Rooftop units should be concealed from public view if required by local code.

10.0 - Façade

Landlord to provide specifications for building façade for Tenant review and approval. All wall system to be signed off by a Landlord's Structural Engineer. Wall system "R" value must meet current Energy code. Wall system options include, but not limited to:

Minimum 3-inch drainable exterior insulating fenestration system (EIFS) on water-vapor barrier on ¾-inch thick glass matt sheathing, AND (where indicated by Lessee's Architect) fibrous cementitious cladding (mfr: Nichiha) on metal furring

on continuous insulation/weather-barrier, system on 6" 16- or 18-ga metal stud framing

Or

Minimum 3-inch drainable exterior insulating fenestration system (EIFS), AND (where indicated by Lessee's Architect) fibrous cementitious cladding (mfr: Nichiha) on metal furring on continuous insulation/weather-barrier system, on water-vapor barrier on 8-inch or 12-inch thick concrete masonry wall construction with 3½-inch 20-ga metal stud furring.

Or if required by local municipality

Brick or split face block Veneer on engineered 6" 16 or 18ga metal studs, R- 19 or higher batt wall insulation, on Tyvek (commercial grade) over 5/8"exterior grade gypsum board or Dens-Glass Sheathing.

11.0 - Canopy

Canopy design per DaVita Shell Prototype. Approximate size to be based on building and site plan. Canopy to accommodate patient arrival with a level grade with barrier-free transition to the finish floor elevation. Controlled storm water drainage requirements of gutters with scuppers and/or downspouts drainage to landscape areas or connected to site storm sewer system as required or properly discharged away from the building, sidewalks, and pavement. Steel bollards at column locations where needed.

12.0 – Waterproofing and Weatherproofing

Landlord shall provide complete water tight building shell inclusive but not limited to, Flashing and/or sealant around windows, doors, parapet walls, Mechanical / Plumbing / Electrical penetrations. Landlord shall properly seal the building's exterior walls, footings, slabs as required in high moisture conditions such as (including but not limited to) finish floor sub-grade, raised planters, and high water table. Landlord shall be responsible for replacing any damaged items and repairing any deficiencies exposed during / after construction of tenant improvement.

13.0 - Windows

Landlord to provide code compliant energy efficient windows and storefront systems to be 1" tinted insulated low –E glass with thermally broken insulated aluminum mullions. Window size and locations to be determined by Tenant's architectural floor plan and shall be coordinate with Landlord's Architect.

14.0 - Thermal Insulation

All exterior walls to have a vapor barrier and insulation that meets or exceeds the local and national energy codes. The R-value to be determined by the size of the stud cavity, if installed on the interior of the wall and should extend from finish floor to bottom of floor or ceiling deck. Should the insulation be installed on the exterior side of the wall sheathing,

insulation shall extend from finish floor to the top of the parapet. Roof deck to have a minimum R-30 insulation mechanically fastened to the underside of roof deck.

15.0 - Exterior Doors

All doors to have weather-stripping and commercial grade hardware (equal to Yale 8800 Series, Grade 1 mortise lockset or better). Doors shall meet all barrier-free requirements including but not limited to American Disability Act (ADA), and State Department of Health requirements. Landlord shall change the keys (reset tumblers) on all doors with locks after construction, but prior to commencement of the Lease, and shall provide Tenant with a minimum of three (3) sets of keys. Final location of doors to be determined by Tenant architectural floor plan and shall be coordinate with Tenant's Architect. At a minimum, the following doors, frames and hardware shall be provided by the Landlord:

a)

- Patient Entry Doors: Provide Storefront with insulated glass doors and Aluminum framing to be 42" width including push paddle/panic bar hardware, push button programmable lock, power assist opener, continuous hinge and lock mechanism.

- Service Doors: Provide 48" wide door (Alternates for approval by Tenant's Project Manager to include: a) 60" or 72"-inch wide double doors (with 1 - 24" and 1 - 36" leaf or 2- 36" leafs), b) 60" Roll up door,) with 20 gauge insulated hollow metal , painted with rust inhibiting paint, Flush bolts, T astragal, heavy duty aluminum threshold, continuous hinge each leaf, door viewer (peep), panic bar hardware (if required by code), push button programmable lockset,

- Teammate Entry Doors: Provide a minimum 36-inch wide, 20-ga, insulated, hollow metal door and thermally-broken, welded, 20-ga hollow-metal frame (both finished with rust-inhibiting paint) with programmable keypad lockset, heavy-duty hinges, aluminum threshold, surface closer, and concealed-overhead stop.

- Emergency Egress Doors: Provide minimum 36" wide door with 20 gauge insulated hollow metal door both painted with rust-inhibiting paint, AND/OR (where indicated by Lessee's Architect) a minimum 42-inch wide aluminum/glass door and aluminum storefront frame, with exit-only panic bar locking hardware, hinges, surface-closer and concealed-overhead stop.

16.0 - Utilities

All utilities to be provided at designated utility entrance points into the building at locations approved by the Tenant. Landlord is responsible for all tap/connection and impact fees for all utilities. All Utilities to be coordinated with Tenant's Architect. Landlord shall have contained within the building a common main room to accommodate the utility services which include, but not limited, to electrical, fire alarm, security alarm and fire riser if in a multi-tenant building.

17.0 - Plumbing

Landlord to provide a segregated/dedicated potable water supply line that will be sized by Tenant's Engineer based on Tenant's water requirements (not tied-in to any other Tenant spaces, fire suppression systems, or irrigation systems unless mandated by Local Building and or Water Dept). Water supply shall be provided with a shut off valve, 2 (two) reduced pressure zone (RPZ) backflow preventers arranged in parallel (with floor drain or open site drain under RPZ's), and meter. Water supply to provide a continuous minimum pressure of 50 psi, maximum 80psi, with a minimum flow rate of 50 gallons per minute to Tenant space. The RPZ's and the Meter will be sized to the incoming line, or per water provider or municipality standards. Landlord to provide Tenant with the most recent site water flow and pressure test results (gallons per minute and psi) for approval. Landlord shall perform water flow and pressure test prior to lease execution. Landlord shall stub the dedicated water line into the Tenant lease space per location coordinated by Tenant.

Provide exterior (anti-freeze when required) hose bibs (minimum of 2) in locations approved by Tenant.

Building sanitary drain size will be determined by Tenant's Mech Engineer based on total combined drainage fixture units (DFU's) for entire building, but not less than 4 inch diameter. The drain shall be stubbed into the building per location coordinated by Tenant at an elevation no higher than 4 feet below finished floor elevation, to a maximum of 10 feet below finished floor elevation. (Coordinate actual depth and location with Tenant's Architect and Engineer.) Provide with a cleanout structure at building entry point. New sanitary building drain shall be properly pitched to accommodate Tenant's sanitary system design per Tenant's plumbing plans, and per applicable Plumbing Code(s). Lift station/sewage ejectors will not be permitted.

Sanitary sampling manhole to be installed by Landlord if required by local municipality.

Landlord to provide and pay for all tap fees related to new sanitary sewer and water services in accordance with local building and regulatory agencies.

18.0 - Fire Suppression System

A Sprinkler System will be installed if required by AHJ or if required by Tenant. Any single story standalone building or building that could expand to greater than 10,000SF will require a sprinkler system. Landlord shall design and install a complete turnkey sprinkler system that meets the requirements of NFPA #13 and all local building and life safety codes per NFPA 101-2000. This system will be on a dedicated water line independent of Tenant's potable water line requirements, or as required by local municipality or water provider. Landlord shall provide all municipal (or code authority) approved shop drawings, service drops and sprinkler heads at heights per Tenant's reflective ceiling plan, flow control switches wired and tested, alarms including wiring and an electrically/telephonically controlled fire alarm control panel connected to a monitoring systems for emergency dispatch.

19.0 - Electrical

Provide underground service with a dedicated meter via a new CT cabinet per utility company standards. Service size to be determined by Tenant's engineer dependent on facility size and gas availability (400amp to 1,000amp service) 120/208 volt, 3 phase, 4 wire to a distribution panel board in the Tenant's utility room (location to be per Code and coordinated with Tenant and their Architect) for Tenant's exclusive use in powering equipment, appliances, lighting, heating, cooling and miscellaneous use. Landlord's service provisions shall include transformer coordination with utility company, transformer pad, grounding, and underground conduit wire sized for service inclusive of excavation, trenching and restoration, utility metering, distribution panel board with main and branch circuit breakers, and electrical service and building grounding per NEC. Tenant's engineer shall have the final approval on the electrical service size and location and the size and quantity of circuit breakers to be provided in the distribution panel board.

Landlord will provide up to 5 sub panels that can accommodate up to 42 circuits based on the Electrical Engineers design.

If lease space is in a multi-tenant building then Landlord to provide meter center with service disconnecting means, service grounding per NEC, dedicated combination CT cabinet with disconnect for Tenant and distribution panel board per above.

If Tenant so chooses to require an Emergency Transfer Switch hook-up for a temporary generator, Landlord will provide one at Landlord costs per Tenants Electrical design.

Landlord to provide main Fire Alarm Control panel that serves the Tenant space and will have the capacity to accommodate devices in Tenant space based on Fire Alarm system approved by local authority having jurisdiction. If lease space is in a multi-tenant building then Landlord to provide Fire Alarm panel to accommodate all tenants and locate panel in a common room with conduit stub into Tenant space. Landlord's Fire Alarm panel shall include supervision of fire suppression system(s) and connections to emergency dispatch or third party monitoring service in accordance with the local authority having jurisdiction.

Fire Alarm system equipment shall be equipped for double detection activation if required.

20.0 - Gas

Natural gas service, at a minimum, will be rated to have 6" water column pressure and supply 800,000-BTU's. Natural gas pipeline shall be run to HVAC units and HWH'sper design drawings. Clinic shall be individually metered and sized per demand by Engineer. Additional electrical service capacity will be required if natural gas service is not available to the building.

21.0 - Mechanical /Heating Ventilation Air Conditioning *

Landlord to be responsible for all costs for the HVAC system based on the below criteria.

Tenant will be responsible for the design, procurement and installation of the HVAC system.

The criteria is as follows:

- Equipment to be Lennox RTU's
- Supply air shall be provided to the Premises sufficient for cooling and ventilation at the rate of 275 to 325 square feet per ton to meet Tenant's demands for a dialysis facility and the base building Shell loads.
- RTU Ductwork drops shall be concentric for air distribution until Tenant's General Contractor modifies distribution to align with Tenant's fit-out design criteria and layout and shall be extended 5' into the space for supply and return air. Extension of system beyond 5-feet shall be by Tenant's General Contractor.
- System to be a fully ducted return air design and will be by Tenant's General Contractor for the interior fit-out
- All ductwork to be externally lined except for the drops from the units.
- Provide 100% enthalpy economizer
- Units to include Power Exhaust
- Control system must be capable of performing all items outlined in the Sequence of Operations specification section
- RTU controller shall be compatible with a Building Management System using BACnet communication protocol.
- Provide high efficiency inverter rated non-overloading motors
- Provide 18" curbs, 36" in Northern areas with significant snow fall
- Units to have disconnect and service outlet at unit
- Units will include motorized dampers for OA, RA & EA
- System shall be capable of providing 55deg supply air temperature when it is in the cooling mode

Equipment will be new and come with a full warranty on all parts including compressors (minimum of 5yrs) including labor. Work to include, but not limited to, the purchase of the units, installation, roof framing, mechanical curbs, flashings, gas & electrical hook-up, coordination with Building Management System supplier, temporary construction thermostats, start-up and commissioning. Anticipate minimum up to five (5) zones with programmable thermostat and or DDC controls (Note: The 5 zones of conditioning may be provided by individual constant volume RTU's, or by a VAV or VVT system of zone control with a single RTU). Tenant's engineer shall have the final approval on the sizes, tonnages, zoning, location and number of HVAC units based on Tenant's design criteria and local and state codes.

Landlord to furnish steel framing members, roof curbs and flashing to support Tenant exhaust fans (minimum of 4) to be located by Tenant's architect.

22.0 - Telephone

Landlord shall provide a single 2" PVC underground conduit entrance into Tenant's utility room to serve as chase way for new telephone service. Entrance conduit location shall be coordinated with Tenant.

23.0 - Cable TV

Landlord shall provide a single 2" PVC underground conduit entrance into Tenant utility room to serve as chase way for new cable television service. Entrance conduit location shall be coordinated with Tenant.

Tenant shall have the right to place a satellite dish on the roof and run appropriate electrical cabling from the Premises to such satellite dish and/or install cable service to the Premises at no additional fee. Landlord shall reasonably cooperate and grant "right of access" with Tenant's satellite or cable provider to ensure there is no delay in acquiring such services.

24.0 - Handicap Accessibility

Full compliance with ADA and all local jurisdictions' handicap requirements. Landlord shall comply with all ADA regulations affecting the Building and entrance to Tenant space including, but not limited to, the elevator, exterior and interior doors, concrete curb cuts, ramps and walk approaches to / from the parking lot, detectable warnings, parking lot striping for four (4) dedicated handicap stalls for a unit up to 20 station clinic and six (6) HC stalls for units over 20 stations handicap stalls inclusive of pavement markings and stall signs with current local provisions for handicap parking stalls, delivery areas and walkways.

Finish floor elevation is to be determined per Tenant's architectural plan in conjunction with Landlord's civil engineering and grading plans. If required, Landlord to construct concrete ramp of minimum 5' width, provide safety rails if needed, provide a gradual transitions from overhead canopy and parking lot grade to finish floor elevation. Concrete surfaces to be toweled for slip resistant finish condition according to accessible standards.

25.0 - Exiting

Landlord shall provide at the main entrance and rear doors safety lights, exterior service lights, exit sign and emergency lights with battery backup signs per doorway, in accordance with applicable building codes, local fire codes and other applicable regulations, ordinances and codes. The exiting shall encompass all routes from access points terminating at public right of way.

26.0 - Site Development Scope of Requirements

Landlord to provide Tenant with a site boundary and topographic ALTA survey, civil engineering and grading plans prepared by a registered professional engineer. Civil engineering plan is to include necessary details to comply with municipal standards. Plans will be submitted to Tenant Architect for coordination purposes. Site development is to include the following:

- Utility extensions, service entrance locations, inspection manholes;
- Parking lot design, stall sizes per municipal standard in conformance to zoning requirement;
- Site grading with Storm water management control measures (detention / retention / restrictions);

- Refuse enclosure location & construction details for trash and recycling;
- Handicap stall location to be as close to front entrance as possible;
- Side walk placement for patron access, delivery via service entrance;
- Concrete curbing for greenbelt management;
- Site lighting;
- Conduits for Tenant signage;
- Site and parking to accommodate tractor trailer 18 wheel truck delivery access to service entrance;
- Ramps and curb depressions.
- Landscaping shrub and turf as required per municipality;
- Irrigation system if Landlord so desires and will be designed by landscape architect and approved by planning department;
- Construction details, specifications / standards of installation and legends;
- Final grade will be sloped away from building.

27.0 - Refuse Enclosure

Landlord to provide a minimum 6" thick reinforced concrete pad approx. 100 to 150SF based on Tenant's requirements' and an 8' x 12' apron way to accommodate dumpster and vehicle weight. Enclosure to be provided as required by local codes.

28.0 - Generator

Landlord to allow a generator to be installed onsite if required by code or Tenant chooses to provide one at Tenants costs.

29.0 - Site Lighting

Landlord to provide adequate lighting per code and to illuminate all parking, pathways, and building access points readied for connection into Tenant power panel. Location of pole fixtures per Landlord civil plan to maximize illumination coverage across site. Parking lot lighting to include timer (to be programmed per Tenant hours of operation) or a photocell. Parking lot lighting shall be connected to and powered by Landlord house panel (if in a Multi-tenant building) and equipped with a code compliant 90 minute battery back up at all access points.

30.0 - Exterior Building Lighting

Landlord to provide adequate lighting and power per code and to illuminate the building main, exit and service entrance, landings and related sidewalks. Lighting shall be connected to and powered by Landlord house panel and equipped with a code compliant 90 minute battery back up at all access points.

31.0 - Parking Lot

Provide adequate amount of handicap and standard parking stalls in accordance with dialysis use and overall building uses. Stalls to receive striping, lot to receive traffic

directional arrows and concrete curbs or parking bumpers. Bumpers to be firmly spike anchored in place onto the asphalt per stall alignment.

Asphalt wearing and binder course to meet geographical location design requirements for parking area and for truck delivery driveway.

Asphalt to be graded gradual to meet handicap and civil site slope standards, graded into & out of new patient drop off canopy and provide positive drainage to in place storm catch basins leaving surface free of standing water, bird baths or ice buildup potential.

32.0 – Signage

Landlord to provide and install (including electrical service) (a) exterior building mounted signage, and (b) a monument or pylon sign. Final sign layout to be provided and approved by Tenant and City.

EXHIBIT B

BUILDING SITE PLAN

(attached)

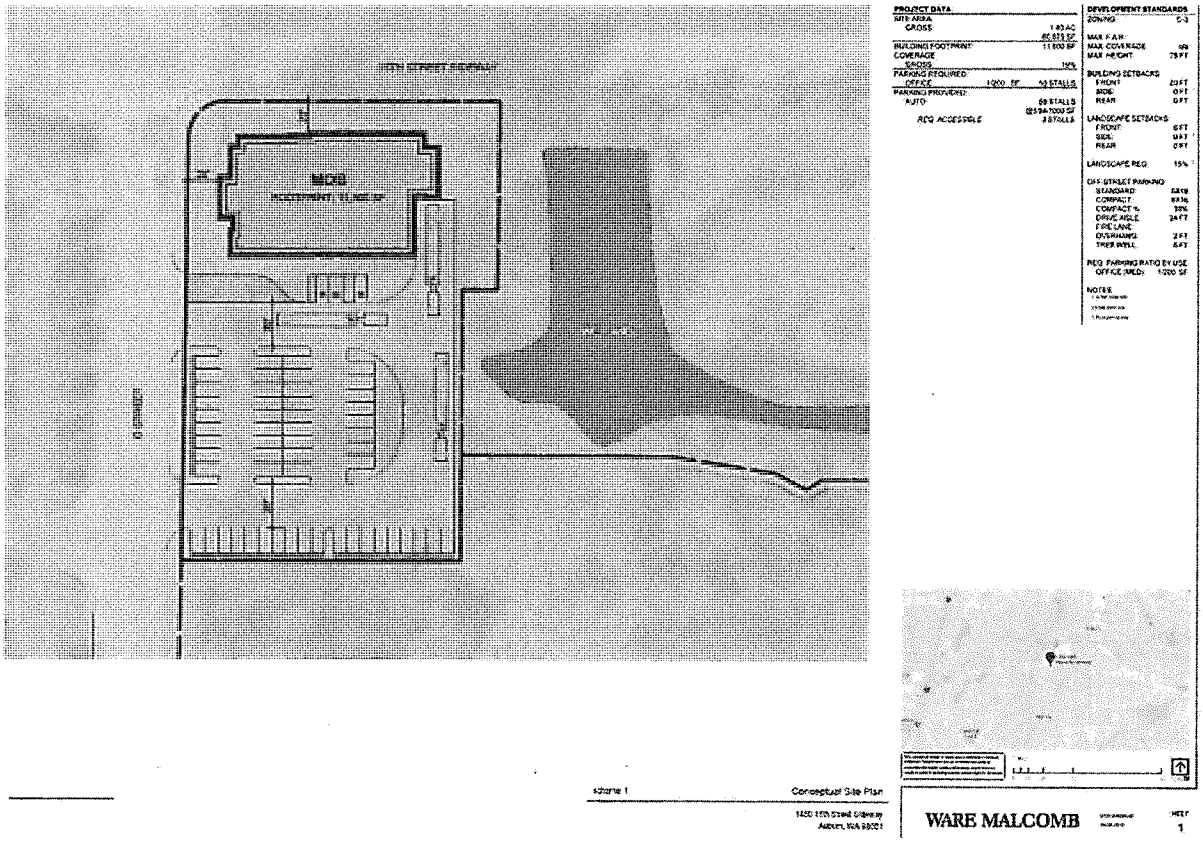

EXHIBIT C

FORM OF COMMENCEMENT DATE MEMORANDUM

COMMENCEMENT DATE MEMORANDUM

With respect to that certain lease ("Lease") dated _____, between GENESIS KC DEVELOPMENT, LLC, a Delaware limited liability company ("Landlord") and _____ ("Tenant"), whereby Landlord leased to Tenant and Tenant leased from Landlord space located at _____ (the "Premises"). Tenant and Landlord hereby acknowledge as follows:

(1) The Lease commences 30 days following Tenant's receipt of the Certificate of Occupancy. Tenant received the Certificate of Occupancy on _____.

(2) The Term of the Lease commenced on _____ (the "Commencement Date").

(3) The Termination Date of the Lease is_____.

(4) It is agreed that the first Lease Year shall end on _____ and that each subsequent Lease Year shall end on _____.

(5) Tenant shall commence payment of Rent on _____.

(6) The Premises contain _____ rentable square feet of space (the "Building Rentable Area".

(7) The last dates upon which the respective renewal options may be exercised are _____, and _____.

All capitalized terms herein, not otherwise defined herein, shall have the meaning assigned in the Lease.

IN WITNESS WHEREOF, this Commencement Date Memorandum is executed the date(s) set forth below.

LANDLORD:	**TENANT**:
GENESIS KC DEVELOPMENT, LLC, a Delaware limited liability company	[DAVITA ENTITY], a _____ _____
By: _____ Name: _____ Title: Assistant General Counsel	By: _____ Name: _____ Title: Assistant General Counsel
Date: _____	Date: _____

EXHIBIT D

FORM OF SUBORDINATION, NON-DISTURBANCE AND ATTORNMENT AGREEMENT

[TO BE CONFORMED TO COUNTY RECORDING REQUIREMENTS]

SUBORDINATION, NON-DISTURBANCE AND ATTORNMENT AGREEMENT

THIS SUBORDINATION, NON-DISTURBANCE AND ATTORNMENT AGREEMENT (this "Agreement") is entered into as of _____, 20__ (the "Effective Date"), between _____ (the "Mortgagee"), and _____ (the "Tenant").

WHEREAS, by Lease dated _____, 20__ (hereinafter called the "Lease"), _____, a _____(hereinafter called "Landlord") has leased to Tenant and Tenant has rented from Landlord the approximately _____ rentable square feet of leased premises ("Tenant's Premises") located at _____ as more fully described in Exhibit A attached hereto and incorporated by reference (such real property, including all buildings, improvements, structures and fixtures located thereon, "Landlord's Premises").

WHEREAS, Mortgagee has made a loan to Landlord in the original principal amount of $_____ (the "Loan"); and

WHEREAS, To secure the Loan, Landlord has encumbered Landlord's Premises by entering into that certain [Mortgage and Security Agreement] dated _____, in favor of Mortgagee (as amended, increased, renewed, extended, spread, consolidated, severed, restated or otherwise changed from time to time, the "Mortgage") recorded on _____, under Clerk's File No. _____, in the Official Public Records of Real Property of the County of _____, State of _____.

WHEREAS, Tenant desires that Mortgagee recognize Tenant's rights under the Lease in the event of foreclosure of Mortgagee's lien, and Tenant is willing to agree to attorn to the purchaser at such foreclosure if Mortgagee will recognize Tenant's right of possession under the Lease.

NOW, THEREFORE, for and in consideration of their respective covenants herein made and the receipt of other good and valuable consideration, the receipt and sufficiency of which is acknowledged, the parties agree as follows:

1. **Definitions.**
The following terms shall have the following meanings for purposes of this Agreement.

1.1 *Foreclosure Event.* A *"Foreclosure Event"* means: (a) foreclosure under the Mortgage; (b) any other exercise by Mortgagee of rights and remedies (whether under the Mortgage or under applicable Law, including bankruptcy Law) as holder of the Loan and/or the Mortgage, as a result of which Successor Landlord becomes owner of Landlord's Premises; or (c) delivery by Landlord to Mortgagee (or its designee or nominee) of a deed or other conveyance of Landlord's interest in Landlord's Premises in lieu of any of the foregoing.

1.2 *Former Landlord.* A *"Former Landlord"* means Landlord and any other party that was a landlord under the Lease at any time before the occurrence of any attornment under this Agreement.

1.3 *Offset Right.* An *"Offset Right"* means any right or alleged right of Tenant to any offset, defense (other than one arising from actual payment and performance, which payment and performance would bind a Successor Landlord pursuant to this Agreement), claim, counterclaim, reduction, deduction or

abatement against Tenant's payment of Rent or performance of Tenant's other obligations under the Lease, arising (whether under the Lease or other applicable law) from Landlord's breach or default under the Lease.

1.4. *Rent.* The *"Rent"* means any fixed rent, base rent or additional rent under the Lease.

1.5 *Successor Landlord.* A *"Successor Landlord"* means any party that becomes owner of Landlord's Premises as the result of a Foreclosure Event.

1.6 *Termination Right.* A *"Termination Right"* means any right of Tenant to cancel or terminate the Lease or to claim a partial or total eviction arising (whether under the Lease or under applicable law) from Landlord's breach or default under the Lease.

2. **Subordination.**

The Lease shall be, and shall at all times remain, subject and subordinate to the lien of the Mortgage, and all advances made under the Mortgage.

3. **Non-disturbance, Recognition and Attornment.**

3.1 *No Exercise of Mortgage Remedies Against Tenant.* So long as the Lease has not been terminated on account of Tenant's default (an "Event of Default"), Mortgagee shall not name or join Tenant as a defendant in any exercise of Mortgagee's rights and remedies arising upon a default under the Mortgage unless applicable law requires Tenant to be made a party thereto as a condition to proceeding against Landlord or prosecuting such rights and remedies. In the latter case, Mortgagee may join Tenant as a defendant in such action only for such purpose and not to terminate the Lease or otherwise adversely affect Tenant's rights under the Lease or this Agreement in such action. If Mortgagee joins Tenant in such action, Landlord, by executing the Consent hereinafter set forth, agrees to indemnify, defend and hold Tenant harmless from and against any loss, cost or expense incurred or suffered by Tenant, including without limitation, legal fees, in being a party to or arising from such action, which indemnity shall survive termination or expiration of this Agreement.

3.2 *Non-disturbance and Attornment.* If the Lease has not been terminated on account of an Event of Default by Tenant, then, when Successor Landlord takes title to Landlord's Premises: (a) Successor Landlord shall not terminate or disturb Tenant's possession or quiet enjoyment of Tenant's Premises under the Lease, except in accordance with the terms of the Lease and this Agreement; (b) Successor Landlord shall be bound to Tenant under all the terms and conditions of the Lease (except as provided in this Agreement); (c) Tenant shall recognize and attorn to Successor Landlord as Tenant's direct landlord under the Lease as affected by this Agreement; and (d) the Lease shall continue in full force and effect as a direct lease, in accordance with its terms (except as provided in this Agreement), between Successor Landlord and Tenant.

3.3 *Further Documentation.* The provisions of Section 3 shall be effective and self-operative without any need for Successor Landlord or Tenant to execute any further documents. Tenant and Successor Landlord shall, however, confirm the provisions of Section 3 in writing upon request by either of them.

3.4 *Consent to Lease.* Mortgagee hereby consents to the Lease and all of the terms and conditions thereof.

4. **Protection of Successor Landlord.**

Notwithstanding anything to the contrary in the Lease or the Mortgage, Successor Landlord shall not be liable for or bound by any of the following matters:

4.1 *Claims Against Former Landlord.* Any Offset Right that Tenant may have against any Former Landlord relating to any event or occurrence before the date of attornment, including any claim for

damages of any kind whatsoever as the result of any breach by Former Landlord that occurred before the date of attornment unless and to the extent that Mortgagee was furnished notice and opportunity to cure the same. (The foregoing shall not limit Tenant's right to exercise against Successor Landlord any Offset Right otherwise available to Tenant because of events occurring after the date of attornment, if any).

4.2 *Prepayments.* Any payment of Rent that Tenant may have made to Former Landlord more than thirty (30) days before the date such Rent was first due and payable under the Lease with respect to any period after the date of attornment other than, and only to the extent that, the Lease expressly required such a prepayment.

4.3 *Payment; Security Deposit.* Any obligation: (a) to pay Tenant any sum(s) that any Former Landlord owed to Tenant or (b) with respect to any security deposited with Former Landlord, unless such security was actually delivered to Mortgagee.

4.4 Lease. Tenant hereby covenants and agrees that, so long as the Mortgage remains in force and effect:

(a) No Modification, Termination or Cancellation. Tenant shall not consent to any material modification, termination or cancellation of the Lease without Mortgagee's prior written consent, which consent shall not be unreasonable withheld and shall be deemed given if Mortgagee fails to respond in writing within 15 days following receipt of written notice.

(b) Notice of Default. Tenant shall notify Mortgagee in writing concurrently with any notice given to Landlord of any breach of or default by Landlord under the Lease. Tenant agrees that Mortgagee shall have the right (but not the obligation) to cure any breach or default specified in such notice within the time period set forth in the Lease for Landlord's performance.

(c) Assignment of Rents. Upon receipt by Tenant of written notice from Mortgagee that Mortgagee has elected to terminate the license granted to Landlord to collect rents, as provided in the Mortgage, and directing Tenant to make payment thereof to Mortgagee, Tenant shall not be required to determine whether Landlord is in default under any obligations to Mortgagee before complying with such direction and shall not be liable to Landlord for failure to pay Landlord any sums that are paid instead to Mortgagee.

5. **Miscellaneous.**

5.1 *Notices.* All notices or other communications required or permitted under this Agreement shall be in writing and given by certified mail (return receipt requested) or by nationally recognized overnight courier service that regularly maintains records of items delivered. Notices shall be effective the next business day after being sent by overnight courier service, and three (3) business days after being sent by certified mail (return receipt requested). Unless and until notice of a change of address is given under this Agreement, notices or other communications shall be given to Mortgagee and Tenant, respectively, at the following address:

Mortgagee: _____
_____
_____
Attn: _____

Landlord: _____
_____
_____

Tenant: _____
c/o DaVita Inc.

Attention: Real Estate Legal
2000 16th Street
Denver, CO 80202

Concurrent copy to: relegal@davita.com
Subject: [City, State (Facility #)]

5.2 *Successors and Assigns.* This Agreement shall bind and benefit the parties their successors and assigns, any Successor Landlord, and its successors and assigns.

5.3 *Entire Agreement.* This Agreement constitutes the entire agreement between Mortgagee and Tenant regarding the subordination of the Lease to the Mortgage and the rights and obligations of Tenant and Mortgagee as to the subject matter of this Agreement.

5.4 *Interaction with Lease and with Mortgage.* If this Agreement conflicts with the Lease, then this Agreement shall govern as between the parties to this Agreement and any Successor Landlord, including upon any attornment pursuant to this Agreement. This Agreement supersedes, and constitutes full compliance with, any provisions in the Lease that provide for subordination of the Lease to, or for delivery of non-disturbance agreements by the holder of the Mortgage. Mortgagee confirms that Mortgagee has consented to Landlord's entering into the Lease.

5.5 *Interpretation; Governing Law.* The interpretation, validity and enforcement of this Agreement shall be governed by and construed under the internal laws of the State where the Premises is located, including its principles of conflict of laws.

5.6 *Amendments.* This Agreement may be amended, discharged or terminated, or any of its provisions waived, only by a written instrument executed by all parties to this Agreement.

5.7 *Execution.* This Agreement may be executed electronically and in any number of counterparts, each of which shall be deemed an original and all of which together shall constitute one and the same instrument.

5.8 *Representations.* Each party represents that it has full authority to enter into this Agreement and that those signatories executing this Agreement on its behalf have full power and authority to executed this Agreement. Mortgagee agrees to keep a copy of this Agreement in its permanent mortgage records with respect to the Loan. This Agreement shall be null and void unless Tenant receives a fully executed original counterpart hereof on or before the sixtieth (60th) day following the date of Tenant's execution.

5.9 *Recordation.* Upon full execution, this Agreement may be recorded in the real property records of the county in which the Premises is located by either party hereto, provided that the recording party delivers to the other party a copy of the recorded document. The recording party shall be responsible for the costs of recording this Agreement.

[Signature page follows]

IN WITNESS WHEREOF, this Agreement has been duly executed by Mortgagee and Tenant as of the date(s) set forth below.

MORTGAGEE:

_____,
a _____

By: _____
Name: _____
Title: _____

Date:_____

STATE OF)
) SS
COUNTY OF)

I, _____, a Notary Public in and for the County and State aforesaid, do hereby certify that _____ the _____ of _____, who is personally known to me to be the same person whose name is subscribed to the foregoing instrument, appeared before me in person and acknowledged that he/she signed, sealed and delivered the said instrument as his/her own free and voluntary act and as the free and voluntary act of said _____, for the uses and purposes therein set forth.

Given under my hand and notarial seal this _____ day of _____, 20__.

_____
Notary Public

My Commission Expires: _____

TENANT:

[DAVITA ENTITY],
a _____ _____

By: _____
Name: _____
Title:_____

Date: _____

STATE OF _____)
) SS
COUNTY OF _____)

I, _____, a Notary Public in and for the County and State aforesaid, do hereby certify that _____ the _____ of _____, who is personally known to me to be the same person whose name is subscribed to the foregoing instrument, appeared before me in person and acknowledged that he/she signed, sealed and delivered the said instrument as his/her own free and voluntary act and as the free and voluntary act of said _____, for the uses and purposes therein set forth.

Given under my hand and notarial seal this _____ day of _____, 20__.

_____
Notary Public

My Commission Expires: _____

LANDLORD'S CONSENT

Landlord consents and agrees to the foregoing Agreement (including without limitation, the provisions of Section 3.1 & 4.4), which was entered into at Landlord's request. The foregoing Agreement shall not alter, waive or diminish any of Landlord's obligations under the Mortgage or the Lease. The above Agreement discharges any obligations of Mortgagee under the Mortgage and related loan documents to enter into a non-disturbance agreement with Tenant and the obligations of Tenant to enter into a subordination agreement with Mortgagee.

LANDLORD:

_____, a ____
_____

By:_____
Name: _____
Title: _____

Date:_____

STATE OF _____)
) SS
COUNTY OF _____)

I, _____, a Notary Public in and for the County and State aforesaid, do hereby certify that _____ the _____ of _____, a _____, who is personally known to me to be the same person whose name is subscribed to the foregoing instrument, appeared before me in person and acknowledged that he/she signed, sealed and delivered the said instrument as his/her own free and voluntary act and as the free and voluntary act of said _____, for the uses and purposes therein set forth.

Given under my hand and notarial seal this _____ day of _____, 20__.

_____
Notary Public

My Commission Expires:_____

EXHIBIT A TO
SUBORDINATION, NON-DISTURBANCE AND ATTORNMENT AGREEMENT

Landlord's Premises

EXHIBIT E

FORM OF ESTOPPEL CERTIFICATE

This ESTOPPEL CERTIFICATE (this "Certificate") is made as of _____ (the "Effective Date"), in connection with that certain Lease Agreement dated _____ (the "Lease Agreement"), by and between _____, a _____ ("Tenant") and _____, a _____ ("Landlord"), for the premises located at _____ (the "Premises"), by _____.

[Landlord/Tenant] hereby certifies, as of the Effective Date to its actual knowledge and belief to [Tenant/Landlord/Lender] as follows:

1. 1. The Lease Agreement is now in full force and effect and has not been amended, modified, or assigned [except _____] (collectively with the Lease Agreement, the "Lease"). There are no other oral or written agreements or understandings between Landlord and Tenant relating to the Premises.

2. The below information is correct:

   (a) Approximate square footage of the Premises: rentable square feet
   (b) Monthly installment of Base Rent:
   (c) Commencement Date:
   (d) Current Term Expiration date:
   (e) Security deposit:
   (f) Prepaid rent in the amount of:
   (g) Renewal Options:

3. No default or breach on the part of either Tenant or Landlord exists under the Lease (except____).

4. Tenant is not currently asserting any credits, defenses, or offsets to the enforcement of the Lease, [except _____].

5. No rent has been paid more than 30 days in advance.

All legal notices to Tenant must be sent to:

Tenant: _____
c/o DaVita Inc.
Attention: Real Estate Legal
2000 16th Street
Denver, CO 80202

With a copy to: relegal@davita.com
Subject: Facility #, City, State

A relying party may not rely on any statement that it knows or has reason to believe is incorrect. This Certificate does not modify the Lease and if any conflict exists between the Lease and this Certificate, the Lease controls. The certifying party delivers this Certificate in good faith and this Certificate will not subject the certifying party to any liability (other than estoppel effect) for damages for inaccuracies, errors or omissions.

By executing this Certificate, the certifying party does not waive any of its claims, defenses, offsets, or rights discovered after the Effective Date, including those relating to reimbursements or overcharges that may be discovered upon reconciliations or audits or as otherwise set forth in the Lease.

[Landlord/Tenant] has executed this Certificate as of the Effective Date.

[TENANT/LANDLORD]:

_____,
a _____

By: _____
Name: _____
Title: _____

EXHIBIT F

FORM OF MEMORANDUM OF LEASE

[TO BE CONFORMED TO COUNTY RECORDING REQUIREMENTS]

Prepared by and Return to:

_____

_____

_____

Parcel ID: _____

MEMORANDUM OF LEASE

This Memorandum of Lease (this "Memorandum") is made and entered into this ___ day of _____, 20__, by and between GENESIS KC DEVELOPMENT, LLC, a Delaware limited liability company ("Landlord") and _____, a _____ ("Tenant"). Tenant and Landlord agree to and acknowledge the following matters:

1. Landlord and Tenant entered into that certain Lease Agreement dated as of _____, 20___ (the "Lease"), wherein Landlord has leased to Tenant, and Tenant has leased from Landlord, subject to the terms, covenants and conditions contained therein, space consisting of approximately _____ rentable square feet (the "Premises"), located at _____ in _____, _____, as legally described on Exhibit A, attached and incorporated herein by reference (the "Property").

2. The term of the Lease is for an initial period of 180 months commencing upon the earlier of the Possession Date or the Commencement Date, as defined in the Lease, (the "Lease Term"), subject to a right to extend and renew the Lease for two successive additional periods of five years each.

3. Pursuant to the Lease, Tenant has a right of first offer to purchase the Property.

4. The Lease contains certain restrictions on Landlord's ability to sell, rent or permit any property owned, leased or controlled by Landlord or any affiliate of Landlord to a business that provides renal dialysis, renal dialysis home training, any aphaeresis service(s) or similar blood separation or cell collection procedures within a five mile radius of the Property.

5. The address of Landlord is c/o DaVita Inc., Attention: Real Estate Legal, 2000 16th Street, Denver, CO 80202, concurrently to: relegal@davita.com, Subject: [City, State (Facility #)].

6. The address of Tenant is c/o DaVita Inc., Attention: Real Estate Legal, 2000 16th Street, Denver, CO 80202, concurrently to: relegal@davita.com, Subject: [City, State (Facility #)].

7. The purpose of this Memorandum is to give record notice to all persons that Tenant has a leasehold interest in the Premises with related use exclusivity rights, [and right of first refusal/options rights] pursuant to the Lease, in addition to other rights and obligations created therein, all of which are confirmed.

8. Any capitalized terms utilized herein that are not otherwise defined shall be deemed to have the same meaning as set forth in the Lease.

9. In the event of a conflict between the terms of the Lease and the terms of this Memorandum, the terms of the Lease shall control.

10. This Memorandum may be executed in any number of counterparts, each of which shall be deemed an original and all of which together shall constitute one and the same instrument.

[Signature pages follow]

IN WITNESS WHEREOF, the parties hereto have executed this Memorandum as of the day and year first above written.

LANDLORD:

GENESIS KC DEVELOPMENT, LLC, a Delaware limited liability company

By: _____
Name: _____
Title: _____

Date:_____

STATE OF_____)
) SS
COUNTY OF _____)

I, _____, a Notary Public in and for the County and State aforesaid, do hereby certify that _____ the _____ of Genesis KC Development, LLC, a Delaware limited liability company, who is personally known to me to be the same person whose name is subscribed to the foregoing instrument, appeared before me in person and acknowledged that he/she signed, sealed and delivered the said instrument as his/her own free and voluntary act and as the free and voluntary act of said limited liability company, for the uses and purposes therein set forth.

Given under my hand and notarial seal this _____ day of _____, 20__.

_____
Notary Public

My Commission Expires: _____

TENANT:

[DAVITA ENTITY],
a _____ _____

By: _____
Name: _____
Title:_____

Date: _____

STATE OF _____)
) SS
COUNTY OF _____)

I, _____, a Notary Public in and for the County and State aforesaid, do hereby certify that _____ the _____ of _____, who is personally known to me to be the same person whose name is subscribed to the foregoing instrument, appeared before me in person and acknowledged that he/she signed, sealed and delivered the said instrument as his/her own free and voluntary act and as the free and voluntary act of said _____, for the uses and purposes therein set forth.

Given under my hand and notarial seal this _____ day of _____, 20__.

_____
Notary Public

My Commission Expires: _____

EXHIBIT A
TO
MEMORANDUM OF LEASE

EXHIBIT G

FORM OF GUARANTY

GUARANTY

WHEREAS, _____, a _____, as assignee of Genesis KC Development, LLC, a Delaware limited liability company ("Landlord") and _____ ("Tenant"), are parties to that certain lease agreement dated _____, covering certain premises located at _____ (the "Premises") in _____ (the "Lease"); and

WHEREAS, the Landlord requires that the undersigned unconditionally becomes a guarantor to Landlord for the obligations of Tenant under the Lease; and

WHEREAS, the undersigned is the ultimate parent corporation.

NOW THEREFORE, in consideration of good and valuable consideration and intending to be legally bound hereby, the undersigned hereby unconditionally becomes a guarantor to Landlord, its successors and assigns as follows:

1. The undersigned guaranties the full, faithful and punctual performance of each and all of the covenants, agreements and conditions of the Lease, to be kept and performed by Tenant (subject to all applicable notice and/or cure periods set forth in the Lease), in accordance with and within the time prescribed by the Lease (hereinafter collectively referred to as the "Liabilities"). Notwithstanding anything herein to the contrary, this Guaranty, and all the obligations of the undersigned hereunder, shall terminate upon the expiration of the initial "Term" (as defined in the Lease) of the Lease.

2. Landlord shall have the right from time to time, and at any time in its sole discretion, without notice to or consent from the undersigned, or without affecting, impairing or discharging in whole or in part, the Liabilities or the obligations of the undersigned hereunder, to modify, change, extend, alter, amend, or supplement in any respect whatever, the Lease, or any agreement or transaction between Landlord and Tenant or between Landlord and any other party liable for the Liabilities, or any portion or provision thereof; to grant extension of time and other indulgences of any kind to Tenant; to compromise, release, substitute, exercise, enforce or fail to refuse to exercise or enforce any claims, rights, or remedies of any kind which Landlord may have at any time against Tenant or any other party liable for the Liabilities, or any thereof, or with respect to any security of any kind held by Landlord at any time under any agreement or otherwise.

3. The undersigned waives: (a) all notice, including but not limited to (i) notice of acceptance of this Guaranty; (ii) notice of presentment, demand for payment, or protest of any of the Liabilities, or the obligation of any person, firm, or corporation held by Landlord as collateral security; (b) trial by jury and the right thereto in any proceeding of any kind, whether arising on or out of, under or by reason of this Guaranty, or any other agreement or transaction between the undersigned, Landlord and/or Tenant; and (c) all notices of the financial condition or of any adverse or other change in the financial condition of Tenant.

4. Landlord may, without notice, assign this Guaranty in whole or in part to Landlord's successor in interest under the Lease, and no assignment of this Guaranty shall operate to extinguish or diminish the liability of the undersigned hereunder. The assignment of the Lease by Tenant to an entity not affiliated with the undersigned, to the extent such assignment is made in accordance with the terms of the Lease, shall automatically terminate this Guaranty, and thereafter, the undersigned shall have no further liability hereunder; provided, however, if Tenant assigns the Lease to any person, corporation, partnership or other entity which acquires all or substantially all of the business or assets of Tenant or stock in Tenant without Landlord's consent in accordance with the terms of the Lease, then the Guaranty shall automatically terminate only if (i) such assignee has a net worth of at least $25,000,000 and such assignee or Tenant provides Landlord with a letter of credit for 100% of the then remaining rent due under the Lease, or such assignee has a net worth of at least $1,000,000,000, (ii) such assignee provide a guaranty to Landlord from

a creditworthy source satisfactory to Landlord in its reasonable discretion, (iii) such assignee provides Landlord, as security for the assignee's obligations under the Lease, a letter of credit in an amount the parties agree is commercially reasonable in light of the assignee's creditworthiness and the amount of base rent payable from the effective date of the assignment through the expiration of the initial Term of the Lease, or (iv) the parties agree upon another mutually satisfactory replacement for this Guaranty.

5. The liability of the undersigned under the Guaranty shall be primary under any right of action which shall accrue to Landlord under the Lease and Landlord may, at its option, proceed against the undersigned without having to commence any action, or have obtained any judgment against Tenant.

6. All of the Liabilities and the obligations of the undersigned hereunder shall be immediately due and payable by the undersigned, anything contained herein to the contrary notwithstanding, immediately upon the occurrence of a default under the Lease which continues beyond the expiration of the applicable notice and/or grace period, if any, under the Lease.

7. The obligations of the undersigned hereunder shall not be affected, impaired or discharged, in whole or in part, by reason of: (a) the entry of an order for relief pursuant to the United States Bankruptcy Code by or against Tenant or the undersigned; or (b) the proposal of or the consummation of a plan of reorganization concerning Tenant or the undersigned.

8. The waiver of any right by Landlord or its failure to exercise promptly any right shall not be construed as the waiver of any other right including the right to exercise the same at any time thereafter. No waiver or modification of any of the terms or conditions of this Guaranty shall be binding against Landlord unless such waiver or modification is in a writing signed by Landlord.

9. The provisions of the Guaranty shall bind all of the respective successors and assigns of the undersigned and shall inure to the benefit of Landlord, its successors and assigns.

10. All rights and remedies of Landlord are cumulative and not alternative. This Guaranty is, and shall be deemed to be, a contract entered into under and pursuant to the laws of the State of in which the Premises are located and shall be in all respects governed, construed, applied and enforced in accordance with the laws of said State.

11. The undersigned represents that at the time of the execution and delivery of this Guaranty nothing exists to impair the effectiveness of the obligations of the undersigned to Landlord hereunder, or the immediate taking effect of this Guaranty between the undersigned and Landlord with respect to the undersigned becoming a surety for the Liabilities.

IN WITNESS WHEREOF, the undersigned has caused this Guaranty to be executed on _____.

DAVITA INC.

By: _____
Name: _____
Title: _____

For Guarantor's Internal Use:

Approved as to form:

By: _____
Name: _____
Title: Assistant General Counsel

DocuSign Envelope ID: 210EE19D-0546-478A-9C07-D85544C91CA7

GUARANTY

WHEREAS, SOUTHERN FINANCIAL GROUP, LLC ("Landlord") and TOTAL RENAL CARE, INC. ("Tenant"), have entered into a certain lease agreement dated on or about the date hereof (the "Lease"), covering certain premises located at the intersection of O Street and 15th Street SW in the City of Auburn, King County Parcel ID #0301500090, #0301500280, and #0301500110 located in Auburn, Washington (the "Premises"); and

WHEREAS, the Landlord requires as a condition to its execution of the Lease that the undersigned unconditionally becomes a guarantor to Landlord for the obligations of Tenant under the Lease; and

WHEREAS, the undersigned is the parent corporation of Tenant and as such is desirous that Landlord enter into the Lease with Tenant.

NOW THEREFORE, in consideration of the execution of the Lease by Landlord and other good and valuable consideration and intending to be legally bound hereby, the undersigned hereby unconditionally becomes a guarantor to Landlord, its successors and assigns as follows:

1. The undersigned guaranties the full, faithful and punctual performance of each and all of the covenants, agreements and conditions of the Lease, to be kept and performed by Tenant (subject to all applicable notice and/or cure periods set forth in the Lease), in accordance with and within the time prescribed by the Lease (hereinafter collectively referred to as the "Liabilities"). Notwithstanding anything herein to the contrary, this Guaranty, and all the obligations of the undersigned hereunder, shall terminate upon the earlier of: (i) expiration of the initial 10 year Lease term, or (ii) purchase of the Premises by Tenant or its affiliate, in accordance with the terms and conditions of the Lease.

2. Landlord shall have the right from time to time, and at any time in its sole discretion, without notice to or consent from the undersigned, or without affecting, impairing or discharging in whole or in part, the Liabilities or the obligations of the undersigned hereunder, to modify, change, extend, alter, amend, or supplement in any respect whatever, the Lease, or any agreement or transaction between Landlord and Tenant or between Landlord and any other party liable for the Liabilities, or any portion or provision thereof; to grant extension of time and other indulgences of any kind to Tenant; to compromise, release, substitute, exercise, enforce or fail to refuse to exercise or enforce any claims, rights, or remedies of any kind which Landlord may have at any time against Tenant or any other party liable for the Liabilities, or any thereof, or with respect to any security of any kind held by Landlord at any time under any agreement or otherwise.

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3. The undersigned waives: (a) all notice, including but not limited to (i) notice of acceptance of this Guaranty; (ii) notice of presentment, demand for payment, or protest of any of the Liabilities, or the obligation of any person, firm, or corporation held by Landlord as collateral security; (b) trial by jury and the right thereto in any proceeding of any kind, whether arising on or out of, under or by reason of this Guaranty, or any other agreement or transaction between the undersigned, Landlord and/or Tenant; and (c) all notices of the financial condition or of any adverse or other change in the financial condition of Tenant.

4. Landlord may, without notice, assign this Guaranty in whole or in part to Landlord's successor in interest under the Lease, and no assignment of this Guaranty shall operate to extinguish or diminish the liability of the undersigned hereunder.

5. The liability of the undersigned under the Guaranty shall be primary under any right of action which shall accrue to Landlord under the Lease and Landlord may, at its option, proceed against the undersigned without having to commence any action, or have obtained any judgment against Tenant.

6. All of the Liabilities and the obligations of the undersigned hereunder shall be immediately due and payable by the undersigned, anything contained herein to the contrary notwithstanding, immediately upon the occurrence of a default under the Lease which continues beyond the expiration of the applicable notice and/or grace period, if any, under the Lease.

7. The obligations of the undersigned hereunder shall not be affected, impaired or discharged, in whole or in part, by reason of: (a) the entry of an order for relief pursuant to the United States Bankruptcy Code by or against Tenant or the undersigned; or (b) the proposal of or the consummation of a plan of reorganization concerning Tenant or the undersigned.

8. The waiver of any right by Landlord or its failure to exercise promptly any right shall not be construed as the waiver of any other right including the right to exercise the same at any time thereafter. No waiver or modification of any of the terms or conditions of this Guaranty shall be binding against Landlord unless such waiver or. modification is in a writing signed by Landlord.

9. The provisions of the Guaranty shall bind all of the respective successors and assigns of the undersigned and shall inure to the benefit of Landlord, its successors and assigns.

10. All rights and remedies of Landlord are cumulative and not alternative. This Guaranty is, and shall be deemed to be, a contract entered into under and pursuant to the laws of the State of Washington and shall be in all respects governed, construed, applied and enforced in accordance with the laws of said State.

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11. The undersigned represents that at the time of the execution and delivery of this Guaranty nothing exists to impair the effectiveness of the obligations of the undersigned to Landlord hereunder, or the immediate taking effect of this Guaranty between the undersigned and Landlord with respect to the undersigned becoming a surety for the Liabilities.

IN WITNESS WHEREOF, the undersigned has caused this Guaranty to be executed as of May 24, 2018.

DAVITA INC.

DocuSigned by:
By: Chet Mehta
7BFAE1B0946142B...

Name: Chet Mehta

Title: Group VP, Finance

Date: May 24, 2018

FOR TENANT'S INTERNAL USE ONLY:

APPROVAL AS TO FORM ONLY

DocuSigned by:
By: Jeff Pretty
EF9D2D4714FD472...

Name: Jeff Pretty

Title: Assistant General Counsel

Certificate Of Completion

Envelope Id: 210EE19D0546478A9C07D85544C91CA7
Status: Completed
Subject: Please DocuSign: Ground Lease guaranty (King 11/Auburn WA CON ground lease)
Source Envelope:
Document Pages: 3
Signatures: 2
Certificate Pages: 5
Initials: 0
AutoNav: Enabled
EnvelopeId Stamping: Enabled
Time Zone: (UTC-07:00) Mountain Time (US & Canada)

Envelope Originator:
Niccole Sacco
2000 16th Street
Denver, CO 80202
niccole.brennan@davita.com
IP Address: 104.129.192.115

Record Tracking

Status: Original
5/24/2018 10:17:56 AM
Holder: Niccole Sacco
niccole.brennan@davita.com
Location: DocuSign

Signer Events	Signature	Timestamp
Jeff Pretty jeff.pretty@davita.com Assistant General Counsel Security Level: Email, Account Authentication (None)	DocuSigned by:  EF9D2D4714FD472...	Sent: 5/24/2018 10:24:21 AM Viewed: 5/24/2018 10:36:49 AM Signed: 5/24/2018 10:36:55 AM
	Using IP Address: 104.129.192.75	

Electronic Record and Signature Disclosure:
Accepted: 5/24/2018 10:36:49 AM
ID: d336b4c1-6075-4810-a9c3-72744876a1ae

Chet Mehta chetan.mehta@davita.com Group VP, Finance Security Level: Email, Account Authentication (None)	DocuSigned by:  7BFAE1B0946142B...	Sent: 5/24/2018 10:36:56 AM Viewed: 5/24/2018 10:45:24 AM Signed: 5/24/2018 10:45:32 AM
	Using IP Address: 24.20.186.99	

Electronic Record and Signature Disclosure:
Accepted: 5/24/2018 10:45:24 AM
ID: 187d82aa-48b8-40b9-8853-6427336d5abb

In Person Signer Events	Signature	Timestamp

Editor Delivery Events	Status	Timestamp

Agent Delivery Events	Status	Timestamp

Intermediary Delivery Events	Status	Timestamp

Certified Delivery Events	Status	Timestamp

Carbon Copy Events	Status	Timestamp
Niccole Sacco niccole.sacco@davita.com Assistant General Counsel Total Renal Care, Inc. Security Level: Email, Account Authentication (None)	COPIED	Sent: 5/24/2018 10:45:33 AM Viewed: 5/24/2018 12:12:56 PM

Electronic Record and Signature Disclosure:
Not Offered via DocuSign

Notary Events	Signature	Timestamp

Envelope Summary Events	Status	Timestamps
Envelope Sent	Hashed/Encrypted	5/24/2018 10:45:33 AM
Certified Delivered	Security Checked	5/24/2018 10:45:33 AM
Signing Complete	Security Checked	5/24/2018 10:45:33 AM
Completed	Security Checked	5/24/2018 10:45:33 AM

Payment Events	Status	Timestamps

Electronic Record and Signature Disclosure

ELECTRONIC RECORD AND SIGNATURE DISCLOSURE

From time to time, DaVita (we, us or Company) may be required by law to provide to you certain written notices or disclosures. Described below are the terms and conditions for providing to you such notices and disclosures electronically through your DocuSign, Inc. (DocuSign) Express user account. Please read the information below carefully and thoroughly, and if you can access this information electronically to your satisfaction and agree to these terms and conditions, please confirm your agreement by clicking the 'I agree' button at the bottom of this document.

Getting paper copies

At any time, you may request from us a paper copy of any record provided or made available electronically to you by us. For such copies, as long as you are an authorized user of the DocuSign system you will have the ability to download and print any documents we send to you through your DocuSign user account for a limited period of time (usually 30 days) after such documents are first sent to you. After such time, if you wish for us to send you paper copies of any such documents from our office to you, you will be charged a $0.00 per-page fee. You may request delivery of such paper copies from us by following the procedure described below.

Withdrawing your consent

If you decide to receive notices and disclosures from us electronically, you may at any time change your mind and tell us that thereafter you want to receive required notices and disclosures only in paper format. How you must inform us of your decision to receive future notices and disclosure in paper format and withdraw your consent to receive notices and disclosures electronically is described below.

Consequences of changing your mind

If you elect to receive required notices and disclosures only in paper format, it will slow the speed at which we can complete certain steps in transactions with you and delivering services to you because we will need first to send the required notices or disclosures to you in paper format, and then wait until we receive back from you your acknowledgment of your receipt of such paper notices or disclosures. To indicate to us that you are changing your mind, you must withdraw your consent using the DocuSign 'Withdraw Consent' form on the signing page of your DocuSign account. This will indicate to us that you have withdrawn your consent to receive required notices and disclosures electronically from us and you will no longer be able to use your DocuSign Express user account to receive required notices and consents electronically from us or to sign electronically documents from us.

All notices and disclosures will be sent to you electronically

Unless you tell us otherwise in accordance with the procedures described herein, we will provide electronically to you through your DocuSign user account all required notices, disclosures, authorizations, acknowledgements, and other documents that are required to be provided or made available to you during the course of our relationship with you. To reduce the chance of you inadvertently not receiving any notice or disclosure, we prefer to provide all of the required notices and disclosures to you by the same method and to the same address that you have given us. Thus, you can receive all the disclosures and notices electronically or in paper format through the paper mail delivery system. If you do not agree with this process, please let us know as described below. Please also see the paragraph immediately above that describes the consequences of your electing not to receive delivery of the notices and disclosures electronically from us.

How to contact DaVita:
You may contact us to let us know of your changes as to how we may contact you electronically, to request paper copies of certain information from us, and to withdraw your prior consent to receive notices and disclosures electronically as follows:
To contact us by email send messages to: emily.briggs@davita.com

To advise DaVita of your new e-mail address
To let us know of a change in your e-mail address where we should send notices and disclosures electronically to you, you must send an email message to us at jennifer.vanhyning@davita.com and in the body of such request you must state: your previous e-mail address, your new e-mail address. We do not require any other information from you to change your email address..
In addition, you must notify DocuSign, Inc to arrange for your new email address to be reflected in your DocuSign account by following the process for changing e-mail in DocuSign.

To request paper copies from DaVita
To request delivery from us of paper copies of the notices and disclosures previously provided by us to you electronically, you must send us an e-mail to emily.briggs@davita.com and in the body of such request you must state your e-mail address, full name, US Postal address, and telephone number. We will bill you for any fees at that time, if any.

To withdraw your consent with DaVita
To inform us that you no longer want to receive future notices and disclosures in electronic format you may:

i. decline to sign a document from within your DocuSign account, and on the subsequent page, select the check-box indicating you wish to withdraw your consent, or you may;
ii. send us an e-mail to emily.briggs@davita.com and in the body of such request you must state your e-mail, full name, IS Postal Address, telephone number, and account number. We do not need any other information from you to withdraw consent.. The consequences of your withdrawing consent for online documents will be that transactions may take a longer time to process..

Required hardware and software

Operating Systems:	Windows2000? or WindowsXP?
Browsers (for SENDERS):	Internet Explorer 6.0? or above
Browsers (for SIGNERS):	Internet Explorer 6.0?, Mozilla FireFox 1.0, NetScape 7.2 (or above)
Email:	Access to a valid email account
Screen Resolution:	800 x 600 minimum
Enabled Security Settings:	•Allow per session cookies •Users accessing the internet behind a Proxy Server must enable HTTP 1.1 settings via proxy connection

** These minimum requirements are subject to change. If these requirements change, we will provide you with an email message at the email address we have on file for you at that time providing you with the revised hardware and software requirements, at which time you will have the right to withdraw your consent.

Acknowledging your access and consent to receive materials electronically
To confirm to us that you can access this information electronically, which will be similar to other electronic notices and disclosures that we will provide to you, please verify that you were able to read this electronic disclosure and that you also were able to print on paper or electronically save this page for your future reference and access or that you were able to e-mail this disclosure and consent to an address where you will be able to print on paper or save it for your future reference and access. Further, if you consent to receiving notices and disclosures exclusively in electronic format on the terms and conditions described above, please let us know by clicking the 'I agree' button below.
By checking the 'I Agree' box, I confirm that:

- I can access and read this Electronic CONSENT TO ELECTRONIC RECEIPT OF ELECTRONIC RECORD AND SIGNATURE DISCLOSURES document; and

- I can print on paper the disclosure or save or send the disclosure to a place where I can print it, for future reference and access; and

- Until or unless I notify DaVita as described above, I consent to receive from exclusively through electronic means all notices, disclosures, authorizations, acknowledgements, and other documents that are required to be provided or made available to me by DaVita during the course of my relationship with you.

GROUND LEASE

BY AND

BETWEEN

SOUTHERN FINANCIAL GROUP,

LLC ("LANDLORD")

AND

TOTAL RENAL CARE, INC.

("TENANT")

FOR PROPERTY AT:

The intersection of O Street and 15th Street SW, King County Parcel ID #0301500090, #0301500280, and #0301500110, Auburn, Washington 98001

Dated: May 23, 2018

TABLE OF CONTENTS

		Page
1.	Demise; Premises	1
2.	Term and Delivery of Premises	2
3.	Rent	3
4.	Renewals	4
5.	Condition of Premises	5
6.	Use	5
7.	Assignment/Subletting	6
8.	Operating Expenses and Utilities	6
9.	Construction of the Improvements	7
10.	Signage	8
11.	Alterations	8
12.	Environmental	9
13.	Damage to Premises by Fire or Casualty	10
14.	Eminent Domain	10
15.	Intentionally Omitted	11
16.	Indemnity	11
17.	Default and Remedies	12
18.	Insurance	13
19.	Subrogation	14
20.	Tenant's Maintenance Responsibilities	14
21.	Intentionally Omitted	15
22.	Title and Parking	15

23. Compliance with Laws 15
24. Brokers 15
25. Tenant to Subordinate 16
26. Quiet Enjoyment 16
27. Memorandum of Lease and Right t Purchase 16
28. Notices 16
29. Estoppel Certificate 17
30. Landlord's Sale of the Building 17
31. Regulatory Compliance 18
32. Cooperation with Tenant's Cost Reporting Responsibilities 19
33. Protected Health Information 20
34. Landlord's Consent 20
35. Surrender of Premises 20
36. Holding Over 21
37. Leasehold Mortgages 21
38. Binding Effect 23
39. Severability 24
40. Applicable Law 24
41. Force Majeure 24
42. Complete Agreement 24
43. Counterparts 24
44. Incorporation of Exhibits and Schedule 24
45. Mortgage 24
46. Costs of Enforcement 24
47. Option to Purchase the Premises 25

48. Anti-Terrorism 25
49. Termination Rights 25

EXHIBITS

EXHIBIT A	LEGAL DESCRIPTION OF THE PREMISES
EXHIBIT B	FORM OF COMMENCEMENT DATE MEMORANDUM
EXHIBITC	FORM OF SUBORDINATION, NON-DISTURBANCE AND ATTORNMENTAGREEMENT
EXHIBIT D	FORM OF ESTOPPEL CERTIFICATE
EXHIBIT E	FORM OF MEMORANDUM OF LEASE
EXHIBIT F	FORM OF DAVITA, INC. GUARANTY

DATA SHEET

Landlord:	Southern Financial Group, LLC, a Texas limited liability company
Address of Landlord:	900 Austin Avenue, 9th Floor P.O. Box 2028 Waco, Texas 76703 Phone: 254-756-4411 Email: jeff@sfgwaco.com & tom@sfgwaco.com
Address for Payment of Rent: Tenant:	Same as above Total Renal Care, Inc., a California corporation
Address of Tenant:	c/o DaVita Inc. Attn: Real Estate Legal 2000 16th Street Denver, CO 80202 Telephone: (303) 876-2800 concurrently to: relegal@davita.com Subject: Auburn, WA (Facility #TBD)
Premises Address:	The intersection of O Street and 15th Street SW, King County Parcel ID #0301500090, #0301500280, and #0301500110, Auburn, Washington

GROUND LEASE

THIS GROUND LEASE (this "Lease"), made and entered into as of May 23, 2018 (the "Effective Date") by and between **SOUTHERN FINANCIAL GROUP, LLC,** a Texas limited liability company ("Landlord"), and **TOTAL RENAL CARE, INC.,** a California corporation ("Tenant").

WITNESSETH:

WHEREAS, Landlord is the fee simple owner of certain real property known as King County Parcel ID #0301500090, #0301500280, and #0301500110, located at the intersection of O Street and 15th Street SW in the City of Auburn (the "City"), County of King ("County"), State of Washington ("the State"), containing approximately 7.06 acres of land (the "Premises") which is legally described on Exhibit A;

WHEREAS, Landlord desires to demise, lease and rent unto Tenant, and Tenant desires to rent and lease from Landlord, upon the terms and conditions of this Lease, (a) the Premises; and (b) all easements, declarations and rights of way, and all improvements presently on the Premises (if any);

WHEREAS, Tenant intends to construct upon the Premises certain improvements, including without limitation a building consisting of an approximately 11,500 square feet (the "Building"), (collectively, with the Building, the "Improvements"), the title of which shall be retained by Tenant until surrendered to Landlord pursuant to Section 36 of this Lease; and

WHEREAS, Tenant intends to use or sublease the Building for the purpose of the operating an outpatient renal dialysis clinic, renal dialysis home training, aphaeresis services and similar blood separation and cell collection procedures, general medical offices, clinical laboratory, including all incidental, related and necessary elements and functions of other recognized dialysis disciplines which may be necessary or desirable to render a complete program of treatment to patients of subtenant and related office and administrative uses (the"Intended Use");

NOW, THEREFORE, for and in consideration of the rent, and the mutual covenants, promises and agreements herein contained, and for other valuable consideration, the receipt of which is hereby acknowledged, Landlord and Tenant hereby agree as follows:

1. Demise: Premises. Landlord hereby leases to Tenant, and Tenant hereby hires from Landlord, the Premises and all easements, declarations and rights of way relating to the Premises and all improvements presently on the Premises (if any) for the rents, covenants and conditions (including limitations, restrictions and reservations affecting the Premises) hereinafter provided.

2. Term and Delivery of Premises.

2.1 **Term.** The term of this Lease (the "Term") shall be for 10 Lease Years (as defined below) and shall commence upon the date on which Tenant's termination rights set forth in Section 49 below expire or are waived by Tenant (the "Commencement Date"). The expiration date of the Term shall be the last day of the 10th Lease Year (the "Termination Date"), unless the Term is renewed in which event the Termination Date shall extend to the end of such exercised renewal period(s). A "Lease Year" shall mean a full 12-month period and the first Lease Year shall begin on the Commencement Date and end on the day before the annual anniversary of the Commencement Date. Upon determination of the Possession Date and Commencement Date, Landlord shall complete, execute and forward to Tenant a Commencement Date Memorandum in the form attached hereto as Exhibit B for Tenant's approval and execution.

2.2 **Notice to Proceed.** Except for payment of the Holding Fee as provided in Section 3, all obligations of the parties hereto are contingent upon Tenant's issuance to Landlord of a written notice of its intent to commence the Lease (such notice is hereinafter referred to as the "Notice to Proceed") on or before the date which is 24 months after the Effective Date (the "Termination Deadline"), and neither the Term nor the accrual of any obligation to pay Rent, Impositions (as defined in Section 8.1) or other charges shall commence until Tenant has provided the Notice to Proceed. Tenant may terminate this Lease at any time prior to the Termination Deadline, and this Lease shall be of no further force or effect and the parties hereto shall be released from all liability under this Lease.

Should Tenant terminate this Lease prior to the issuance of a Notice to Proceed, Tenant shall (i) reimburse Landlord for Landlord's reasonable legal fees (not to exceed $2;500.00), and real estate or broker commissions actually paid to Tenant's and Landlord's Brokers, and (ii) forfeit any Holding Fees (as defined in Section 3) accrued prior to the effective date of such termination.

In the event Tenant provides Landlord with the Notice to Proceed, but elects to terminate this Lease prior to the Termination Deadline (on or before 24 months following the Effective Date), pursuant to this Section 2.2, Tenant shall (i) reimburse Landlord for Landlord's reasonable legal fees (not to exceed $2,500.00), and real estate or broker commissions actually paid to Tenant's and Landlord's Brokers; (ii) forfeit any Holding Fees (as defined in Section 3) or Rent accrued prior to the effective date of such early termination, and (iii) make a one-time payment to Landlord equal to one (1) month of Base Rent($5,000.00).

2.3 **Possession Date; Delay in Delivery.** Landlord shall deliver possession of the Premises to Tenant within two (2) business days following Landlord's receipt of the Notice to Proceed (the "Estimated Possession Date"). The date on which Landlord actually delivers possession of the Premises to Tenant is the "Possession Date". Landlord acknowledges that its obligation to deliver possession to Tenant on or before

the Estimated Possession Date constitutes a material inducement to Tenant to enter into this Lease. If the Possession Date occurs more than 60 days following the Estimated Possession Date, then Tenant may elect to terminate this Lease, upon which termination, neither party shall have further obligations under this Lease after the date of termination, except those that expressly survive such termination or receive two days of Base Rent and Additional Rent abatement (in an amount equal to the applicable rent rate for periods following any rent abatement) for each day of delay in delivery beyond the Estimated Possession Date.

3. **Rent**. Beginning on the first day of the month following the Effective Date, Tenant agrees to pay Landlord a holding fee ("Holding Fee") in the amount equal to 75% of the initial Base Rent per month ($3,750.00). Tenant shall pay the Holding Fee until the earlier of (i) the date that Tenant provides Landlord with the Notice to Proceed; or (ii) the date Tenant terminates this Lease pursuant to Section 2 above.

No Holding Fee or Rent shall be due during the period from the date Landlord receives the Notice to Proceed until the Commencement Date.

Beginning on the Commencement Date, Tenant shall pay as initial annual base rent Sixty Thousand and 00/100 Dollars ($60,000.00) ("Base Rent"). Tenant shall pay such Base Rent in monthly installments in the amount of Five Thousand and 00/100 Dollars ($5,000.00), in advance, on the first day of each calendar month during the Term, such monthly installment and any Additional Rent (defined below) or other. charges to be prorated for any partial calendar month in which the Commencement Date or Termination Date occurs. In the event the Commencement Date does not fall on the first date of the calendar month, then Tenant shall pay for such proration on the first day of the month following the Commencement Date. All sums (other than the Base Rent) which may be due and payable under this Lease shall be deemed to be "Additional Rent" hereunder and in the event that Base Rent shall be prorated or shall abate pursuant to the terms of this Lease then such Additional Rent shall be prorated or abate to the same extent and in the same manner, unless otherwise specifically provided for in this Lease. Beginning on the first day of the second Lease Year, and annually thereafter, Base Rent shall be increased over the Base Rent for the prior Lease Year by two percent (2%).

All amounts (unless otherwise provided herein) other than Base Rent and the adjustments thereto described in this Section 3 and Section 4 below owed by Tenant to Landlord hereunder shall be deemed Additional Rent. As a condition to payment of Base Rent or Additional Rent, Landlord shall provide Tenant with a completed Form W-9 Request for Taxpayer Information and Certification and an executed Commencement Date Memorandum in the form attached as Exhibit B. Tenant shall have no obligation to remit any payment to Landlord until it receives or mutually agrees upon a Commencement Date Memorandum executed by Landlord, such payment shall not incur any late charges or interest and Tenant shall not be

deemed in default hereunder for failure to timely pay any such amount. Upon any assignment by Landlord of its rights, title and interest in and to this Lease, Landlord shall cause such successor landlord to deliver a completed Form W-9 to Tenant.

Except as otherwise provided in this Lease, it is the intention of the parties that Landlord shall receive Base Rent, Additional Rent and all other sums payable by Tenant under this Lease free of all taxes, expenses, charges, damages and deductions of any nature whatsoever (except as otherwise provided herein). Tenant shall be under no obligation to pay principal or interest on any mortgage on the fee of the Premises, penalties or interest for late or partial payment nor any income, franchise, margin, inheritance, estate, transfer, excise, gift or capital gain taxes, that are or may be payable by Landlord or that may be imposed against Landlord or against the rents payable hereunder, or succession tax by reason of any present, future or retroactive law which may be enacted during the Term.

If Landlord does not receive any payment of Rent or Additional Rent on or before the fifth business day following the day it is due, then Tenant shall pay a late fee ("Late Fee") equal to 5% of the amount overdue, to compensate Landlord for the loss of the use of the amount not paid and the administrative costs caused by the delinquency.

Upon request from Tenant, Landlord shall provide to Tenant electronically, true and accurate records of items that constitute Additional Rent, if any, including without limitation insurance, taxes, and other "Impositions" (as defined in Section 8 below). Tenant or its duly authorized representative shall have the right to request and inspect such records from time to time for a period of three years after the close of each calendar year. If any audit of Landlord's submitted reports shall disclose an overcharge, Landlord shall promptly pay to Tenant, within 30 days, the amount of such overcharge, and if such audit discloses an overcharge of more than 5%, Landlord shall reimburse Tenant its actual costs incurred in connection with such audit. The provisions of this paragraph shall survive the termination or expiration of this Lease.

4. Renewals. Tenant shall have the right and option to renew this Lease for five (5) additional periods of five (5) years each, next immediately ensuing after the expiration of the initial Term and any subsequent renewal term, as applicable, by notifying Landlord in writing not less than six months before the expiration of the immediately preceding initial Term or subsequent renewal term of Tenant's intention to exercise its option to renew; provided, however, that if Tenant shall fail to give any such notice within the aforesaid time limit, Tenant's right to exercise its option shall nevertheless continue until 30 days after Landlord shall have given Tenant notice of Landlord's election to terminate such option and Tenant may exercise such option at any time until the expiration of said 30-day period. It is the intention of the parties to avoid forfeiture of Tenant's rights to extend the Term under any of the options set forth in this Section 4 through inadvertent failure to give notice of exercise thereof within the time limits prescribed. Accordingly, if Tenant shall fail to given notice to Landlord of Tenant's election to extend the Term for any of the renewal terms and if Landlord shall fail to give notice to Tenant of Landlords' election to terminate Tenant's rights to extend this Lease under the option applicable thereto, then, and so often as such event shall occur, the Term shall be

automatically extended from year to year and upon all of the terms and conditions then in effect, subject to Tenant's right under such option to extend the Term for the remainder of the renewal term covered thereby and to Landlord's right to place the 30-day limit on such option by a notice in the manner provided in this Section 4. In the event Tenant so elects to extend this Lease, then, for such extended period of the Term, all of the terms, covenants and conditions of this Lease shall continue to be, and shall be, in full force and effect during such extended period of the Term, except that Base Rent for each renewal term shall be increased by ten percent (10%) over the Base Rent for the initial Term or renewal term, as the case may be. The initial Term and each renewal term granted to and elected by Tenant in accordance with the terms of this Section 4, shall be hereinafter collectively referred to as the "Term".

5. Condition of Premises. The Premises are demised and let in an "as is" condition as of the Possession Date. Landlord covenants and warrants that, as of the Possession Date, the Premises will be free and clear of all liens, encumbrances, restrictions, covenants, and other matters affecting title to the Premises, which are not set forth in the public record.

6. Use. It is intended that Tenant shall cause or permit the Premises to be used for the Intended Use, or for any other lawful purposes (collectively, the "Permitted Use"). The Premises may be operated during such days and hours as Tenant may determine, without the imposition of minimum or maximum hours of operation. Neither the foregoing language nor any other language contained in this Lease shall be construed to obligate Tenant to build, operate or rebuild a dialysis center or other business related to the Intended Use within the Building.

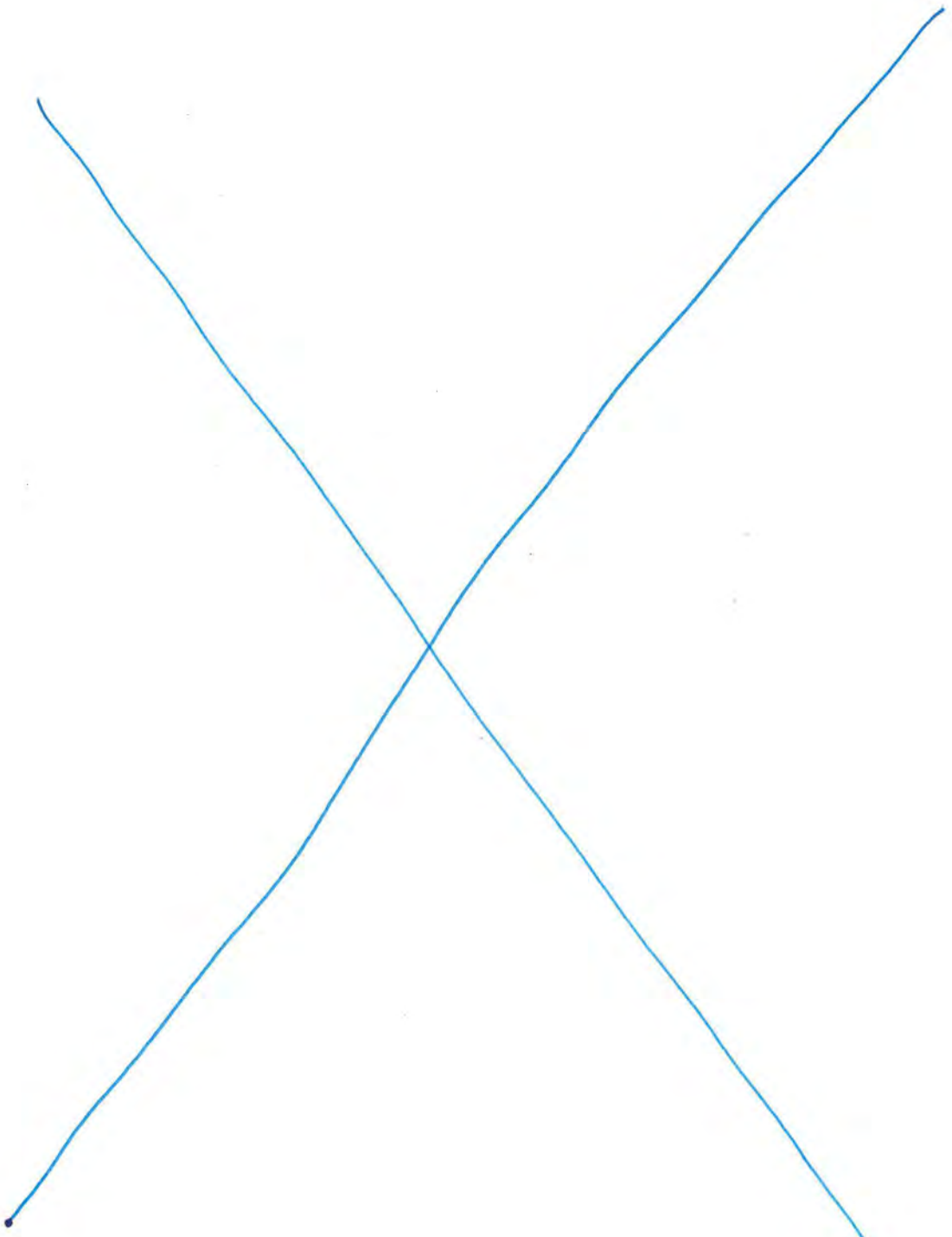
Landlord shall not rent or permit any property owned, leased or controlled by Landlord or any affiliate of Landlord within a radius of five miles from the Premises to be occupied or used by a business that derives more than 10% of its revenues from renal dialysis, renal dialysis home training, any aphaeresis service(s) or similar blood separation or cell collection procedures, except services involving the collection of blood or blood components from volunteer donors. Landlord shall not display or permit to be displayed upon any such property within such radius any advertisement for any such business, other than Tenant's advertisement(s) for Tenant's business(es). Landlord covenants that it will provide notice of such radius restriction to any third parties with whom Landlord conducts business within the radius restriction. Landlord further covenants that in any lease, sublease, license agreement or similar agreement hereafter executed by Landlord affecting any property owned, leased or controlled by Landlord within the foregoing radius, Landlord will insert a restrictive clause preventing such property from being used for any purposes herein prohibited. In the event the radius restrictions are violated and Landlord has failed to promptly commence an action or proceeding (or arbitration, if applicable) against the violating owner, tenant or occupant or at any point in such action or proceeding (or arbitration, if applicable) fails to use commercially reasonable and good faith efforts to seek and obtain a temporary restraining order, preliminary injunction, permanent injunction or other court order or judgment enjoining or stopping such violation, then, in addition to all other rights at law and in equity, Tenant may, while such violation is continuing, reduce the Rent to an amount equal to

50% of the Rent. This paragraph shall survive for two years following the termination or expiration of this Lease.

7. Assignment/Subletting. Tenant shall have the right, at any time, to assign this Lease or sublet all or any portion of the Premises subject to Landlord's consent, such consent not to be unreasonably withheld, delayed or conditioned. Notwithstanding anything to the contrary herein, Landlord's consent shall not be required for Tenant to assign its interest in this Lease to Genesis KC Development, LLC, a Delaware limited liability company. Tenant shall promptly provide Landlord with written notice of any such assignment or subletting. Landlord shall have no right to recapture any subleased or assigned space. A failure by Landlord to respond within 30 days of Tenant's notice of Tenant's election to sublease or assign, shall be deemed to be Landlord's consent to the same. Notwithstanding any assignment in accordance with this Section 7, Tenant (meaning the initial Tenant executing this Lease) and any guarantor of such Tenant's obligations under this Lease shall at all times remain fully and primarily responsible and liable for the payment of the rental herein specified and for compliance with all other obligations of Tenant under this Lease.

8. Operating Expenses and Utilities.

8.1 Tenant shall pay prior to the due date all real estate taxes, assessments, water and sewer charges and other governmental levies, and any applicable ownership association fees ("Impositions") which are charged, levied, assessed or. imposed against the Premises and the Improvements located on the Premises from and after the Commencement Date and during the Term. The amount to be paid by Tenant on account of taxes during the first and last calendar years in which any portion of the Term falls shall be prorated per diem so that Tenant is liable only for so much of such taxes as the portion of the Term which falls within such calendar year bears to a full calendar year. If real estate taxes are payable in arrears, Tenant shall be responsible for real estate taxes on the basis of the years for which taxes are assessed as opposed to the years during which such taxes are payable. In case of special taxes which may be payable in installments, only the amount of each installment payable during a calendar year shall be included in taxes for that calendar year, and any one time (as opposed to on-going) special assessments for public improvements having a useful economic life exceeding the remaining term of this Lease shall be prorated between Landlord and Tenant using a straight-line method, based on the proportion of that economic life falling within the remaining Term. Taxes payable by Tenant shall not include (i) "roll back" real estate taxes, (ii) any penalties or interest for late or partial payment if not caused by Tenant, (iii) any income, franchise, margin, inheritance, estate, transfer, excise, gift or capital gain taxes, that are or may be payable by Landlord or that may be imposed against Landlord or against the rents payable hereunder, or (iv) special assessments which were first levied prior to the Commencement Date. Landlord and Tenant shall use their best efforts to cause the tax bills to be sent directly to Tenant from the tax collector and shall cause the Premises to be assessed separately and apart from any other land or improvements. Landlord shall provide to Tenant a copy of all final tax bill(s) for each calendar year within ten days after Landlord's receipt of such tax bill(s), and in any event at least 30 days before the same are due and payable.



8.2 Tenant shall pay the entire cost (after applying any discounts or incentives) of all utilities and other services necessary in the operation of the Premises,

including but not limited to, gas, fuel oil, electrical, telephone and other utility charges, janitorial services (if Tenant shall contract for such services) and grounds maintenance. Tenant shall contract directly with all utility providers such that all utilities for the Premises shall be in Tenant's name.

8.3 Tenant may contest the amount, assessment or validity of any Imposition described in this Section 8 by appropriate proceedings. However, Tenant shall promptly pay such Imposition unless such proceedings shall operate to prevent or stay the collection of the Imposition so contested. The Landlord, at Tenant's sole cost and expense, shall join in any such contestation proceedings if any Law (as defined below) shall so require. Landlord agrees to cooperate with Tenant and appoints Tenant as its agent for the sole purpose of obtaining information and other data from the applicable taxing authority and instituting and maintaining any proceeding or contest allowed under this Section 8 with respect to all Impositions, provided that Tenant shall give written notice to Landlord of any such proceeding or contest.

8.4 Tenant may at its option pay any tax, assessment or other Imposition in installments to the extent permitted by applicable Law.

8.5 Landlord appoints Tenant the attorney-in-fact of Landlord for the purpose of making all payments to be made by Tenant pursuant to any of the provisions of this Lease to persons other than Landlord. In case any person to whom any sum is directly payable by Tenant under any of the provisions of this Lease shall refuse to accept payment of such sum from Tenant, Tenant shall thereupon give written notice of such fact to Landlord and shall pay such sum directly to Landlord, who shall thereupon pay such sum to such person.

8.6 Notwithstanding anything to the contrary contained herein, Tenant shall not be responsible for payment of any increases in real property taxes attributable to Landlord's sale of the Premises to a third party.

9. Construction of the Improvements. Subject to compliance with all applicable Laws, ordinances and regulations (defined herein) Tenant has the right, but not the obligation, to construct, at its sole cost and expense, the Building and other Improvements on the Premises, including, but not limited to, installing utilities, paving, canopies and drop-off lanes, generators and generator pads, trash containers, parking lots and landscaping. In connection with the demolition of any existing improvements and/or the construction of the new Improvements on all or part of the Premises, Tenant shall have the right to modify or change the contour or grade, or both, of the Premises, and to remove trees and/or vegetation, if any from the Premises as necessary for the construction of the Improvements.

Tenant shall select all personnel, labor, materials, equipment, services, utilities and other elements, enter into contracts therefore and determine and do any and all matters
and things which Tenant, in its sole discretion, shall deem necessary or advisable in connection with the construction of the Improvements. Tenant shall contract for the installation of the Improvements with a contractor of Tenant's choice. Landlord shall not charge Tenant a fee or other charges for the supervision and/or overhead associated with the construction of the Tenant Improvements, nor shall Landlord provide such services unless agreed to by Landlord and Tenant pursuant to a separate written agreement. Landlord agrees to cooperate with Tenant and all governmental authorities having jurisdiction, to facilitate Tenant's construction, maintenance and operation of the Premises, including, without limitation, Landlord's joinder in documents relating to the granting of entitlements, easements and similar matters.

Tenant will directly contract with local utility companies, and shall have, for use by Tenant and its servants, agents, employees and independent contractors, on or in connection with the Improvements, all necessary or appropriate rights of access, ingress and egress to and from the Premises during the course of the construction of the Improvements and the right to do all such other things as may be incidental to the construction of the Improvements. Landlord shall cooperate reasonably with Tenant in all ways so that the construction of the Improvements may proceed as expeditiously as possible. Tenant shall indemnify and hold Landlord harmless from all claims or liabilities caused by Tenant's failure to comply with any applicable Law, rule or regulation.

During the Term, including any extensions, title to all Improvements (including without limitation, the Building) shall remain in Tenant alone, and Tenant shall be entitled to claim all depreciation to any Improvements constructed on the Premises by Tenant. To the maximum extent permitted by applicable Laws, Landlord hereby waives any rights which Landlord may have, as to any of Tenant's furniture, fixtures, equipment, personal property, tenant improvements and alterations in the nature of a landlord's lien, security interest or otherwise and further waives the right to enforce any such lien or security interest.

10. Signage. Tenant shall have the right to erect, affix and display such signage as Tenant may consider necessary or desirable on the exterior and interior walls, doors and windows of the Building (including directional and designated parking signage in parking areas) and signs on the exterior of the Building and monument signs at locations on the Premises as Tenant may so desire. All such signs shall comply with all applicable zoning Laws or private restrictions, and shall be subject to applicable municipal permits.

11. Alterations. Tenant may, at any time and from time to time during the Term, make any alterations, changes, additions and improvements to the Improvements and the Premises that Tenant deems necessary or appropriate. Tenant may at any time during the Term install within the Building any and all trade fixtures and

operating equipment which it may deem necessary or advisable in connection with the conduct of its business. Any and all of such fixtures and equipment may at any time and from time to time during the Term be removed by Tenant (or any lessee, licensee or user of all or any portion of the Premises under a sublease, license or similar agreement with Tenant or any other person, if permitted thereunder (each, an "Occupant")), from the Building.

12. Environmental.

12.1 Tenant shall not cause or permit any hazardous or toxic substances, materials or waste, including, without limitation, medical waste and asbestos ("Hazardous Substances") to be used, generated, stored or disposed of in, on or under, or transported to or from, the Premises in violation of any applicable local, state, and federal laws, ordinances, statutes, rules, regulations, executive orders, judgments, decrees, case law and/or other determination of an arbitrator or a court or other governmental authority, in each case applicable to or binding upon such person or any of its property or to which such person or any of its property is subject ("Laws") whether now in existence or hereafter adopted, relating to Hazardous Substances or otherwise pertaining to the environment (the "Environmental Laws"). Tenant shall periodically cause to be removed from the Premises such Hazardous Substances placed thereon by Tenant or Tenant's Occupants, agents, servants, employees, guests, invitees or independent contractors in accordance with good business practices, such removal to be performed by persons or entities duly qualified to handle and dispose of Hazardous Substances. Without limiting the generality of the foregoing, Landlord acknowledges that the following Hazardous Substances, among others, are required for the Intended Use: bleach, cidex, hibiclens, metricide, hydrogen peroxide and formaldehyde. Upon the expiration or earlier termination of this Lease, Tenant shall cause all Hazardous Substances placed on the Premises by Tenant or its Occupants to be removed from the Premises, at Tenant's cost and expense and disposed of in strict accordance with Environmental Laws.

12.2 Tenant shall indemnify, defend (by counsel reasonably acceptable to Landlord) and hold Landlord harmless, from and against any and all claims, liabilities, penalties, fines, judgment, forfeitures, losses, costs (including clean-up costs) or expenses (including reasonable attorney's fees, consultant's fees and expert's fees) for the death of or injury to any person or damage to any property whatsoever, arising from or caused in whole or in part, directly or indirectly, by (a) the presence after the Possession Date in, on, under or about the Premises of any Hazardous Substances caused by Tenant, agents, servants, employees, guests, invitees or independent contractors; (b) any discharge or release by Tenant, agents, servants, employees, guests, invitees or independent contractors after the Possession Date in or from the Premises of any Hazardous Substances; (c) Tenant's use, storage, transportation, generation, disposal, release or discharge after the Possession Date of Hazardous Substances to, in, on, under, about or from the Premises; or (d) Tenant's failure after the Possession Date to comply with any Environmental Law (other than to the extent caused by or related to Landlord's use, generation, storage or disposal of Hazardous Substances in, on or under the Premises).

12.3 Landlord shall indemnify, defend (by counsel reasonably acceptable to Tenant) and hold Tenant harmless, from and against any and all claims, liabilities, penalties, fines, judgment, forfeitures, losses, costs (including clean-up costs) or expenses (including reasonable attorney's fees, consultant's fees and expert's fees) for the death of or injury to any person or damage to any property whatsoever, arising from or caused in whole or in part, directly or indirectly, by the presence in, on, under or about the Premises of any Hazardous Substances discovered during the due diligence period provided in Section 49.1. Notwithstanding anything to the contrary herein, Landlord shall only be obligated to indemnify Tenant pursuant to this Section 12.3 if Tenant exercises its termination rights set forth in Section 49, below. The indemnities set forth in this Section 12 shall survive termination or expiration of this Lease.

12.4 Landlord represents and warrants to Tenant that (a) to Landlord's knowledge, there are no Hazardous Substances in, on, under or about the Premises, including without limitation asbestos or mold, and (b) Landlord has received no notice from any governmental or private entity relating to Hazardous Substances in, on, under or about the Premises.

12.5 Tenant shall promptly deliver to Landlord copies of all notices made by Tenant to, or received by Tenant from, any state, county, municipal or other agency having authority to enforce any Environmental Law or from the United States Occupational Safety and Health Administration ("Enforcement Agency") concerning environmental matters or Hazardous Substances at the Premises. Landlord shall promptly deliver to Tenant copies of all notices received by Landlord from any Enforcement Agency concerning environmental matters or Hazardous Substances at the Premises.

13. Damage to Premises by Fire or Casualty. In the event of damage to or destruction of the whole or any part of the Improvements by fire or any other casualty during the Term of this Lease, Tenant, at Tenant's sole cost and expense, and subject to all applicable Laws, shall either (a) repair and restore such Improvements to such condition as Tenant's deems desirable, or (b) demolish such Improvements and remove any resulting debris and either pave or plant grass over the stripped area. All such repairs and restoration shall be performed in a commercially reasonable time and in a manner and quality consistent with the terms and conditions of Section 9 hereof. All insurance proceeds attributable to the damage to or the destruction of the Improvements shall be made available to Tenant for the purpose of performing its obligations under this Section and with any surplus insurance proceeds to be used as Tenant determines in its sole and absolute discretion.

14. Eminent Domain.

14.1 **Taking.** If by any lawful authority through condemnation or under the power of eminent domain: (a) the whole of the Premises shall be permanently taken; (b) less than the entire Premises shall be permanently taken, but the remainder of the Premises are not, in Tenant's reasonable judgment, fit for Tenant or any Tenant Occupant to carry on the normal operation of its business therein; (c) Tenant

determines, in its reasonable judgment, that after such taking adequate parking space will not be available on the Premises; (d) there is any substantial impairment of ingress or egress from or to or visibility of the Premises which would unreasonably impair Tenant Occupant to carry on the normal operation of its business therein; (e) all or any portion of the Premises shall be taken resulting in a material interference with the operations of or access to Tenant's or and Tenant Occupant's business, or (f) a temporary taking of all or a material portion of the Premises continues for a period of one year, then in any such event, Tenant may terminate this Lease by written notice to Landlord within 30 days of initial notice of condemnation by the condemning authority, effective as of the date of such taking, and Rent and Additional Rent shall be prorated as of the date of such termination.

14.2 **Rent Adjustment.** Upon taking of less than all of the Premises, if Tenant does not exercise its right to terminate this Lease under Section 14.1 hereof, this Lease shall remain in effect for the balance of the Premises not so taken, Rent shall be abated as provided below and Tenant shall, in a commercially reasonable prompt and diligent manner, restore the remainder of the Premises as near as possible to the condition it was in immediately prior to such taking. Upon a taking of any portion of the Premises, annual fixed Rent shall be reduced by an amount equal to the product of (a) fourteen percent (14%) of the annual fixed Rent otherwise payable under this Lease, multiplied by (b) a fraction, the numerator of which is the square footage of Premises taken and the denominator of which is the square footage of the Premises immediately prior to such taking. Upon a taking of any portion of the Building, annual fixed Rent shall be reduced by an amount equal to the product of (c) eighty-six percent (86%) of the annual fixed Rent otherwise payable under this Lease, multiplied by (d) a fraction, the numerator of which is the total square feet of the Building taken and the denominator of which is the total square feet of the Building immediately prior to such taking.

14.3 **Awards.** Both Landlord and Tenant shall have the right to participate in any condemnation proceedings. Each shall notify the other promptly of any contemplated or threatened condemnation proceeding of which it shall become aware and shall keep the other informed of developments with respectthereto.

The full amount of any award whether pro tanto or final for any taking (the "Award") shall, notwithstanding any allocation made by the awarding authority, be paid into an escrow account, with an escrow agent which shall be appointed pursuant to a mutually agreed to escrow agreement, provided that there shall first be deducted from the Award all reasonable fees and expenses of collection, including but not limited to, reasonable attorneys' fees and experts' fees. The Landlord and the Tenant shall then attempt to fairly allocate (taking into account) the Award between the Landlord's interest in the Premises and the Tenant's interest in the remainder of the Term of this Lease, taking into account their respective interests, any restoration obligation of the Tenant, any existing appraisals used to determine or to contest the amount of the Award and any other relevant information and analysis. Upon determination of the allocation of the Award between the Landlord and the Tenant, the Landlord's and Tenant's portion thereof shall be paid forthwith. Should the Landlord and Tenant be unable to reach an agreement, then escrow shall hold the funds and the matter shall be settled by binding arbitration in

the state of Washington or another location mutually agreeable to the parties. An award of arbitration may be confirmed in a court of competent jurisdiction

15. Intentionally Omitted.

16. Indemnity. Tenant agrees to indemnify Landlord and save Landlord harmless from any and all liability, claims and loss for personal injury or property damage, or both, sustained or claimed to have been sustained by any person or persons, or property in, upon or about the Premises caused or brought about by the act or neglect of Tenant or its Occupants, agents, servants or employees. Landlord agrees to indemnify Tenant and save Tenant harmless from any and all liability, claims and loss for personal injury or property damage, or both, sustained or claimed to have been sustained by any person or persons, or property in, upon or about the Premises caused or brought about by the act or neglect of Landlord or its agents, servants or employees. The indemnities set forth in this Section 16 shall survive termination or expiration of this Lease.

17. Default and Remedies.

17.1 **Tenant Default and Landlord Remedies.** In the event that (a) Tenant defaults in the payment of Rent or Additional Rent hereunder and such Rent or Additional Rent remains due and unpaid for 15 business days following written notice of such default from Landlord to Tenant; (b) Tenant defaults in the performance of any other provisions of this Lease and such default is not cured within 30 days following written notice from Landlord specifying such default (unless such default is not reasonably capable of being cured within such 30 day period and Tenant is diligently prosecuting such cure to completion); (c) a petition in bankruptcy is filed by or against Tenant (provided Tenant shall have 90 calendar days to stay any involuntary proceeding); or (d) Tenant makes an assignment for the benefit of its creditors, or a receiver is appointed for Tenant and such receiver is not dismissed within 60 days of its appointment; then, in any of these events, Landlord may, at its option (x) proceed for past due installments of Rent or Additional Rent, reserving its right to pursue later the remaining installments when due; or for a material breach (y) declare the rights of Tenant under this Lease terminated and, thereafter, recover possession of the Premises through legal process. Notwithstanding the remedy Landlord may seek, the foregoing cure periods shall be applicable.

Upon and after termination of this Lease, Tenant shall pay to Landlord the Rent up to the time of such termination, in addition to any amounts payable by Tenant to Landlord pursuant to the immediately following paragraph. Landlord shall make a commercially reasonable effort to mitigate its damages and relet the Premises or any part thereof to any person, firm or corporation other than Tenant for such rent, for such time and upon such terms as Landlord in Landlord's reasonable discretion shall determine.

In the event of any such termination, Landlord may: (A) choose to have Tenant remain liable for, and pay on the days originally fixed for such payment hereunder, the full amount of all Rent and Additional Rent as if this Lease had not been terminated; provided, however, if Landlord relets the Premises there shall be credited against such obligation the amount actually received by Landlord as a result of such reletting after

deducting all costs and expenses incurred by Landlord in connection with reletting the Premises including, without limitation, all repossession costs, brokerage commissions, legal expenses, reasonable attorneys' fees, alteration costs and expenses of preparation for such reletting; or (B) demand Tenant pay to Landlord on such demand, as and for liquidated and agreed damages for Tenant's default, the present value (based on a discount rate then established by the Federal Reserve closest to the Premises) of the amount by which the aggregate Rent that would have been payable under this Lease by Tenant from the date of such termination until what would have been the last day of the Term but for such termination exceeds the fair market rental value of the Premises for the same period.

17.2 **Landlord Default and Tenant Remedies.** Subject to the terms and provisions below, and in addition to any other remedy expressly available to Tenant pursuant to this Lease or at law or in equity, should Landlord fail to perform any term or covenant under this Lease (each and any such failure, a "Landlord Default") and if any such Landlord Default is not cured and continues for 30 days (unless a shorter notice and cure period is expressly provided herein, in which case such shorter period shall govern) following written notice by Tenant to Landlord (and to any "Mortgagee" (as defined in Section 26 below) that has delivered written notice to Landlord requesting notice of a Landlord Default 'and a right to cure) of such Landlord Default (unless a different period is expressly provided for in any other provision of this Lease or such default is not reasonably capable of being cured within such expressed period and Landlord or Mortgagee is diligently prosecuting such cure to completion, but in no event to extend beyond 90 days), then Tenant shall have the option, (at Tenant's sole discretion) to remedy such Landlord Default and, in connection therewith, incur expenses for the account of Landlord, and any and all such sums expended or obligations incurred by Tenant in connection therewith shall be paid by Landlord to Tenant upon demand, and if Landlord fails to immediately reimburse and pay same to Tenant, Tenant may, in addition to any other right or remedy that Tenant may have under this Lease, deduct such amount (together with interest thereon at the maximum rate permitted by applicable Law from the date of any such expenditure by Tenant until the date of repayment thereof by Landlord to Tenant) from subsequent installments of Base Rent and Additional Rent that from time to time become due and payable by Tenant to Landlord hereunder. In all events Tenant shall have the right to remedy any Landlord Default without prior notice in the event of an emergency (so long as Tenant gives notice within a reasonable period of time thereafter) and invoice Landlord and abate Rent and Additional Rent in the manner set forth in the preceding sentences of this Section 17.2.

If Landlord is or becomes a Referral Source (as defined in Section 31) and if this Lease is terminated for any reason before the first anniversary of the Commencement Date, then Landlord and Tenant shall not enter into any similar lease agreement with each other for the Premises or substantially similar space before the first anniversary of the Commencement Date.

18. Insurance.

18.1 **Landlord's Insurance.** During the Term, Landlord shall procure

and maintain in full force and effect a policy of commercial liability insurance in a minimum amount of $1,000,000.00 per claim and $3,000,000.00 in the aggregate for both bodily injury and property damage insuring Landlord's activities with respect to the Premises for loss, damage or liability for personal injury or death of any person or loss or damage to property occurring in, upon or about the Premises. The reasonable costs of Landlord's Insurance shall be paid by Tenant as Additional Rent.

18.2 **Tenant's Insurance.** During the Term, Tenant shall obtain and keep in force with respect to the Premises (i) a policy or policies of property insurance (including, to the extent required, sprinkler leakage, vandalism and malicious mischief coverage, and any other endorsements and earthquake, terrorism and flood insurance to the extent Tenant reasonably deems prudent) for full replacement value of the Building; and (ii) commercial general liability insurance in a minimum amount of $1,000,000.00 per occurrence and $3,000,000.00 in the aggregate for both bodily injury and property damage. In no event shall Tenant's insurance provide coverage or indemnity to Landlord for any claim, loss, suit, action or other legal proceeding in which Landlord or its agents, servants, employees, guests, invitees or independent contractors bear responsibility. Rather, it is the intent of this Section to provide general liability coverage to Landlord, as an additional insured, when it is made a party to a claim, loss, suit, action or other legal proceeding for which it bears no responsibility. In the event that both Landlord and Tenant bear responsibility for the claim, loss, suit, action or other legal proceeding, then each party will look to its own insurance for coverage. Tenant may carry any insurance required by this Lease under a blanket policy or under a policy containing a self-insured retention.

18.3 **General Requirements.** All policies of insurance required to be carried under this Lease by Landlord shall be written by companies rated A- VII or better in Best's Key Rating Guide. Upon request, Landlord and Tenant shall each furnish to the other party a certificate evidencing the insurance required to be maintained pursuant to this Lease. Tenant and Landlord shall endeavor to give to any party listed as an additional insured 30 days written notice prior to any cancellation of the policy.

19. Subrogation. Each of the parties hereto hereby releases the other and the other's partners, agents and employees, to the extent of each party's property insurance coverage, from any and all liability for any loss or damage which may be inflicted upon the property of such party even if such loss or damage shall be brought about by the fault or negligence of the other party or its partners, agents or employees; provided, however, that this release shall be effective only with respect to loss or damage occurring during such time as the appropriate policy of insurance shall contain a clause to the effect that this release shall not affect said policy or the right of the insured to recover thereunder. If any policy does not permit such a waiver, and if the party to benefit therefrom requests that such a waiver be obtained, the other party agrees to obtain an endorsement to its insurance policies permitting such waiver of subrogation if it is commercially available and if such policies do not provide therefor. If an additional premium is charged for such waiver, the party

benefiting from the waiver, if it desires to have the waiver, agrees to pay to the other the amount of such additional premium promptly upon being billed therefor.

20. Tenant's Maintenance Responsibilities. Throughout the Term, Tenant, at its sole expense, shall maintain the Premises including the Improvements in good condition, in accordance with any declarations or covenants affecting the Premises, and shall be responsible for any and all maintenance and repairs thereto, ordinary wear and tear and casualty excepted.

21. Intentionally Omitted.

22. Title and Parking. Landlord hereby represents and warrants to Tenant that Landlord has good and indefeasible fee simple title to the Premises and has the right and authority to enter into this Lease. Landlord hereby represents to Tenant that to Landlord's knowledge, other than those of public record, there are no covenants, restrictions, liens (other than the lien for real estate taxes not yet due and payable) or other encumbrances affecting Premises. Landlord further represents that Landlord and those signatories executing this Lease on behalf of Landlord have full power and authority to execute this Lease.

Landlord shall not make any modifications to the Premises (including, without limitation, the parking areas, driveways and walks) without Tenant's prior written consent, such consent not to be unreasonably withheld, conditioned or delayed. Tenant shall be entitled to the exclusive use of the entire parking area on the Premises in accordance with a parking ratio as may be required by local code.

23. Compliance with Laws. Both parties shall comply with all applicable Laws throughout the Term. Tenant acknowledges and agrees that the Premises shall be delivered in its current "as is" "where is" condition. In addition to Tenant's other covenants and obligations set forth in this Lease, Tenant covenants and agrees that during the Lease Term and for such further time as Tenant, or any other person claiming under it, shall hold the Premises or any part thereof, Tenant shall procure, at its sole expense, any permits and licenses, required for the development of and the transaction of business at the Premises and otherwise comply with all applicable laws, ordinances and governmental regulations.

TENANT ACKNOWLEDGES AND AGREES THAT, EXCEPT AS EXPRESSLY SET FORTH IN THIS LEASE, NEITHER LANDLORD NOR ANY EMPLOYEE OR AGENT OF LANDLORD HAS MADE ANY REPRESENTATION OR WARRANTY, EITHER EXPRESS OR IMPLIED, AS TO THE PREMISES AND THAT THIS LEASE CONSTITUTES THE FULL AND FINAL AGREEMENT OF LANDLORD AND TENANT WITH RESPECT TO THE LEASE OF THE PREMISES BY TENANT. TENANT HEREBY WAIVES ANY CLAIM OR CAUSE OF ACTION BASED UPON ANY WARRANTIES, EITHER EXPRESS OR IMPLIED, AS TO HABITABILITY, MERCHANTABILITY, SUITABILITY, QUALITY, CONDITION OR FITNESS FOR ANY PARTICULAR

PURPOSE WITH REGARD TO THE PREMISES OR THE ADJACENT PROPERTIES.

24. Brokers. Landlord and Tenant each represent to the other that it has had no dealings with any real estate broker or agent in connection with the negotiation of this Lease, except for Cushman & Wakefield and Leibsohn and Company, representing Tenant (collectively, the "Tenant's Broker"), and Linn Larsen, LLC, representing Landlord. Landlord shall pay Tenant's Broker a brokerage commission pursuant to a separate agreement. In the event Landlord does not timely pay Tenant's Broker such brokerage commission, Tenant may offset the amount of such brokerage commission against Base Rent and Additional Rent due Landlord.

25. Tenant to Subordinate. Tenant shall, upon written request of the holder of a mortgage or deed of trust in the nature of a mortgage, which holder is a commercial or institutional lender, on the Premises ("Mortgagee") subordinate any interest which it has by virtue of this Lease, and any extensions and renewals thereof to any mortgages or deeds of trust placed upon the Premises by Landlord, if and only if such Mortgagee shall execute, deliver and record in the appropriate registry of deeds a recognition and non-disturbance agreement in form and content substantially similar to Exhibit C or such other commercially reasonable form as may be agreed upon by the parties. Tenant shall respond to any such requests within 15 business days following receipt of the Mortgagee's written request. If Tenant fails to respond within such initial 15 business day period, then Landlord may deliver a second written request, and if Tenant fails to respond within ten business days following receipt of the second written request, such failure shall be a default under this Lease, provided that Landlord's second notice states in balded and capitalized font that a failure to respond within ten business days of receipt is the basis for a default under the Lease. Such agreements shall provide by their terms that notwithstanding any foreclosure of such mortgage or deed of trust Tenant may continue to occupy the Premises during the Term or any extensions or renewals thereof under the same terms, conditions and provisions of this Lease unless Tenant shall be in default beyond any applicable grace periods provided for herein. Landlord shall, at or prior to the Commencement Date, secure from Landlord's present Mortgagee of the Premises a non-disturbance agreement in a form reasonably acceptable to Tenant. Landlord shall also secure from any future Mortgagee or lienholders of Landlord non-disturbance agreements during the Term. If Landlord shall not obtain such non-disturbance agreement, then this Lease shall not be subordinate to any such future lien, mortgage, or refinancing.

26. Quiet Enjoyment. If and so long as Tenant shall pay all Rent and Additional Rent and other charges herein provided, Landlord warrants peaceful and quiet occupation and enjoyment of the Premises by Tenant.

27. Memorandum of Lease and Right to Purchase. Upon or after the Commencement Date, Landlord and Tenant will enter into and have recorded a recordable Memorandum of Lease and Right to Purchase in the form attached as Exhibit E (the "Memorandum of Lease"). Landlord shall pay as and when due any and all State, County, and municipal conveyance and/or transfer taxes and fees due in connection with this Lease and the cost of recording the Memorandum of Lease. Landlord and Tenant acknowledge that the Memorandum of Lease may be modified based on other easements

agreed to or other agreed upon modifications that arise prior to the Commencement Date, in which event an amendment to the Memorandum of Lease will be entered into and recorded by the parties.

28. Notices. All notices, demands and requests which may be or are required to be given by either party to the other shall be in writing and shall be either (a) sent by registered or certified mail, return receipt requested, postage prepaid, (b) delivered, by hand, or (c) sent by overnight courier such as Federal Express. All notices to Landlord should be addressed to Landlord at Southern Financial Group, LLC, 900 Austin Avenue, 9th Floor, Waco, Texas 76701 or P.O. Box 2028, Waco, Texas 76703, Telephone: 254-756-4411 ext. 414, Email: jeff@sfgwaco.com or tom@sfgwaco.com or at such other place as Landlord may from time to time designate in written notice to Tenant. All notices to Tenant shall be addressed to Tenant c/o DaVita Inc., Attention: Real Estate Legal, 2000 16th Street, Denver, CO 80202, Telephone: (303) 876-2800, concurrently to: relegal@davita.com, *Subject: Auburn, WA (Facility #TBD),* or to any such other place as Tenant may from time to time designate in written notice to Landlord. In addition, all correspondence to Tenant related to Taxes, Insurance, Rent or Additional Rent shall be sent to P.O. Box 1476, Tacoma, WA 98401-1476; Attention: Rent Department, concurrently to: rentdepartment@davita.com. All notices, demands and requests which shall be served upon Landlord and Tenant in the manner aforesaid shall be deemed sufficiently served or given for all purposes hereunder. Notwithstanding anything contained in this Lease to the contrary, any written notice by either Landlord or Tenant to the other party may be transmitted by facsimile or electronic transmission, and that the facsimile or electronic copies of such party's signature shall have the same effect as if it were an original signature, provided that the party providing such notice obtains a confirmation page or delivery confirmation email and further provided that within three business days after the electronic transmission of any such notice, Landlord or Tenant shall execute and deliver to the other party an original copy of the notice via one of the methods provided in this Section.

29. Estoppel Certificate. Each of Landlord and Tenant agrees at any time and from time to time upon not less than 15 business days' prior written request by the other to execute, acknowledge and deliver to the other an estoppel certificate in the form attached as Exhibit D certifying that (a) this Lease is unmodified and in full force and effect (or if there have been modifications that the same is in full force and effect as modified and stating the modifications), (b) the dates to which Rent and other charges have been paid in advance, if any, (c) all of the defaults of Landlord or Tenant hereunder, if any, (and if there are no defaults a statement to that effect), and (d) any other information reasonably requested, it being intended that any such estoppel certificate delivered pursuant to this Section 29 may be relied upon by any prospective purchaser of the Premises or any mortgagee or assignee of any mortgage upon the fee or leasehold of the Premises or by any prospective assignee of this Lease or subtenant of the whole or any portion of the Premises and/or by other party interested in the Premises or any part thereof. If either party fails to execute, acknowledge and deliver an estoppel certificate within 15 business days following its receipt of the initial written request, as required in this Section 29, the requesting party may send a second written request, and if the

recipient party shall thereafter fail to execute, acknowledge and deliver the estoppel certificate within ten business days following receipt of the second request, such failure shall be a default under this Lease, provided that the second notice states in balded and capitalized font that a failure to respond within ten business days of receipt is the basis for a default under the Lease.

30. Landlord's Sale of the Premises. Upon Landlord's transfer of interest in the Premises (the "Landlord's Sale"), Landlord shall be released from all liability to Tenant and Tenant's successors and assigns arising from this Lease because of any act, occurrence or omission of Landlord occurring after such Landlord's Sale, and Tenant shall look solely to Landlord's successor in connection with the same; provided, however, that Landlord shall not be released from liability to Tenant and Tenant's successors and assigns from its obligations under this Lease because of any act, occurrence or omission of Landlord occurring prior to such Landlord's Sale or for any offsets due Tenant under this Lease in the event the successor in interest is a mortgagee which has not assumed liability for offsets, unless such liability is expressly assumed by Landlord's successor-in-interest in the Premises. Within no less than 30 days prior to the effective date of a transfer of interest in the Premises, Landlord shall notify Tenant whether Landlord's successor-in-interest and assignee to this Lease would or would not be a Referral Source as described below.

31. Regulatory Compliance. Landlord represents and warrants that: (i) it is not currently excluded from participation in any federal health care program, as defined under 42 U.S.C. Section 1320a-7b; (ii) it is not currently excluded, debarred, suspended or otherwise ineligible to participate in Federal procurement or non-procurement programs; and (iii) it has not been convicted of a criminal offense that falls within the scope of 42 U.S.C. Section 1320a-7(a) (each of (i), (ii) and (iii), an "Exclusion"). Landlord will notify Tenant within two business days of learning of any Exclusion or any basis that may give rise to an Exclusion. In the event of an Exclusion, Tenant may immediately terminate this Lease without further liability. Tenant may screen Landlord against applicable Exclusion databases on an annual basis.

Landlord represents and warrants to Tenant that Landlord is not a "referring physician" or a "referral source" as to Tenant for services paid for by Medicare or other federal or state health care programs, as the terms are defined under any federal or state health care anti-referral or anti-kickback regulation, interpretation or opinion ("Referral Source"). Landlord covenants, during the Term, it will not transfer the Premises to any individual or entity who is a Referral Source as to Tenant without complying with all other provisions of this Lease.

If Landlord or Landlord's successor becomes a Referral Source during the Term, the following Section 31.1 through 31.3 will apply, but will have no effect until that time:

31.1 Lease Unrelated to Referrals. It is not the purpose of this Lease to

exert any influence over the reason or judgment of any party with respect to the referral of patients or other business between Landlord and Tenant. Rather, any referrals made between the parties will be based solely upon the medical judgment and discretion of the patient's physician. Landlord and Tenant further agree and acknowledge that: (a) Base Rent is (i) set forth in advance; (ii) consistent with fair market value in an arms-length transaction; (iii) does not take into account the volume or value of any referrals or other business generated between the parties; and (iv) would be reasonable even if no referrals were made between the parties; (b) Tenant's Proportionate Share does not exceed Tenant's pro-rata share of expenses; and (c) the Premises Rentable Area does not exceed the reasonable square footage needed for the legitimate business plans of Tenant.

31.2 Compliance with Law. The parties enter into this Lease with the intent of conducting their relationship in full compliance with applicable laws, including the Anti- Kickback Statute, and agree and certify that neither party will violate the Anti-Kickback Statute in performing under this Lease. Notwithstanding any unanticipated effect of any provisions of this Lease, neither party will intentionally conduct itself under the terms of this Lease in a manner that violates any such law. Landlord agrees not to request an advisory opinion related to the legality of this Lease without the approval of Tenant. If a change in applicable health care laws or reimbursement systems affects the legality of this Lease, Tenant may terminate this Lease. Landlord shall notify Tenant of, and cooperate with, any request from a duly authorized government representative (e.g., Secretary of HHS, Comptroller General) for access to books, documents and records related to this Lease. Landlord will indemnify Tenant from any liability arising out of Landlord's refusal to cooperate.

31.3 Covered Person; Additional Requirements. A "Covered Person" means any: (i) individual or entity who (a) provides patient care items or services on behalf of DaVita Dialysis, or (b) performs billing or coding functions on behalf of DaVita Dialysis;
(ii) DaVita Dialysis domestic dialysis joint venture partner; or (iii) medical director for any domestic DaVita Dialysis clinic. If Landlord, its members, partners, shareholders or trustees is or becomes a Covered Person during the Term, the following provisions will apply:

(a) Tenant shall provide the Covered Person a copy of, or access to, Tenant's applicable code of conduct (the "Code of Conduct") and relevant policies and procedures (the "Policies and Procedures") designed to ensure compliance with this Section 32.3 and relevant Federal health care program requirements.

(b) Upon notification by Tenant, the Covered Person shall: (i) participate in all Tenant-required compliance training, including online general compliance training, on an annual basis; (ii) complete all training within the timeframes required by Tenant; (iii) comply with the Policies and Procedures and Code of Conduct; and
(iv) certify in writing or electronic form that the Covered Person read, understood and shall abide by the Code of Conduct and return the certification to Tenant

within 30 days after receiving notice.

(c) The Covered Person shall report immediately to Tenant any suspected or known violations of Tenant's policies and procedures or of any violation of applicable federal healthcare program laws and regulations.

32. Cooperation with Tenant's Cost Reporting Responsibilities. Landlord's full cooperation with applicable authorities in connection with cost reporting is essential for Tenant's continued operation of its business. Therefore, Landlord agrees to provide to Tenant, within 30 days of Tenant's request, any and all information that is reasonably necessary for Tenant to fulfill its cost reporting requirements .to such applicable authorities.

33. Protected Health Information.

33.1 Landlord acknowledges and agrees that from time to time during the Term, Landlord and/or its employees, representatives or assigns may be exposed to, or have access to, Protected Health Information ("PHI"), as defined by the Health Insurance Portability and Accountability Act of 1996 and related regulations ('HIPAA"), 45 CFR Parts 160 and 164. Landlord agrees that it will not use or disclose, and Landlord shall cause its employees, or assigns not to use or disclose, PHI for any purpose unless required by a court of competent jurisdiction or by any governmental authority in accordance with the requirements of HIPAA and all other applicable medical privacy Laws. Landlord further agrees that, notwithstanding the rights granted to Landlord pursuant to this Lease, except when accompanied by an authorized representative of Tenant, neither Landlord nor its employees, agents, representatives or contractors shall be permitted to enter areas of the Premises designated by Tenant as location where patient medical records are kept or

stored or where such entry is prohibited by applicable state or federal health care privacy Laws.

33.2 Landlord shall preserve, and cause any of its employees, agents and representatives to preserve, any "Confidential Information" of or pertaining to Tenant and shall not, without first obtaining Tenant's prior written consent, disclose to any person or organization, or use for its own benefit, any Confidential Information of or pertaining to Tenant during and after the Term, unless such Confidential Information is required to be disclosed by a court of competent jurisdiction or by any governmental authority. As used herein, the term "Confidential Information" shall mean any business, financial, personal or technical information relating to the business or other activities of Tenant that Landlord obtains. in connection with the Lease.

34. Landlord's Consent. Unless otherwise expressly stated herein, whenever Landlord's consent is required under this Lease, such consent shall not be unreasonably withheld, conditioned or delayed, and Landlord's reasonable satisfaction shall be sufficient for any matters under this Lease.

35. Surrender of Premises. At the expiration of the Term, whether by expiration of time or otherwise, and subject to Tenant's right under this Lease, Tenant shall surrender the Premises to Landlord together with all alterations, changes and improvements then a part of the Premises in good order and condition; reasonable wear and tear, loss or damage by fire or casualty and condemnation excepted; at which time title to the Improvements shall revert to Landlord. Tenant shall have the right, but not obligation, to remove its trade fixtures, equipment and any personal property from the Building and the Premises. All trade fixtures, equipment and personal property remaining on the Premises 30 days after the expiration of the Term which Tenant has not elected to remove shall, without compensation to Landlord, become Landlord's property. Notwithstanding in this Lease to the contrary, if the Building is not in the condition required under this Lease on the surrender of the Premises to Landlord, Tenant's liability to Landlord for performing any required repairs and replacements will not exceed, in the aggregate, the cost of demolishing the Building. Subject to the rights of a Leasehold Mortgagee (as defined below) as provided in Section 38, upon such expiration or termination all Improvements

on the Premises or portion thereof so terminated shall become the sole property of the Landlord at no cost to the Landlord.

36. Holding Over. In the event Tenant remains in possession of the Premises after the expiration of the Term, or any extensions hereof without the written consent of Landlord, this Lease shall continue on a month-to-month basis, terminable by either party upon 30 days' prior written notice and Tenant shall be obligated to pay Rent at 150% the then current rate at the end of the Term (including all adjustments), with all other sums then payable hereunder prorated on a daily basis for each day that Landlord is kept out of possession of the Premises. Notwithstanding the foregoing, in the event that applicable Law, including without limitation applicable health care Law, limits the period of any such holdover, both parties shall comply with such applicable Law.

37. Leasehold Mortgages. Notwithstanding anything contained in this Lease to the contrary, on one or more occasions during the Term, Tenant may, without Landlord's prior consent, mortgage or otherwise encumber its interest in this Lease, Tenant's interest in the Improvements, including but not limited to the Building, or any part thereof or property therein, and any sublease, under one or more mortgage(s) and to assign this Lease and any sublease as collateral security for such mortgages, upon the condition that all rights acquired under such mortgages shall be subject to each and all of the covenants, conditions and restrictions set forth in this Lease, and to all rights and interests of Landlord herein, none of which covenants, conditions or restrictions is or shall be waived by Landlord by reason of the right given to so mortgage such interest in this Lease, except as may be expressly provided in this Section 37.

37.1 If Tenant shall mortgage this leasehold pursuant to the provisions hereof, and if the holder(s) of any such mortgage(s) (each, a "Leasehold Mortgagee") shall send to Landlord a true copy thereof, together with written notice specifying the name and address of the Lease Mortgagee(s) and the pertinent recording data with respect to such mortgage(s), Landlord agrees that so long as any such leasehold mortgage(s) shall remain unsatisfied, the following provisions shall apply:

(a) There shall be no cancellation, surrender or modification of this Lease by joint action of Landlord and Tenant without the prior consent in writing of the Leasehold Mortgagee(s).

(b) Landlord shall, upon serving Tenant with any notice of default, simultaneously serve a copy of such notice upon the Leasehold Mortgagee(s). The Leasehold Mortgagee(s) shall thereupon have the same period, after service of such notice upon it, as is allowed to Tenant, to remedy or cause to be remedied the defaults complained of, and Landlord shall accept such performance by or at the instigation of the Leasehold Mortgagee(s) in response to any such notice of default as if the same had been performed by Tenant.

(c) Notwithstanding anything contained herein to the contrary, while such leasehold mortgage(s) remains unsatisfied, or until written notice of satisfaction is given by the holder(s) thereof to Landlord, if any default shall

occur, which, pursuant to any provision of this Lease; entitles Landlord to terminate this Lease, and if before the expiration of fifteen (15) days from the date of service of notice of termination upon such Leasehold Mortgagee(s), such Leasehold Mortgagee(s) shall have notified Landlord of its desire to nullify such notice and shall have paid to Landlord all rent and other payments herein provided for and then in default, and shall have complied or commenced the work of complying with all of the other requirements of this Lease, if any are then in default, and shall prosecute the same to completion with reasonable diligence, then in such event Landlord shall not be entitled to terminate this Lease and any notice of termination theretofore given shall be void and of no effect.

(d) Landlord agrees that the name of the Leasehold Mortgagee(s) may be added to the "Loss Payable Endorsement" of any and all insurance policies required to be carried by Tenant hereunder on condition that the insurance proceeds are to be applied in the manner specified in this Lease and that the leasehold mortgage(s) or collateral documents shall so provide.

(e) Landlord agrees that in the event of termination of this Lease by reason of any default by Tenant, Landlord shall enter into a new Lease of the Premises with the Leasehold Mortgagee(s) or its nominee(s) or assignee(s) for the remainder of the term of this Lease effective as of the date of such termination, at the rent and upon the terms, provisions, covenants and agreements as contained herein and subject only to the same conditions of title as this Lease is subject to on the date of execution hereof together with any exceptions to title created by or at the behest of Tenant, and to the rights, if any, of the parties then in possession of any part of the Premises, provided:

(i) said Leasehold Mortgagee(s) or its nominee(s) or assignee(s) shall make written request upon Landlord for such new lease within thirty (30) days after the date of such termination and such written request shall be accompanied by payment to Landlord of all sums due to Landlord under this Lease;

(ii) said Leasehold Mortgagee(s) or its nominee(s) or assignee(s) shall pay to Landlord at the time of the execution and delivery of such new lease, any and all sums which would at the time of the execution and delivery thereof be due pursuant to this Lease but for such termination, and in addition thereto, any expenses, including reasonable attorneys' fees, which Landlord shall have incurred by reason of such default;

(iii) said Leasehold Mortgagee(s) or its nominee(s) or assignee(s) shall perform and observe all covenants herein contained on Tenant's part to be performed and shall further remedy any other condition which Tenant under the terminated Lease was obligated to perform under the terms of this Lease; and upon execution and delivery of such new lease and any subleases which may have theretofore been assigned and

transferred by Tenant to Landlord, as security under this Lease, shall thereupon be deemed to be held by Landlord as security for the performance of all of the obligations of the tenant under the new lease;

(iv) Landlord shall not warrant possession of the Premises to the tenant under the new lease;

(v) such new lease shall be expressly made subject to the rights, if any, of Tenant under theterminated lease;

(vi) the tenant under such new lease shall have the right, title and interest in and to the buildings and improvements on the Premises as Tenant had under the terminated lease; and

(vii) said Leasehold Mortgagee(s) or its nominee(s) or assignee(s) shall bear the cost of recording such new lease or short form thereof if it or Landlord desires recordation thereof.

(f) Nothing herein contained shall require the Leasehold Mortgagee(s) or its nominee(s) or assignee(s) to cure any default of Tenant under this Lease unless such Leasehold Mortgagee shall choose to do so under subparagraph (b) above or shall choose to nullify any notice of termination from Landlord pursuant to subparagraph (c), or if such Leasehold Mortgagee(s) elects that Landlord enter into a new lease for the Premises pursuant to the provisions of subparagraph (e) above.

(g) The proceeds from any insurance policies relating to the Premises or arising from a condemnation of the Premises are to be held by any Leasehold Mortgagee(s) and distributed pursuant to the provisions of this Lease.

(h) Landlord shall, upon request, execute, acknowledge and deliver to each Leasehold Mortgagee, an agreement prepared at the sole cost and expense of Tenant, in form satisfactory to such Leasehold Mortgagee(s), among Landlord, Tenant and Leasehold Mortgagee(s), agreeing to all of the provisions of this Section 37. The term "mortgage," whenever used in this Section 37, shall include whatever security instruments are used in the locale of the Premises, such as, without limitation, mortgages, deeds of trust, security deeds and conditional deeds, as well as financing statements, security agreements and other documentation required pursuant to the Uniform Commercial Code, and shall also include any instruments required in connection with a sale-leaseback (or an assignment of lease and sublease) transaction,

38. Binding Effect. All covenants, agreements, stipulations, provisions, conditions and obligations set forth herein shall extend to, bind and inure to the benefit of, as the case may require, the successors and assigns of Landlord and Tenant respectively, as fully as if any such successor or assign was referenced to wherever reference to Landlord or Tenant, as the case may be, occurs in this Lease.

39. Severability. If any term, covenant or condition of this Lease or the application thereof to any person or circumstance shall, to any extent, be invalid or unenforceable, the remainder of this Lease, or the application of such term, covenant or condition to persons or circumstances other than those as to which it is held invalid or unenforceable, shall not be affected thereby and each term, covenant or condition of this Lease shall be valid and be enforced to the fullest extent permitted by Law.

40. Applicable Law. The Laws of the State where the Premises are located shall govern the validity, performance and enforcement of this Lease, without regard to such State's conflict-of-law principles.

41. Force Majeure. Whenever a day is appointed herein on which, or a period of time is appointed within which, either party hereto is required to do or complete any act, matter or thing the time for the doing or completion thereof shall be extended by a period of time equal to the number of days on or during which such party is prevented from, or is interfered with, the doing or completion of such act, matter or thing because of strikes, lock-outs, embargoes, unavailability of labor or materials, wars, insurrections, rebellions, civil disorder, declaration of national emergencies, acts of God or other causes beyond such party's reasonable control.

42. Complete Agreement. Any stipulations, representations, promises or agreements, oral or written, made prior to or contemporaneously with this agreement shall have no legal or equitable consequences and the only agreement made and binding upon the parties with respect to the leasing of the Premises is contained herein, and it is the complete and total integration of the intent and understanding of Landlord and Tenant with respect to the leasing of the Premises. No amendment or modification of this Lease shall be valid or binding unless reduced to writing and executed by the parties hereto in the same manner as the execution of this Lease.

43. Counterparts. This Lease may be executed in any number of counterparts via facsimile or electronic transmission or otherwise, each of which shall be deemed an original and all of which together shall constitute one and the same instrument.

44. Incorporation of Exhibits and Schedule. This Lease is subject to the provisions of the attached Exhibits A-F inclusive, which exhibits are hereby made a part of this Lease.

45. Mortgage. As used in this Lease, the word "mortgage" shall be deemed to include a deed of trust and the word "mortgagee" shall be deemed to include the trustee or beneficiary of a deed of trust.

46. Costs of Enforcement. If Landlord or Tenant defaults under this Lease or there is a dispute under this Lease, then the defaulting party or the party not prevailing in such dispute shall pay, on demand, the out-of-pocket costs and expenses incurred by the other party in enforcing or establishing its rights hereunder, including, without limitation,

court costs and reasonable attorneys' fees.

47. Option to Purchase the Premises. For and in consideration for Tenant's execution of this Lease, Landlord agrees to grant Tenant a one-time option to purchase (the "Option") the Premises, at any time during the Term, in accordance with the terms listed below:

(a) Exercise of Option. Tenant shall provide Landlord with written notification (the "Option Notice") of Tenant's desired timing of the sale (the "Sale"), which shall contain a draft of a proposed purchase and sale agreement containing terms and conditions reasonably acceptable to Landlord and consistent with the terms set forth herein.

(b) Purchase Price. The purchase price for the Premises during the first two (2) Lease Years shall be $950,000.00, and shall increase by ten percent (10%) for each Lease Year thereafter during the Term.

(c) Closing. The closing, in the event Tenant exercises the Option, for payment of the purchase price and delivery of the deed shall be held no later than 90 days following the effective date of the purchase and sale agreement described in 47(a) above.

(d) Fees and Costs. The Sale shall not be subject to any brokerage fees. Landlord and Tenant shall equally share the normal closing costs for the Sale, and shall cooperate, at no cost, with the other party's 1031 exchange.

48. Anti-Terrorism. Each party hereto represents and warrants to the other that such party is not, and is not acting, directly or indirectly, for or on behalf of any person or entity named as a Specially Designated National or Blocked Person (as defined in the Presidential Executive Order 13224) and that such party is not engaged in this transaction, directly or indirectly, on behalf of, and is not facilitating this transaction, directly or indirectly, on behalf of, any such person or entity. Each party hereby agrees to defend, indemnify and hold harmless the other party from and against any and all claims, damages, losses, risks, liabilities and expenses, including reasonable attorneys' fees and costs, arising from or related to any breach of the foregoing representations and warranties.

49. Termination Rights.

49.1 **Due Diligence and Inspections.** Beginning on the Commencement Date, or earlier, upon Tenant's written request, Tenant shall have 90 days (the "Due Diligence Period") to inspect the Premises and all matters relevant to its acquisition, development, usage, operation or marketability. Tenant's obligations under this Lease are subject to Tenant being satisfied, in its sole and absolute discretion, that the Premises is suitable to Tenant. At any time during the Due Diligence Period, Tenant and its agents, employees, representatives and contractors may enter the Premises at reasonable times to conduct such inspections, tests and investigations of the Premises as Tenant may elect, including,

without limitation, physical, engineering, soils, geotechnical, and environmental tests. Tenant agrees to indemnify and defend (including reasonable attorney fees and costs) Landlord for any action, loss or damages asserted against Landlord as a result of Tenant and its agents, employees, representatives or contractors investigation of or access to the Premises, provided however, that the foregoing indemnity will not apply to, and Tenant will not indemnify Landlord or the Premises from, any such actions, loss, claims, demands, damages, costs, liabilities or expenses which arise from or relate to the discovery of any pre-existing conditions of or at the Premises or which are caused by the acts or omissions of Landlord or its agents, employees, representatives or contractors. If Tenant's inspections include the performance of any subsurface investigation, Landlord agrees that Landlord is the owner of any and all residual. soil, water or other environmental media collected or produced in connection with such investigation. On or before the expiration of the Due Diligence Period, Tenant may terminate this Lease upon written notice to Landlord, at Tenant's sole and absolute discretion, in which event neither of the parties shall have any further rights or obligations under this Lease, except those which expressly survive termination of this Lease.

49.2 **Entitlements.** "Required Approvals" shall mean all land use approvals and other public and private approvals which are necessary for the construction and use of the Building and other Improvements on the Premises for the Intended Use and the grant, amendment or release of any easements, covenants and restrictions in the form deemed necessary or desirable by Tenant in its sole and absolute discretion. The phrase "Required Approvals" includes, but is not limited to, building permits, zoning amendments, variances, site plan approvals, subdivisions, access and utility easements, and side yard agreements. All Required Approvals must be valid, enforceable by Tenant, unconditional (or subject only to those conditions acceptable to Tenant in its sole and absolute discretion), final unappealable and unappealed. Landlord shall fully cooperate with Tenant, at no cost to Landlord, to obtain the Required Approvals by signing consents, joining in the application for the Required Approvals, participating in meetings regarding the Required Approvals, cooperating with reasonable requests for documentation regarding the Required Approvals, and taking other reasonable actions requested by Tenant to obtain the Required Approvals.

Notwithstanding anything contained in this Lease to the contrary, if, despite good faith efforts, Tenant has not obtained all Required Approvals or waived this contingency in writing by the date which is six (6) months following expiration of the Due Diligence Period, or if Tenant determines at any time in its good faith business judgment that such contingency will not be timely satisfied, Tenant may terminate this Lease upon written notice to Landlord, in which event neither of the parties shall have any further rights or obligations under this Lease, except those which expressly survive termination of this Lease.

49.3 **Due Diligence Materials, Permits, Approvals.** In the event Tenant terminates this Lease in accordance with Section 49.1 or 49.2, Tenant shall promptly deliver to, and Landlord shall have and maintain the exclusive use, possession and ownership of, all due diligence information and materials regarding the Premises obtained by Tenant during the Due Diligence Period, including, without limitation, all topographical,

engineering, environmental and other studies, reports, title commitments and/or policies, surveys, engineering plans, development agreements, licenses, permits, maps, certificates of occupancy, correspondence, notices, court filings, plans, tax statements, and other like materials irrespective of whether the information is furnished to Tenant by Landlord or independently obtained by Tenant from a third party (collectively, the "Due Diligence Materials"). In such event, Tenant agrees, from time to time on or after the date of such termination, upon the reasonable request of Landlord, to execute and deliver to Landlord such documents or instruments of transfer and confirmation and to take such action as may be reasonably necessary in order to vest and confirm title to the Due Diligence Materials in Landlord.

50. Guaranty: Contemporaneously with the execution of this Lease, Tenant shall cause DaVita, Inc., a Delaware corporation, to execute a guaranty agreement in the form attached hereto as Exhibit F.

[Signature pages follow]

IN TESTIMONY WHEREOF, Landlord and Tenant have caused this Lease to be executed as of the dates set forth below.

LANDLORD:

SOUTHERN FINANCIAL GROUP, LLC, a
Texas limited liability company

By: Jm. Jones

Name: Jeff Jones

Title: President

Date: May 23, 2018

STATE OF Texas)
) SS
COUNTY OF McLennan)

I, Laurie Johnson, a Notary Public in and for the County and State aforesaid, do hereby certify that Jeff Jones the President of Southern Financial Group, who is personally known to me to be the same person whose name is subscribed to the foregoing instrument, appeared before me in person and acknowledged that he/she signed, sealed and delivered the said instrument as his/her own free and voluntary act and as the free and voluntary act of said President, for the uses and purposes therein set forth.

Given under my hand and notarial seal this 23rd day of May, 2018

Laurie Johnson
Notary Public

My Commission Expires: 10-24-20

LAURIE JOHNSON NOTARY PUBLIC STATE OF TEXAS ID 12561582-3 EXP. 10-24-2020

TENANT:

TOTAL RENAL CARE, INC.,
a California corporation

By: Jennie Funk

Name: Jennie Funk

Title: Division VP

Date: 5-21-18

FOR TENANT'S INTERNAL PURPOSES ONLY:

APPROVED AS TO FORM ONLY:

By: _____

Name: Jeff Pretty

Title: Assistant General Counsel

STATE OF Washington)
) SS
COUNTY OF King)

I, Tara-Lyn D. Poole, a Notary Public in and for the County and State aforesaid, do hereby certify that Jennie Funk the DVP of DaVita Renal Care, CA corp, who is personally known to me to be the same person whose name is subscribed to the foregoing instrument, appeared before me in person and acknowledged that he/she signed, sealed and delivered the said instrument as his/her own free and voluntary act and as the free and voluntary act of said DVP, for the uses and purposes therein set forth.

Given under my hand and notarial seal this 21 day of May, 2018

Tara-Lyn D. Poole
Notary Public

My Commission Expires: Oct 19, 2021

TARA-LYN D POOLE NOTARY PUBLIC COMMISSION EXPIRES 10-19-21 STATE OF WASHINGTON

EXHIBIT A

LEGAL DESCRIPTION AND SITE PLAN OF THE PREMISES

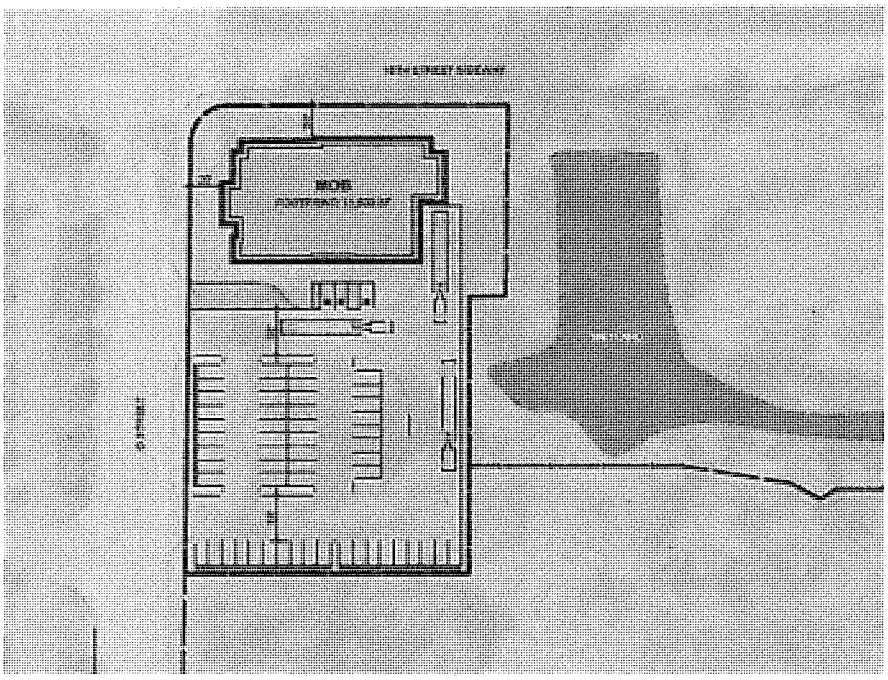
(attached)

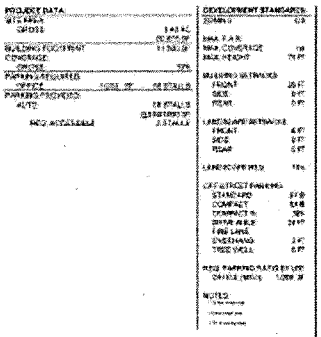
PARCEL A:

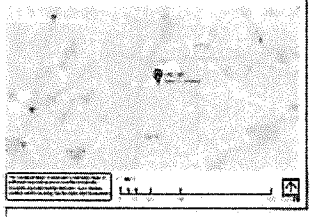
LOTS 10 AND 11 OF CITY OF AUBURN LOT LINE ADJUSTMENT NO. LLA-0010-09 RECORDED MAY 8, 1990 UNDER RECORDING NO. 9005081375, IN KING COUNTY, WASHINGTON.

PARCEL B:

LOT 9, AUBURN 400 CORPORATE PARK DIVISION NO. 1, ACCORDING TO THE PLAT THEREOF RECORDED IN VOLUME 128 OF PLATS, AT PAGES 97 THROUGH 99, IN KING COUNTY, WASHINGTON.







Conceptual Site Plan

WARE MALCOMB

EXHIBIT B

FORM OF COMMENCEMENT DATE MEMORANDUM

COMMENCEMENT DATE MEMORANDUM

With respect to that certain lease ("Lease") dated_____ between _____, a limited liability company ("Landlord") and _____("Tenant"), whereby Landlord leased to Tenant and Tenant leased from Landlord the property located at _____ as further described in the Lease (the "Premises"). Tenant and Landlord hereby acknowledge as follows:

(1) Landlord delivered possession of the Premises to Tenant on _____(the "Possession Date").

(2) The Term of the Lease commenced on_____(the "Commencement Date").

(3) The Termination Date of the Lease is_____

(4) It is agreed that the first Lease Year shall end on _____ and that each subsequent Lease Year shall end on_____

(5) Tenant shall commence payment of Rent on_____

(6) The Premises contains approximately _____rentable square feet.

(7) The last dates upon which the respective renewal options may be exercised are _____,and_____

All capitalized terms herein, not otherwise defined herein, shall have the meaning assigned in the Lease.

[Signature pages follow]

IN WITNESS WHEREOF, this Commencement Date Memorandum is executed the date(s) set forth below.

LANDLORD

[LANDLORD ENTITY].
a _____

By:_____

Name:
_____

Title: _____

Date:
_____

TENANT

[TENANT ENTITY].
a _____

By:_____

Name: _____

Title: _____

Date: _____

FOR TENANT'S INTERNAL PURPOSES ONLY:

APPROVED AS TO FORM ONLY:

Exhibit

FOFFFR
By:_____

Name: _____

Title: _____

Date: _____

EXHIBITC

FORM OF SUBORDINATION, NON-DISTURBANCE ANDATTORNMENTAGREEMENT

[TO BE CONFORMED TO COUNTY RECORDING REQUIREMENTS]

SUBORDINATION, NON-DISTURBANCE AND ATTORNMENT AGREEMENT

THIS SUBORDINATION, NON-DISTURBANCE AND ATTORNMENT AGREEMENT (this "Agreement") is entered into as of_____, 20 (the "Effective Date"), between _____ (the "Mortgagee"), and _____ (the "Tenant").

WHEREAS, by Ground Lease dated _____, 20__ (hereinafter called "the "Lease", _____, a _____ (hereinafter called "Landlord") has leased to Tenant and Tenant has rented from Landlord the approximately____ rentable square feet of real property ("Tenant's Premises") located at_____as more fully described in Exhibit A attached hereto and incorporated by reference (such real property, including all buildings, improvements, structures and fixtures located thereon, "Landlord's Premises").

WHEREAS, Mortgagee has made a loan to Landlord in the original principal amount of$_____(the "Loan"); and

WHEREAS, To secure the Loan, Landlord has encumbered Landlord's Premises by entering into that certain [Mortgage and Security Agreement] dated _____, in favor of Mortgagee (as amended, increased, renewed, extended, spread, consolidated, severed, restated or otherwise changed from time to time, the "Mortgage") recorded on _____, under Clerk's File No. _____, in the Official Public Records of Real Property of the County of , State of _____.

WHEREAS, Tenant desires that Mortgagee recognize Tenant's rights under the Lease in the event of foreclosure of Mortgagee's lien, and Tenant is willing to agree to attorn to the purchaser at such foreclosure if Mortgagee will recognize Tenant's right of possession under the Lease.

NOW, THEREFORE, for and in consideration of their respective covenants herein made and the receipt of other good and valuable consideration, the receipt and sufficiency of which is acknowledged, the parties agree as follows:

1. Definitions.

The following terms shall have the following meanings for purposes of this Agreement.

1.1 *Foreclosure Event.* A *"Foreclosure Event"* means: (a) foreclosure under the Mortgage; (b) any other exercise by Mortgagee of rights and remedies (whether under the Mortgage or under applicable Law, including bankruptcy Law) as holder of the Loan and/or the Mortgage, as a result of which Successor Landlord becomes owner of Landlord's Premises; or (c) delivery by Landlord to Mortgagee (or its designee or nominee) of a deed or other conveyance of Landlord's interest in Landlord's Premises in lieu of any of the foregoing.

1.2 *Form (:Jr Landlord.* A *"Former Landlord"* means Landlord and any other party that was a landlord under the Lease at any time before the occurrence of any attornment under this Agreement.

1.3 *Offset Right.* An *"Offset Right"* means any right or alleged right of Tenant to any offset, defense (other than one arising from actual payment and performance, which payment and performance would bind a Successor Landlord pursuant to this Agreement), claim, counterclaim, reduction, deduction or abatement against Tenant's payment of Rent or performance of Tenant's other obligations under the Lease, arising (whether under the Lease or other applicable law) from Landlord's breach or default under the Lease.

1.4. *Rent.* The *"Rent"* means any fixed rent, base rent or additional rent under the Lease.

1.5 *Successor Landlord.* A *"Successor Landlord"* means any party that becomes owner of Landlord's Premises as the result of a Foreclosure Event.

1.6 *Termination Right.* A *"Termination Right"* means any right of Tenant to cancel or terminate the Lease or to claim a partial or total eviction arising (whether under the Lease or under applicable law) from Landlord's breach or default under the Lease.

2. Subordination.

The Lease shall be, and shall at all times remain, subject and subordinate to the lien of the Mortgage, and all advances made under the Mortgage.

3: Non-disturbance, Recognition and Attornment.

3.1 *No Exercise of Mortgage Remedies Against Tenant.* So long as the Lease has not been terminated on account of Tenant's default (an "Event of Default"), Mortgagee shall not name or join Tenant as a defendant in any exercise of Mortgagee's rights and remedies arising upon a default under the Mortgage unless applicable law requires Tenant to be made a party thereto as a condition to proceeding against Landlord or prosecuting such rights and remedies. In the latter case, Mortgagee may join Tenant as a defendant in such action only for such purpose and not to terminate the Lease or otherwise adversely affect Tenant's rights under the Lease or this Agreement in such action. If Mortgagee joins Tenant in such action, Landlord, by executing the Consent hereinafter set forth, agrees to indemnify, defend and hold Tenant harmless from and against any loss, cost or expense incurred or suffered by Tenant, including without limitation, legal fees, in being a party to or arising from such action, which indemnity shall survive termination or expiration of this Agreement.

3.2 *Non-disturbance and Attornment.* If the Lease has not been terminated on account of an Event of Default by Tenant, then, when Successor Landlord takes title to Landlord's Premises: (a) Successor Landlord shall not terminate or disturb Tenant's possession or quiet enjoyment of Tenant's Premises under the Lease, except in accordance with the terms of the Lease and this Agreement; (b) Successor Landlord shall be bound to Tenant under all the terms and conditions of the Lease (except as provided in this Agreement); (c) Tenant shall recognize and attorn to Successor Landlord as Tenant's direct landlord under the Lease as affected by this Agreement; and (d) the Lease shall continue in full force and effect as a direct lease, in accordance with its terms (except as provided in this Agreement), between Successor Landlord and Tenant.

3.3 *Further Documentation.* The provisions of Section 3 shall be effective and self-operative without any need for Successor Landlord or Tenant to execute any further documents. Tenant and Successor Landlord shall, however, confirm the provisions of Section 3 in writing upon request by either of them.

3.4 *Consent to Lease.* Mortgagee hereby consents to the Lease and all of the terms and conditions thereof.

4. Protection of Successor Landlord.

Notwithstanding anything to the contrary in the Lease or the Mortgage, Successor Landlord shall not be liable for or bound by any of the following matters:

4.1 *Claims Against Former Landlord.* Any Offset Right that Tenant may have against any Former Landlord relating to any event or occurrence before the date of

attornment, including any claim for damages of any kind whatsoever as the result of any breach by Former Landlord that occurred before the date of attornment. unless and to the extent that Mortgagee was furnished notice and opportunity to cure the same. (The foregoing shall not limit Tenant's right to exercise against Successor Landlord any Offset Right otherwise available to Tenant because of events occurring after the date of attornment, if any).

4.2 *Prepayments.* Any payment of Rent that Tenant may have made to Former Landlord more than thirty (30) days before the date such Rent was first due and payable under the Lease with respect to any period after the date of attornment other than, and only to the extent that, the Lease expressly required such a prepayment.

4.3 *Payment; Security Deposit.* Any obligation: (a) to pay Tenant any sum(s) that any Former Landlord owed to Tenant or (b) with respect to any security deposited with Former Landlord, unless such security was actually delivered to Mortgagee.

4.4 Lease. Tenant hereby covenants and agrees that, so long as the Mortgage remains in force and effect:

(a) No Modification Termination or Cancellation. Tenant shall not consent to any material modification, termination or cancellation of the Lease without Mortgagee's prior written consent, which consent shall not be unreasonably withheld and shall be deemed given if Mortgagee fails to respond in writing within 15 days following receipt ofwritten notice.

(b) Notice of Default. Tenant shall notify Mortgagee in writing concurrently with any notice given to Landlord of any breach of or default by Landlord under the Lease. Tenant agrees that Mortgagee shall have the right (but not the obligation) to cure any breach or default specified in such notice within the time period set forth in the Lease for Landlord's performance.

(c) Assignment of Rents. Upon receipt by Ten nt of written notice from Mortgagee that Mortgagee has elected to terminate the license granted to Landlord to collect rents, as provided in the Mortgage, and directing Tenant to make payment thereof to Mortgagee, Tenant shall not be required to determine whether Landlord is in default under any obligations to Mortgagee before complying with such direction and shall not be liable to Landlord for failure to pay Landlord any sums that are paid instead to Mortgagee.

5. Miscellaneous.

5.1 *Notices.* All notices or other communications required or permitted under this Agreement shall be in writing and given by certified mail (return receipt requested) or by nationally recognized overnight courier service that regularly maintains records of items delivered. Notices shall be effective the next business day after being sent by overnight courier service, and three (3) business days after being sent by certified mail (return receipt requested). Unless and until notice of a change of address is given under this Agreement, notices or other communications shall be given to Mortgagee and Tenant, respectively, at the following address:

Mortgagee: _____
_____
_____

Attn: _____

Landlord: _____
_____
_____

Tenant: c/o DaVita Inc.
Attention: Real Estate Legal
2000 16th Street
Denver, CO 80202

Concurrent copy to: relegal@davita.com
Subject: Auburn, WA (Facility #TBD)

5.2 *Successors and Assigns.* This Agreement shall bind and benefit the parties their successors and assigns, any Successor Landlord, and its successors and assigns.

5.3 *Entire Agreement.* This Agreement constitutes the entire agreement between Mortgagee and Tenant regarding the subordination of the Lease to the Mortgage and the rights and obligations of Tenant and Mortgagee as to the subject matter of this Agreement.

5.4 *Interaction with Lease and with Mortgage.* If this Agreement conflicts with the Lease, then this Agreement shall govern as between the parties to this Agreement and

any Successor Landlord, including upon any attornment pursuant to this Agreement. This Agreement supersedes, and constitutes full compliance with, any provisions in the Lease that provide for subordination of the Lease to, or for delivery of non-disturbance agreements by the holder of the Mortgage. Mortgagee confirms that Mortgagee has consented to Landlord's entering into the Lease.

5.5 *Interpretation; Governing Law.* The interpretation, validity and enforcement of this Agreement shall be governed by and construed under the internal laws of the State where the Premises is located, including its principles of conflict of laws.

5.6 *Amendments.* This Agreement may be amended, discharged or terminated, or any of its provisions waived, only by a written instrument executed by all parties to this Agreement.

5.7 *Execution.* This Agreement may be executed electronically and in any number of counterparts, each of which shall be deemed an original and all of which together shall constitute one and the same instrument.

5.8 *Representations.* Each party represents that it has full authority to enter into this Agreement and that those signatories executing this Agreement on its behalf have full power and authority to executed this Agreement. Mortgagee agrees to keep a copy of this Agreement in its permanent mortgage records with respect to the Loan. This Agreement shall be null and void unless Tenant receives a fully executed original counterpart hereof on or before the sixtieth (60th) day following the date of Tenant's execution.

5.9 *Recordation.* Upon full execution, this Agreement may be recorded in the real property records of the county in which the Premises is located by either party hereto, provided that the recording party delivers to the other party a copy of the recorded document. The recording party shall be responsible for the costs of recording this. Agreement.

[Signature page follows]

IN WITNESS WHEREOF, this Agreement has been duly executed by Mortgagee and Tenant as of the date(s) set forth below.

MORTGAGEE:

_____

a _____

By:_____

Name:

_____

Title: _____

Date:

_____

STATE OF)
) ss
COUNTY)

OF

I, _____, a Notary Public in and for the County and State aforesaid, do hereby certify that _____ the of

_____

_____, who is personally known to me to be the same person whose name is subscribed to the foregoing instrument, appeared before me in person and acknowledged that he/she signed, sealed and delivered the said instrument as his/her own free and voluntary act and as the free and voluntary act of said _____, for the uses and purposes therein set forth.

Given under my hand and notarial seal this _day of _____, 20.

_____

Notary Public

My Commission Expires:_____

TENANT:

[TENANT ENTITY],
a_____

By:_____

Name: _____

Title: _____

Date: _____

STATE OF _____)
) SS
COUNTY OF _____)

I, _____, a Notary Public in and for the County and State aforesaid, do hereby certify that _____ the _____ of _____, who is personally known to me to be the same person whose name is subscribed to the foregoing instrument, appeared before me in person and acknowledged that he/she signed, sealed and delivered the said instrument as his/her own free and voluntary act and as the free and voluntary act of said _____, for the uses and purposes therein set forth.

Given under my hand and notarial seal this _____ day of _____, 20__.

_____
Notary Public

My Commission Expires:_____

LANDLORD'S CONSENT

Landlord consents and agrees to the foregoing Agreement (including without limitation, the provisions of Section 3.1 & 4.4), which was entered into at Landlord's request. The foregoing Agreement shall not alter, waive or diminish any of Landlord's obligations under the Mortgage or the Lease. The above Agreement discharges any obligations of Mortgagee under the Mortgage and related loan documents to enter into a non-disturbance agreement with Tenant and the obligations of Tenant to enter into a subordination agreement with Mortgagee.

LANDLORD:

_____, a_
_____

By:_____

Name: _____

Title: _____

Date: _____

STATE OF _____)
) SS
COUNTY OF _____)

I, _____, a Notary Public in and for the County and State aforesaid, do hereby certify that _____ the _____ of _____, who is personally known to me to be the same person whose name is subscribed to the foregoing instrument, appeared before me in person and acknowledged that he/she signed, sealed and delivered the said instrument as his/her own free and voluntary act and as the free and voluntary act of said _____, for the uses and purposes therein set forth.

Given under my hand and notarial seal this _____ day of _____, 20__.

_____
Notary Public

My Commission Expires: _____

EXHIBIT A TO
SUBORDINATION, NON-DISTURBANCE AND ATTORNMENT AGREEMENT

Landlord's Premises

EXHIBIT D

FORM OF ESTOPPEL
CERTIFICATE ESTOPPEL
CERTIFICATE

THIS ESTOPPEL GERTIFICATE is made as of the___ day of _____,
20 by _____ in connection with that certain Ground Lease dated _____ by and between
Landlord (the "Lease") for the property located at _____ (the "Premises").

[Landlord/Tenant] hereby certifies to the best of [Landlord's/Tenant's] knowledge to (Tenant/Landlord or Lender or both) as follows:

1. The Lease is now in full force and effect and has not been amended, modified, or assigned except by the_____dated _____.
There are no other oral or written agreements or understandings between Landlord and Tenant relating to the Premises. As of the date hereof, the Lease is in full force and effect.

2. To [Landlord's/Tenant's] knowledge and belief, the information set forth below is true and correct as of the date hereof:

(a) Approximate square footage of the Premises:__ rentable square feet

(b) Monthly installment of Rent as of the date hereof: $ _____

(c) Termination date: _____

(d) Security deposit: _____

(e) Prepaid rent in the amount of: _____

(f) Renewal Options:_____

3. To the best of [Landlord's/Tenant's] actual knowledge and belief, without inquiry or investigation, there exists no default, no facts or circumstances exist that, with the passage of time or giving of notice,

will or could constitute a default, event of default or breach on the part of either Tenant or Landlord under the Lease (except _____).

4. No rent has been or will be paid more than 30 days in advance.

5. All legal notices to Tenant shall be sent to:

Tenant: _____

c/o DaVita Inc.
Attention: Real Estate Legal
2000 16th Street
Denver, CO 80202

Concurrently to: relegal@davita.com
Subject: Auburn, WA (Facility#_)

IN WITNESS WHEREOF,_____has executed this Estoppel Certificate as of the date first above written.

TENANT:

_____

Exhibit

By:_____
Name: _____
Title: _____
Date: _____

EXHIBIT E

FORM OF MEMORANDUM OF LEASE

[TO BE CONFORMED TO COUNTY RECORDING REQUIREMENTS]

Prepared by and Return to:

_____

_____

_____

Parcel ID: _____

MEMORANDUM OF LEASE AND RIGHT OF FIRST REFUSAL

This Memorandum of Lease (this "Memorandum") is made and entered into this _____ day of _____,20_, by and between _____,a _____ ("Landlord") and_____, a _____ ("Tenant"). Tenant and Landlord agree to and acknowledge the following matters:

1. Landlord and Tenant entered into that certain Ground Lease dated as of _____,20_(the "Lease"), wherein Landlord has leased to Tenant, and Tenant has leased from Landlord, subject to the terms, covenants and conditions contained therein, certain real property (the "Premises"), located at _____ in__,_____, as legally described on Exhibit A, attached and incorporated herein by reference.

2. The term of the Lease is for an initial period of 10 years commencing upon the Commencement Date, as defined in the Lease, (the "Lease Term"), subject to a right to extend and renew the Lease for five (5) additional periods of five (5) years each.

3. Pursuant to the Lease, Tenant has the option to purchase the Premises during the Term.

4. The Lease contains certain restrictions on Landlord's ability to sell, rent or permit any property owned, leased or controlled by Landlord or any affiliate of Landlord to a business that provides renal dialysis, renal dialysis home training, any aphaeresis service(s) or similar blood separation or cell collection procedures within five miles from the Premises.

5. The address of Tenant is c/o DaVita Inc., Attention: Real Estate Legal, 2000 16th Street, Denver, CO 80202, concurrently to: relegal@davita.com, Subject: Auburn, WA (Facility #TBD).

6. The address of Landlord is : _____

7. The purpose of this Memorandum is to give record notice to all persons that Tenant has a leasehold interest in the Premises with related use exclusivity rights, and the right to purchase the Premises pursuant to the Lease, in addition to other rights and obligations created therein, all of which are confirmed.

8. Any capitalized terms utilized herein that are not otherwise defined shall be deemed to have the same meaning as set forth in the Lease.

9. In the event of a conflict between the terms of the Lease and the terms of this Memorandum, the terms of the Lease shall control.

10. This Memorandum may be executed in any number of counterparts, each of which shall be deemed an original and all of which together shall constitute one and the same instrument.

[Signature pages follow]

IN WITNESS WHEREOF, the parties hereto have executed this Memorandum as of the day and year first above written.

LANDLORD:

_____

By:_____
Name: _____
Title: _____
Date: _____

STATE OF _____)
) SS
COUNTY OF _____)

I, _____, a Notary Public in and for the County and State aforesaid, do hereby certify that _____ the _____ of _____, who is personally known to me to be the same person whose name is subscribed to the foregoing instrument, appeared before me in person and acknowledged that he/she signed, sealed and delivered the said instrument as his/her own free and voluntary act and as the free and voluntary act of said _____, for the uses and purposes therein set forth.

Given under my hand and notarial seal this _____ day of _____, 20__.

_____
Notary Public

My Commission Expires: _____

TENANT:

[DAVITA ENTITY],

a _____ _____

By:_____
Name: _____
Title: _____
Date: _____

STATE OF _____)
) SS
COUNTY OF _____)

I, _____, a Notary Public in and for the County and State aforesaid, do hereby certify that _____ the _____ of _____, who is personally known to me to be the same person whose name is subscribed to the foregoing instrument, appeared before me in person and acknowledged that he/she signed, sealed and delivered the said instrument as his/her own free and voluntary act and as the free and voluntary act of said _____, for the uses and purposes therein set forth.

Given under my hand and notarial seal this _____ day of _____, 20__.

_____
Notary Public

My Commission Expires: _____

EXHIBIT A
TO
MEMORANDUM OF LEASE

Legal Description of the Premises

EXHIBIT F

GUARANTY

WHEREAS, SOUTHERN FINANCIAL GROUP, LLC ("Landlord") and TOTAL RENAL CARE, INC. ("Tenant"), have entered into a certain lease agreement dated on or about the date hereof (the "Lease"), covering certain premises located at the intersection of O Street and 15th Street SW in the City of Auburn, King County Parcel ID #0301500090, #0301500280, and #0301500110 located in Auburn, Washington (the "Premises"); and

WHEREAS, the Landlord requires as a condition to its execution of the Lease that the undersigned unconditionally becomes a guarantor to Landlord for the obligations of Tenant under the Lease; and

WHEREAS, the undersigned is the parent corporation of Tenant and as such is desirous that Landlord enter into the Lease with Tenant.

NOW THEREFORE, in consideration of the execution of the Lease by Landlord and other good and valuable consideration and intending to be legally bound hereby, the undersigned hereby unconditionally becomes a guarantor to Landlord, its successors and assigns as follows:

1. The undersigned guaranties the full, faithful and punctual performance of each and all of the covenants, agreements and conditions of the Lease, to be kept and performed by Tenant (subject to all applicable notice and/or cure periods set forth in the Lease), in accordance with and within the time prescribed by the Lease (hereinafter collectively referred to as the "Liabilities"). Notwithstanding anything herein to the contrary, this Guaranty, and all the obligations of the undersigned hereunder, shall terminate upon the earlier of: (i) expiration of the initial 10 year Lease term, or (ii) purchase of the Premises by Tenant or its affiliate, in accordance with the terms and conditions of the Lease.

2. Landlord shall have the right from time to time, and at any time in its sole discretion, without notice to or consent from the undersigned, or without affecting, impairing or discharging in whole or in part, the Liabilities or the obligations of the undersigned hereunder, to modify, change, extend, alter, amend, or supplement in any respect whatever, the Lease, or any agreement or transaction between Landlord and Tenant or between Landlord and any other party liable for the Liabilities, or any portion or provision thereof; to grant extension of time and other indulgences of any kind to Tenant; to compromise, release, substitute, exercise, enforce or fail to refuse to exercise or enforce any claims, rights, or remedies of any kind which Landlord may have at any time against Tenant or any other party liable for the Liabilities, or any thereof, or with respect to any security of any kind held by Landlord at any time under any agreement or otherwise.

3. The undersigned waives: (a) all notice, including but not limited to (i) notice of acceptance of this Guaranty; (ii) notice of presentment, demand for payment, or protest of any of the Liabilities, or the obligation of any person, firm, or corporation held by Landlord as collateral security; (b) trial by jury and the right thereto in any proceeding of any kind, whether arising on or out of, under or by reason of this Guaranty, or any other agreement or transaction between the undersigned, Landlord and/or Tenant; and (c) all notices of the financial condition or of any adverse or other change in the financial condition of Tenant.

4. Landlord may, without notice, assign this Guaranty in whole or in part to Landlord's successor in interest under the Lease, and no assignment of this Guaranty shall operate to extinguish or diminish the liability of the undersigned hereunder.

5. The liability of the undersigned under the Guaranty shall be primary under any right of action which shall accrue to Landlord under the Lease and Landlord may, at its option, proceed against the undersigned without having to commence any action, or have obtained any judgment against Tenant.

6. All of the Liabilities and the obligations of the undersigned hereunder shall be immediately due and payable by the undersigned, anything contained herein to the contrary notwithstanding, immediately upon the occurrence of a default under the Lease which continues beyond the expiration of the applicable notice and/or grace period, if any, under the Lease.

7. The obligations of the undersigned hereunder shall not be affected, impaired or discharged, in whole or in part, by reason of: (a) the entry of an order for relief pursuant to the United States Bankruptcy Code by or against Tenant or the undersigned; or (b) the proposal of or the consummation of a plan of reorganization concerning Tenant or the undersigned.

8. The waiver of any right by Landlord or its failure to exercise promptly any right shall not be construed as the waiver of any other right including the right to exercise the same at any time thereafter. No waiver or modification of any of the terms or conditions of this Guaranty shall be binding against Landlord unless such waiver or. modification is in a writing signed by Landlord.

9. The provisions of the Guaranty shall bind all of the respective successors and assigns of the undersigned and shall inure to the benefit of Landlord, its successors and assigns.

10. All rights and remedies of Landlord are cumulative and not alternative. This Guaranty is, and shall be deemed to be, a contract entered into under and pursuant to the laws of the State of Washington and shall be in all respects governed, construed, applied and enforced in accordance with the laws of said State.

11. The undersigned represents that at the time of the execution and delivery of this Guaranty nothing exists to impair the effectiveness of the obligations of the undersigned to Landlord hereunder, or the immediate taking effect of this Guaranty between the undersigned and Landlord with respect to the undersigned becoming a surety for the Liabilities. ,

IN WITNESS WHEREOF, the undersigned has caused this Guaranty to be executed as of_____

DAVITA INC.

By:_____

Name: _____

Title: _____

Date: _____

FOR TENANT'S INTERNAL USE ONLY:

APPROVAL AS TO FORM ONLY

By: _____

Name: _____

Title: Assistant General Counsel

eGIS CDPW



666.7 0 333.3 666.7 Feet

NAD_1983_StatePlane_Washington_North_FIPS_4601_Feet

1in = 333 ft 1: 4,000

Printed Date: 5/21/2018

Map Created by City of Auburn eGIS

Imagery Date: May 2015

Information shown is for general reference purposes only and does not necessarily represent exact geographic or cartographic data as mapped. The City of Auburn makes no warranty as to its accuracy.

Legend

- Parcels
- Parcels Labels
- Street Painted Lines_1k
  - Airport
  - Bike Lane
  - Bike Lane Symbol
  - Crosswalk
  - Dashed Dividng Line
  - Directional Symbols
  - Fog Line
  - Parking
  - HOV Lane
  - HOV Symbol
  - On Street Parking
  - Painted Road Line
  - Railroad Crossing
  - Solid Dividing Line
  - Stop Line
- Trees_1k
- Buildings
- BuildingsRep
- Curbs_1k
- Parking_1k
- Driveways_1k
- Streets_1k
- Streets County_1k

Notes

Type any additional notes- delete text to leave blank

eGIS CDPW



333.3 0 166.7 333.3 Feet

NAD_1983_StatePlane_Washington_North_FIPS_4601_Feet

1in = 167 ft 1: 2,000

Printed Date: 5/21/2018

Map Created by City of Auburn eGIS

Imagery Date: May 2015

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Legend

- Wetlands
- Parcels
- Parcels Labels
- Street Painted Lines_1k
  - Airport
  - Bike Lane
  - Bike Lane Symbol
  - Crosswalk
  - Dashed Dividng Line
  - Directional Symbols
  - Fog Line
  - Parking
  - HOV Lane
  - HOV Symbol
  - On Street Parking
  - Painted Road Line
  - Railroad Crossing
  - Solid Dividing Line
  - Stop Line
- Trees_1k
- Buildings
- BuildingsRep
- Curbs_1k
- Parking_1k
- Driveways_1k
- Streets_1k

Notes

Type any additional notes- delete text to leave blank

CITY OF AUBURN WASHINGTON

Nancy Backus, Mayor

25 West Main Street * Auburn WA 98001-4998 * www.auburnwa.gov * 253-931-3000

May 21, 2018

Genesis KC Development LLC
c/o Mark Kinney
6245 South Victor Ave
Tulsa, OK 74136
Mark.kinney@davita.com

Re: Confirmation of Zoning – Auburn WA
King Co. Parcel Numbers: 030150028, 0301500090, 0301500110
(File No. ZCL18-0007)

Dear Mark Kinney:

This letter is a response to your Confirmation of Zoning request, received May 17, 2018. The subject properties referenced by the above King County parcel numbers are within the City of Auburn's corporate limits.

1. The zoning designation for the subject property is C-3, Heavy Commercial Zone.
2. The subject property zoning requirements are regulated by ACC Chapter 18.23 – Commercial and Industrial Zones (attached). Note that other codes and design standards apply to the subject property.
3. Permitted uses within the C-3 zone include "Medical Clinics" and "Hospitals", therefore a kidney dialysis center would be a permitted use.
4. There are no open code violations on this site to date.
5. The subject sites are wetlands, which, if developed, would require off-site mitigation, as regulated by ACC Chapter 16.10 (attached).

Please note that this letter only addresses the property's zoning designation and does not authorize any project or site plan currently proposed or in the future. A pre-application conference is highly recommended prior to application for development, to learn all requirements regarding critical areas, traffic, development engineering, utilities, and other requirements. Submitting a public record request with the Clerk's office would give you access to additional information, such as previous communication and the pre-application conference summary regarding this site (file numbers PRE16-0023 & COR16-0001).

If you have any further questions, please feel free to contact me at (253) 288-4301 or cmalik@auburnwa.gov.

Sincerely,

C Malik

Cecile Malik, Planner
Community Development & Public Works Department

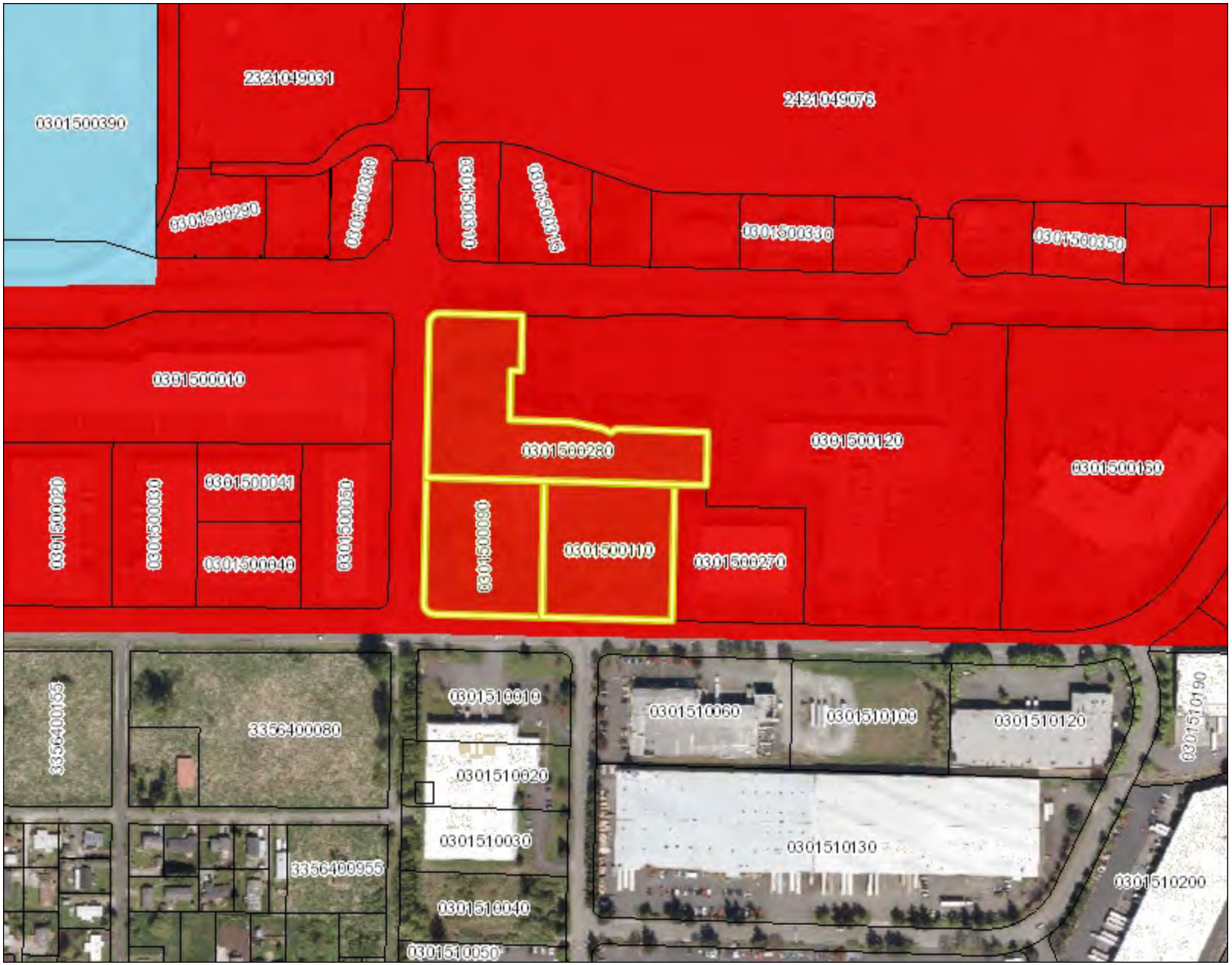
CM/jo

CORR18-0078

CC: File No. ZCL18-0007

Enclosures: ACC Chapter 18.23 Commercial and Industrial Zones
ACC Chapter 16.10 Critical Areas
Zoning, Imagery 2015, and Wetland Maps

eGIS CDPW



666.7 0 333.3 666.7 Feet

NAD_1983_StatePlane_Washington_North_FIPS_4601_Feet

1in = 333 ft 1: 4,000

Printed Date: 5/21/2018

Map Created by City of Auburn eGIS

Imagery Date: May 2015

Information shown is for general reference purposes only and does not necessarily represent exact geographic or cartographic data as mapped. The City of Auburn makes no warranty as to its accuracy.

Legend

- Parcels
- Parcels Labels
- Zoning
  - C1 Light Commercial District
  - C2 Central Business District
  - C3 Heavy Commercial District
  - C4 Mixed Use Commercial
  - CN Neighborhood Shopping Distric
  - DUC Downtown Urban Center
  - I Institutional Use District
  - Lakeland Hills South PUD
  - LF Airport Landing Field District
  - M1 Light Industrial District
  - M2 Heavy Industrial District
  - P1 Public Use District
  - PUD Planned Unit Development
  - R1 Residential 1 DU/Acre
  - R5 Residential 5 DU/Acre
  - R7 Residential 7 DU/Acre
  - R10 Residential 10 DU/Acre
  - R20 Residential 20 DU/Acre
  - Residential Conservency
  - RMHC Residential Manufactured/M
  - RO Residential Office District
  - RO-H Residential Office District (Hc
  - TV Terrace View

Notes

Type any additional notes- delete text to leave blank

Chapter 16.10
CRITICAL AREAS

Sections:

16.10.010 Purpose and intent.
16.10.020 Definitions.
16.10.030 Applicability – Regulated activities.
16.10.040 Exemptions and nonconforming uses.
16.10.050 Critical areas maps.
16.10.060 Relationship to other regulations.
16.10.070 Critical area review process and application requirements.
16.10.080 Classification and rating of critical areas.
16.10.090 Buffer areas and setbacks.
16.10.100 Alteration or development of critical areas – Standards and criteria.
16.10.110 Mitigation standards, criteria and plan requirements.
16.10.120 Performance standards for mitigation planning.
16.10.130 Monitoring program and contingency plan.
16.10.140 Procedural provisions.
16.10.150 Reasonable use provision.
16.10.160 Variances.
16.10.170 Special exception for public agencies and utilities.
16.10.180 Severability.

16.10.010 Purpose and intent.

A. The city of Auburn contains numerous areas that can be identified and characterized as critical or environmentally sensitive. Such areas within the city include wetlands, streams, wildlife habitat, significant trees, geologic hazards, ground water protection areas, and flood hazards.

B. The city finds that these critical areas perform a variety of valuable and beneficial biological and physical functions that benefit the city and its residents. Alteration of certain critical areas may also pose a threat to public safety or to public and private property or the environment. The city therefore finds that identification, regulation and protection of critical areas are necessary to protect the public health, safety and general welfare. The city further finds that the functions of critical areas and the purpose of these regulations include the following:

1. Wetlands. Wetlands perform a variety of functions that include maintaining water quality; storing and conveying storm water and flood water; recharging ground water; providing important fish and wildlife habitat; and serve as areas for recreation, education and scientific study, and aesthetic appreciation.

Wetland buffers serve to moderate runoff volume and flow rates; reduce sediment, chemical nutrient and toxic pollutants; provide shading to maintain desirable water temperatures; provide habitat for wildlife; and protect wetland resources from harmful intrusion.

The primary goals of wetland regulation are to avoid adverse effects to wetlands; to achieve no net loss of wetland function and value – acreage may also be considered in achieving the overall goal; to provide levels of protection that reflect the sensitivity of individual wetlands and the intensity of proposed land uses; and to restore and/or enhance existing wetlands, where possible.

2. Streams. Streams and their associated riparian corridors provide important fish and wildlife habitat; help to maintain water quality; store and convey storm water and flood water; recharge ground water; and serve as areas for recreation, education and scientific study and aesthetic appreciation. Stream buffers serve to moderate runoff volume and flow rates; reduce sediment, chemical nutrient and toxic pollutants; provide shading to maintain desirable water temperatures; provide habitat for wildlife; and protect stream resources from harmful intrusion.

The primary goals of stream regulation are to avoid adverse effects to streams and associated riparian corridors; to achieve no net loss of functions and values of the larger ecosystem in which the stream is located; to protect fish and wildlife resources; to protect water quality through appropriate management techniques; and, where possible, to provide for stream enhancement and rehabilitation.

3. Wildlife Habitat. Wildlife habitat provides opportunities for food, cover, nesting, breeding and movement for fish and wildlife; maintains and promotes diversity of species and habitat; coordinates habitat protection with elements of the open space system; helps to maintain air and water quality; helps control erosion; serves as areas for recreation, education, scientific study, and aesthetic appreciation; and provides neighborhood separation and visual diversity within urban areas.

The primary goals of wildlife habitat regulation are to avoid adverse effects to critical habitats for fish and wildlife; to achieve no net loss of functions and values of the larger ecosystem in which the wildlife habitat is located; to implement the goals of the Endangered Species Act; to promote connectivity between habitat areas to allow for wildlife movement; to provide multi-purpose open space corridors; and where possible to provide for fish and wildlife habitat enhancement and rehabilitation that reflect the sensitivity of the species.

4. Ground Water Protection Areas. Ground water protection areas provide a source of potable water and contribute to stream discharge/flow. Such areas contribute to the recharge of aquifers, springs and/or wells and are susceptible to contamination of water supplies through infiltration of pollutants through the soil.

The primary goals of ground water protection regulations are to protect ground water quality by maintaining the quantity of recharge; avoiding or limiting land use activities that pose potential risk of aquifer contamination; and to minimize or avoid adverse effects to ground water protection areas through the application of performance standards, and to comply with the requirements of the Federal Safe Drinking Water Act and Washington Administrative Code that require Group A public water systems to develop and implement a wellhead protection program.

5. Geologic Hazard Areas. Geologic hazard areas include lands or areas characterized by geologic, hydrologic and topographic conditions that render them susceptible to varying degrees of risk of landslides, erosion, seismic or volcanic activity.

The primary goals of regulating geologic hazards are to avoid and minimize potential impacts to life and property by regulating and/or limiting land uses where necessary, and to conduct appropriate levels of analysis and ensure sound engineering and construction practices to address identified hazards.

6. Flood Hazard Areas. Floodplains help to store and convey storm water and flood water; recharge ground water; provide important areas for riparian habitat; and serve as areas for recreation, education, and scientific study. Development within floodplain areas can be hazardous to those inhabiting such development, and to those living upstream and downstream.

Floods also cause substantial damage to public and private property that results in significant costs to the public and individuals.

The primary goals of flood hazard regulations are to limit or condition development within the regulatory floodplain to avoid substantial risk of damage to public and private property and that results in significant costs to the public and individuals; to avoid significant increases in peak storm water flows or loss of flood storage capacity; to protect critical habitat for fish and wildlife, and to meet the purposes set forth in Chapter 15.68 ACC. Requirements for the identification, assessment, alteration, and mitigation of flood hazard areas are contained in Chapter 15.68 ACC.

C. This chapter of the Auburn City Code and other sections as incorporated by reference contain standards, procedures, criteria and requirements intended to identify, analyze, and mitigate potential impacts to the city's critical areas, and to enhance and restore degraded resources where possible. The general intent of these regulations is to avoid impacts to critical areas. In appropriate circumstances, impacts to specified critical areas resulting from regulated activities may be minimized, rectified, reduced and/or compensated for, consistent with the requirements of this chapter.

D. It is the further intent of this chapter to:

1. Comply with the requirements of the Growth Management Act (Chapter 36.70A RCW) and implement rules to identify and protect critical areas and to perform the review of development regulations required by RCW 36.70A.215;

2. Develop and implement a comprehensive, balanced and fair regulatory program that avoids impacts to critical resources where possible, that requires that mitigation be performed by those affecting critical areas, and that thereby protects the public from injury, loss of life, property or financial losses due to flooding, erosion, landslide, seismic events, soil subsidence, or steep slope failure;

3. Implement the goals and policies of the Auburn comprehensive plan, including those pertaining to natural features and environmental protection, as well as goals relating to land use, housing, economic development, transportation, and adequate public facilities;

4. Serve as a basis for exercise of the city's substantive authority under the State Environmental Policy Act (SEPA) and the city's environmental review procedures, where necessary to supplement these regulations, while also reducing the city's reliance on project-level SEPA review;

5. Provide consistent standards, criteria and procedures that will enable the city to effectively manage and protect critical areas while accommodating the rights of property owners to use their property in a reasonable manner;

6. Provide greater certainty to property owners regarding uses and activities that are permitted, prohibited, and/or regulated due to the presence of critical areas;

7. Coordinate environmental review and permitting of proposals involving critical areas with existing development review and approval processes to avoid duplication and delay pursuant to the Regulatory Reform Act, Chapter 36.70B RCW;

8. Establish conservation and protection measures for threatened and endangered fish species in compliance with the requirements of the Endangered Species Act and the Growth

Management Act requirements to preserve or enhance anadromous fisheries, WAC 365-195-925;

9. Alert members of the public, including appraisers, assessors, owners, potential buyers or lessees, to the development limitations of critical areas and their required buffers.

E. Best Available Science. The city has considered and included the best available science in developing these regulations, consistent with RCW 36.70A.172 and WAC 365-195-900, et seq. This has been achieved through research and identification of relevant technical sources of information, consultation with experts in the disciplines covered by this chapter, and consultation and requests for technical information regarding best available science from state and federal resource agencies.

Preparation of this chapter has included the use of relevant nonscientific information, including consideration of legal, social, policy, economic, and land use issues. This reflects the city's responsibilities under numerous laws and programs, including other provisions of the Growth Management Act, and the need to weigh and balance various factors as part of decision making to accomplish municipal objectives. This may result in some risk to the functions and values of some critical areas. The city will also use its authority under the State Environmental Policy Act (SEPA) to identify, consider and mitigate, where appropriate, significant adverse effects on critical resources not otherwise addressed by the regulations of this chapter.

The city intends to review and monitor implementation of its critical areas regulations and to use an adaptive management approach. It will make adjustments to the regulations, as appropriate, in response to changing conditions, new information about best available science, or empirical data indicating the effectiveness of its regulatory program. This will occur in the context of the city's ongoing review and revision of its comprehensive plan and development regulations pursuant to the Growth Management Act.

Additional information, both scientific and nonscientific, regarding compliance with WAC 365-195-915(c), including identification of risks to resources, is contained in the findings and conclusions and the overall record supporting adoption of Auburn's critical areas regulations. (Ord. 6295 § 3, 2010; Ord. 5894 § 1, 2005.)

16.10.020 Definitions.

SHARE

For purposes of this chapter, the following definitions shall apply:

"Anadromous fish" means fish that spawn and rear in freshwater and mature in the marine environment, such as salmon, steelhead, sea-run cutthroat, and bull trout.

"Applicant" means the person, party, firm, corporation, or other entity that proposes or has performed any activity that affects a critical area.

"Aquifer" means, generally, any water bearing soil or rock unit. Specifically, a body of soil or rock that contains sufficient saturated permeable material to conduct ground water and yield economically significant quantities of ground water to wells or springs.

"Artificially created wetlands" means wetlands created from nonwetland sites through purposeful, legally authorized human action, such as irrigation and drainage ditches, grass-lined swales, canals, retention or detention facilities, wastewater treatment facilities, farm ponds, and landscape amenities.

"Best Available Science." As defined in the Procedural Criteria for Adopting Comprehensive Plans and Development Regulations for Best Available Science at WAC 365-195-900, et seq.

“Buffer or buffer area, critical area” means a naturally vegetated, undisturbed, enhanced or revegetated zone surrounding a critical area that protects the critical area from adverse impacts to its integrity and value, and is an integral part of the resource’s ecosystem.

“City” means the city of Auburn.

“Clearing” means the removal of timber, brush, grass, ground cover or other vegetative matter from a site, which exposes the earth’s surface of the site, or any actions, which disturb the existing ground surface.

“Comprehensive plan” means the city of Auburn comprehensive plan as now adopted or hereafter amended.

“Critical areas” or “environmentally sensitive areas” means areas that possess important natural functions and embody a variety of important natural and community values. Such areas include wetlands, streams, fish and wildlife habitat, geologic hazard areas, ground water protection areas, and flood hazard areas. If not conducted properly, development or alteration of such areas may cause significant impacts to the valuable functions and values of these areas and/or may generate risks to the public health and general welfare, and/or to public and private property.

“Critical area report” means a report prepared by a qualified consultant to determine the presence, type, class, size, function and/or value of an area subject to these regulations. Also see “Stream reconnaissance report,” “Wetland impact assessment report” and “Wildlife report.”

“Critical erosion hazard areas” means lands or areas underlain by soils identified by the U.S. Department of Agriculture Soil Conservation Service (SCS) (now known as the Natural Resource Conservation Service) as having “severe” or “very severe” erosion hazards. This includes, but is not limited to, the following group of soils when they occur on slopes of 15 percent or greater: Alderwood-Kitsap (AkF), Alderwood gravelly sandy loam (AgD), Kitsap silt loam (KpD), Everett (EvD), and Indianola (InD). Additional soil groups may be identified through site-specific analysis.

“Critical geologic hazard areas” means lands or areas subject to high or severe risks of geologic hazard, including critical erosion hazard areas, critical landslide hazard areas, and critical seismic hazard areas.

“Critical habitat” or “critical wildlife habitat” means habitat areas associated with threatened, endangered, or sensitive species of plants or wildlife (pursuant to WAC 232-12-297(2.4), (2.5) and (2.6)) and which, if altered, could reduce the likelihood that the species will maintain and reproduce over the long term.

“Critical landslide hazard areas” means lands or areas where there is a high (Class III) or very high (Class IV) risk of landslide due to a combination of slope, soil permeability, and water.

“Critical seismic hazard areas” means lands or areas where there is a high risk of seismic events and damage.

“Delineation manual,” “wetland delineation manual,” or “wetland delineation methodology” means the manual and methodology used to identify wetlands in the field, as described in the Washington State Wetlands Identification and Delineation Manual (Publication No. 96-94), adopted by the Department of Ecology in 1997 (pursuant to RCW 36.70A.175 and 90.58.380), and which is based on the U.S. Corps of Engineers Wetlands Delineation Manual (1987). Use of this manual is required by RCW 36.70A.175 and 90.58.380.

“Department” means the city of Auburn department of planning and development or successor agency, unless the context indicates a different city department.

“Director” means the director of the city of Auburn department of planning and development or successor agency.

“Earth/earth material” means naturally occurring rock, soil, stone, sediment, or combination thereof.

“Enhancement” means the improvement of an existing viable wetland, stream or habitat area or the buffers established for such areas, through such measures as increasing plant diversity, increasing wildlife habitat, installing environmentally-compatible erosion controls, increasing structural diversity or removing plant or animal species that are not indigenous to the area. Enhancement also includes actions performed to improve the quality of an existing degraded wetland, stream, or habitat area. See also “Restoration.”

“Erosion” means a process whereby wind, rain, water, and other natural agents mobilize and transport soil particles.

“Erosion hazard areas” means lands or areas that, based on a combination of slope inclination and the characteristics of the underlying soils, are susceptible to varying degrees of risk of erosion. Erosion hazard areas are classified as “low” (areas sloping less than 15 percent) or “high” (areas sloping 15 percent or more) on the following Soil Conservation Service (SCS), now known as the Natural Resource Conservation Service (NRCS), soil types: Alderwood-Kitsap (AkF), Alderwood gravelly sandy loam (AgD), Kitsap silt loam (KpD), Everett (EvD) and Indianola (InD). Additional soil groups may be identified through site-specific analysis.

“Excavation” means the removal or displacement of earth material by human or mechanical means.

“Existing and ongoing agricultural activities” means those activities conducted on lands defined in RCW 84.34.020(2), and those activities involved in the production of crops and livestock. Such activity must have been in existence as of July 1, 1990 (the effective date of the Growth Management Act). The definition includes, but is not limited to, operation and maintenance of farm and stock ponds or drainage ditches, irrigation systems, changes between agricultural activities or crops, and normal operation, maintenance or repair of existing serviceable structures, facilities, or improved areas. Activities, which bring an area into agricultural use from a previous nonagricultural use, are not considered part of an ongoing activity. An operation ceases to be ongoing when the area on which it was conducted is proposed for conversion to a nonagricultural use or has lain idle for a period of longer than five years, unless the idle land is registered in a federal or state soils conservation program. Forest practices are not included in this definition.

“Exotic” means any species of plant or animal that is foreign and not indigenous to the lower Puget Sound area.

“Fill/fill material” means a deposit of earth material placed by human or mechanical means.

“Filling” means the act of transporting and placing (by any manner or mechanism) fill material from, to, or on any surface water body or wetland, soil surface, sediment surface, or other fill material.

“Geologic hazard areas” means lands or areas characterized by geologic, hydrologic, and topographic conditions that render them susceptible to varying degrees of risk of landslides, erosion, seismic or volcanic activity.

“Grading” means any excavating, filling, clearing, leveling or contouring of the ground surface by human or mechanical means.

“Ground water protection areas” means land areas designated by the city beneath which ground water occurs that is a current or potential future source of drinking water for the city.

“Habitat management” means management of land and its associated resources/features to maintain species in suitable habitats within their natural geographic distribution so that isolated subpopulations are not created. This does not imply maintaining all habitat or individuals of all species in all cases.

“Hazardous materials” means any material, either singularly or in combination, that is a physical or health hazard as defined and classified in Article 80 of the Uniform Fire Code as adopted or amended by the city, whether the materials are in usable or waste condition; and any material that may degrade ground water quality when improperly stored, handled, treated, used, produced, recycled, disposed of, or otherwise mismanaged. Hazardous materials shall also include, without exception:

1. All materials defined as or designated by rule as a dangerous waste or extremely hazardous waste under Chapter 70.105 RCW and Chapter 173-303 WAC;

2. Any substance defined as or designated by rule as a hazardous substance under Chapter 70.105 RCW and Chapter 173-303 WAC; and

3. Petroleum or petroleum products, including any waste oils or sludges.

“Hazardous materials inventory statement” means a form provided by the fire department and completed by a business owner that provides specified information regarding hazardous materials at the business.

“Hydrologically isolated” means wetlands which: (1) have no surface water connection to a lake, river, or stream during any part of the year; (2) are outside of and not contiguous to any 100-year floodplain of a lake, river, or stream; and (3) have no contiguous hydric soil between the wetland and any lake, river, or stream. May also be a pond excavated from uplands with no surface water connection to a stream, lake, or other wetland.

“In-kind wetland mitigation” means replacement of wetlands with wetlands whose characteristics closely approximate those destroyed or degraded by a regulated activity.

“Injection well” means a “well” that is used for the subsurface emplacement of fluids. (From WAC 173-218-030.)

“Intentionally created streams” means streams created through purposeful human action, such as irrigation and drainage ditches, grass-lined swales, and canals. This definition does not include stream modifications performed pursuant to city authorization, such as changes or redirection of stream channels.

“Lahar” means mudflows or debris flows associated with volcanic activity and which pose a threat to life, property, and structures.

“Landslide” means episodic downslope movement of a mass of soil or rock.

“Landslide hazard areas” means areas that, due to a combination of slope inclination, relative soil permeability, and hydrologic conditions are susceptible to varying degrees of risk of landsliding. Landslide hazard areas are classified as Classes I through IV based on the degree of risk as follows:

1. Class I/Low Hazard. Areas with slopes of 15 percent or less.

2. Class II/Moderate Hazard. Areas with slopes of between 15 percent and 40 percent and that are underlain by soils that consist largely of sand, gravel or glacial till.

3. Class III/High Hazard. Areas with slopes between 15 percent and 40 percent that are underlain by soils consisting largely of silt and clay.

4. Class IV/Very High Hazard. Areas with slopes steeper than 15 percent with identifiable zones of emergent water (e.g., springs or ground water seepage), areas of identifiable landslide deposits regardless of slope and all areas sloping more steeply than 40 percent.

The slopes referenced above include only those where the surface drops 10 feet or more vertically within a horizontal distance of 25 feet.

“Mature and old-growth forested wetlands” means wetlands containing mature or old-growth forested areas, generally requiring a century or more to develop. These systems represent two priority habitats, as defined by the Washington Department of Fish and Wildlife.

“Mitigation” means activities which include:

1. Avoiding the impact altogether by not taking a certain action or parts of actions.

2. Minimizing impacts by limiting the degree or magnitude of the action and its implementation.

3. Rectifying the impact by repairing, rehabilitating, or restoring the affected environment.

4. Reducing or eliminating the impact over time by preservation and maintenance operations during the life of the action.

5. Compensating for the impact by replacing or providing substitute resources or environments.

While monitoring without additional actions is not considered mitigation for the purposes of these regulations, it shall be part of a comprehensive mitigation program.

“Mitigation sequencing” means considering or performing mitigation actions, as defined in the definition of “mitigation,” in a preferred sequence from (1) through (5). Avoidance is preferred and must be considered prior to pursuing other forms of mitigation.

“Native” means any species of plant or animals which are or were indigenous to the lower Puget Sound area.

“Natural heritage wetlands” means wetlands that are identified by scientists of the Washington Natural Heritage Program/DNR as high quality, relatively undisturbed wetlands, or wetlands that support state-listed threatened or endangered plants.

“Off-site mitigation” means performance of mitigation actions, pursuant to standards established in this chapter, on a site or in an area other than that proposed for conduct of a regulated activity.

“Out-of-kind mitigation” means replacement of wetlands or habitat with substitute wetlands or habitat whose characteristics do not closely approximate those adversely affected, destroyed, or degraded by a regulated activity.

“Permanent erosion control” means continuous on-site and off-site control measures that are needed to control conveyance or deposition of earth, turbidity, or pollutants after development, construction, or restoration.

“Plant association of infrequent occurrence” means one or more plant species which because of the rarity of the habitat and/or the species involved, or for other botanical or environmental reasons, do not often occur in the city of Auburn. Examples include but are not limited to:

1. Wetlands with a coniferous forested class or subclass consisting of trees such as western red cedar, Sitka spruce, or lodge pole pine growing on organic soils;

2. Bogs with a predominance of sphagnum moss, or those containing sphagnum moss, and typically including one or more species such as Labrador tea, sundew, bog laurel, or cranberry.

“Qualified consultant,” for purposes of these regulations, shall mean a person who has attained a degree from an accredited college or university in the subject matter necessary to evaluate the critical area in question (e.g., biology, ecology, or horticulture/arboriculture for wetlands, streams, wildlife habitat, and geology and/or civil engineering for geologic hazards, and hydrogeologist for ground water protection areas), and/or who is professionally trained and/or certified or licensed by the state of Washington to practice in the scientific disciplines necessary to identify, evaluate, manage, and mitigate impacts to the critical area in question.

“Reasonable use” means a legal concept articulated by federal and state courts in regulatory taking cases.

“Regulated activities” means activities that have a potential to significantly impact a critical area that is subject to the provisions of this chapter. Regulated activities generally include, but are not limited to, any filling, dredging, dumping or stockpiling, release of contaminants to soil or water, draining, excavation, flooding, clearing or grading, construction or reconstruction, driving pilings, obstructing, clearing, or harvesting.

“Restoration” means actions taken to re-establish wetland, stream or habitat functional values, and the characteristics that have been destroyed or degraded by past alterations (e.g., filling or grading). See also “Enhancement.”

“Salmonids” means the family of fish which includes salmon, trout, and char.

“Secondary habitat” means areas that offer less diversity of animal and plant species than critical habitat but are important for performing the essential functions of habitat.

“Seismic hazard areas” means areas that, due to a combination of soil and ground water conditions, are subject to risk of ground shaking, subsidence, or liquefaction of soils during earthquakes. These areas are typically underlain by soft or loose saturated soils (such as alluvium), have a shallow ground water table, and are typically located on the floors of river valleys.

“Site” means the location containing a regulated critical area and on which a regulated activity is proposed. The location may be a parcel or portion thereof, or any combination of contiguous parcels where a proposed activity may impact a critical area.

“Slope” means an inclined earth surface, the incline of which is expressed as the ratio of horizontal distance to vertical distance. The slopes referenced above includes only those where the surface drops 10 feet or more vertically within a horizontal distance of 25 feet.

“Spring” means a source of water where an aquifer comes in contact with the ground surface.

“Stream reconnaissance report” means a type of critical area report prepared by an applicant’s qualified consultant to describe a stream and to characterize its conditions, wildlife, habitat values and water quality. The report also includes an analysis of impacts.

“Streams” means those areas where surface waters produce a defined channel or bed that demonstrates clear evidence of the passage of water and includes, but is not limited to, bedrock channels, gravel beds, sand and silt beds and defined-channel swales. The channel or bed need not contain water year-round. This definition is not intended to include artificially created irrigation ditches, canals, storm or surface water devices, or other entirely artificial watercourses unless they are used by salmonids or created for the purposes of stream mitigation.

“Structural diversity, vegetative” means the relative degree of diversity or complexity of vegetation in a wildlife habitat area as indicated by the stratification or layering of different plant communities (e.g., ground cover, shrub layer and tree canopy), the variety of plant species and the spacing or pattern of vegetation.

“Substrate” means the soil, sediment, decomposing organic matter or combination of those located on the bottom surface of the wetland, lake, stream, or river.

“Temporary erosion control” means on-site and off-site control measures that are needed to control conveyance or deposition of earth, turbidity, or pollutants during development, construction, or restoration.

“Tertiary habitat” means habitat that supports some wildlife but does not satisfy the definition of secondary or critical habitat.

“Tree” means any self-supporting perennial woody plant characterized by natural growth of one main stem or trunk with a definite crown, and maturing at a height of at least six feet above the ground.

“Tree base fee” means the current cost of the tree based on species and minimum code required installation size, installation (labor and equipment) maintenance for two years and fund administration.

“Utility” includes natural gas, electric, telephone and telecommunications, cable communications, water, sewer or storm drainage and their respective facilities, lines, pipes, mains, equipment and appurtenances.

“Variance” means permission to depart from the requirements of the specific regulations of this title for a particular piece of property.

“Volcanic hazard areas” means areas identified by the U.S. Geological Survey (maps dated 1998 or as hereafter revised) as subject to a risk of large lahars with a recurrence interval of 500 to 1,000 years.

“Water dependent use” means a principal use which can only exist when the land/water interface provides biological or physical conditions necessary for the use.

“Well” includes any excavation that is drilled, cored, bored, washed, driven, dug, jetted or otherwise constructed when the intended use of an excavation is for the location, diversion, artificial recharge, or withdrawal of ground water.

“Wellhead protection area” means the portion of a well’s, wellfield’s or spring’s zone of contribution defined as such using the criteria established by the city.

“Wetland” or “wetlands” means areas that are inundated or saturated by surface water or ground water at a frequency and duration sufficient to support, and that under normal circumstances do support, a prevalence of vegetation typically adapted for life in saturated soil conditions. Wetlands generally include swamps, marshes, bogs, and similar areas. Wetlands do not include those artificial wetlands intentionally created from nonwetland sites, including but not limited to irrigation and drainage ditches, grass-lined swales, canals, detention facilities, wastewater treatment facilities, farm ponds, and landscape amenities. However, wetlands include those artificial wetlands intentionally created from nonwetland areas to mitigate conversion of wetlands. (Definition taken from the Washington State Wetlands Identification and Delineation Manual, Ecology Publication No. 96-94.)

“Wetland impact assessment report” means a report prepared by a qualified consultant that identifies, characterizes and analyzes potential impacts to wetlands consistent with applicable provisions of these regulations. A wetland impact assessment may be combined with and include a formal wetland delineation.

“Wildlife report” means a report prepared by a qualified consultant that evaluates plant communities and wildlife functions and values on a site, consistent with the format and requirements established by this chapter. The report also includes an analysis of impacts. (Ord. 6287 § 2, 2010; Ord. 5894 § 1, 2005.)

16.10.030 Applicability – Regulated activities.

A. The provisions of this chapter shall apply to any activity that potentially affects a critical area or its buffer unless otherwise exempt. Such regulated activities include but are not limited to:

1. Removing, excavating, disturbing or dredging soil, sand, gravel, minerals, organic matter, or materials of any kind;

2. Dumping, discharging or filling with any material;

3. Draining, flooding or disturbing the water level or water table, or diverting or impeding water flow;

4. Driving pilings or placing obstructions;

5. Constructing, reconstructing, demolishing, or altering the size of any structure or infrastructure;

6. Destroying or altering vegetation through clearing, grading, harvesting, shading, or planting vegetation that would alter the character of or impact a critical area;

7. Release of contaminants to soil or water;

8. Activities that result in significant changes in water temperature, physical or chemical characteristics of water sources, including quantity and pollutants; and

9. Any other activity potentially affecting a critical area or buffer not otherwise exempt from the provisions of this chapter as determined by the director.

B. To avoid duplication, the following permits and approvals shall be subject to and coordinated with the requirements of this chapter: land clearing; grading; subdivision or short subdivision; building permit; planned unit development (if permitted by the city code); shoreline substantial development; variance; conditional use permit; and any other permits that may lead to the development or alteration of land.

C. Administrative actions, such as rezones, annexations, and the adoption of plans and programs, shall be subject to the requirements of this chapter. However, the director may, using discretion, permit any studies or evaluations required by this chapter to use methodologies and provide a level of detail appropriate to the administrative action proposed. (Ord. 6187 § 3, 2008; Ord. 5991 § 3, 2006; Ord. 5894 § 1, 2005.)

16.10.040 Exemptions and nonconforming uses.

A. The following activities performed on sites containing critical areas as defined by this chapter shall be exempt from the provisions of this chapter:

1. Existing and ongoing agricultural activities, as defined in this chapter;

2. Activities involving artificially created wetlands or streams intentionally created from nonwetland sites, including but not limited to grass-lined swales, irrigation and drainage ditches, retention or detention facilities, and landscape features, except wetlands or streams created as mitigation or that provide critical habitat for salmonids and except when the site contains another critical area;

3. Normal and routine maintenance, operation, repair and reconstruction of existing roads, streets, utilities and associated structures; provided, that reconstruction of any structures may not increase the impervious area and may not cause further encroachment on the critical area or its buffer, and may not result in adverse impacts to surface water and ground water quality. Operation and maintenance includes vegetation management performed in accordance with best management practices that is part of ongoing maintenance of structures, infrastructure, or utilities; provided, that such management actions are part of regular and ongoing maintenance, do not expand further into the critical area, are not the result of an expansion of the structure or utility, and do not directly impact an endangered or threatened species;

4. Minor Utility and Street Projects. Utility or street projects which have minor or short duration impacts to critical areas, as determined by the director in accordance with the criteria below, and which do not significantly impact the functions or values of a critical area(s); provided, that such projects are constructed with best management practices and additional restoration measures are provided. Minor activities shall not result in the transport of sediment or increased storm water. Such allowed minor utility projects shall meet the following criteria:

a. There is no practical alternative to the proposed activity with less impact on critical areas;

b. The activity involves the placement of underground piping, conduit, traffic signal equipment, lighting equipment, utility pole(s), signs, anchor, or vault or other small component of a utility or street facility;

5. Normal maintenance, repair and reconstruction of residential or commercial structures, facilities and landscaping; provided, that reconstruction of any structures may not increase the previous floor area;

6. The addition of floor area within an existing building which does not increase the building footprint;

7. Additions to a legally established single-family residential structure in existence before May 13, 2005, located within a wetland or stream buffer may be permitted if all of the following criteria area met:

a. The addition is no greater than 500 square feet of building footprint over that in existence as of May 13, 2005;

b. The addition is not located closer to the critical area than the existing structure;

c. Impacts on critical area functions are avoided consistent with the purpose and intent of this title; and

d. There are no changes in slope stability, flood conditions or drainage;

8. Site investigative work and studies that are prerequisite to preparation of an application for development authorization including soils tests, water quality studies, wildlife studies and similar tests and investigations; provided, that any disturbance of the critical area shall be the minimum necessary to carry out the work or studies;

9. Educational activities, scientific research, and outdoor passive recreational activities, including but not limited to interpretive field trips, birdwatching and hiking, that will not have a significant effect on the critical area;

10. Emergency activities necessary to prevent an immediate threat to public health, safety, property or the environment which requires immediate action within a time too short to allow full compliance with this chapter as long as any alteration undertaken pursuant to this subsection is reported to the city as soon as possible. Only the minimum intervention necessary to reduce the risk to public health, safety or welfare and/or the imminent risk of damage to private property shall be authorized by this exemption. The director shall confirm that an emergency exists or existed and determine what, if any, additional applications and/or measures shall be required to protect the environment consistent with the provision of this section and to repair any damage to a pre-existing resource;

11. Activities affecting previously legally filled wetlands or wetlands accidentally created by human actions prior to July 1, 1990 (the effective date of the Growth Management Act). The latter shall be documented through photographs, statements and/or other conclusive evidence;

12. Activities in storm and water quality basins and “wetlands” created by poorly maintained or plugged culverts or lines, and artificially created ditches that are not used by salmonids;

13. Minor activities not mentioned above and determined by the director to have minimal impacts to a critical area.

B. Notwithstanding the exemptions provided by this subsection, any otherwise exempt activities occurring in or near a critical area shall comply with the purpose and intent of these standards and shall consider on-site alternatives that avoid or minimize significant adverse impacts.

C. Exempt activities occurring in flood hazard areas shall not alter flood storage capacity or conveyance except in conformance with flood drainage requirements of Chapter 15.68 ACC.

D. No property owner or other entity shall undertake exempt activities in subsections (A)(2), (7) or (13) of this section without first providing 14 days’ notice to the city and receiving confirmation in writing that the proposed activity is exempt. In case of any question as to whether a particular activity is exempt from the provisions of this section, the director’s determination shall govern and shall be confirmed in writing.

E. An established use or existing structure that was lawfully permitted prior to May 13, 2005, but which is not in compliance with this chapter, shall be deemed a nonconforming use as defined in ACC 18.04.650. Unless otherwise provided for, existing structures, which intrude into critical areas buffers, shall not be reconstructed in such a manner that results in the further intrusion into the buffer area. Structures or developments that are nonconforming solely due to being contrary to the provisions of this chapter shall not be subject to the nonconforming use provisions of Chapter 18.54 ACC. (Ord. 5894 § 1, 2005.)

16.10.050 Critical areas maps.

Maps have been developed by the city that show the general location of critical areas. These maps are available for reference at the city planning and development department. These maps shall be used for informational purposes as a general guide only for the assistance of property owners and other interested parties; the boundaries and locations shown are generalized. The actual presence or absence, type, extent, boundaries and classification of critical areas on a specific site shall be identified in the field by a qualified consultant and determined by the city, according to the procedures, definitions and criteria established by this chapter. In the event of any conflict between the critical area location or designation shown on the city’s maps

and the criteria or standards of this section, the criteria and standards shall prevail. (Ord. 6287 § 2, 2010; Ord. 5894 § 1, 2005.)

16.10.060 Relationship to other regulations.

A. These critical area regulations shall apply as an overlay and in addition to zoning, land use and other regulations established by the city of Auburn. In the event of any conflict between these regulations and any other regulations of the city, the regulations which provide greater protection to critical areas shall apply.

B. Areas characterized by particular critical areas may also be subject to other regulations established by this chapter due to the overlap or multiple functions of some sensitive or critical areas. Wetlands, for example, may be defined and regulated according to the wetland, habitat and stream management provisions of this chapter. In the event of any conflict between overlapping regulations for multiple critical areas on the same site, the regulations which provide greater protection to critical areas shall apply. (Ord. 5894 § 1, 2005.)

16.10.070 Critical area review process and application requirements.

A. Pre-Application Conference. A pre-application conference is available and encouraged prior to submitting an application for a project permit.

B. Application Requirements.

1. Timing of Submittals. Concurrent with submittal of a State Environmental Policy Act (SEPA) checklist, or concurrent with submittal of an application for projects exempt from SEPA, a critical area report must be submitted to the city for review when the city believes that a critical area may be present. The purpose of the report is to determine the extent, characteristics and functions of any critical areas located on or potentially affected by activities on a site where regulated activities are proposed. The report will also be used by the city to determine the appropriate critical area classification and, if applicable, to establish appropriate buffer requirements.

2. Report Contents. Reports and studies required to be submitted by this chapter shall contain, at a minimum, the information indicated in the provisions of this chapter applicable to each critical area. The director may tailor the information required to reflect the complexity of the proposal and the sensitivity of critical areas that may potentially be present.

C. Consultant Qualifications and City Review. All reports and studies required of the applicant by this section shall be prepared by a qualified consultant as that term is defined in these regulations. The city may retain a qualified consultant paid for by the applicant to review and confirm the applicant's reports, studies and plans if the following circumstances exist:

1. The city has technical information that is unavailable to the applicant; or

2. The applicant has provided inaccurate or incomplete information on previous proposals or proposals currently under consideration.

D. Review Process. This section is not intended to create a separate critical area review permit for development proposals. To the extent possible, the city shall consolidate and integrate the review and processing of critical area-related aspects of proposals with other land use and environmental considerations and approvals. Any permits required by separate codes or regulations, such as floodplain development permits or shoreline substantial development permits, shall continue to be required. (Ord. 6295 § 4, 2010; Ord. 5894 § 1, 2005.)

16.10.080 Classification and rating of critical areas.

A. To promote consistent application of the standards and requirements of this chapter, critical areas within the city of Auburn shall be rated or classified according to their characteristics, function and value, and/or their sensitivity to disturbance.

B. Classification of critical areas shall be determined by the director based on consideration of the following factors and in the following order:

1. Consideration of the technical reports submitted by qualified consultants in connection with applications subject to these regulations;

2. Application of the criteria contained in these regulations; and

3. Critical areas maps maintained by the planning and development department.

C. Wetland Classification. Wetlands shall be designated Category I, Category II, Category III, Category IV and as artificially created according to the criteria in this section. Wetland classifications incorporate the Washington State Wetlands Rating System for Western Washington (Department of Ecology, 2004, Publication No. 04-06-025). Wetland rating categories shall be applied as the wetland exists on the date of adoption of the rating system by the local government, as the wetland naturally changes thereafter, or as the wetland changes in accordance with permitted activities. Wetland rating categories shall not change due to illegal modifications.

1. “Category I wetlands” are those wetlands which meet any of the following criteria:

a. Represent a unique or rare wetland type; or

b. Are more sensitive to disturbance than most wetlands; or

c. Are relatively undisturbed and contain ecological attributes that are impossible to replace within a human lifetime; or

d. Are providing a high level of functions, scoring 70 points or more out of 100 (DOE Wetlands Rating System, 2004); or

e. Are characterized as a national heritage wetland; or

f. Are characterized as a bog; or

g. Are over one acre and characterized as a mature and old-growth forested wetland.

2. “Category II wetlands” are those wetlands which are not Category I wetlands and which meet any of the following criteria:

a. Provide high levels of some functions, being difficult, though not impossible to replace; or

b. Perform most functions relatively well, scoring 51 – 69 out of 100 points (DOE Wetlands Rating System, 2004).

3. “Category III wetlands” are those wetlands that are not Category I or II wetlands, and which meet the following criterion:

a. Provide moderate levels of functions, scoring between 30 – 50 out of 100 points (DOE Wetlands Rating System, 2004).

4. “Category IV wetlands” are those wetlands that meet the following criterion:

a. Provide low levels of functions, scoring less than 30 out of 100 points (DOE Wetlands Rating System, 2004).

5. “Artificially created wetlands” are purposefully created landscape features, ponds and storm water detention or retention facilities. Artificially created wetlands do not include wetlands created as mitigation, and wetlands modified for approved land use activities. Purposeful creation must be demonstrated to the director through documentation, photographs, statements and/or other evidence. Artificial wetlands intentionally created from nonwetland sites are excluded from regulation under this section.

D. Stream Classification. Streams shall be designated Class I, Class II, Class III and Class IV according to the criteria in this section:

1. “Class I streams” are those natural streams identified as “shorelines of the state” under the city of Auburn shoreline master program.

2. “Class II streams” are those natural streams that are not Class I streams and are either perennial or intermittent and have one of the following characteristics:

a. Contain fish habitat; or

b. Has significant recreational value, as determined by the director.

3. “Class III streams” are those natural streams with perennial (year-round) or intermittent flow and do not contain fish habitat.

4. “Class IV streams” are those natural streams and drainage swales with channel width less than two feet taken at the ordinary high water mark, that do not contain fish habitat.

5. “Intentionally created streams” are those manmade streams defined as such in these regulations, and do not include streams created as mitigation. Purposeful creation must be demonstrated through documentation, photographs, statements and/or other evidence. Intentionally created streams may include irrigation and drainage ditches, grass-lined swales and canals. Intentionally created streams are excluded from regulation under this section, except manmade streams that provide “critical habitat,” as designated by federal or state agencies, for salmonids.

E. Wildlife Habitat Classification. Wildlife habitat areas shall be classified as critical, secondary or tertiary according to the criteria in this section:

1. “Critical habitat” are those habitat areas which meet any of the following criteria:

a. The documented presence of species or habitat listed by federal or state agencies as “endangered,” “threatened,” or “sensitive”; or

b. The presence of unusual nesting or resting sites such as heron rookeries;

c. Category I wetlands, as defined in these regulations; or

d. Class I streams, as defined in these regulations.

2. “Secondary habitat” is habitat which is valuable to fish and wildlife and supports a wide variety of species due to its undisturbed nature, a diversity of plant species and structure, presence of water, or the area’s size, location, or seasonal importance.

3. “Tertiary habitat” is habitat which is not classified as critical or secondary. It is habitat which, while supporting some wildlife and performing other valuable functions, does not currently possess essential characteristics necessary to support diverse wildlife communities. Tertiary habitat also includes habitat which has been created purposefully by human actions to serve other or multiple purposes, such as open space areas, landscape amenities, and detention facilities.

F. Ground Water Protection Areas. Ground water protection areas in this chapter correspond to water resource protection areas, which are described in the “Water Resource Protection Report” prepared for the city by Pacific Groundwater Group, December 2000. Water resource protection areas are based on time-related “capture zones” also referred to as “time-of-travel zones” which are derived using a numerical ground water flow model developed for the city and upon geologic conditions. A capture zone is the area that supplies ground water recharge to a pumping well or a spring. A time-related capture zone is the area that supplies ground water recharge to a pumping well or spring within a specified period of time. The location of ground water protection areas have been revised to include all of a parcel where capture zones include a portion of the parcel.

Ground water protection areas have been divided into four zones as follows:

1. “Ground water protection zone 1” represents the land area overlying the one-year time-of-travel zone of any well or spring owned by the city.

2. “Ground water protection zone 2” represents the land area in the central part of the city beneath which the principal aquifer used by the city for water supply is overlain by highly permeable sand and gravel deposits. These geologic conditions provide a direct pathway for contaminants that may be released to the soil to reach the aquifer.

3. “Ground water protection zone 3” represents the land area overlying the region between the one-year and 10-year time-of-travel zone of any well or spring owned by the city.

4. “Ground water protection zone 4” represents the land area within the city limits not designated as water resource protection zones 1, 2 or 3.

G. Geologic Hazard Classifications. Geologic hazard areas shall be classified according to the criteria in this section:

1. Critical Erosion Hazard Areas. Critical erosion hazard areas are lands or areas underlain by soils identified by the U.S. Department of Agriculture Soil Conservation Service (SCS), now known as the Natural Resource Conservation Service, as having “severe” or “very severe” erosion hazards. This includes the following group of soils when they occur on slopes of 15 percent or greater: Alderwood-Kitsap (AkF), Alderwood gravelly sandy loam (AgD), Kitsap silt loam (KpD), Everett (EvD), and Indianola (InD).

2. Landslide Hazard Areas. Landslide hazard areas are classified as Class I, Class II, Class III, or Class IV as follows:

a. Class I/Low Hazard. Areas with slopes of 15 percent or less.

b. Class II/Moderate Hazard. Areas with slopes of between 15 percent and 40 percent and that are underlain by soils that consist largely of sand, gravel, or glacial till.

c. Class III/High Hazard. Areas with slopes between 15 percent and 40 percent that are underlain by soils consisting largely of silt and clay.

d. Class IV/Very High Hazard. Areas with slopes steeper than 15 percent with mappable zones of emergent water (e.g., springs or ground water seepage), areas of known (mappable) landslide deposits regardless of slope, and all areas with slopes 40 percent or greater.

3. Seismic Hazard Areas. Seismic hazard areas are lands that, due to a combination of soil and ground water conditions, are subject to severe risk of ground shaking, subsidence, or liquefaction of soils during earthquakes. These areas are typically underlain by soft or loose saturated soils (such as alluvium), have a shallow ground water table and are typically located on the floor of river valleys. (Ord. 6287 § 2, 2010; Ord. 5894 § 1, 2005.)

16.10.090 Buffer areas and setbacks.

A. General Provisions. The establishment of on-site buffers, buffer areas or setbacks shall be required for all development proposals and activities in or adjacent to critical areas. The purpose of the buffer shall be to protect the integrity, function, value, and resources of the subject critical area (in the case of wetlands, streams, and/or wildlife habitat areas), and/or to protect life, property and resources from risks associated with development on unstable or critical lands (in the case of geologic hazard areas). Buffers shall typically consist of an undisturbed area of native vegetation retained or established to achieve the purpose of the buffer. No buildings or structures shall be allowed within the buffer unless as otherwise permitted by this section. If the site has previously been disturbed, the buffer area shall be revegetated pursuant to an approved enhancement plan. Buffers shall be protected during construction by placement of a temporary barricade, notice of the presence of the critical area and implementation of appropriate erosion and sedimentation controls. Restrictive covenants or conservation easements may be required to provide long-term preservation and protection of buffer areas.

B. Required buffer widths shall reflect the sensitivity of the particular critical area and resource or the risks associated with development and, in those circumstances permitted by these regulations, the type and intensity of human activity proposed to be conducted on or near the critical area.

C. Buffers shall be measured as follows:

1. Wetland buffers – the buffer shall be measured perpendicular from the wetland edge as delineated and marked in the field using the 1997 Washington State Wetlands Identification and Delineation Manual;

2. Stream buffers – the buffer shall be measured from the ordinary high water mark;

3. Geologic hazard area buffers shall be required for critical landslide hazard areas and shall be measured from the top and toe and along the sides of the slope.

D. Buffer Width Variances. A variance from buffer width requirements may be granted by the city subject to the variance criteria set forth in ACC 16.10.160. Minor variances, defined as up to and including 10 percent of the requirement, shall be considered by the director. Variance requests which exceed 10 percent shall be considered by the hearing examiner.

E. Buffer widths shall be established for specific critical areas according to the following standards and criteria:

1. Wetland buffers shall be established as follows:

Wetland Category	**Minimum Buffer Width**	**Maximum Buffer Width** (see subsection (E)(1)(g) of this section)
Category I	100 feet	200 feet
Category II	50 feet	100 feet
Category III	25 feet	50 feet
Category IV	25 feet	30 feet

Different buffer width requirements may apply to various portions of a site, without requiring averaging or variances, based on the site plan, the intensity of land uses in various locations, and differences in the category of wetland.

a. Buffer width averaging may be allowed where the applicant demonstrates to the director that the wetland contains variations in sensitivity due to existing physical characteristics, that lower intensity land uses would be located adjacent to areas where buffer width is reduced, that width averaging will not adversely impact the wetland functional values and/or that the total area contained within the buffer after averaging is no less in area than contained within the standard buffer prior to averaging. Buffer width averaging may be allowed only where such reduction shall not result in greater than a 35 percent reduction in the buffer width established in this section and the applicant demonstrates the following:

i. The proposed buffer area is extensively vegetated and has less than 25 percent slopes, and the reduction will not result in adverse impacts to the wetland; or

ii. The project includes a buffer enhancement plan, as part of the mitigation required by this chapter and has less than 25 percent slopes. The buffer enhancement plan shall use plant species which are native to the project area, and shall substantiate that an enhanced buffer will improve the functional attributes of the buffer to provide additional protection for wetland functional values; or

iii. The acreage included in the buffer would substantially exceed the size of the wetland and the reduction will not result in adverse impacts to the wetland and the project includes a buffer enhancement plan which ensures that the reduction will not result in adverse impacts to the wetland.

b. Buffer width may be reduced by up to 35 percent if an applicant undertakes measures approved by the director to enhance or restore the buffer. The restoration or enhancement may include, but is not limited to, planting of native trees or shrubs, increasing the diversity of plant cover types or replacement of exotic species with native species which approximate in composition a naturally occurring plant community.

c. Application of subsections (E)(1)(a) and (b) of this section shall not result in a buffer width less than 25 feet.

d. Certain uses and activities which are consistent with the purpose and function of the wetland buffer and do not detract from its integrity may be permitted by the director within the buffer depending on the sensitivity of the wetland. Examples of uses and activities with minimal impacts which may be permitted in appropriate cases include permeable pedestrian trails, viewing platforms, and utility easements; provided, that any impacts to the buffer resulting from such permitted activities shall be mitigated. Uses permitted within the buffer shall generally be located as far from the wetland as possible.

e. Where existing buffers are degraded, the director may allow limited filling within the buffer when the applicant demonstrates that the buffer will be enhanced according to standards of this chapter, including appropriate soil preparation, will not result in slopes exceeding 25 percent, and there will be no net loss of wetland or buffer functions and values.

f. Long-term protection of a regulated wetland and its associated buffer shall be provided by one of the following methods. It shall be placed in a separate tract on which development is prohibited, protected by execution of an easement dedicated to the city, a conservation organization or land trust, or similarly preserved through a permanent protective mechanism acceptable to the city. The location and limitations associated with the wetland and its buffer shall be shown on the face of the deed or plat applicable to the property and shall be recorded with the King or Pierce County recording department.

g. The director may require increased buffer widths up to the amount in this column when a larger buffer is deemed necessary to protect wetland functions and values based on site conditions, site design, intensity and operational characteristics of the development/land use. Examples where increased buffers may be required include, but are not limited to, where a larger buffer is necessary to maintain viable populations of species listed as endangered, threatened or sensitive, or when land adjacent to the buffer is susceptible to severe erosion and erosion control measures are inadequate to effectively prevent adverse wetland impacts.

2. Stream buffers shall be established as follows:

Stream Class	**Minimum Buffer Width**
Class I (see subsection (E)(2)(b) of this section)	100 feet
Class II	75 feet
Class III	25 feet
Class IV	25 feet

a. The applicable minimum buffer for Class I streams shall be the larger of the buffer established by these regulations or that established by the city’s shoreline master program.

b. The buffer widths required in this section may be increased by the director up to a maximum of 50 percent for Class I, II and IV streams and up to 100 percent for Class III streams in response to site-specific conditions and based on the report information submitted to characterize the functions and values of the stream. This includes, but is not limited to, situations where the critical area serves as habitat for threatened, endangered or sensitive species. The applicant may propose to implement one or more enhancement measures, listed in order of preference below, which will be considered in establishing buffer requirements:

i. Removal of fish barriers to restore accessibility to anadromous fish.

ii. Enhancement of fish habitat using log structures incorporated as part of a fish habitat enhancement plan.

iii. Enhancement of wildlife habitat by adding structures that are likely to be used by wildlife, including wood duck houses, bat boxes, nesting platforms, snags, root wads/stumps, birdhouses, and heron nesting areas.

iv. Additional mitigating measures may include but are not limited to:

(A) Landscaping outside the buffer area with native vegetation or a reduction in the amount of clearing outside the buffer area;

(B) Planting native vegetation within the buffer area, especially vegetation that would increase value for fish and wildlife, increase stream bank or slope stability, improve water quality, or provide aesthetic/recreational value;

(C) Creating a surface channel where a stream was previously culverted or piped;

(D) Removing or modifying existing stream culverts (such as at road crossings) to improve fish passage and flow capabilities which are not detrimental to fish;

(E) Upgrading retention/detention facilities or other drainage facilities beyond required levels; or

(F) Similar measures determined applicable by the director.

c. No structures or improvements shall be permitted within the stream buffer area, including buildings, decks, docks, except as otherwise permitted or required under the city’s adopted shoreline master program, or under one of the following circumstances:

i. When the improvements are part of an approved enhancement, restoration or mitigation plan; or

ii. For construction of new public roads and utilities, and accessory structures, when no feasible alternative location exists; or

iii. Construction of foot trails, according to the following criteria:

(A) Designed to minimize impact of permeable materials;

(B) Designed to minimize impact on the stream system;

(C) Of a maximum width of 12 feet;

(D) Located within the outer half of the buffer, i.e., the portion of the buffer that is farther away from the stream; or

iv. Construction of footbridges; or

v. Construction of educational facilities, such as viewing platforms and informational signs.

d. Buffer width averaging may be allowed for Class II and Class III streams only; provided, that all of the following are demonstrated by the applicant:

i. One or more of the enhancement measures identified in subsection (E)(2)(b)(i) through (iv) of this section is implemented;

ii. The total area contained within the buffer after averaging is no less in area than contained within the standard buffer prior to averaging;

iii. The buffer width averaging will result in stream functions and values equal or greater than before averaging; and

iv. The buffer width is not reduced by more than 35 percent in any location than the buffer widths established by this chapter.

e. Stream buffer widths may be reduced by the director on a case-by-case basis by up to 35 percent if an applicant demonstrates that a reduction will not result in any adverse impact to the stream. Further, if an existing buffer is vegetated, a buffer enhancement plan may be required to demonstrate how the function and values of the buffer and stream will be improved. If the existing buffer has been disturbed and/or is not vegetated, an enhancement plan shall be required that identifies measures to enhance the buffer functions and values and provide additional protection for the stream function and values. Enhancement plans are subject to approval by the planning director.

f. Long-term protection of a regulated stream and its associated buffer shall be provided by one of the following methods, except for the portion of Class I streams which are owned by the State Department of Natural Resources. The stream and buffer shall be placed in a separate tract on which development is prohibited, protected by execution of an easement dedicated to the city, a conservation organization, land trust, or similarly preserved through a permanent protective mechanism acceptable to the city. The location and limitations associated with the stream and its buffer shall be shown on the face of the deed or plat applicable to the property and shall be recorded with the King or Pierce County recording department.

3. Wildlife Habitat Areas.

a. Buffer widths for critical habitat areas shall be determined by the director based on consideration of the following factors: species recommendations of the Department of Fish and Wildlife; recommendations contained in the wildlife report and the nature and intensity of land uses and activities occurring on the site and on adjacent sites. Buffers shall not be required for secondary or tertiary habitat.

b. Buffer widths for critical habitat areas may be modified by averaging buffer widths or by enhancing or restoring buffer quality.

c. Certain uses and activities which are consistent with the purpose and function of the buffer for critical habitat areas and do not detract from its integrity may be permitted by the director within the buffer depending on the sensitivity of the habitat area. Examples of uses and activities with minimal impact which may be permitted in appropriate cases include permeable pedestrian trails and viewing platforms and utility easements; provided, that any impacts to the buffer resulting from permitted facilities shall be mitigated. When permitted, such facilities shall generally be located as far from the critical habitat area as possible.

d. Long-term protection of critical habitat areas and their associated buffer(s) shall be provided by one of the following methods. The critical habitat area and buffer(s) shall be placed in a separate tract on which development is prohibited, protected by execution of an easement, dedicated to the city, a conservation organization, land trust, or similarly preserved through a permanent protective mechanism acceptable to the city. The location and limitations associated with the critical habitat area and its buffer(s) shall be shown on the face of the deed or plat applicable to the property and shall be recorded with the King or Pierce County recording department.

4. Geologic Hazard Areas.

a. Required buffer widths for geologic hazard areas shall reflect the sensitivity of the geologic hazard area in question and the types and the risks associated with development and, in those circumstances permitted by these regulations, the type and intensity of human activity and site design proposed to be conducted on or near the area.

b. Required buffers may vary in width. The widths of the buffer shall reflect the sensitivity of the geologic hazard area in question and the types and density of uses proposed on or adjacent to the geologic hazard. In determining the appropriate buffer width, the director shall consider the recommendations contained in any geologic hazards report required by these regulations and prepared by a qualified consultant.

c. Buffers may be reduced to a minimum width of 15 feet when the applicant demonstrates through the geologic hazard report that the reduction will adequately protect the geologic hazard and the proposed development through use of proposed engineering techniques. (Ord. 5894 § 1, 2005.)

16.10.100 Alteration or development of critical areas – Standards and criteria.

Alteration of specific critical areas and/or their buffers may be allowed by the director subject to the criteria of this section. Alteration shall implement the mitigation standards as identified in ACC 16.10.110, and the performance standards of ACC 16.10.120 and the monitoring requirements of ACC 16.10.130.

A. Wetlands.

1. Category I Wetlands. Alterations of Category I wetlands shall be avoided subject to the reasonable use provisions of this chapter.

2. Category II Wetlands.

a. Alteration and mitigation shall comply with the mitigation performance standards and requirements of these regulations;

b. Where enhancement, restoration or creation is proposed, replacement ratios shall comply with the requirements of these regulations; and

c. No net loss of wetland functions and values may occur.

3. Category III and IV Wetlands.

a. Alteration and mitigation shall comply with the mitigation performance standards and requirements of these regulations;

b. Where enhancement, restoration or creation is proposed, replacement ratios shall comply with the requirements of these regulations; and

c. No net loss of wetland functions and values may occur.

B. Streams.

1. Relocation of a Class II, III and IV stream exclusively to facilitate general site design shall not be allowed. Relocation of a stream may take place only when it is part of an approved mitigation or enhancement/restoration plan, and will result in equal or better habitat and water quality, and will not diminish the flow capacity of the stream.

2. Bridges shall be used to cross Class I streams; boring/micro-tunneling may be considered for utility crossings if it would result in the same or lower impacts as bridging.

3. Culverts are allowable only under the following circumstances:

a. Only in Class II, III, and IV streams;

b. When fish passage will not be impaired;

c. When the following design criteria are met:

i. Oversized culverts will be installed;

ii. Culverts will include gradient controls and creation of pools within the culvert for Class II streams;

iii. Gravel substrate will be placed in the bottom of the culvert to a minimum depth of one foot for Class II and Class III streams;

d. The applicant or successors shall, at all times, keep any culvert free of debris and sediment to allow free passage of water and, if applicable, fish.

4. The city may require that an existing culvert be removed from a stream as a condition of approval, unless the culvert is not detrimental to fish habitat or water quality, or removal would be a long-term detriment to fish or wildlife habitat or water quality.

C. Wildlife Habitat.

1. Critical Habitat. Alterations of critical habitat shall be avoided, subject to the reasonable use provisions of this chapter.

2. Secondary Habitat. Alterations of secondary habitat may be permitted; provided, that the applicant mitigates adverse impacts consistent with the performance standards of ACC 16.10.120, and other requirements of this chapter.

3. Tertiary Habitat. Alterations of tertiary habitat are permitted consistent with applicable provisions of these regulations and provided that no other regulated critical area is present.

D. Ground Water Protection Areas. Requests to establish the following land uses and activities applied for on or after the effective date of the ordinance codified in this chapter shall be prohibited in ground water protection zones 1, 2, and 3:

1. Class V injection wells that inject industrial, municipal, or commercial waste fluids (as defined in WAC 173-218-030);

2. Surface impoundments for treating, storing and disposing of dangerous waste (as defined in WAC 173-303-040 and 173-304-100);

3. Waste piles for treating or storing solid waste (as defined in WAC 173-303-040, 173-303-660 and 173-304-420);

4. Hazardous waste treatment, storage, and disposal (as defined in WAC 173-303-040);

5. All types of solid waste landfills (as defined in WAC 173-304-100);

6. On-site sewage systems (as defined in WAC 246-272-01001) except as related to R-R, rural residential zoned properties;

7. Recycling facilities that accept, store, or use hazardous materials;

8. Underground storage of hazardous materials excluding the underground storage of petroleum and other regulated substances as regulated by Chapter 173-360 WAC;

9. Use, storage, treatment, or production of perchlorethylene (PCE), other than in closed-loop systems that do not involve any discharge of PCE;

10. Petroleum refining, reprocessing, and storage;

11. Petroleum-product pipelines not associated with underground storage of petroleum and other regulated substances as regulated by Chapter 173-360 WAC; and

12. Storage or distribution of gasoline treated with the additive methyl tertiary butyl ether (MTBE).

E. Geologic Hazard Areas.

1. General Standards. The city may approve, condition or deny proposals for the alteration of geologic hazard areas, as appropriate, based on the degree to which the significant risks posed by critical hazard areas to public and private property and to public health and safety can be mitigated. The objective of mitigation measures shall be to render a site containing a critical

geologic hazard as safe as one not containing such hazard or one characterized by a low hazard. In appropriate cases, conditions may include limitations of proposed uses, modification of density, alteration of site layout and other appropriate changes to the proposal. Where potential impacts cannot be effectively mitigated or where the risk to public health, safety and welfare, public or private property, or important natural resources is significant notwithstanding mitigation, the proposal shall be denied.

2. Specific Standards.

a. Class IV Landslide Hazard Areas. Alteration shall be prohibited subject to the reasonable use provisions of this chapter.

b. Critical Seismic Hazard Areas.

i. For one-story and two-story residential structures, the applicant shall conduct an evaluation of site response and liquefaction potential based on the performance of similar structures under similar foundation conditions; or

ii. For all other proposals, the applicant shall conduct an evaluation of site response and liquefaction potential including sufficient subsurface exploration to provide a site coefficient (S) for use in the static lateral force procedure described in the International Building Code.

c. When development is permitted in geologic hazard areas by these regulations, an applicant and/or its qualified consultant shall provide assurances which, at the city's discretion, may include one or more of the following:

i. A letter from the geotechnical engineer and/or geologist who prepared the geologic hazard report required by these regulations, stating that the risk of damage from the proposal, both on-site and off-site, are minimal subject to the conditions set forth in the report, that the proposal will not increase the risk of occurrence of the potential geologic hazard, and that measures to eliminate or reduce risks have been incorporated into its recommendations;

ii. A letter from the applicant, or the owner of the property if not the applicant, stating its understanding and acceptance of any risk of injury or damage associated with development of the site and agreeing to notify any future purchasers of the site, portions of the site, or structures located on the site of the geologic hazard;

iii. A legally enforceable hold harmless agreement, which shall be recorded as a covenant and noted on the face of the deed or plat, and executed in a form satisfactory to the city, acknowledging that the site is located in a geologic hazard area; the risks associated with development of such site; and a waiver and release of any and all claims of the owner(s), their directors, employees, or successors, or assigns against the city of Auburn for any loss, damage, or injury, whether direct or indirect, arising out of issuance of development permits for the proposal; and

iv. Posting of a bond, guarantee or other assurance device approved by the city to cover the cost of monitoring, maintenance and any necessary corrective actions.

F. Flood Hazard Areas. Development standards are defined by Chapter 15.68 ACC. (Ord. 5894 § 1, 2005.)

16.10.110 Mitigation standards, criteria and plan requirements.

A. Mitigation Standards. Adverse impacts to critical area functions and values shall be mitigated. Mitigation actions shall generally be implemented in the preferred sequence identified in this chapter. Proposals which include less preferred and/or compensatory mitigation shall demonstrate that:

1. All feasible and reasonable measures as determined by the department have been taken to reduce impacts and losses to the critical area, or to avoid impacts where avoidance is required by these regulations;

2. The restored, created or enhanced critical area or buffer will be as viable and enduring as the critical area or buffer area it replaces; and

3. No overall net loss will occur in wetland or stream functions and values. The mitigation shall be functionally equivalent to or greater than the altered wetland or stream in terms of hydrological, biological, physical, and chemical functions.

B. Location and Timing of Mitigation.

1. The preferred location of mitigation is on site when ecologically preferable to other identified alternatives. Mitigation may be allowed off site when it is determined by the department that on-site mitigation is not ecologically preferable to other identified alternatives, or, in the case of wetlands, where the affected site is identified as appropriate for off-site mitigation in the Mill Creek Special Area Management Plan (SAMP), April 2000. The burden of proof shall be on the applicant to demonstrate that mitigation cannot be provided on site or is consistent with the SAMP. If it is determined that on-site mitigation is not ecologically preferable to other identified alternatives, mitigation shall be provided in the same drainage basin as the permitted activity on property owned, secured, or controlled by the applicant, or provided by the applicant using alternative mitigation options such as mitigation banking or in-lieu fee programs. The mitigation should result in no net loss to the critical area functions impacted and associated watershed. Where mitigation is authorized to be located outside the city limits, the applicant shall assure to the satisfaction of the department that other requirements of this chapter will be met, including but not limited to, monitoring and maintenance.

2. In-kind mitigation shall be provided except when the applicant demonstrates, and the department concurs, that greater functional and habitat value can be achieved through out-of-kind mitigation.

3. When wetland, stream or habitat mitigation is permitted by these regulations, the mitigation project shall occur near an adequate water supply (river, stream, ground water) with a hydrologic connection to the critical area to ensure a successful mitigation or restoration. A natural hydrologic connection is preferential as compared to one which relies upon manmade or constructed features requiring routine maintenance.

4. Any mitigation plan shall be completed before initiation of other permitted activities, unless a phased or concurrent schedule that assures completion prior to occupancy has been approved by the department.

C. Wetland Replacement Ratios.

1. Where wetland alterations are permitted by the director, the applicant shall enhance or create areas of wetlands in order to compensate for wetland losses. The compensation shall be

determined according to acreage, function, type, location, timing factors and projected success of enhancement or creation.

2. The following acreage replacement and enhancement ratios shall be implemented; however, the department may vary these standards if the applicant can demonstrate and the director agrees that the variation will provide adequate compensation for lost wetland area, functions and values, or if other circumstances as determined by the director justify the variation. Except as provided for Category IV wetlands in subsection (C)(3) of this section, in no case shall the amount of mitigation be less than the area of affected wetland. The director may at his discretion increase these standards where mitigation is to occur off-site or in other appropriate circumstances.

3. Category IV wetlands can be mitigated by either: (a) meeting one of the replacement ratios (*see following table); or (b) implementing mitigation which ensures no net loss of values and functions of the larger ecosystem in which the critical area is located.

Wetland Category	**Wetland Creation Ratio (Acres)**	**Wetland Enhancement Ratio (Acres)**
	(Acres Created or Enhanced: Acres Impacted)	
Category I	6:1	12:1
Category II	Forested 3:1	6:1
	Scrub/Shrub 2:1	4:1
	Emergent 2:1	4:1
Category III	Forested 3:1	6:1
	Scrub/Shrub 2:1	4:1
	Emergent 2:1	4:1
Category IV*	1.25:1*	2.5:1*

(Ord. 6476 § 1, 2013; Ord. 5894 § 1, 2005.)

16.10.120 Performance standards for mitigation planning.

SHARE

The performance standards in this section shall be incorporated into mitigation plans submitted to the city for impacts to critical areas.

A. Wetlands and Streams.

1. Use plants native to the Puget Lowlands or Pacific Northwest ecoregion; non-native, introduced plants or plants listed by the Washington State Department of Agriculture as noxious weeds (Chapter 16-750 WAC) shall not be used;

2. Use plants adapted to and appropriate for the proposed habitats and consider the ecological conditions known or expected to be present on the site. For example, plants assigned a facultative wetland (FACW) wetland indicator status should be used for sites with soils that are inundated or saturated for long periods during the growing season. Use nearby reference wetlands or aerial photos to identify plants suitable to the site conditions and hydrologic regimes

planned for the mitigation site. Avoid planting significant areas of the site with species that have questionable potential for successful establishment, such as species with a narrow range of habitat tolerances;

3. Utilize plant species' heterogeneity and structural diversity that emulates native plant communities described in "Natural Vegetation of Oregon and Washington" (Franklin, J.F. and C.T. Dyrness, 1988) or other regionally recognized publications on native landscapes;

4. Specify plants that are commercially available from native-plant nurseries or available from local sources. If collecting some or all native plants from donor sites, collect in accordance with ecologically accepted methods, such as those described in the "Washington Native Plant Society's Policy on Collection and Sale of Native Plants," that do not jeopardize the survival or integrity of donor plant populations;

5. Use perennial plants in preference to annual species; the use of annuals species should be limited to a temporary basis in order to provide erosion control, support the establishment of perennial plants, or if mitigation monitoring determines that native plants are not naturally colonizing the site or if species diversity is unacceptably low compared to approved performance standards;

6. Use plant species high in food and cover value for native fish and wildlife species that are known or likely to use the mitigation site (according to reference wetlands, published information, and professional judgment);

7. Install a temporary irrigation system and specify an irrigation schedule unless a sufficient naturally-occurring source of water is demonstrated;

8. Identify methods of soil preparation. For stream substrate or wetland soils, at least one foot of clean inorganic and/or organic materials, such as cobble, gravel, sand, silt, clay, muck, soil, or peat, as appropriate, shall be ensured. The stream substrate or wetland soils shall be free from solid, dangerous, or hazardous substance as defined by Chapter 70.105 RCW and implementing rules;

9. Confine temporary stockpiling of soils to upland areas. Identify construction access routes and measures to avoid resultant soil compaction. Unless otherwise approved by the director, comply with all applicable best management practices for clearing, grading, and erosion control to protect any nearby surface waters from sediment and turbidity;

10. Show densities and placement of plants; these should be based on the ecological tolerances of species proposed for planting, as determined by a qualified consultant;

11. Provide sufficient specifications and instructions to ensure proper placement and spacing of seeds, tubers, bulbs, rhizomes, springs, plugs and transplanted stock, and other habitat features, and to provide a high probability of success, and to reduce the likelihood of prolonged losses of wetland functions from proposed development;

12. Do not rely on fertilizers and herbicides to promote establishment of plantings; if fertilizers are used, they must be applied per manufacturer specifications to planting holes in organic or controlled release forms, and never broadcast on the ground surface; if herbicides are used to control invasive species or noxious weeds and to help achieve performance standards, only those approved for use in aquatic ecosystems by the Washington Department of Ecology shall be used; herbicides shall only be used in conformance with all applicable laws and regulations

and be applied per manufacturer specifications by an applicator licensed in the state of Washington; and

13. Include the applicant's mitigation plan consultant in the construction process to ensure the approved mitigation plan is completed as designed. At a minimum, the consultant's participation will include site visits to inspect completed rough and final grading, installation of in-water or other habitat structures, and to verify the quality and quantity of native plant materials before and after installation;

14. Signs and Fencing of Wetlands and Streams Critical Areas.

a. Temporary Markers. The outer perimeter of the critical area or buffer and the limits of those areas to be disturbed pursuant to an approved permit or authorization shall be marked in the field in such a way as to ensure that no unauthorized intrusion will occur, and verified by the department prior to the commencement of authorized activities. This temporary marking shall be maintained throughout construction, and shall not be removed until permanent signs, if required, are in place.

b. Permanent Signs. As a condition of any permit or authorization issued pursuant to this chapter, the department may require the applicant to install permanent signs along the boundary of a critical area or buffer. Permanent signs shall be made of metal face and attached to a metal post, firmed anchored, or other materials of equal durability approved by the director. Signs must be posted at an interval of one per lot or every 50 feet, whichever is less, and must be maintained by the property owner in perpetuity. The sign shall be worded as follows or with alternative language approved by the director:

"Habitat Conservation Area"

Do Not Disturb

Contact the City of Auburn Planning Department regarding uses and restrictions

c. Fencing.

i. The director shall condition any permit or authorization issued pursuant to this chapter to require the application to install a permanent fence at the edge of the critical area or buffer, when fencing will prevent future impacts on the critical area.

ii. The applicant shall be required to install a permanent fence around the critical area or buffer when domestic grazing animals are present or may be introduced on-site.

iii. Fencing installed as part of a proposed activity or as required in this subsection shall be designed so as to not interfere with species migration, including fish runs, and shall be constructed in a manner that minimizes habitat impacts.

B. Wetlands. Do not exceed a maximum water depth of 6.6 feet (two meters) at mean low water unless approved as part of a planned interspersion of wetland vegetation classes and deep-water habitats.

1. Do not exceed a slope of 25 percent (4H:1V) in the wetland unless it can be clearly demonstrated by supporting documentation that wetland hydrology and hydric soils capable of supporting hydrophytic (wetland) vegetation will be created on steeper slopes;

2. Do not exceed a slope of 25 percent (4H:1V) in the wetland buffer; and

3. Limit deep-water habitat (greater than 6.6 feet at mean low water) in compensatory wetland to no more than 60 percent of the total area, and approach this limit only when deep-water habitat is highly interspersed with wetland vegetation classes, including aquatic bed, emergent, scrub-shrub, and forested.

C. Wildlife Habitat Conservation Areas.

1. Incorporate relevant performance standards from subsections A and B of this section, as determined by the director;

2. Include the following additional mitigation measures in mitigation planning:

a. Locate buildings and structures in a manner that minimizes adverse impacts on critical habitats used by threatened or endangered species and identified by the Washington State Department of Fish and Wildlife, NOAA Fisheries, and U.S. Fish and Wildlife Service;

b. Integrate retained habitat into open space and landscaping;

c. Wherever possible, consolidate critical habitats into larger, unfragmented, contiguous blocks;

d. Use native plant species for landscaping of disturbed or undeveloped areas and in any habitat enhancement or restoration activities;

e. Create habitat heterogeneity and structural diversity that emulates native plant communities described in Natural Vegetation of Oregon and Washington (Franklin, J.F. and C.T. Dyrness, 1988) or other regionally recognized publications on native landscapes;

f. Remove and/or control any noxious weeds or exotic animals which are problematic to the critical habitat area as determined by the director or consultant hired by the city to review the mitigation plan; and

g. Preserve significant or existing native trees, preferably in stands or groups, consistent with achieving the goals and standards of this chapter; the plan shall reflect the report prepared pursuant to ACC 16.10.070.

D. Geologic Hazard Areas.

1. Incorporate relevant performance standards from the preceding subsections, as determined by the director;

2. The following additional performance standards shall be reflected in proposals within geologic hazard areas:

a. A geologic hazard report shall be prepared to identify and evaluate potential hazards and to formulate mitigation measures;

b. Construction methods will not adversely affect geologic hazards or will reduce adverse impacts on geologic hazards;

c. Site planning shall minimize disruption of existing topography and natural vegetation;

d. Impervious surface coverage shall be minimized;

e. Disturbed areas shall be replanted with permanent vegetation as soon as feasible pursuant to a mitigation or landscape plan;

f. Clearing and grading shall be limited to between April 1st and October 31st unless the geologic hazard report specifically addresses measures necessary to perform clearing and grading during other portions of the year;

g. The limited use of retaining walls that minimize disturbance or alteration of existing natural slope areas are preferred over graded slopes;

h. Temporary erosion and sedimentation controls, pursuant to an approved plan, shall be implemented during construction;

i. A drainage plan shall be prepared for large projects as required by the city engineer;

j. Development shall not increase instability or create a hazard to the site or adjacent properties, or result in a significant increase in sedimentation or erosion.

E. Ground Water Protection Areas. A mitigation plan is required of all development except an individual single-family or two-family (duplex) dwelling unit. The mitigation plans shall include the following minimum measures and incorporate the appropriate responses.

1. Ground Water Protection Zones 1, 2 and 3.

a. Indicate how hazardous materials shall be stored and used such that any unauthorized release or discharge of the hazardous materials is prevented.

b. Specify that pesticides, herbicides, and fertilizers shall be applied in strict conformance with manufacturer's instructions and by persons licensed to perform such applications, if applicable.

c. Document hazardous materials management procedures, including, but not limited to, operations plans, drawings and as-built diagrams, emergency response and spill cleanup plans, and employee training documentation. This information can be provided in the form of copies of permits or other documentation required by other authorities.

d. Indicate that any fill material shall be documented to be free of contaminants that exceed Method A and Method B soil cleanup standards specified in Chapter 173-340 WAC prior to placement on the ground, if applicable.

e. Specify that any contaminant release reported to the Washington State Department of Ecology (Ecology) per Chapter 173-340 WAC shall also be reported to the city of Auburn public works department concurrent with notification of Ecology.

f. Include a provision that the mitigation plan will be kept up-to-date. Updates shall occur whenever there is a change in use or business occupancy or when there are significant changes in facility operations or hazardous materials management. A copy of the plan is to be available for review by city inspectors at the business or businesses within the

development. The plan should cover the facility site in general as well as have a section(s) specific to any tenants within the development.

2. Ground Water Protection Zone 4. Business owners shall implement best management practices for water resource protection. (Ord. 5894 § 1, 2005.)

16.10.130 Monitoring program and contingency plan.

A. For all actions requiring a mitigation plan, a monitoring program shall be prepared and implemented by the applicant to evaluate the success of the mitigation project and to determine necessary corrective actions. This program shall determine if the original goals and objectives are being met. The monitoring program shall be reviewed and approved by the city prior to implementation. The monitoring program shall include a contingency plan in the event that implementation of the mitigation plan is inadequate or fails.

B. A performance and maintenance security is required to ensure the applicant's compliance with the terms of the approved mitigation plan. The amount of the performance security shall equal 125 percent of the cost of the mitigation project for the length of the monitoring period; the director may agree to reduce the security in proportion to work successfully completed over the period of the security.

C. Incorporate the following into monitoring programs prepared to comply with this chapter:

1. Appropriate, accepted, and unbiased qualitative or precise and accurate quantitative sampling methods to evaluate the success or failure of the project compared to performance standards approved by the city;

2. Quantitative sampling methods that include permanent photopoints installed at the completion of construction and maintained throughout the monitoring period and shall also include permanent transects, sampling points (e.g., quadrants or water quality or quantity monitoring stations), and wildlife monitoring stations;

3. Clearly stipulated qualitative and quantitative sampling methods that are approved by the city before implementation by the project proponent;

4. Appropriate qualitative and/or quantitative performance standards that will be used to measure the success or failure of the mitigation. For wetlands, streams and habitat areas these will include, at a minimum, standards for plant survival and diversity, including structural diversity, the extent of wetland hydrology, hydric soils, and habitat types and requirements as appropriate; all proposed standards are subject to review and approval by the city or the consultant selected by the city to review the monitoring plan;

5. Monitoring programs for a minimum period of three years for buffer enhancement and a minimum of five years for other types of mitigation programs that include, at a minimum, preparation of an as-built plan; biannual monitoring and preparation of annual monitoring reports following implementation; and a maintenance plan. More stringent monitoring requirements may be required on a case-by-case basis for more complex mitigation plans;

6. Monitoring reports shall be submitted to the director by December 1st of the year in which monitoring is conducted. The reports are to be prepared by a qualified consultant and must contain all qualitative and quantitative monitoring data, photographs, and an evaluation of each of the applicable performance standards. If performance standards are not being met, appropriate corrective or contingency measures must be identified and communicated to the director and upon concurrence, implemented to ensure that performance standards will be met;

7. Provision for the extension of the monitoring period beyond the minimum timeframe if performance standards are not being met at the end of the initial five-year period; and provision for additional financial securities or bonding to ensure that any additional monitoring and contingencies are completed to ensure the success of the mitigation. (Ord. 5894 § 1, 2005.)

16.10.140 Procedural provisions.

A. Interpretation and Conflicts. The director shall have the authority to administer the provisions of this chapter, to make determinations with regard to the applicability of the regulations, to interpret the intent of unclear provisions, to require additional information, to determine the level of detail and appropriate methodologies for critical area reports and studies, to prepare application forms and informational materials as required, and to promulgate procedures and rules for unique circumstances not anticipated within standards and procedures contained in this section. Administrative interpretations may be appealed to the hearing examiner as prescribed in ACC 18.70.050.

B. Penalties and Enforcement. Compliance with these regulations and penalties for their violation shall be enforced pursuant to the procedures set forth in Chapter 1.25 ACC.

C. Appeals from Critical Area Review Decisions. Appeals of critical area review decisions shall be governed by the procedures set forth in ACC 18.70.050. (Ord. 5894 § 1, 2005.)

16.10.150 Reasonable use provision.

A. The standards and requirements of these regulations are not intended, and shall not be construed or applied in a manner, to deny all reasonable use of private property. If an applicant demonstrates to the satisfaction of the hearing examiner that strict application of these standards would deny all reasonable use of a property, development may be permitted subject to appropriate conditions.

B. Applications for a reasonable use exception shall be processed as a Type III decision, pursuant to ACC 14.03.030 and Chapter 2.46 ACC.

C. An applicant for relief from strict application of these standards shall demonstrate that all of the following criteria are met:

1. No reasonable use with less impact on the critical area and its buffer is possible.

There is no feasible and reasonable on-site alternative to the activities proposed, considering possible changes in site layout, reductions in density and similar factors, that would allow a reasonable and economically viable use with fewer adverse impacts;

2. The proposed activities, as conditioned, will result in the minimum possible impacts to affected critical areas;

3. All reasonable mitigation measures have been implemented or assured;

4. The inability to derive reasonable use is not the result of the applicant’s actions or that of a previous property owner, such as by segregating or dividing the property and creating an undevelopable condition; and

5. The applicant shall demonstrate that the use would not cause a hazard to life, health or property.

D. The burden of proof shall be on the applicant to provide evidence in support of the application and to provide sufficient information on which any decision has to be made.

E. Approval of a reasonable use exception shall not eliminate the need for any other permit or approval otherwise required for a proposal by applicable city codes.

F. Except when application of this title would deny all reasonable use of a site, an applicant who seeks an exception from the regulations of the title shall pursue a variance as provided in ACC 16.10.160. (Ord. 6442 § 13, 2012; Ord. 5894 § 1, 2005.)

16.10.160 Variances.

Applications for variances to the strict application of the terms of this chapter to a property may be submitted to the city. Minor variances, defined as up to and including 10 percent of the requirement, may be granted by the director as a Type II decision as defined by Chapter 14.03 ACC. Variance requests which exceed 10 percent may be granted by the hearing examiner as a Type III decision, pursuant to ACC 14.03.030 and Chapter 2.46 ACC. Approval of variances from the strict application of the critical area requirements shall conform to the following criteria:

A. There are unique physical conditions peculiar and inherent to the affected property which make it difficult or infeasible to strictly comply with the provisions of this section;

B. The variance is the minimum necessary to accommodate the building footprint and access;

C. The proposed variance would preserve the functions and values of the critical area, and/or the proposal does not create or increase a risk to the public health, safety and general welfare, or to public or private property;

D. The proposed variance would not adversely affect surrounding properties adjoining;

E. Adverse impacts to critical areas resulting from the proposal are minimized; and

F. The special circumstances or conditions affecting the property are not a result of the actions of the applicant or previous owner. (Ord. 6442 § 14, 2012; Ord. 5894 § 1, 2005.)

16.10.170 Special exception for public agencies and utilities.

A. If the application of this chapter would prohibit a development proposal by a public agency or public utility, the agency or utility may apply for an exception pursuant to this section.

B. Exception Request and Review Process. An application for a public agency and utility exception shall be made to the city and shall include a critical area identification form; critical area report, including mitigation plan, if necessary; and any other related project documents such as permit applications to other agencies, special studies, and environmental documents prepared pursuant to the State Environmental Policy Act (Chapter 43.21C RCW). The director shall prepare a recommendation to the hearing examiner based on review of the submitted information, a site inspection, and the proposal's ability to comply with public agency and utility exception review criteria in subsection D of this section.

C. Hearing Examiner Review. The hearing examiner shall review the application and director's recommendation, and conduct a public hearing pursuant to the provisions of Chapter 2.46 ACC. The hearing examiner shall approve, approve with conditions, or deny the request based on the proposal's ability to comply with all of the public agency and utility exception criteria in subsection D of this section.

D. Public Agency and Utility Review Criteria. The criteria for review and approval of public agency and utility exceptions follow:

1. There is no other practical alternative to the proposed development with less impact on critical areas;

2. The application of this chapter would unreasonably restrict the ability to provide utility services to the public;

3. The proposal does not pose an unreasonable threat to the public health, safety, or welfare on or off the development proposal site;

4. The proposal attempts to protect and mitigate impacts to the critical area functions and values consistent with other applicable regulations and standards.

E. Burden of Proof. The burden of proof shall be on the applicant to bring forth evidence in support of the application and to provide sufficient information on which any decision has to be made on the application. (Ord. 6442 § 15, 2012; Ord. 5894 § 1, 2005.)

16.10.180 Severability.

If any provision of these regulations or its application to any person or circumstance is held invalid by a court of competent jurisdiction, the remainder of these regulations or the application to other persons or circumstances shall not be affected. (Ord. 5894 § 1, 2005.)

Chapter 18.23
COMMERCIAL AND INDUSTRIAL ZONES

Sections:

18.23.010 Purpose.
18.23.020 Intent of commercial and industrial zones.
18.23.030 Uses.
18.23.040 Development standards.
18.23.050 Additional development standards for C-2, central business zone.
18.23.060 Additional development standards for the EP, environmental park zone.

18.23.010 Purpose.

This chapter lists the land uses that may be allowed within the commercial and industrial zones established by ACC 18.02.070 (Establishment of zones), determines the type of land use approval required for each use, and provides basic and additional development standards for sites, buildings, and associated improvements. (Ord. 6433 § 26, 2012.)

18.23.020 Intent of commercial and industrial zones.

A. General. This section describes the intent for each of the city's commercial and industrial zones. These intent statements are to be used to guide the interpretation of the regulations associated with each zone. The planning director is authorized to make interpretations of these regulations based on his/her analysis of them together with clear and objective reasons for such interpretation.

B. C-N, Neighborhood Shopping Center Zone. The C-N zone is intended to provide areas appropriate for neighborhood shopping establishments which provide limited retail business, service and office facilities for the convenience of residents of the neighborhood. A neighborhood shopping center is designed and located so as to minimize traffic congestion on public highways and streets in its vicinity and to best fit the general land use pattern of the area to be served by the center. The protective standards contained in this chapter are intended to minimize any adverse effect of the neighborhood shopping center on nearby property values and to provide for safe and efficient use of the neighborhood shopping center itself.

C. C-1, Light Commercial Zone. The C-1 zone is intended for lower intensity commercial adjacent to residential neighborhoods. This zone generally serves as a transition zone between higher and lower intensity land uses, providing retail and professional services. This zone represents the primary commercial designation for small- to moderate-scale commercial activities compatible by having similar performance standards and should be developed in a manner which is consistent with and attracts pedestrian-oriented activities. This zone encourages leisure shopping and provides amenities conducive to attracting shoppers and pedestrians.

D. C-2 Central Business District Zone. The intent of the C-2 zone is to set apart the portion of the city proximate to the center for financial, commercial, governmental, professional, and cultural activities. Uses in the C-2 zone have common or similar performance standards in that they represent types of

enterprises involving the rendering of services, both professional or to the person, or on-premises retail activities. This zone encourages and provides amenities conducive to attracting pedestrians.

E. C-3, Heavy Commercial Zone. The intent of the C-3 zone is to allow for medium to high intensity uses consisting of a wide range of retail, commercial, entertainment, office, services, and professional uses. This zone is intended to accommodate uses which are oriented to automobiles either as a mode or target of the commercial service while fostering a pedestrian orientation. The uses allowed can include outside activities, display, fabrication or service features when not the predominant portion of the use. The uses enumerated in this classification have potential for impacts to surrounding properties and street systems than those uses permitted in the more restrictive commercial classifications.

F. C-4, Mixed-Use Commercial Zone. The intent of the C-4 zone is to provide for a pedestrian-oriented mix of retail, office, and limited multiple-family residential uses. This classification is also intended to allow flexibility in design and the combination of uses that is responsive to market demands. The uses enumerated in this classification anticipate a mix of multiple-family residential, retail, and office uses that are coordinated through a site-specific planning process. The multiple-family residential must be located in a multi-story building; the ground floor of which must contain a permitted use or combination of uses, other than parking, as listed in this chapter. Certain heavy commercial uses permitted in other commercial classifications are not permitted in this zone because of the potential for conflicts with multifamily residential uses, in order to achieve a quality of environment that is conducive to this mix of uses.

G. M-1, Light Industrial Zone. The intent of the M-1 zone is to accommodate a variety of industrial, commercial, and limited residential uses in an industrial park environment, to preserve land primarily for light industrial and commercial uses, to implement the economic goals of the comprehensive plan and to provide a greater flexibility within the zoning regulations for those uses which are non-nuisance in terms of air and water pollution, noise, vibration, glare or odor. The light industrial/commercial character of this zone is intended to address the way in which industrial and commercial uses are carried out rather than the actual types of products made.

The character of this zone will limit the type of primary activities which may be conducted outside of enclosed buildings to outdoor displays and sales. Uses which are not customarily conducted indoors or involve hazardous materials are considered heavy industrial uses under this title and are not appropriate for the M-1 zone. An essential aspect of this zone is the need to maintain a quality of development that attracts rather than discourages further investment in light industrial and commercial development. Consequently, site activities which could distract from the visual quality of development of those areas, such as outdoor storage, should be strictly regulated within this zone.

H. EP, Environmental Park Zone. The environmental park district is intended to allow uses in proximity to the Auburn Environmental Park that benefit from that location and will complement the park and its environmental focus. Uses allowed in this zone will focus upon medical, biotech and “green” technologies including energy conservation, engineering, water quality and similar uses. Other uses complementary to and supporting these uses are also allowed. Incorporation of sustainable design and green building practices will be a primary aspect of this zone. The construction of leadership in energy and environmental design (LEED) and built green certified buildings is encouraged and built green will be required for multiple-family dwellings. The city recognizes that much of the property in this zone was

developed under earlier standards, so the goals of the district will be realized over a period of time as properties are redeveloped.

I. M-2, Heavy Industrial Zone. The M-2 zone is intended to accommodate a broad range of manufacturing and industrial uses. Permitted activity may vary from medium to higher intensity uses that involve the manufacture, fabrication, assembly, or processing of raw and/or finished materials. Heavy industrial uses should not be located near residential development.

While other uses may be sited within this zone, permits for such uses should not be issued if such uses will discourage use of adjacent sites for heavy industry, interrupt the continuity of industrial sites, or produce traffic in conflict with the industrial uses. (Ord. 6433 § 26, 2012.)

18.23.030 Uses.

A. General Permit Requirements. Table 18.23.030 identifies the uses of land allowed in each commercial and industrial zone and the land use approval process required to establish each use.

B. Requirements for Certain Specific Land Uses. Where the last column in Table 18.23.030 ("Standards for Specific Land Uses") includes a reference to a code section number, the referenced section determines other requirements and standards applicable to the use regardless of whether it is permitted outright or requires an administrative or conditional use permit.

Table 18.23.030 Permitted, Administrative, Conditional and Prohibited Uses by Zone

PERMITTED, ADMINISTRATIVE, CONDITIONAL AND PROHIBITED USES BY ZONE									P – Permitted C – Conditional A – Administrative X – Prohibited
LAND USE	Zoning Designation								Standards for Specific Land Uses
	C-N	C-1	C-2	C-3	C-4	M-1	EP	M-2	
INDUSTRIAL, MANUFACTURING AND PROCESSING, WHOLESALING									
Building contractor, light	X	X	X	P	X	P	X	P	
Building contractor, heavy	X	X	X	X	X	A	X	P	
Manufacturing, assembling and packaging – Light intensity	X	X	X	P	X	P	P	P	ACC 18.31.180

Table 18.23.030 Permitted, Administrative, Conditional and Prohibited Uses by Zone

PERMITTED, ADMINISTRATIVE, CONDITIONAL AND PROHIBITED USES BY ZONE									P – Permitted C – Conditional A – Administrative X – Prohibited
LAND USE	Zoning Designation								Standards for Specific Land Uses
	C-N	C-1	C-2	C-3	C-4	M-1	EP	M-2	
Manufacturing, assembling and packaging – Medium intensity	X	X	X	A	X	P	A	P	ACC 18.31.180
Manufacturing, assembling and packaging – Heavy intensity	X	X	X	X	X	X	X	A	ACC 18.31.180
Outdoor storage, incidental to principal permitted use on property	X	X	X	P	X	P	P	P	ACC 18.57.020(A)
Storage – Personal household storage facility (mini-storage)	X	P	X	P	X	P	X	P	ACC 18.57.020(B)
Warehousing and distribution	X	X	X	X	X	P	P	C	ACC 18.57.020(C)
Warehousing and distribution, bonded and located within a designated foreign trade zone	X	X	X	P	X	P	P	P	
Wholesaling with on-site retail as an incidental use (coffee, bakery, e.g.)	X	X	X	P	X	P	P	P	

RECREATION, EDUCATION AND PUBLIC ASSEMBLY USES

Commercial recreation facility, indoor	X	P	P	P	P	P	P	A	
Commercial recreation facility, outdoor	X	X	X	A	X	P	A	A	ACC 18.57.025(A)

Table 18.23.030 Permitted, Administrative, Conditional and Prohibited Uses by Zone

PERMITTED, ADMINISTRATIVE, CONDITIONAL AND PROHIBITED USES BY ZONE									P – Permitted C – Conditional A – Administrative X – Prohibited
LAND USE	Zoning Designation								Standards for Specific Land Uses
	C-N	C-1	C-2	C-3	C-4	M-1	EP	M-2	
Conference/convention facility	X	X	A	A	X	A	X	X	
Library, museum	X	A	A	A	X	A	P	X	
Meeting facility, public or private	A	P	P	P	X	A	P	A	
Movie theater, except drive-in	X	P	P	P	P	X	X	X	
Private school – Specialized education/training (for profit)	A	A	P	P	P	P	P	P	
Religious institutions, lot size less than one acre	A	P	P	P	A	A	A	A	
Religious institutions, lot size more than one acre	C	P	P	P	A	A	A	A	
Sexually oriented businesses	X	X	X	P	X	P	X	P	Chapter 18.74 ACC
Sports and entertainment assembly facility	X	X	A	A	X	A	X	A	
Studio – Art, dance, martial arts, music, etc.	P	P	P	P	P	P	A	A	

RESIDENTIAL

Caretaker apartment	X	P	P	P	X	P	P	P	
Live/work unit	X	X	P	P	P	P	P	X	
Work/live unit	X	P	P	P	P	P	P	X	

Table 18.23.030 Permitted, Administrative, Conditional and Prohibited Uses by Zone

PERMITTED, ADMINISTRATIVE, CONDITIONAL AND PROHIBITED USES BY ZONE									P – Permitted C – Conditional A – Administrative X – Prohibited
LAND USE	Zoning Designation								Standards for Specific Land Uses
	C-N	C-1	C-2	C-3	C-4	M-1	EP	M-2	
Multiple-family dwellings as part of a mixed-use development2	X	X	P	P	P	P	P	X	ACC 18.57.030
Multiple-family dwellings, stand-alone	X	X	X	X	X	X	X	X	
Nursing home, assisted living facility	X	P	P	P	C	X	X	X	
Senior housing2	X	X	A	A	X	X	X	X	

RETAIL

Building and landscape materials sales	X	X	X	P	X	P	X	P	ACC 18.57.035(A)
Construction and heavy equipment sales and rental	X	X	X	X	X	A	X	P	
Convenience store	A	A	P	P	X	P	P	P	
Drive-through espresso stands	A	A	A	P	A	P	A	A	
Drive-through facility, including banks and restaurants	A	A	A	P	P	P	X	P	ACC 18.52.040
Entertainment, commercial	X	A	P	P	X	A	X	A	
Groceries, specialty food stores	P	P	P	P	P	P	P	X	ACC 18.57.035(B)

Table 18.23.030 Permitted, Administrative, Conditional and Prohibited Uses by Zone

PERMITTED, ADMINISTRATIVE, CONDITIONAL AND PROHIBITED USES BY ZONE									P – Permitted C – Conditional A – Administrative X – Prohibited
LAND USE	Zoning Designation								Standards for Specific Land Uses
	C-N	C-1	C-2	C-3	C-4	M-1	EP	M-2	
Nursery	X	X	X	P	A	P	X	P	ACC 18.57.035(C)
Outdoor displays and sales associated with a permitted use (auto/vehicle sales not included in this category)	P	P	P	P	P	P	P	P	ACC 18.57.035(D)
Restaurant, cafe, coffee shop	P	P	P	P	P	P	P	P	
Retail									
Community retail establishment	A	P	P	P	P	P	X	P	
Neighborhood retail establishment	P	P	P	P	P	P	X	P	
Regional retail establishment	X	X	X	P	P	P	X	A	
Tasting room	P	P	P	P	P	P	P	P	
Tavern	P	P	X	P	P	P	X	A	
Wine production facility, small craft distillery, small craft brewery	A	P	P	P	P	P	P	P	

SERVICES

Animal daycare (excluding kennels and animal boarding)	A	A	A	P	A	P	X	P	ACC 18.57.040(A)

Table 18.23.030 Permitted, Administrative, Conditional and Prohibited Uses by Zone

PERMITTED, ADMINISTRATIVE, CONDITIONAL AND PROHIBITED USES BY ZONE									P – Permitted C – Conditional A – Administrative X – Prohibited
LAND USE	Zoning Designation								Standards for Specific Land Uses
	C-N	C-1	C-2	C-3	C-4	M-1	EP	M-2	
Animal sales and services (excluding kennels and veterinary clinics)	P	P	P	P	P	P	X	P	ACC 18.57.040(B)
Banking and related financial institutions, excluding drive-through facilities	P	P	P	P	P	P	P	P	
Catering service	P	P	P	P	A	P	A	P	
Daycare, including mini daycare, daycare center, preschools or nursery schools	A	P	P	P	P	P	P	X	
Dry cleaning and laundry service (personal)	P	P	P	P	P	P	P	P	
Equipment rental and leasing	X	X	X	P	X	P	X	P	
Kennel, animal boarding	X	X	X	A	X	A	X	A	ACC 18.57.040(C)
Government facilities; this excludes offices and related uses that are permitted outright	A	A	A	A	A	A	A	A	
Hospital	X	P	P	P	X	P	X	P	
Lodging – Hotel or motel	X	P	P	P	P	A	P	A	
Medical – Dental clinic	P	P	P	P	P	P	X	X	
Mortuary, funeral home, crematorium	A	P	X	P	X	P	X	X	

Table 18.23.030 Permitted, Administrative, Conditional and Prohibited Uses by Zone

PERMITTED, ADMINISTRATIVE, CONDITIONAL AND PROHIBITED USES BY ZONE									P – Permitted C – Conditional A – Administrative X – Prohibited
LAND USE	Zoning Designation								Standards for Specific Land Uses
	C-N	C-1	C-2	C-3	C-4	M-1	EP	M-2	
Personal service shops	P	P	P	P	P	P	X	X	
Pharmacies	P	P	P	P	P	X	X	X	
Print and copy shop	P	P	P	P	P	P	X	X	
Printing and publishing (of books, newspaper and other printed matter)	X	A	P	P	P	P	P	P	
Professional offices	P	P	P	P	P	P	P	P	
Repair service – Equipment, appliances	X	A	P	P	P	P	X	P	ACC 18.57.040(D)
Veterinary clinic, animal hospital	A	P	P	P	P	P	X	X	

TRANSPORTATION, COMMUNICATIONS AND INFRASTRUCTURE

Ambulance, taxi, and specialized transportation facility	X	X	X	A	X	P	X	P	
Broadcasting studio	X	P	X	P	X	P	X	P	
Heliport	X	X	X	C	X	C	X	C	
Motor freight terminal 1	X	X	X	X	X	X	X	X	See Footnote No. 1
Parking facility, public or commercial, surface	X	P	P	P	P	P	P	X	

Table 18.23.030 Permitted, Administrative, Conditional and Prohibited Uses by Zone

PERMITTED, ADMINISTRATIVE, CONDITIONAL AND PROHIBITED USES BY ZONE									P – Permitted C – Conditional A – Administrative X – Prohibited
LAND USE	Zoning Designation								Standards for Specific Land Uses
	C-N	C-1	C-2	C-3	C-4	M-1	EP	M-2	
Parking facility, public or commercial, structured	X	P	P	P	P	P	P	X	
Towing storage yard	X	X	X	X	X	A	X	P	ACC 18.57.045(A)
Utility transmission or distribution line or substation	A	A	A	A	A	A	A	A	
Wireless communication facility (WCF)	–	–	–	–	–	–	–	–	ACC 18.04.912, 18.31.100
VEHICLE SALES AND SERVICES									
Automobile washes (automatic, full or self-service)	X	A	X	P	P	P	X	P	ACC 18.57.050(A)
Auto parts sales with installation services	X	A	A	P	P	P	X	P	
Auto/vehicle sales and rental	X	A	X	P	X	P	X	P	ACC 18.57.050(B)
Fueling station	X	A	A	P	P	P	X	P	ACC 18.57.050(C)
Mobile home, boat, or RV sales	X	X	X	P	X	P	X	P	
Vehicle services – Repair/body work	X	X	A	P	X	P	X	P	ACC 18.57.050(D)

Table 18.23.030 Permitted, Administrative, Conditional and Prohibited Uses by Zone

PERMITTED, ADMINISTRATIVE, CONDITIONAL AND PROHIBITED USES BY ZONE									P – Permitted C – Conditional A – Administrative X – Prohibited
LAND USE	Zoning Designation								Standards for Specific Land Uses
	C-N	C-1	C-2	C-3	C-4	M-1	EP	M-2	
OTHER									
Any commercial use abutting a residential zone which has hours of operation outside of the following: Sunday: 9:00 a.m. to 10:00 p.m. or Monday – Saturday: 7:00 a.m. to 10:00 p.m.	A	A	A	A	A	A	A	A	
Other uses may be permitted by the planning director or designee if the use is determined to be consistent with the intent of the zone and is of the same general character of the uses permitted. See ACC 18.02.120(C)(6), Unclassified Uses.	P	P	P	P	P	P	P	P	

1 Any motor freight terminal, as defined by ACC 18.04.635, in existence as of the effective date of the ordinance codified in this section, is an outright permitted use in the M-1 and M-2 zones. Any maintenance, alterations and additions to an existing motor freight terminal which are consistent with ACC 18.23.040, Development standards, are allowed.

2 Any mixed-use development or senior housing project vested prior to Resolution No. 5187 (December 7, 2015) is an outright permitted use in the C-1 zone. Subsequently, if a nonresidential use within a vested mixed-use development changes, then the nonresidential use shall maintain a minimum of 10 percent of the cumulative building ground floor square footage consisting of the uses permitted outright, administratively, or conditionally, listed under “Recreation, Education, and Public Assembly,” “Retail,” or “Services” of the C-1 zone.

(Ord. 6644 § 2, 2017; Ord. 6508 § 1, 2014; Ord. 6433 § 26, 2012.)

18.23.040 Development standards.

A. Hereafter, no use shall be conducted and no building, structure and appurtenance shall be erected, relocated, remodeled, reconstructed, altered or enlarged unless in compliance with the requirements in

Tables 18.23.040A (C-N, C-1, C-2, C-3, and C-4 Zone Development Standards) and 18.23.040B (M-1, EP and M-2 Zone Development Standards) and in compliance with the provisions of this title, and then only after securing all permits and approvals required hereby. These standards may be modified through either an administrative variance or variance, subject to the procedures of Chapter 18.70 ACC.

Table 18.23.040A C-N, C-1, C-2, C-3, and C-4 Zone Development Standards

Development Standard	Requirement by Zone				
	C-N Neighborhood Shopping Center	C-1 Light Commercial	C-2 Central Business	C-3 Heavy Commercial	C-4 Mixed-Use Commercial
Minimum lot area	2 acres	None	None	None	None (1)
Minimum lot width, depth	None	None	None	None	None
Maximum lot coverage	55 percent	None	None	None	None
Minimum setbacks	Minimum setbacks required for structures. See also ACC 18.31.070 for specific exceptions to these setback standards.				
Front	50 ft	20 ft	None	20 ft	20 ft
Side – Interior	None (2)	None (2)	None	None (2)	None (2)
Side – Street	50 ft	15 ft	None	15 ft	15 ft
Rear	None (2)	None (2)	None	None (2)	None (2)
Height limit	Maximum allowable height of structures. See also ACC 18.31.030 (Height limitations – Exceptions) for specific height limit exceptions.				
Maximum height	30 ft	45 ft (3)	ACC 18.23.050	75 ft	75 ft
Additional development standards	None	None	ACC 18.23.050	None	None
Fences and hedges	See Chapter 18.31 ACC				

Table 18.23.040A C-N, C-1, C-2, C-3, and C-4 Zone Development Standards

Development Standard	Requirement by Zone				
	C-N Neighborhood Shopping Center	C-1 Light Commercial	C-2 Central Business	C-3 Heavy Commercial	C-4 Mixed-Use Commercial
Landscaping	See Chapter 18.50 ACC				
Parking	See Chapter 18.52 ACC				
Signs	See Chapter 18.56 ACC				
Lighting	See Chapter 18.55 ACC				
Nonconforming structures, land and uses	See Chapter 18.54 ACC				

Notes:

(1) Residential uses: no minimum lot size; provided, that residential density does not exceed 20 units per gross acre (this includes privately owned open space tracts but excludes dedicated public roads).

(2) A 25-foot setback is required when adjacent to a residential zone.

(3) Buildings within the Auburn north business area, as established by Resolution No. 2283, may exceed 45 feet if one additional foot of setback is provided from each property line (or required minimum setback) for each foot the building exceeds 45 feet in height.

Table 18.23.040B M-1, EP and M-2 Zone Development Standards

Development Standard	Requirement by Zone		
	M-1 Light Industrial	EP Environmental Park	M-2 Heavy Industrial
Minimum lot area	None	None	None
Minimum lot width, depth	None	None	None
Maximum lot coverage	None	35 percent	None

Table 18.23.040B M-1, EP and M-2 Zone Development Standards

Development Standard	Requirement by Zone		
	M-1 Light Industrial	EP Environmental Park	M-2 Heavy Industrial
Minimum setbacks	Minimum setbacks required for structures. See also ACC 18.31.070 for specific exceptions to these standards.		
Front	20 ft	20 ft	30 ft
Side – Interior	None (1)	15 ft	None (1)
Side – Corner	20 ft	20 ft	30 ft
Rear	None (1)	20 ft (1)	None (1)
Height limit	Maximum allowable height of structures. See also ACC 18.31.030 (Height limitations – Exceptions) for specific height limit exceptions.		
Maximum height	45 ft (2)	35 ft	45 ft (2)
Additional development standards	None	ACC 18.23.060	None
Fences and hedges	See Chapter 18.31 ACC		
Landscaping	See Chapter 18.50 ACC		
Parking	See Chapter 18.52 ACC		
Signs	See Chapter 18.56 ACC		
Lighting	See Chapter 18.55 ACC		
Nonconforming structures, land and uses	See Chapter 18.54 ACC		

Notes:

(1) A 25-foot setback is required when adjacent to a residential zone.

(2) Buildings may exceed 45 feet if one foot of setback is provided from each property line (or required minimum setback) for each foot the building exceeds 45 feet.

(Ord. 6433 § 26, 2012.)

18.23.050 Additional development standards for C-2, central business zone.

A. Maximum Building Height.

1. The maximum height of that portion of a building that abuts a street(s) shall be no higher than the right-of-way width of the abutting street(s). Building height may increase; provided, that the building is stepped back one foot (from the abutting street right(s)-of-way) for each foot of increased building height.

2. If the building abuts more than one street and the abutting streets have different right-of-way widths, then the height of the building allowed at any street frontage shall be the average of the abutting street right-of-way widths.

3. The following rooftop features may extend up to 15 feet above the maximum height limit: stair towers, elevator penthouses, and screened mechanical equipment.

B. Minimum setbacks: none required, see subsection D of this section for specific building orientation requirements.

C. Fences shall be decorative and relate architecturally to the associated building. Acceptable materials are brick, wood, stone, metal, or textured concrete. Typical galvanized wire mesh (chain link), barbed wire or razor wire are not permitted. For further information see Chapter 18.31 ACC.

The provisions of this section shall not apply to temporary fences required during construction projects permitted by the city.

D. Building Orientation Requirements. The following requirements apply to the construction of all new buildings or structures:

1. Existing buildings or structures, including facades, that do not have setbacks or otherwise cannot comply are exempt from these requirements regardless of the amount of improvements made to the building, structure or facade as long as any alteration does not make the existing facade more nonconforming.

2. Existing buildings, structures, or facades that are set back and within 20 feet of a street shall comply to the fullest extent possible as determined by the planning director, with the following requirements when any cumulative structural improvements are made that exceed 50 percent of the assessed value of the existing building, structure, or facade.

3. Any addition to an existing building, regardless of value, that will be within 20 feet of a street shall also comply to the fullest extent possible, as determined by the planning director, with the following requirements.

a. For each lineal foot of frontage a building has on a street, there shall be provided an area(s) for pedestrian amenities at the rate of one square foot of ground area for each lineal foot of building frontage. Pedestrian amenities shall consist of such features as landscaping, benches, entryways with

accents such as brick pavers, artwork, or a combination of these or similar features. The pedestrian amenities shall be located on the property between the street right-of-way and the building. The planning director shall approve the amount and type of the pedestrian amenities.

b. For buildings that have a street frontage that exceeds 50 feet, then at least 25 percent of the building's frontage shall be immediately adjacent to the street right-of-way.

c. For buildings that have a street frontage that is less than 25 feet, then no pedestrian amenities will be required and the building may be located at the property line. There shall, however, be provided a landing in front of each door that opens to a street that is large enough such that no part of any door will encroach into the street right-of-way when the door is being opened or closed.

d. For buildings that provide additional setbacks, except as restricted by subsection (D)(3)(b) of this section, the area between the street right-of-way and the building shall only contain pedestrian amenities.

e. If a building has more than two street frontages, then at least two of the frontages shall comply with subsections (D)(3)(b) and (g) of this section and contain pedestrian amenities between the building and the street right-of-way. Any remaining frontages shall either have pedestrian amenities, windows, murals, flat surfaced artwork or other similar architectural features that would avoid large blank walls.

f. For new buildings that will infill between two other existing buildings, the new building shall be set back no further than either of the adjacent buildings unless additional setback is required to comply with subsection (D)(3)(a) of this section. The proposed setback shall be reviewed by the planning director to ensure the setback will maintain building continuity along the street.

g. Buildings shall have windows that encompass at least 60 percent of the first floor facade and at least 40 percent of the facade of each additional floor. At least 50 percent of the area of the first floor windows of nonresidential buildings shall provide visibility to the inside of the building. This subsection shall only apply to the facades of new buildings with street frontage and shall not lessen the requirements of the Uniform Building or Fire Codes.

h. The building's principal pedestrian entrance shall be oriented to the street. If the building is at a corner, either street or alley, then the principal pedestrian entrance shall be at the corner unless a better architectural design is attained at another location and approved by the planning director.

i. Buildings that are at the intersection of either two streets or a street and an alley shall provide for a sight distance triangular setback as required by Chapter 18.31 ACC. These triangular areas may contain pedestrian amenities that satisfy the requirements of subsection (D)(3)(a) of this section.

j. A site plan shall be prepared by the proponent which addresses compliance with the requirements as outlined in subsections (D)(3)(a) through (i) of this section. The site plan shall be approved by the planning director prior to the submittal of any building permit.

k. For the sole purposes of this subsection D the term "street" shall include the right-of-way of private and public streets. The term shall also include pedestrian walkways, encumbered by an easement or similar means, that are used by the general public to travel from one property to another.

E. Mechanical equipment on rooftops shall be sited and designed to minimize noise and effectively screen the equipment from view from adjacent properties and rights-of-way. The following methods, or a combination thereof, may be used:

1. Set back from the roof edge to obscure visibility from below;

2. Integration into the building architecture, using building walls, roof wells or roof parapets to conceal the equipment;

3. Equipment enclosure or sight-obscuring fencing or landscaping;

4. Overhead trellis or roof to obscure visibility from above.

Materials used to screen mechanical equipment shall be the same as or compatible with the design of the principal structure.

F. Stair towers and elevator penthouses shall be designed to be architecturally integrated into the principal structure. This may include using the same building materials, repeating common building forms, colors or elements, or incorporating the roof and wall of the stair tower or elevator penthouse into the upper wall of the structure. (Ord. 6433 § 26, 2012.)

18.23.060 Additional development standards for the EP, environmental park zone.

A. Fences and Hedges. Fences shall be decorative and relate architecturally to the associated building. Acceptable materials are brick, wood, stone, metal, or textured concrete. Colored chain link fences may be allowed subject to the planning director's approval. Barbed wire or razor wire fences are not permitted. For further information on fencing see ACC 18.31.020. The provisions of this section shall not apply to temporary fences during construction projects permitted by the city.

B. Loading and unloading docks shall not be visible from the street.

C. Mechanical equipment on rooftops shall be sited and designed to minimize noise and effectively screen the equipment from view from adjacent properties and rights-of-way. The following methods, or a combination thereof, may be used:

1. Set back from the roof edge to obscure visibility from below;

2. Integration into the building architecture, using building walls, roof wells or roof parapets to conceal the equipment;

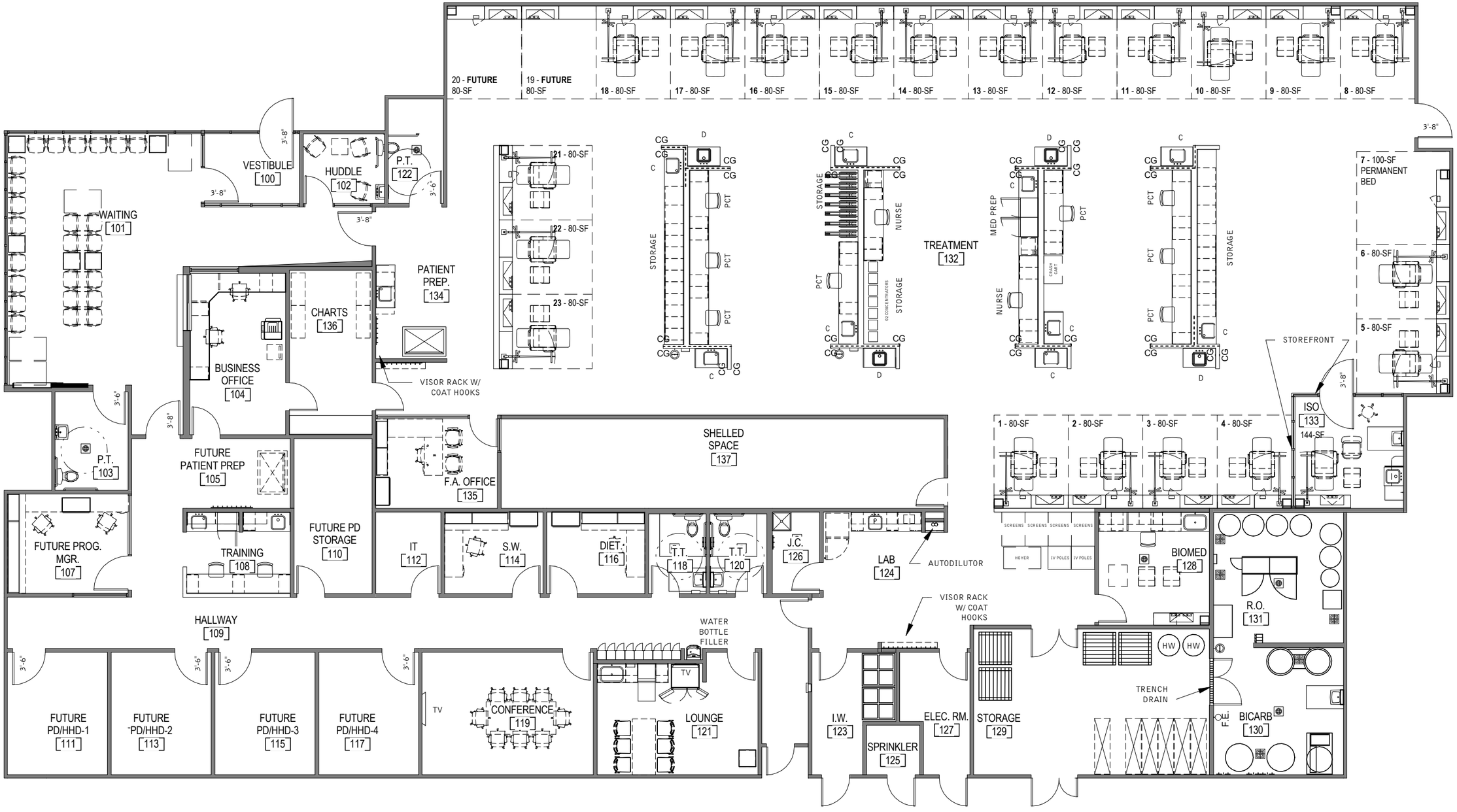
3. Equipment enclosure or sight-obscuring fencing or landscaping;

4. Overhead trellis or roof to obscure visibility from above.

Materials used to screen mechanical equipment shall be the same as or compatible with the design of the principal structure. (Ord. 6433 § 26, 2012.)

Appendix 16

Single Line Drawing



This preliminary Space Plan represents our understanding of the space code requirements. The final construction documents are subject to review and comments from the landlord as well as local governmental agencies. Changes to the plan may be required to address comments after review of the plans through the plan check process. All square footages noted are preliminary and also may change when the Space Plan is finalized.

3/32"=1'-0"

0 4' 8' 16' 20'

NORTH

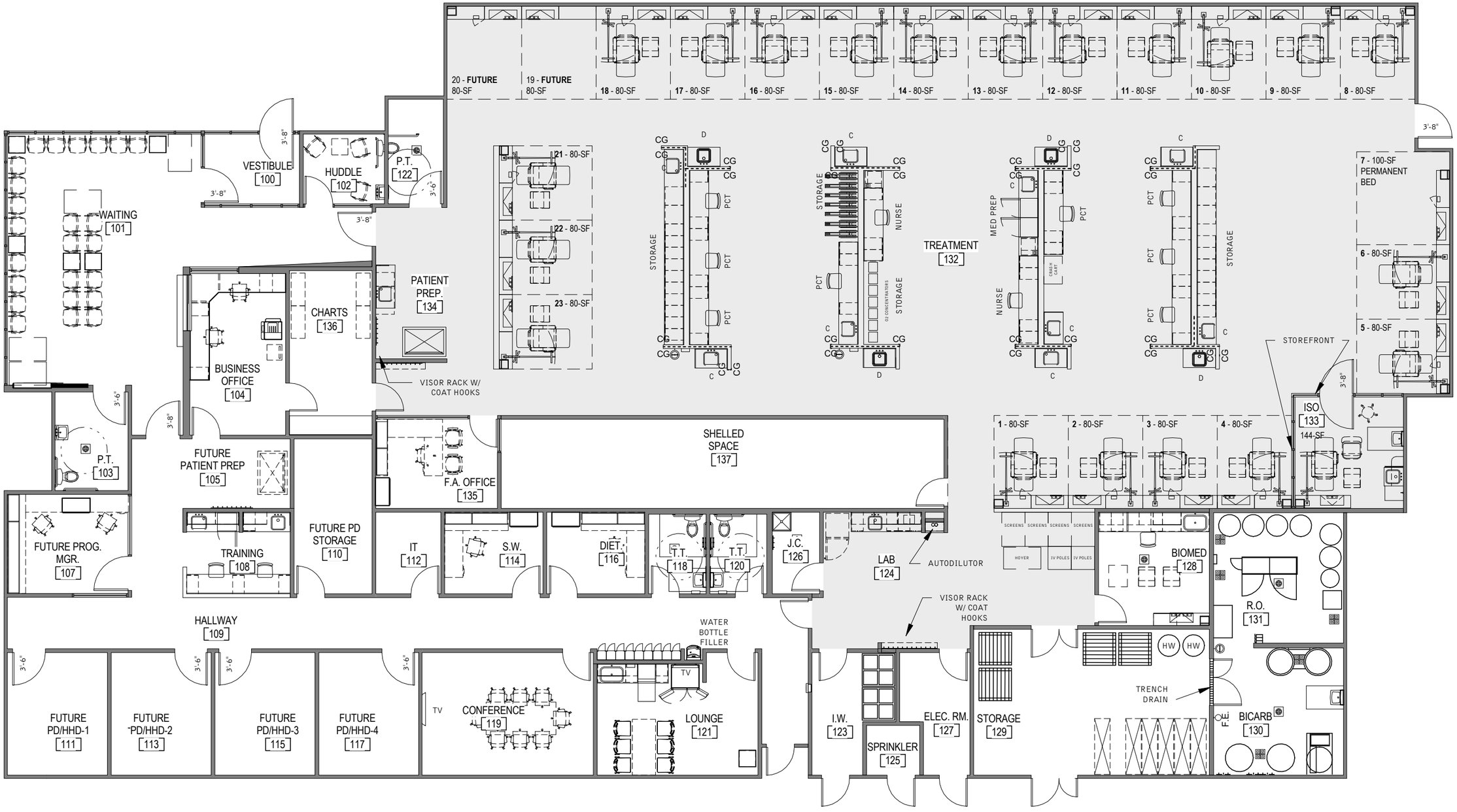
PRELIMINARY FLOOR PLAN - 11,500 (USF) 11,500 (RSF)

DAVITA AUBURN
1700 O Street, Auburn, WA 98001

WARE MALCOMB

SEA18-6058-00
05.25.2018

SHEET
PFP5-1



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PRELIMINARY FLOOR PLAN - 11,500 (USF) 11,500 (RSF)

DAVITA AUBURN

1700 O Street, Auburn, WA 98001

WARE MALCOMB

SEA18-6058-00

05.25.2018

SHEET **PFP5-2**

SQUARE FOOTAGE ALLOCATION

Category	After Completion
Treatment Floor Area	
Chronic Dialysis Stations	1,600
Isolation Station	143
Permanent Bed Station	100
Expansion Stations	160
Nurse Station / Med Prep Area	370
Patient Prep	237
Circulation	2,784
Lab Prep	332
Storage	88
Treatment Floor Area Total	**5,810**
Non-Treatment Floor Area	
Water Room	419
Re-Use	0
Bio-Med	143
Staff Toilet / Lounge	349
Janitorial / Electric	182
Business Office / Medical Records	346
Reception	949
Conference Room / Huddle	300
Home Training, PD & HHD Nurses	0
Patient Toilets	145
Storage / Med Waste / Wheelchair	1,040
Staff Offices	1,090
HVAC / Circulation	622
Clean Supplies/Kidney Care Training	106
Non-Treatment Floor Area Total	**5,690**
Total Space	**11,500**

MAX. TREATMENT FLOOR SQUARE FOOTAGE

Category	Sq. Ft.	No. of Stations	Sq. Ft. Total
(a) General use in-center station and each nonisolation station	150	20	3,000
(b) Each isolation station and each permanent bed station	200	1 Bed / 1 ISO	400
(c) Future expansion of two in-center treatment stations; and	150	2	300
(d) Other treatment floor space is 75% of the sum of (a), (b), and (c)			2,775
Maximum Treatment Floor Area Square Footage			**6,475**

This preliminary Space Plan represents our understanding of the space code requirements. The final construction documents are subject to review and comments from the landlord as well as local governmental agencies. Changes to the plan may be required to address comments after review of the plans through the plan check process. All square footages noted are preliminary and also may change when the Space Plan is finalized.

PRELIMINARY FLOOR PLAN - 11,500 (USF) 11,500 (RSF)

DAVITA AUBURN
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SEA18-6058-00
05.25.2018

SHEET
PFP5-3

Appendix 17

DaVita Quality Index (DQI) Data
DaVita Continuous Quality Improvement (CQI) Data

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

TITLE: CONTINUOUS QUALITY IMPROVEMENT PROGRAM

PURPOSE: To improve patient safety and outcomes including the reduction of medical errors in accordance with the Quality Assessment and Performance Improvement (QAPI) requirements in the CMS Conditions for Coverage.

POLICY:

1. Each dialysis facility will have a Continuous Quality Improvement (CQI) Committee comprised of at least the following individuals from the interdisciplinary team:
    - Facility Medical Director
    - Facility Administrator (FA)/designee
    - Registered Nurse
    - Biomed Technician
    - Registered Dietitian
    - Social Worker

2. Facility Administrators (FAs) conduct periodic Facility Health Meetings (FHM, formerly known as QIFMM) with the CQI committee to review issues and indicators regarding facility's management and performance. FHMs are conducted monthly.

3. Written documentation and plans of action will be documented within the FHM application known as Facility Health Record and will be maintained in a confidential manner. Copies of the QI meeting minutes will be provided upon request to CMS.

4. The Facility Medical Director is responsible for verifying the execution of the Quality Improvement Program, including implementation, continuous monitoring, development of action plans and program evaluation. The FA or designee of the facility will serve as the facility program coordinator unless otherwise appointed by the CQI Committee.

5. The facility CQI Program is organized, documented and reflects current knowledge and professional standards.

6. The facility will develop an annual CQI plan/calendar of indicators for review. Annually, a review of the CQI calendar of activities will occur and revisions/updates made as necessary.

7. The facility will measure, analyze, and track quality indicators or other aspects of performance. The program must include, but not be limited to, the following:
    - Patient Safety, including
        - Review of sentinel events

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Origination Date: September 2007
Revision Date: March 2008, September 2008, March 2011, March 2013, September 2013, April 2017

  - Review of trends of adverse patient occurrences including falls and blood loss
  - Review of product, equipment, or medication notices or recalls
  - Review of all patients on less than a 2K+ or on a 4K+ dialysate, their weekly pre-dialysis serum potassium results, dialysate order start date, if physician was contacted, and any dialysate order changes
- Infection Control, including
  - Incidence of infections
  - Vaccination rates for Hepatitis B, Influenza, and Pneumococcal
- Adequacy of Dialysis (Kt/V)
- Nutritional Status (Albumin)
- Mineral Metabolism and Renal Bone Disease
- Anemia Management
- Vascular Access
- Growth and Capacity
- Mortality – review of deaths
- Hospitalizations and Emergency Ambulance Transfers
- Patient Satisfaction and Grievances
- Other indicators as reflected in the Facility Health Record application

8. Continuous monitoring of the above indicators will be reflected in the meeting minutes. Any area identified as underperforming will be reviewed to identify root causes for underperformance, will have an action plan identified that will result in performance improvement, and will track this change in performance over time to verify improvements are sustained.

9. Each action plan will be evaluated as to priority with Patient Safety and Clinical Outcomes indicators considered for the highest level of priority.

DaVita In Center Hemodialysis DQI Score - May 2013

Facility Name	DQI Score	CVC Rate	Kt/V Rate	Vaccination (Flu) Rate	Albumin Rate	Med Review Rate	Fluid IDWG Rate	BCR Rate	CAHPS Rate
Battle Ground Dialysis	44.0	13.0%	95.7%	90.5%	47.8%	87.0%	39.1%		
Belfair Dialysis		0.0%	100.0%	100.0%	71.4%	100.0%	28.6%		
Bellevue Dialysis Center	64.0	12.5%	95.8%	90.2%	75.0%	100.0%	27.1%		87.5%
Blue Mountain Kidney Center	89.3	0.0%	100.0%	100.0%	81.0%	100.0%	28.6%		66.7%
Burley Dialysis Center	69.3	12.5%	92.0%	100.0%	80.0%	100.0%	12.0%		100.0%
Caldwell Dialysis Center	85.6	5.6%	100.0%	91.7%	63.9%	97.2%	25.0%	100.0%	87.5%
Cascade Dialysis		18.2%	100.0%	100.0%	81.8%	100.0%	18.2%		100.0%
Chinook Kidney Center	90.0	8.1%	100.0%	92.1%	80.6%	100.0%	21.0%	100.0%	80.0%
Cornell Road Dialysis	73.0	8.9%	97.8%	95.3%	75.6%	95.6%	22.2%	100.0%	46.2%
Davita-mount Baker Kidney Center	68.0	14.2%	98.1%	88.6%	74.5%	100.0%	30.2%	100.0%	84.6%
Downtown Spokane Renal Center	49.4	28.1%	100.0%	83.6%	68.4%	100.0%	28.1%		69.2%
East Wenatchee Dialysis		21.4%	100.0%	100.0%	57.1%	100.0%	42.9%	100.0%	100.0%
Echo Valley Dialysis		41.7%	100.0%	90.0%	75.0%	100.0%	25.0%		100.0%
Ellensburg Dialysis Center	90.7	11.5%	100.0%	100.0%	88.5%	100.0%	7.7%		80.0%
Everett Dialysis Center	52.9	13.4%	97.0%	98.5%	76.1%	100.0%	37.3%		60.0%
Federal Way Community Dialysis Center	88.2	8.6%	100.0%	97.1%	84.3%	100.0%	21.4%		66.7%
Four Rivers Dialysis Center	60.0	15.5%	96.6%	90.9%	81.0%	91.4%	19.0%	100.0%	77.8%
Gate City Dialysis Center		12.5%	100.0%		87.5%	100.0%	25.0%		100.0%
Graham Dialysis Center	86.7	9.1%	100.0%	97.8%	71.7%	95.7%	21.7%	100.0%	77.8%
Hermiston Community Dialysis Center	75.6	9.1%	100.0%	97.5%	90.9%	100.0%	50.0%	100.0%	88.9%
Hillsboro Dialysis Center		0.0%	100.0%	100.0%	72.7%	100.0%	27.3%	100.0%	66.7%
Kennewick Dialysis	80.0	6.9%	96.6%	96.8%	79.3%	100.0%	20.7%	100.0%	60.0%
Kent Dialysis Center	65.0	10.4%	95.0%	92.4%	78.8%	97.5%	37.5%	100.0%	72.4%
Lake Road Dialysis	83.0	3.7%	100.0%	92.7%	82.6%	100.0%	31.2%	100.0%	73.5%
Lakewood Community Dialysis Center	50.0	13.6%	93.9%	94.0%	80.3%	100.0%	39.4%	100.0%	45.5%
Lone Peak Dialysis	70.0	12.1%	84.8%	85.1%	84.8%	92.4%	12.1%	100.0%	80.0%
Mcminnville Dialysis	73.3	10.5%	97.4%	100.0%	78.9%	100.0%	31.6%		50.0%
Meridian Park Dialysis Center	87.0	6.1%	96.0%	95.8%	86.0%	100.0%	18.0%	100.0%	87.5%
Mid Columbia Kidney Center	66.0	6.0%	97.6%	94.0%	81.0%	97.6%	35.7%	100.0%	58.3%
Mill Creek Dialysis Center	47.1	30.0%	97.6%	97.4%	78.0%	95.1%	22.0%		54.5%
Moscow Dialysis		50.0%	100.0%	100.0%	71.4%	100.0%	28.6%		100.0%
Mt Adams Kidney Center	55.3	7.9%	97.4%	97.3%	82.9%	100.0%	47.4%		65.0%
Nampa Dialysis Center	53.3	16.7%	97.2%	94.1%	77.8%	100.0%	36.1%	100.0%	87.5%
North Spokane Renal Center	46.0	23.4%	98.7%	82.4%	75.6%	98.7%	32.1%	100.0%	57.9%
Northeast Portland Renal Center	53.0	7.1%	95.2%	90.1%	75.0%	100.0%	22.6%	50.0%	44.4%
Olympia Dialysis Center	74.4	6.9%	96.7%	100.0%	86.7%	100.0%	40.0%	100.0%	71.4%
Olympic View Dialysis Center	68.2	16.4%	100.0%	94.9%	78.2%	100.0%	23.6%		80.0%
Oregon Kidney Center	81.2	11.9%	98.5%	93.9%	91.2%	100.0%	29.4%		66.7%
Parkland Dialysis	53.0	18.6%	93.9%	96.5%	71.1%	92.1%	28.1%	100.0%	79.4%
Pilchuck Dialysis	66.7	18.8%	100.0%	100.0%	65.6%	100.0%	18.8%	100.0%	83.3%
Portland Gateway Dialysis	80.0	1.7%	100.0%	96.6%	73.3%	95.0%	16.7%		66.7%
Portland Mlk Dialysis		20.0%	90.0%	100.0%	80.0%	100.0%	10.0%		100.0%
Puyallup Dialysis	43.5	30.4%	91.2%	91.9%	73.5%	98.0%	26.5%		61.9%
Rainier View Dialysis	72.2	15.8%	100.0%	90.6%	80.7%	100.0%	14.0%	100.0%	77.8%
Redondo Heights Dialysis	48.0	23.2%	98.3%	90.0%	74.1%	100.0%	32.8%		
Renton Dialysis		66.7%	100.0%	100.0%	100.0%	100.0%	33.3%		
Seaview Dialysis Center		7.7%	100.0%	100.0%	71.4%	100.0%	21.4%		100.0%

DaVita In-Center Hemodialysis DQI Score - May 2012

Facility Name	DQI Score	CVC Rate	Kt/V Rate	Vaccination (Flu) Rate	Albumin Rate	Med Review Rate	Fluid IDWG Rate	BCR Rate	CAHPS Rate
Sherwood Dialysis Center	55.6	14.3%	100.0%	100.0%	76.2%	85.7%	23.8%	0.0%	50.0%
Snake River Dialysis Center		0.0%	100.0%	50.0%	100.0%	100.0%	0.0%		
Spokane Valley Renal Center	64.0	27.3%	96.4%	90.4%	85.5%	98.2%	27.3%	100.0%	88.2%
Table Rock Dialysis Center	70.0	13.5%	98.7%	97.4%	77.3%	100.0%	29.3%	100.0%	58.3%
Tacoma Dialysis Center	59.0	16.0%	98.8%	90.2%	79.3%	96.3%	39.0%	100.0%	80.0%
Treasure Valley Dialysis Center	57.0	19.6%	97.8%	89.8%	82.6%	100.0%	23.9%	100.0%	64.7%
Tumwater Dialysis	40.0	31.3%	87.5%	92.9%	75.0%	100.0%	28.1%	66.7%	80.0%
Twin Falls Dialysis Center	76.5	7.0%	96.5%	100.0%	77.2%	100.0%	29.8%		73.3%
Union Gap Dialysis	67.0	6.9%	100.0%	93.3%	83.1%	98.3%	49.2%	100.0%	75.0%
Utah Valley Dialysis Center	93.0	7.3%	100.0%	97.2%	86.5%	100.0%	26.1%	91.7%	78.9%
Vancouver Dialysis Center	47.1	20.3%	96.7%	91.8%	86.9%	100.0%	32.8%		68.8%
Weber Valley Dialysis		5.9%	100.0%	100.0%	82.4%	100.0%	11.8%		75.0%
Wenatchee Valley Dialysis	70.6	11.5%	98.4%	95.0%	80.6%	100.0%	38.7%		90.9%
West Bountiful Dialysis		15.4%	100.0%	100.0%	76.9%	100.0%	38.5%	50.0%	100.0%
West Linn Dialysis Center		0.0%	100.0%	87.5%	87.5%	93.8%	12.5%		100.0%
Westwood Dialysis Center	70.0	13.5%	97.4%	94.6%	73.7%	100.0%	21.1%	100.0%	88.9%
Whidbey Island Dialysis Center	69.3	13.0%	95.7%	95.8%	82.6%	100.0%	13.0%		77.8%
Willamette Valley Renal Center	82.4	9.5%	100.0%	100.0%	83.3%	88.1%	11.9%		72.7%
Yakima Dialysis Center	80.0	4.5%	98.2%	91.7%	80.4%	100.0%	25.0%		69.7%
Zillah Dialysis	81.2	5.4%	100.0%	100.0%	64.9%	97.3%	27.0%		64.3%

Facility Name	DQI Score	CVC Rate	Kt/V Rate	Vaccination (Flu) Rate	Med Review Rate	Fluid PW Above TW	CAHPS Composite Score Rate	BSI Rate	HMT Rate
Battle Ground Dialysis	43.89	14.29%	96.67%	86.67%	100.00%	43.33%		0.00	8.49%
Belfair Dialysis		12.50%	100.00%	100.00%	100.00%	25.00%		0.00	6.87%
Bellevue Dialysis Center	77.00	12.50%	100.00%	89.80%	100.00%	18.37%	76.84%	0.69	3.46%
Blue Mountain Kidney Center		5.88%	100.00%	100.00%	100.00%	0.00%		0.00	10.50%
Burley Dialysis Center	86.67	6.45%	100.00%	96.77%	100.00%	6.45%		1.09	2.79%
Caldwell Dialysis Center	74.44	5.56%	91.67%	88.89%	100.00%	19.44%		0.85	3.59%
Cascade Dialysis		10.53%	94.74%	94.74%	100.00%	0.00%		0.00	5.59%
Chinook Kidney Center	92.00	6.15%	100.00%	98.48%	100.00%	24.24%	75.91%	0.00	5.37%
Cornell Road Dialysis	82.22	8.89%	97.83%	91.30%	89.13%	28.26%		0.00	4.04%
Davita-mount Baker Kidney Center	68.00	10.53%	99.14%	91.38%	100.00%	35.34%	74.32%	0.85	3.33%
Downtown Spokane Renal Center	54.00	31.15%	98.39%	82.26%	100.00%	33.87%	74.70%	0.00	7.39%
East Wenatchee Dialysis		20.00%	100.00%	100.00%	100.00%	20.00%		0.00	0.50%
Echo Valley Dialysis		12.50%	100.00%	87.50%	100.00%	12.50%		0.00	4.35%
Ellensburg Dialysis Center	89.00	9.09%	100.00%	100.00%	100.00%	9.09%	75.11%	0.00	7.43%
Everett Dialysis Center	38.00	18.18%	85.29%	97.06%	100.00%	64.71%	68.56%	0.51	6.86%
Federal Way Community Dialysis Center	49.00	19.48%	100.00%	93.59%	100.00%	30.77%	71.86%	0.41	5.05%
Four Rivers Dialysis Center	98.00	5.77%	100.00%	92.31%	100.00%	19.23%	82.98%	0.00	4.11%
Gate City Dialysis Center		0.00%	100.00%	100.00%	100.00%	42.86%		0.00	13.10%
Graham Dialysis Center	70.00	13.33%	100.00%	97.78%	100.00%	33.33%		0.00	6.09%
Hermiston Community Dialysis Center	96.00	9.30%	100.00%	97.67%	100.00%	11.63%	72.71%	0.00	4.48%
Hillsboro Dialysis Center		14.29%	100.00%	100.00%	100.00%	0.00%		0.00	3.05%
Kennewick Dialysis	95.00	9.68%	100.00%	87.10%	100.00%	16.13%		0.00	4.38%
Kent Dialysis Center	47.00	14.63%	96.34%	93.90%	100.00%	29.27%	62.17%	2.46	6.01%
Lake Road Dialysis	66.00	11.34%	97.96%	94.90%	96.94%	38.78%	75.19%	0.69	4.48%
Lakewood Community Dialysis Center	41.00	21.18%	95.45%	96.59%	100.00%	35.23%	57.95%	0.77	6.85%
Lone Peak Dialysis	56.00	10.53%	94.83%	75.86%	100.00%	39.66%	73.95%	1.60	3.99%
Mcminnville Dialysis	76.67	15.79%	100.00%	97.37%	100.00%	18.42%		0.00	5.23%
Meridian Park Dialysis Center	58.00	14.58%	100.00%	91.67%	100.00%	39.58%	81.10%	1.32	3.98%
Mid Columbia Kidney Center	87.00	4.94%	97.53%	93.83%	100.00%	24.69%	80.63%	0.39	5.40%
Mill Creek Dialysis Center	66.00	19.15%	97.87%	100.00%	100.00%	36.17%	78.04%	0.00	4.83%
Moscow Dialysis		12.50%	100.00%	100.00%	100.00%	12.50%		0.00	10.48%
Mt Adams Kidney Center	71.00	10.81%	100.00%	98.67%	100.00%	30.67%	75.11%	0.45	4.75%
Nampa Dialysis Center	80.00	12.20%	100.00%	97.56%	100.00%	31.71%		0.00	4.02%
North Spokane Renal Center	81.00	12.33%	100.00%	85.14%	100.00%	22.97%	75.60%	0.00	2.83%
Northeast Portland Renal Center	43.00	14.08%	97.22%	93.06%	100.00%	44.44%	58.11%	0.45	7.82%
Olympia Dialysis Center	70.00	3.33%	100.00%	96.77%	100.00%	41.94%		0.00	8.11%
Olympic View Dialysis Center	73.00	7.94%	96.83%	93.65%	100.00%	34.92%	65.43%	0.00	6.55%
Oregon Kidney Center	91.00	3.17%	100.00%	96.83%	100.00%	33.33%	90.32%	0.00	3.05%

Parkland Dialysis	32.00	14.29%	93.40%	95.28%	100.00%	38.68%	70.52%	0.63	8.25%
Pilchuck Dialysis	78.89	12.20%	100.00%	95.35%	100.00%	6.98%		0.00	7.82%
Portland Gateway Dialysis	75.00	5.77%	98.15%	96.30%	100.00%	42.59%	69.05%	0.00	5.43%
Portland Mlk Dialysis		11.76%	88.24%	94.12%	100.00%	35.29%		0.00	8.33%
Puyallup Dialysis	28.00	23.86%	95.56%	94.44%	100.00%	46.67%	63.11%	2.37	6.60%
Rainier View Dialysis	67.50	6.12%	96.00%	86.00%	100.00%	28.00%	85.89%	1.29	6.71%
Redondo Heights Dialysis	26.00	27.78%	90.91%	94.55%	100.00%	49.09%	74.95%	1.79	8.93%
Renton Dialysis		18.75%	100.00%	100.00%	100.00%	43.75%		0.00	10.98%
Seaview Dialysis Center		5.88%	100.00%	94.12%	100.00%	35.29%		0.00	6.00%
Sherwood Dialysis Center	76.67	8.70%	91.30%	100.00%	100.00%	17.39%		1.35	4.40%
Snake River Dialysis Center		0.00%	100.00%	50.00%	100.00%	0.00%		0.00	6.41%
Spokane Valley Renal Center	71.00	20.00%	98.18%	94.55%	100.00%	25.45%	86.61%	0.00	5.96%
Table Rock Dialysis Center	50.00	21.95%	97.59%	96.39%	100.00%	45.78%	55.79%	0.00	5.70%
Tacoma Dialysis Center	40.50	22.58%	93.55%	86.02%	100.00%	34.41%	75.65%	0.74	7.91%
Treasure Valley Dialysis Center	77.00	14.89%	100.00%	97.87%	100.00%	19.15%	77.10%	0.00	6.22%
Tumwater Dialysis	45.56	15.63%	96.88%	90.63%	100.00%	34.38%		0.00	9.44%
Twin Falls Dialysis Center	75.00	4.92%	100.00%	98.36%	100.00%	22.95%	64.75%	0.59	7.06%
Union Gap Dialysis	70.00	12.12%	100.00%	92.54%	100.00%	1.49%	72.30%	1.60	5.54%
Utah Valley Dialysis Center	72.00	5.83%	98.33%	99.17%	100.00%	28.33%	65.30%	1.89	5.38%
Vancouver Dialysis Center	62.50	13.56%	100.00%	87.10%	100.00%	38.71%	74.08%	0.57	4.79%
Weber Valley Dialysis		7.69%	100.00%	100.00%	92.31%	15.38%		0.00	7.19%
Wenatchee Valley Dialysis	51.00	21.05%	97.44%	94.87%	100.00%	47.44%	76.00%	0.43	5.29%
West Bountiful Dialysis		9.09%	100.00%	90.91%	100.00%	36.36%		2.94	4.82%
West Linn Dialysis Center		0.00%	100.00%	93.33%	100.00%	13.33%		0.00	4.63%
Westwood Dialysis Center	28.33	18.42%	100.00%	86.84%	100.00%	44.74%		2.86	8.78%
Whidbey Island Dialysis Center	90.00	9.09%	100.00%	90.91%	100.00%	27.27%		0.00	3.61%
Willamette Valley Renal Center	58.00	19.51%	100.00%	100.00%	100.00%	24.39%	65.78%	0.00	4.37%
Yakima Dialysis Center	86.00	7.55%	99.07%	96.26%	100.00%	18.69%	64.99%	0.00	6.56%
Zillah Dialysis	59.00	4.76%	100.00%	100.00%	100.00%	23.81%	66.50%	1.71	12.50%

Appendix 18

DaVita's Physician, Community and Patient Services

POLICY # COMP-DD-018	Revision: 5.0	Page 1 of 6
TITLE: No-Cost Patient Education		
Department: Compliance (Team Quest)	Effective date: 12/09/2016	

Teammates must promptly report all potential violations of DaVita's Code of Conduct, Corporate Integrity Agreement (CIA) obligations*, Compliance Policies and Procedures and/or applicable laws or regulations. Reports should be made to the Compliance Department (Team Quest), or the Compliance Hotline (888-458-5848 or DaVitaComplianceHotline.com). In accordance with DaVita's Non-Retaliation policy, DaVita will not tolerate any form of retaliation against anyone who files a compliance report in good faith. Questions regarding any Compliance Policy may be directed to Team Quest via the QUESTionLine at 855-687-9645 or QUESTionLine@davita.com.*

1. PURPOSE

The purpose of this policy is to provide guidelines for no-cost patient education and teammate interaction with participants related to such initiatives.

2. SCOPE

This policy applies to DaVita Inc.'s Kidney Care business (DaVita) and, subject to approval by the chief compliance officer or his/her designee, it may be enhanced or modified by a business unit-specific policy(ies). Kidney Care is comprised of DaVita's domestic dialysis business, as well as any other subsidiaries and affiliated entities related to Kidney Care and DaVita's Strategic Business Initiatives (SBI). DaVita Medical Group (DMG) business and international operations are not part of Kidney Care.

This policy applies to all no-cost Patient Education Programs, teammates and Participants, including upstream non-DaVita Patients and community members. This policy does not apply to education provided or furnished to patients of other healthcare providers that are under contract with DaVita (e.g. Patient Pathways, Hospital Services Group, etc.).

3. DEFINITIONS

Term	Definition
Core Patient Education Program Materials	Materials that provide an overview of key elements addressed in Patient Education Programs.
DaVita Patient	A patient whose DaVita placement request has been accepted and who has been formally admitted to dialyze at. A patient can be considered formally admitted prior to their first day of dialysis at DaVita.
Health Care Provider	Any individual nephrologist or physician practice; any hospital or related corporate entity that is or has entered into a Letter of Intent with DaVita Dialysis to become a Joint Venture Partner; or any joint venture in which DaVita owns an interest that provides dialysis services, whether directly or indirectly owned by DaVita.
Healthy Transitions	A Patient Education Program intended to provide insurance and employment education to the chronic kidney disease community.

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Term	Definition
Individualized Education Program	A program that is provided in a one-on-one setting and tailored to address the needs or circumstances of a particular Participant.
Kidney Smart	A Patient Education Program provided to the entire community, regardless of affiliation to physicians/providers or a patient's employment/insurance status.
Modality Education	A Patient Education Program intended to provide information about modality options for patients diagnosed with End-Stage Renal Disease.
One on One Education	Education that provides general information (i.e. information that is not tailored to the specific patient) to a Participant in a one-on-one setting.
Participant	An individual who takes part in a no-cost Patient Education Program.
Patient Education Program	A no-cost educational program that provides general information to Participants in order to raise awareness or improve health outcomes.
Referral Source	Physicians, hospitals, or any other person or entity in a position to refer, recommend, or arrange for any item or service from or furnished by a DaVita facility, DaVita business unit or subsidiary or an immediate family member of the Referral Source. Examples of Referral Sources include hospitals, nephrologists, and nephrology associated nurses, physician assistants, physician practice managers, social workers, discharge planners, and case managers.
Strategic Business Initiative (SBI)	SBIs include DaVita Clinical Research, DaVita Health Solutions, DaVita Labs, Falcon Physician, VillageHealth, Lifeline Vascular Access, Paladina Health and Nephrology Practice Solutions.

4. POLICY

4.1. Patient Education Programs must be designed to provide bona fide, general (non-individualized) education for which a participant (or third-party payer) would not otherwise pay.

4.1.1. Content of Patient Education Programs should be limited to the following. Education concerning topics not listed below may only be offered in limited settings and require approval from the Justice League of DaVita (JLD) and documentation.

- Information regarding disease state awareness and preventions, such as taking control of kidney disease.
- Suggestions for making healthy choices.
- Treatment options (education must not be limited to a single option and should include all modality options).
    - Educational programs that include a discussion of treatment modalities must include the *No Medical Advice Given Disclaimer*.
- Information regarding vascular access awareness, such as access function early recognition and patient actions for access issues.
- General education about healthcare insurance and/or employment options.
    - Individualized healthcare insurance and/or employment education may be provided for Participants who are late-stage patients.

4.1.2. Inappropriate Content

- Discussions related to DaVita-specific financial assistance must be limited to Participants who are DaVita Patients and are not appropriate for potential DaVita Patients.

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- Medical advice must not be provided as part of Patient Education Programs.
- Information may not be tailored to the specific participant except as expressly approved for Healthy Transitions.
- The content of Patient Education Programs must be provider-neutral and must not include marketing or promotional materials for any specific provider. Rather, content must be unbiased and may not include information and educational materials that are designed to influence a Participant's choice.
- DaVita should never initiate the shift in focus from bona fide education to DaVita promotion. If a Participant requests information specific to DaVita items or services:
    - Teammates should provide a HIPAA Marketing Authorization form (available on the eP&P VillageWeb site) and obtain the Participant's signature.
    - Teammates should refer the participant to a designated non-educator teammate for non-education discussions (e.g., for home educators, refer to facility administrator or home lead where participant is interested in dialysis).
- It is inappropriate to discuss or offer Patient Education Programs to Referral Sources in order to induce or reward referrals to DaVita.

4.1.3 All Patient Education Program presentations and materials must include the *No Medical Advice Given Disclaimer*.

4.1.4 Educational content concerning topics not listed in Section 4.1.1. above may only be offered in limited settings and require JLD's approval and documentation.

4.2. Educators

4.2.1. Patient Education Programs may only be conducted by DaVita teammates who have completed the appropriate training courses in StarLearning, which must be completed annually.

4.2.2. Each educator also must satisfy the additional requirements, if any, of the applicable Patient Education Program

4.2.3. Educators may not be offered incentives based on Participants choosing DaVita as their healthcare provider after completing a Patient Education Program.

- Any allowable incentives must align with the Teammate Incentive Handbook.

4.2.4. Educators' appearance, including clothing, must be provider-neutral, except as specifically approved by JLD.

4.3. Appropriate Venues

4.3.1. Patient Education Programs may only be offered in the following venues.

- Community-based locations (e.g., libraries, or other meeting rooms/conference rooms available for community use, senior centers and other types of community centers).
    - If there are no free community locations suitable for education classes, a reasonable fee may be paid to non-Referral Sources only to use a publicly available space (e.g., library meeting rooms, hotel conference rooms or other similar spaces). Referral Sources may not be paid to use space for Patient Education Programs.

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- Practice or provider office/facility
    - Patient Education Programs occurring in a practice or provider office must be offered and open to the public in a region, irrespective of whether the practice is affiliated with or otherwise involved in a financial arrangement (e.g., joint venture partnership) with DaVita.
    - Referral Sources may not be paid to use a practice office for Patient Education Programs.
- Patient Education Programs must not be offered at the hospital bedside. Patient Education Programs must not be delivered in the patient's home or other personal residence with the following exceptions:
    - Website or webinar, pursuant to the requirements of 4.5.1.
    - Healthy Transitions

4.4. Financial

4.4.1. Patient Education Programs must be offered at no-cost to all Participants, regardless of the Participant's treating physician, other healthcare provider, payer or employment status.

4.4.2. Patient Education Programs must not replace, coordinate with or otherwise offset currently offered or reimbursable education or services (e.g., Medicare Improvements for Patients & Providers Act) provided by the Participant's treating physician.

4.4.3. Under no circumstance can Patient Education Programs be billed by any party.

4.4.4. It is appropriate to refer Participants with financial assistance questions to the American Kidney Fund (AKF), and inform Participants that there may be financial assistance available to ESRD patients from AKF or certain state aid programs regardless of their choice of dialysis provider.

4.5. Delivery Method

4.5.1. Patient Education Programs may be offered in the following ways:

- Websites or Webinar
    - Participants may be directed to educational websites or webinars to access Patient Education Programs subject to the requirement that all content of the website (including hyperlinks) and webinars must be provider-neutral.
- Live Classes
    - Participants may be invited to attend live Patient Education Programs.
    - Patient Education Programs must be open to the public.
- One-on-one patient or limited attendance Patient Education Programs may be provided, via telephone or live session, under the following circumstances.
    - All other options are not feasible.
    - If a live session, the public is welcome to attend.
    - An educator is available.

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- Team Quest and JLD have approved the request or previously provided written approval through a formal process for providing one-on-one or limited attendance Patient Education Programs.

- Notwithstanding the above, Healthy Transitions has been approved for one-on-one telephone sessions.
  - Currently Healthy Transitions is the only preapproved Individualized Education Program.

- Kidney Smart
  - All Kidney Smart classes must be posted on CERT (the scheduling system) 24 hours in advance.
  - Modality Education classes must be posted on CERT if they are scheduled more than one business day in advance. Educators should make every effort to schedule Modality Education so that it can be posted and open to the public.

4.6. Materials

4.6.1. All collateral materials used or handed out in connection with Patient Education Programs must be approved in advance by JLD and/or Team Quest. If teammates are found to be using materials not approved by JLD or Team Quest, teammates may be subject to corrective action up to and including termination.

4.6.2. Upon request of the Health Care Provider, materials for the Patient Education Programs may be provided by educators to hospitals, physician practices and other healthcare providers to educate those providers about the Patient Education Programs and raise awareness of available Patient Education Programs.

4.6.3. Pre-recorded Patient Education Programs may not be provided to hospitals, physician practices, or other Health Care Providers without prior consent from Team Quest of the JLD.

4.6.4. Core Patient Education Program materials must be made publicly available online at no-cost (e.g., posted on a publicly available website such as KidneySmart.org or DaVita.com).

4.7. HIPAA Authorization

4.7.1. Valid HIPAA authorizations (available on the eP&P VillageWeb site) must be obtained before contacting the Participant or collecting protected health information (PHI) (e.g., Participant contact information) belonging to the Participant.

- If a Participant is recommended to a Patient Education Program by the Participant's treating physician, the educator must receive the HIPAA authorization form that has been signed by the Participant from the Participant's treating physician prior to the educator contacting the Participant for educational purposes or causing the Participant to be contacted for educational purposes.
  - If a Participant contacts Healthy Transitions directly, Healthy Transitions may obtain verbal consent to have the HIPAA form and consent form mailed to the Participant.

- If a Participant reaches out to DaVita directly, a HIPAA authorization should be collected at the time of providing the education.

4.8. Post Education Follow Up

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4.8.1. After the Patient Education Program is complete, educators may follow up with the Participant only if;

- A signed HIPAA Authorization Form is on file.

4.8.2. Patient Education Program educators are only permitted to use documents approved by Team Quest and JLD for follow-up purposes.

4.8.3. Information gathered through a Patient Education Program may only be used for Patient Education Program purposes, unless patient authorization has been obtained prior to the use or the use has received written JLD approval.

4.9. New Pilot Program

4.9.1. Any pilot programs related to Patient Education Programs must be approved by JLD and Team Quest. The following information must be provided for review by JLD and Team Quest:

- Explanation of why this initiative is being proposed and what the potential educational benefits are.
- List of anyone outside of DaVita who will be involved (physicians, medical directors, other healthcare entities or providers).
- A response to the following questions:
  - Will anyone be paid for participating in this initiative?
  - When will the initiative begin?
  - With whom will the results of the initiative be shared?
  - Do you anticipate publishing the results of the pilot or initiative?
- Any other information requested by JLD or Team Quest.

4.10. Patient Education Programs are subject to the DaVita Document Retention Policy (available on the JLD VillageWeb page).

5. PROCEDURES

→ N/A

6. APPLICABLE DOCUMENTS

→ No Medical Advice Given Disclaimer
→ HIPAA Marketing Authorization (available on the eP&P VillageWeb site)
→ HIPAA Marketing Authorization- Maine and Montana (available on the eP&P VillageWeb site)
→ HIPAA Marketing Authorization- Maryland (available on the eP&P VillageWeb site)
→ Kidney Smart Program Requirements
→ Valid HIPAA Authorization Form (available on the eP&P VillageWeb site)
→ Valid HIPAA Authorization Form – Maine and Montana (available on the eP&P VillageWeb site)
→ Valid HIPAA Authorization Form – Maryland (available on the eP&P VillageWeb site)
→ Document Retention Policy (available on the JLD VillageWeb page)

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Appendix 19

AJKD Original Investigation

"Clinical Outcomes Associated With Receipt of Integrated Pharmacy Services by Hemodialysis Patients: A Quality Improvement Report"

AJKD
Original Investigation

Clinical Outcomes Associated With Receipt of Integrated Pharmacy Services by Hemodialysis Patients: A Quality Improvement Report

Eric D. Weinhandl, MS,[1] Thomas J. Arneson, MD,[1] and Wendy L. St. Peter, PharmD[1,2]

Background: Reducing medication-related problems and improving medication adherence in hemodialysis patients may improve clinical outcomes. In 2005, a large US dialysis organization created an integrated pharmacy program for its patients. We aimed to compare the outcomes of hemodialysis patients enrolled in this program and matched control patients.

Study Design: Quality improvement report.

Setting & Participants: Hemodialysis patients with concurrent Medicare and Medicaid eligibility who chose to receive program services and propensity score–matched controls; the propensity score was an estimated function of demographic characteristics, comorbid conditions, medication exposure, serum concentrations, and vascular access method.

Quality Improvement Plan: Program services included medication delivery, refill management, medication list reviews, telephonic medication therapy management, and prior authorization assistance.

Outcomes: Relative rates of death and hospitalization.

Measurements: Survival estimates calculated with the Kaplan-Meier method; mortality hazards compared with Cox regression; hospitalization rates compared with Poisson regression.

Results: In outcome models, there were 8,864 patients receiving integrated pharmacy services and 43,013 matched controls. In intention-to-treat and as-treated analyses, mortality HRs for patients receiving integrated pharmacy services versus matched controls were 0.92 (95% CI, 0.86-0.97) and 0.79 (95% CI, 0.74-0.84), respectively. Corresponding relative rates of hospital admissions were 0.98 (95% CI, 0.95-1.01) and 0.93 (95% CI, 0.90-0.96), respectively, and of hospital days, 0.94 (95% CI, 0.90-0.98) and 0.86 (95% CI, 0.82-0.90), respectively. Cumulative incidences of disenrollment from the pharmacy program were 23.4% at 12 months and 37.0% at 24 months.

Limitations: Patients were not randomly assigned to receive integrated pharmacy services; as-treated analyses may be biased because of informative censoring by disenrollment from the pharmacy program; data regarding use of integrated pharmacy services were lacking.

Conclusions: Receipt of integrated pharmacy services was associated with lower rates of death and hospitalization in hemodialysis patients with concurrent Medicare and Medicaid eligibility. Studies are needed to measure pharmacy program use and assess detailed clinical and economic outcomes.

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INDEX WORDS: Hemodialysis; hospitalization; integrated pharmacy; medication therapy management; mortality.

Clinical management of dialysis patients often involves treatment of multiple comorbid conditions. Dialysis patients are prescribed on average 9-10 oral medications and 2-3 parenteral medications.[1-3] Such complex regimens are associated with frequent medication-related problems and widespread nonadherence.[1,4-8] Many medication-related problems can be resolved through medication therapy management with clinical pharmacist involvement.[9-11] Nonadherence is more complex and may require addressing financial barriers, health literacy, and psychosocial factors and simplifying medication regimens.[8,12-15] Little is known about the effects of pharmacy services on clinical outcomes in dialysis patients.[16] A small trial found lower hospitalization risk in patients who received clinical pharmacist care, but the baseline imbalance was significant.[17]

In 2005, DaVita, a large US dialysis organization, created DaVita Rx, an integrated pharmacy program. Program services expanded over time to include individualized prescription reviews for dosage, allergies, and interactions; prior authorization assistance; no-cost medication delivery to dialysis facilities or homes; refill management with periodic patient reminders; and clinical pharmacists who are always available for telephone consultation. Notably, the decision to enroll

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in DaVita Rx is voluntary. In this retrospective observational study, we used linked data from DaVita records and the US Renal Data System (USRDS) to assess relative rates of mortality and hospitalization of DaVita Rx enrollees and matched control patients who received maintenance hemodialysis therapy between 2006 and 2008.

METHODS

Protection of Human Subjects

Patient data were obtained through a data licensing agreement between DaVita Clinical Research (Minneapolis, MN) and the Chronic Disease Research Group. Data were linked to the USRDS database by USRDS staff under a data use agreement with the National Institute of Diabetes and Digestive and Kidney Diseases; the agreement stipulated confidentiality rules and security regulations. Study approval was obtained from the Hennepin County Medical Center Human Subjects Research Committee (Minneapolis, MN).

Study Cohort

DaVita data included 219,785 patients who received any dialysis treatment at a DaVita facility between January 2006 and December 2008 (study era). Using Social Security numbers, first and last names, and dates of birth and end-stage renal disease (ESRD) onset, 216,767 patients (98.6%) were linked to data in the USRDS database.

DaVita Rx enrollees included patients with one or more prescription fills from DaVita Rx pharmacies during the study era. Each enrollee had one or more enrollment episodes. To construct episodes, we identified each series of consecutive calendar months with one or more prescription fills in each month, joined discrete series that were separated by 3 or fewer months without a prescription fill, and in each resultant series, presumed continued enrollment for 3 months after the last month. We defined the index date as the first day of the first month of the episode. Nonenrollees were patients with one or more calendar months during the study era not included in a DaVita Rx enrollment episode. From each nonenrollee, we defined a control candidate from each month not included in an enrollment episode; essentially, each control candidate represented a month during which a patient could have enrolled in DaVita Rx but did not. The index date of each control candidate was defined as the first day of the month.

We applied 8 inclusion criteria, including concurrent Medicare and Medicaid enrollment (dual eligibility) on the index date (Fig 1). Dually eligible beneficiaries were automatically enrolled in Medicare Part D during the study era, paid no premiums, and incurred little out-of-pocket cost for medications. The constraint of dual eligibility limited confounding by financial barriers to medication.

Data Elements

For each DaVita Rx enrollment episode and control candidate, we identified all characteristics listed in Table 1. All characteristics except laboratory values and vascular access method were ascertained from USRDS data. Age, ESRD duration, kidney transplant waiting list registration, and state of residence were defined on the index date. Vascular access method was defined at the last hemodialysis session before the index date. Cumulative hospital days were measured from Medicare Part A inpatient facility claims during the 1 month and 6 months preceding the index date. Cumulative doses of epoetin alfa, iron, and vitamin D analogues were measured from Medicare Part B outpatient facility claims

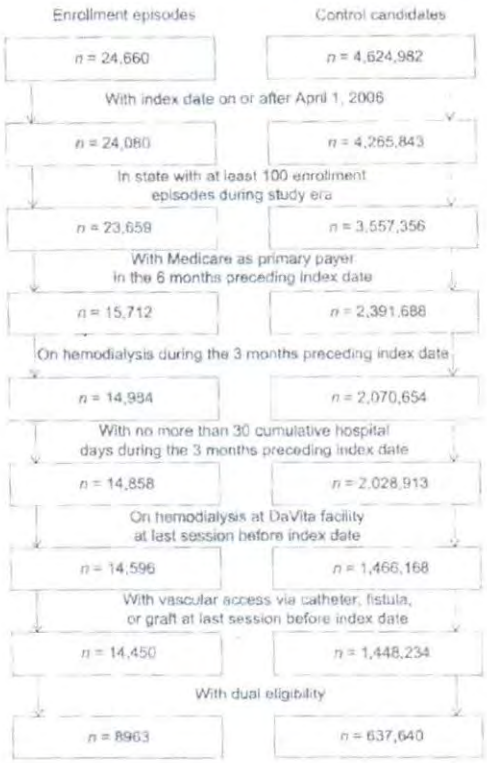

Figure 1. Sample size of study cohort, with iterative application of inclusion criteria.

during the 3 months preceding the index date. Medication use was identified from Medicare Part D prescription drug event records during the 3 months preceding the index date. Laboratory values were calculated as weighted mean values of end-of-month values in the 1, 2, and 3 months preceding the index date, with weights of 1.00, 0.50, and 0.25, respectively. Comorbid conditions were defined from Medicare claims during the 6 months preceding the index date; in claims, we required one or more inpatient or 2 or more outpatient claims with relevant diagnosis codes to define conditions.[18,19] Regarding follow-up, we ascertained dates of death and hospitalization from USRDS data. Causes of hospitalization (cardiovascular, infectious, and other) were determined from principal diagnoses.

Matching Algorithm

We used propensity score matching.[20] In the set of DaVita Rx enrollment episodes and control candidates, we fit a logistic regression model of enrollment. Predictors included all characteristics listed in Table 1 and a categorical factor for the unique combination of year and month of the index date. We parameterized continuous factors with restricted cubic splines. From the fitted model, we calculated the propensity score for enrollment in each enrollment episode and control candidate. Finally, for each enrollment episode with propensity score p, we selected up to 5 control candidates with the same index date and state of residence and absolute differences from p in propensity scores <0.001. If more than 5 control candidates were available, the 5 with the smallest absolute differences were selected. If 5 or fewer candidates were available, all were selected.

Statistical Analysis

For analysis, we retained all DaVita Rx enrollment episodes (enrollees) and matched control candidates (control patients), except episodes with no matched control candidates. We calculated tabular summaries of measured factors in enrollees and control patients before and after matching. We assessed match quality with standardized differences; differences <10% indicate similarity. We used both intention-to-treat and as-treated analyses. In the former, we followed up patients from the date of the first prescription fill on or after the index date (enrollees) or from the index date (control patients) to the earliest of death, kidney transplant, cessation of hemodialysis therapy, loss of Medicare as primary payer status, 30 months after the start of follow-up, or December 31, 2008. In the latter, we added the end of the enrollment episode (enrollees) or the beginning of a new enrollment episode (control patients) to the list of dates on which follow-up may end.

During follow-up, we analyzed 2 outcomes: death and hospitalization. We calculated survival estimates with the Kaplan-Meier method. We compared survival with unadjusted Cox regression, overall and within 6-month intervals. We used the sandwich covariance estimator to account for within-pair correlation due to matching. As a sensitivity analysis, we compared survival in the subset of enrollees and their matched control patients still at risk after 3 months of follow-up. We calculated tabular summaries of hospital admissions and days per patient-year. We compared rates with unadjusted Poisson regression, overall and within 6-month intervals. We also compared rates by hospitalization cause. We used generalized estimating equations to account for intracluster correlation. As a post hoc analysis, we calculated percentages of enrollees and control patients with one or more Part D–covered fills during as-treated follow-up, by medication class.

RESULTS

Descriptive Analysis

The study cohort included 8,963 DaVita Rx enrollees with dual eligibility. Counts of enrollees were 2,827 (31.5%), 2,694 (30.1%), and 3,442 (38.4%) in 2006, 2007, and 2008, respectively. We identified one or more matched control patients for 8,864 enrollees (98.9%) and 5 matched control patients for 8,334 enrollees (93.0%). Characteristics of enrollees and control patients, before and after propensity score matching, are listed in Table 1. Compared with all control patients, enrollees were younger (mean age, 55.5 vs 58.9 years), more likely to be Hispanic (32.5% vs 20.7%), and more likely to be wait-listed for kidney transplant (20.5% vs 16.1%). Enrollees had less cardiovascular (42.6% vs 49.0%) and psychiatric disease (6.6% vs 11.2%) and accumulated fewer hospital days during the previous 1 month (mean, 0.6 vs 0.9) and 6 months (4.6 vs 5.6). Enrollees used fewer Part D–covered medications (mean, 7.8 vs 8.6); in particular, enrollees were less likely to use nitrates (9.8% vs 13.4%) or proton pump inhibitors (30.5% vs 35.8%). Enrollees also had higher albumin (mean, 3.9 vs 3.8 g/dL) and phosphorus (5.6 vs 5.5 mg/dL) levels. After matching, there were no substantial differences in measured factors.

Survival Analysis

In intention-to-treat analysis, 1,283 and 6,890 (cumulative incidences, 14.5% and 16.0%) deaths occurred in DaVita Rx enrollees and matched control patients, respectively. Corresponding mortality rates were 126 and 137 deaths per 1,000 patient-years. Survival percentages in enrollees versus control patients were 94.8% versus 93.7% at 6 months, 88.7% versus 87.3% at 12 months, 82.7% versus 81.1% at 18 months, 76.7% versus 75.6% at 24 months, and 70.9% versus 69.9% at 30 months (Fig 2A). Survival percentages in the subset of enrollees still at risk after 3 months were higher than in their matched controls in months 1-24 (Fig 2B). However, differences were much smaller than in the previous analysis. Excess survival in enrollees was 0.6% at 12 months and 0.2% at 24 months. In as-treated analysis, 932 (10.5%) and 6,118 (14.2%) deaths occurred in enrollees and matched control patients, respectively. Corresponding mortality rates were 113 and 144 deaths per 1,000 patient-years. Survival percentages in enrollees versus control patients were 95.0% versus 93.5% at 6 months, 89.5% versus 86.7% at 12 months, 84.2% versus 80.2% at 18 months, 79.1% versus 74.2% at 24 months, and 73.1% versus 68.4% at 30 months (Fig 2C). Survival differences in the subset of enrollees and their matched controls still at risk after 3 months were not much smaller than in the previous analysis (Fig 2D).

Relative hazards of death for enrollees versus matched control patients from unadjusted Cox regression are listed in Table 2. In intention-to-treat analysis, the mortality hazard ratio (HR) for enrollees versus control patients was 0.92 (95% confidence interval [CI], 0.86-0.97). The association was strongly protective in months 1-6 of follow-up (HR, 0.81), attenuated in months 7-12 (HR, 0.93) and 13-18 (HR, 0.96), and not protective in months 19-24 (HR, 1.07) and 25-30 (HR, 1.04). In the subset of enrollees and their matched controls still at risk after 3 months, the mortality HR for enrollees versus control patients was 0.97 (95% CI, 0.91-1.03). In as-treated analysis, the HR for enrollees versus control patients was 0.79 (95% CI, 0.74-0.84). The HR was 0.76-0.80 in months 1-24 and not protective in months 25-30. In the subset of enrollees and their matched controls still at risk after 3 months, the HR for enrollees versus control patients was 0.82 (95% CI, 0.76-0.88).

In as-treated analysis, DaVita Rx enrollees and matched control patients were censored at dates of disenrollment from the pharmacy program and enrollment into the pharmacy program, respectively. The cumulative incidence of disenrollment (enroll-

Table 1. Characteristics of DaVita Rx Enrollees and Control Patients Not Enrolled in DaVita Rx

	Before Matching			After Matching		
	DaVita Rx Enrollees	Control Patients	Standardized Difference[a]	DaVita Rx Enrollees	Control Patients	Standardized Difference[a]
Sample size	8,963	673,640		8,864	43,013	
Mean age,[b] y	55.5	58.9	23.6	55.6	56.0	2.9
Hispanic ethnicity, %	32.5	20.7	25.2	32.3	32.9	1.3
Race, %						
White	46.2	42.1	8.3	46.3	45.5	1.5
Black	46.7	49.6	6.0	46.6	47.0	0.9
Native American	1.3	2.1	7.1	1.3	1.2	0.9
Asian or Pacific islander	4.9	5.4	2.4	4.9	5.4	2.3
Other race	1.0	0.8	2.1	1.0	0.8	1.2
Sex, %						
Men	50.6	48.4	4.4	50.6	50.2	0.8
Women	49.4	51.6	4.4	49.4	49.8	0.8
Mean ESRD duration,[b] y	4.5	4.9	7.8	4.5	4.7	3.4
Primary cause of ESRD, %						
Diabetes mellitus	46.2	46.5	0.7	46.2	46.0	0.5
Hypertension	30.9	29.8	2.3	30.8	31.2	0.8
Glomerulonephritis	9.9	9.3	2.0	9.9	9.5	1.1
Cystic kidney disease	1.8	1.6	1.3	1.8	1.7	1.0
Other cause	8.2	9.2	3.7	8.3	8.3	0.0
Unknown cause	3.0	3.4	2.5	3.0	3.4	2.0
Comorbid conditions,[c] %						
Cardiovascular disease	42.6	49.0	12.9	42.7	43.3	1.2
Cardiac arrhythmia	12.4	15.9	10.7	12.4	12.6	0.3
Cerebrovascular disease	7.8	10.7	11.0	7.8	7.9	0.4
Congestive heart failure	26.6	30.5	8.8	26.7	26.7	0.1
Myocardial infarction	4.2	5.9	8.4	4.2	4.4	1.1
Peripheral vascular disease	11.8	14.7	8.9	11.8	12.4	1.7
Pulmonary circulation disease	2.2	2.5	2.0	2.3	2.2	0.2
Valvular disease	6.2	7.6	5.9	6.2	6.3	0.5
Alcohol or drug abuse	3.4	3.4	0.1	3.4	3.3	0.5
Cancer	2.6	3.6	6.1	2.7	2.7	0.1
Chronic pulmonary disease	15.0	18.2	9.0	15.0	15.2	0.8
Coagulopathy	3.6	4.6	5.4	3.6	3.8	1.3
Diabetes	57.3	56.9	3.2	57.4	57.7	0.6
Electrolyte and fluid disorders	35.1	34.4	1.4	35.0	35.2	0.3
Hypothyroidism	5.6	7.4	8.0	5.6	5.8	0.9
Liver disease	4.8	4.9	0.3	4.8	4.7	0.7
Neurologic disorders	7.3	9.9	9.8	7.4	7.5	0.5
Obesity	3.7	3.5	0.9	3.7	3.7	0.1
Psychiatric disease	6.6	11.2	18.6	6.6	7.1	1.7
Rheumatic disease	2.7	3.1	2.4	2.8	2.7	0.4
Weight loss	3.5	4.8	7.2	3.5	3.6	0.4
Mean hospital days						
During 1 mo preceding index date	0.6	0.9	13.0	0.6	0.6	0.0
During 6 mo preceding index date	4.6	5.6	10.8	4.6	4.6	0.4
Mean intravenous medication doses[d]						
Epoetin alfa, IU/wk	18,041	19,533	8.4	18,058	17,911	0.8
Iron, mg/mo	274	269	2.5	273	272	0.4
Vitamin D analogue, μg/mo	12.7	12.6	1.0	12.7	12.9	1.8
Mean Part D–covered medications[d]	7.8	8.6	19.3	7.8	7.8	0.5
Part D–covered medication use,[d] %						
Antibiotic agents						
Azithromycin	7.0	7.2	0.7	7.0	7.0	0.1
First-generation cephalosporin	5.6	5.8	1.0	5.6	5.5	0.4
Fluoroquinolone	11.3	13.7	7.5	11.3	11.9	1.7
Penicillin	7.6	8.3	2.7	7.6	7.7	0.3

(Continued)

Table 1 (Cont'd). Characteristics of DaVita Rx Enrollees and Control Patients Not Enrolled in DaVita Rx

	Before Matching			After Matching		
	DaVita Rx Enrollees	Control Patients	Standardized Difference[a]	DaVita Rx Enrollees	Control Patients	Standardized Difference[a]
Bone and mineral metabolism agents						
Cinacalcet	29.5	28.9	1.3	29.4	29.6	0.4
Phosphate binder	70.8	69.0	4.0	70.7	70.3	1.1
Cardiovascular agents						
Hematologic agents						
Clopidogrel	11.5	13.5	6.5	11.5	11.8	1.1
Warfarin	7.1	8.6	6.1	7.1	7.1	0.3
Antihypertensive agents						
Central α agonist	22.5	21.4	2.6	22.5	22.6	0.3
ACE inhibitor	32.5	31.2	2.8	32.3	32.0	0.8
ARB	17.5	17.5	0.2	17.6	17.3	0.6
α-β-Blocker	19.7	19.5	0.7	19.7	19.4	0.7
Cardioselective β-blocker	34.7	34.5	0.4	34.7	34.1	1.2
DHP calcium channel blocker	41.1	38.4	5.5	40.9	40.4	1.0
Loop diuretic	10.9	10.9	0.1	10.9	10.4	1.5
Nitrate	9.8	13.4	12.2	9.9	10.5	2.0
Vasodilator	16.8	15.9	2.4	16.7	16.6	0.4
Statin	28.5	29.6	2.4	28.5	28.2	0.7
Antidiabetic agents						
Insulin	21.3	24.6	7.9	21.4	22.1	1.7
Sulfonylurea	9.6	8.1	5.0	9.6	9.5	0.4
Thiazolidinedione	8.3	7.1	4.4	8.3	7.8	1.7
Gastrointestinal agents						
Metoclopramide	10.4	11.8	4.5	10.5	10.2	0.7
Promethazine	5.3	6.9	6.9	5.3	5.2	0.4
Antiulcer agents						
H_2 antagonist	8.1	9.4	4.7	8.1	8.2	0.1
Proton pump inhibitor	30.5	35.8	11.4	30.6	31.0	0.9
Other agents						
β-Agonist	7.6	9.7	7.9	7.7	7.9	0.9
Anticonvulsant	12.2	14.3	6.5	12.3	12.5	0.5
Levothyroxine	7.8	10.0	8.4	7.8	7.8	0.0
Opioid analgesic	39.0	43.2	8.6	39.0	39.5	1.0
Selective serotonin reuptake inhibitor	11.4	14.2	8.7	11.5	11.3	0.7
Mean serum concentrations[d]						
Albumin, g/dL	3.9	3.8	18.4	3.9	3.9	0.0
Hemoglobin, g/dL	12.1	12.1	2.7	12.1	12.1	0.9
Calcium, mg/dL	9.2	9.3	6.3	9.3	9.3	0.0
Phosphorus, mg/dL	5.6	5.5	10.7	5.6	5.6	1.3
Parathyroid hormone, pg/mL	424	399	5.3	422	421	0.2
Transplant waiting list registration,[b] %	20.5	16.1	10.8	20.5	20.3	0.5
Vascular access method,[e] %						
Catheter	21.4	24.5	7.5	21.5	21.3	0.5
Fistula	48.9	44.4	9.0	48.8	47.9	1.7
Graft	29.7	31.1	3.1	29.8	30.9	2.4

Note: Before and after propensity score matching. Conversion factors for units: calcium in mg/dL to mmol/L, ×0.2495; phosphorus in mg/dL to mmol/L, ×0.3229.

Abbreviations: ACE, angiotensin-converting enzyme; ARB, angiotensin receptor blocker; DHP, dihydropyridine; ESRD, end-stage renal disease; H_2, histamine type 2.

[a]Absolute difference between DaVita Rx enrollees and control patients not enrolled in DaVita Rx, in percentage of 1 standard deviation. Standardized differences <10% indicate similarity.

[b]On index date.

[c]During the 6 months preceding the index date.

[d]During the 3 months preceding the index date.

[e]At last hemodialysis session before the index date.

ees) and enrollment (control patients) is shown in Fig 3; by study cohort construction, disenrollment could not occur in the first 3 months. The cumulative incidence of disenrollment was 23.4% at 12 months and 37.0% at 24 months. Disenrollment occurred more frequently among enrollees in 2006 versus enrollees in 2007 and 2008 (data not shown). In control patients, the cumulative incidence of enrollment was 17.1% at 12 months and 27.1% at 24 months.

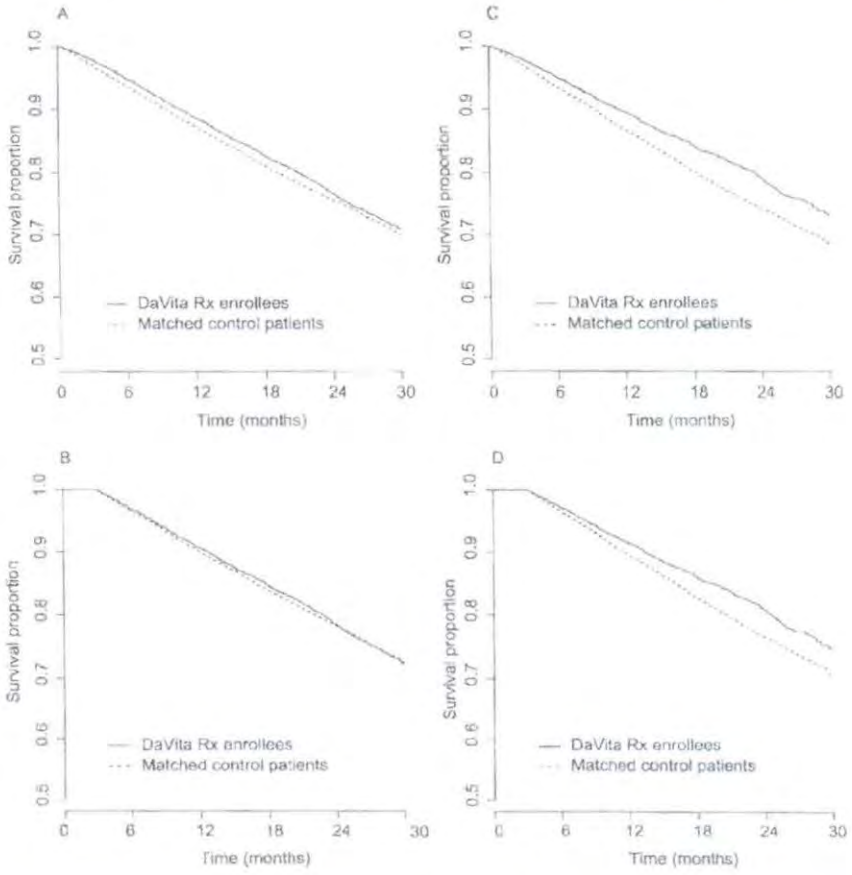

Figure 2. Kaplan-Meier estimates of survival in intention-to-treat analysis of (A) DaVita Rx enrollees and matched control patients and (B) the subset of enrollees and matched control patients alive at 3 months after the index date and as-treated analysis of (C) enrollees and matched control patients and (D) the subset of enrollees and matched control patients alive at 3 months after the index date.

Hospitalization

In intention-to-treat analysis, admission rates for DaVita Rx enrollees and matched control patients were 1.84 and 1.88 admissions per year, respectively (Table 3). The all-cause admission relative rate for enrollees versus control patients was 0.98 (95% CI, 0.95-1.01). The relative rate was 0.98-1.01 in months 1-24 and farther from unity in months 25-30 (0.89). In enrollees, distributions of admission causes were 29.9% for cardiovascular disease, 22.3% for infection, and 47.8% for other causes. Cause-specific admission relative rates were 0.98 (95% CI, 0.93-1.03) for cardiovascular disease, 0.98 (95% CI, 0.93-1.03) for infection, and 0.98 (95% CI, 0.94-1.02) for other causes. Regarding hospital days, rates for enrollees and matched control patients were 11.1 and 11.8 days per patient-year, respectively. The all-cause hospital day relative rate for enrollees versus control patients was 0.94 (95% CI, 0.90-0.98). The relative rate was 0.92-0.98 in months 1-24 and farther from unity in months 25-30 (0.88). Cause-specific hospital day relative rates were 0.95 (95% CI, 0.89-1.01) for cardiovascular disease, 0.93 (95% CI, 0.87-1.00) for infection, and 0.93 (95% CI, 0.88-0.99) for other causes.

In as-treated analysis, admission rates for DaVita Rx enrollees and matched control patients were 1.76 and 1.91 admissions per year, respectively. Regarding hospital days, rates for enrollees and matched control patients were 10.4 and 12.2 days per patient-year, respectively. The all-cause admission and hospital day relative rates for enrollees versus control patients were 0.93 (95% CI, 0.90-0.96) and 0.86 (95% CI, 0.82-0.90), respectively. All-cause admission and hospital day relative rates became more protective as follow-up elapsed. Cause-specific relative rates were homogeneous.

Dispensed Medication

Percentages of patients with one or more Part D–covered fill during as-treated follow-up are listed in Table 4. Medications dispensed to >50% of enroll-

Table 2. Relative Hazards of Death for DaVita Rx Enrollees in Intention-to-Treat and As-Treated Analyses

	Intention-to-Treat			As-Treated		
	No.[a]	HR (95% CI)	P	No.[a]	HR (95% CI)	P
From index date[b]						
All months	8,864	0.92 (0.86-0.97)	0.003	8,864	0.79 (0.74-0.84)	<0.001
Months 1-6	8,864	0.81 (0.73-0.90)	<0.001	8,864	0.76 (0.68-0.85)	<0.001
Months 7-12	6,770	0.93 (0.84-1.04)	0.2	5,946	0.80 (0.70-0.91)	<0.001
Months 13-18	4,473	0.96 (0.83-1.10)	0.5	3,340	0.79 (0.66-0.93)	0.006
Months 19-24	2,667	1.07 (0.90-1.26)	0.4	1,706	0.78 (0.61-0.98)	0.03
Months 25-30	1,784	1.04 (0.84-1.29)	0.7	971	1.06 (0.79-1.41)	0.7
From 3 mo after the index date[c]						
All months	7,829	0.97 (0.91-1.03)	0.4	7,829	0.82 (0.76-0.88)	<0.001
Months 4-6	7,829	0.91 (0.79-1.05)	0.2	7,829	0.82 (0.71-0.95)	0.008
Months 7-12	6,770	0.94 (0.85-1.05)	0.3	5,946	0.81 (0.71-0.92)	<0.001
Months 13-18	4,473	0.97 (0.84-1.11)	0.7	3,340	0.79 (0.66-0.94)	0.007
Months 19-24	2,667	1.09 (0.92-1.28)	0.3	1,706	0.79 (0.62-0.99)	0.04
Months 25-30	1,784	1.06 (0.85-1.31)	0.6	971	1.06 (0.79-1.43)	0.7

Note: By start of follow-up (referent: matched control patients not enrolled in DaVita Rx).

Abbreviations: CI, confidence interval; HR, hazard ratio.

[a]DaVita Rx enrollees alive at beginning of the follow-up interval.

[b]In DaVita Rx enrollees and matched control patients.

[c]In the subset of DaVita Rx enrollees and matched control patients alive at 3 months after the index date.

ees were phosphate binders (89.1%), β-blockers (65.6%), angiotensin-converting enzyme inhibitors or angiotensin receptor blockers (58.5%), opioid analgesics (58.4%), and dihydropyridine calcium channel blockers (51.2%). Medications more likely dispensed to enrollees versus control patients included phosphate binders (crude odds ratio [OR], 1.89), cinacalcet (crude OR, 1.23), angiotensin-converting enzyme inhibitors or angiotensin receptor blockers (crude OR, 1.18), β-blockers (crude OR, 1.14), and dihydropyridine calcium channel blockers (crude OR, 1.13).

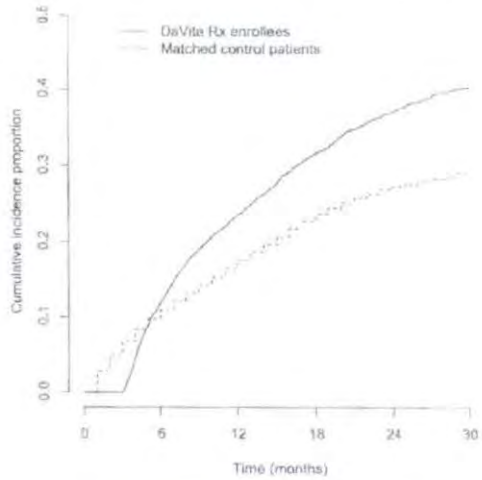

Figure 3. Estimates of cumulative incidence of DaVita Rx disenrollment in enrollees and new enrollment in matched control patients.

DISCUSSION

Patients with ESRD have high rates of death and hospitalization and account for >6% of Medicare costs, ~$33 billion dollars in 2009.[21] There is a continuing need to evaluate new models of care to improve health and reduce costs in this population. To our knowledge, this study is the first to evaluate clinical outcomes in hemodialysis patients who received medications and some medication therapy management services from a pharmacy program that was integrated with dialysis treatment. In intention-to-treat analysis with matched control patients, we found that patients who received program services were 8% less likely to die and accumulated 2% fewer hospital admissions and 6% fewer days. In as-treated analyses, associations were more pronounced; patients who received program services were 21% less likely to die and accumulated 7% fewer hospital admissions and 14% fewer hospital days. Associations in intention-to-treat analyses may be attenuated because analyses ignore both disenrollment from the pharmacy program (23% after 1 year) and new enrollment among control patients (17% after 1 year). However, associations in as-treated analyses may be exaggerated; if patients who discontinued were sicker than those who continued, risk ratios may be biased away from unity.

Dialysis patients typically have multiple comorbid conditions and take an average of 9 or 10 oral medications.[1-3] Medication coordination and delivery are complicated by clinical factors and the health care system. Many medications are excreted by the kidneys; clearance in ESRD is reduced, necessitating

Table 3. Absolute and Relative Rates of Hospital Admissions and Days in Intention-to-Treat and As-Treated Analyses

	Hospital Admissions				Hospital Days			
	Rate per Year				Rate per Year			
	Enrollees[a]	Controls	Relative Rate (95% CI)	P	Enrollees[a]	Controls	Relative Rate (95% CI)	P
Intention-to-treat								
All cause	1.84	1.88	0.98 (0.95-1.01)	0.2	11.1	11.8	0.94 (0.90-0.98)	0.003
Interval-specific								
Months 1-6	1.82	1.86	0.98 (0.94-1.02)	0.3	10.6	11.4	0.93 (0.88-0.99)	0.01
Months 7-12	1.87	1.91	0.98 (0.93-1.02)	0.4	11.4	12.3	0.92 (0.86-0.98)	0.01
Months 13-18	1.87	1.84	1.01 (0.95-1.07)	0.8	11.7	11.8	0.98 (0.90-1.06)	0.6
Months 19-24	1.89	1.90	0.99 (0.91-1.07)	0.7	11.7	12.2	0.94 (0.85-1.05)	0.3
Months 25-30	1.70	1.91	0.89 (0.81-0.98)	0.02	10.9	12.3	0.88 (0.76-1.01)	0.07
Cause-specific								
Cardiovascular	0.55	0.56	0.98 (0.93-1.03)	0.4	2.8	2.9	0.95 (0.89-1.01)	0.1
Infectious	0.41	0.42	0.98 (0.93-1.03)	0.3	3.5	3.7	0.93 (0.87-1.00)	0.05
Other	0.88	0.89	0.98 (0.94-1.02)	0.4	4.9	5.2	0.93 (0.88-0.99)	0.01
As-treated								
All cause	1.76	1.91	0.93 (0.90-0.96)	<0.001	10.4	12.2	0.86 (0.82-0.90)	<0.001
Interval-specific								
Months 1-6	1.80	1.88	0.96 (0.92-1.00)	0.05	10.4	11.6	0.90 (0.85-0.95)	<0.001
Months 7-12	1.76	1.93	0.92 (0.88-0.97)	0.001	10.3	12.6	0.82 (0.77-0.88)	<0.001
Months 13-18	1.70	1.90	0.91 (0.85-0.97)	0.006	10.4	12.4	0.85 (0.77-0.93)	<0.001
Months 19-24	1.71	1.97	0.89 (0.81-0.98)	0.01	10.5	12.9	0.83 (0.72-0.95)	0.006
Months 25-30	1.54	1.98	0.80 (0.71-0.91)	<0.001	9.1	13.1	0.72 (0.60-0.85)	<0.001
Cause-specific								
Cardiovascular	0.53	0.58	0.93 (0.88-0.98)	0.006	2.6	3.0	0.88 (0.83-0.94)	<0.001
Infectious	0.39	0.43	0.91 (0.86-0.96)	<0.001	3.2	3.9	0.84 (0.78-0.90)	<0.001
Other	0.84	0.91	0.94 (0.90-0.98)	0.003	4.5	5.4	0.85 (0.81-0.90)	<0.001

Note: Referent group for relative rates comprises the matched control patients not enrolled in DaVita Rx.
Abbreviation: CI, confidence interval.
[a]DaVita Rx enrollees.

dose adjustment. Absorption, distribution, and metabolism characteristics of medications can be affected by decreased kidney function. Adding to the complexity of dose selection is the dialysis procedure itself. Many medications are removed to some extent by dialysis, so dosing schedules must account for modality (ie, hemodialysis vs peritoneal dialysis) and, in the case of hemodialysis, session duration and dialysis filter characteristics.

Moreover, health care services for dialysis patients inevitably are fragmented. Health care occurs at multiple sites, including outpatient dialysis facilities, outpatient clinics, emergency departments, and acute care hospitals.[22,23] Dialysis facilities monitor hemodialysis patients 3 or more times per week, but other facilities cannot readily access salient information, including currently prescribed medications. Importantly, dialysis patients are hospitalized for an average of 12 days per year.[24] Transitions between inpatient stays and outpatient dialysis increase the risk of adverse drug events.[23] Care also is provided by multiple physicians, some of whom may lack detailed knowledge about ESRD. In one study, dialysis patients saw an average of 4.7 physicians.[25]

Unsurprisingly, many studies have found that dialysis patients experience a multitude of medication-related problems, including inappropriate laboratory monitoring, over- or underdosage, drug use without indication, failure to receive medication, and drug interactions.[4,11] Nonadherence also is widespread.[7,8] Patients with ESRD appear to be relatively less medication adherent than other patient populations.[26] A recent review noted that barriers to medication adherence in patients with ESRD include pill burden; demographic, socioeconomic, and psychosocial factors; health literacy; health beliefs; and patient satisfaction.[13] More specifically, in a survey of 1,662 dialysis patients in Georgia and North Carolina, the following factors were cited most commonly as barriers to medication adherence: lack of payment options (prevalence, 42%), lack of medication delivery (40%), lack of refill reminders (38%), insufficient availability of dialysis-related medications at local pharmacies (32%), and lack of preauthorization assistance (26%).[27]

DaVita Rx was created to improve medication coordination and delivery and provide some medication therapy management services for patients who receive dialysis treatment at DaVita facilities. By

Table 4. Percentages of DaVita Rx Enrollees and Matched Control Patients With One or More Part D–Covered Fills During As-Treated Follow-up

	DaVita Rx Enrollees (%)	Control Patients (%)	OR[a]
Antibiotic agents			
Azithromycin	20.5	21.1	0.97
First-generation cephalosporin	14.5	15.8	0.90
Fluoroquinolone	29.8	31.0	0.94
Penicillin	20.7	22.3	0.91
Bone and mineral metabolism agents			
Cinacalcet	47.9	42.9	1.23
Phosphate binder	89.1	81.3	1.89
Cardiovascular agents			
Hematologic agents			
Clopidogrel	16.7	16.6	1.01
Warfarin	10.2	10.6	0.96
Antihypertensive agents			
Central α-agonist	29.1	28.5	1.03
ACE inhibitor or ARB	58.5	54.5	1.18
ACE inhibitor	43.3	40.8	1.10
ARB	23.9	22.0	1.11
β-Blocker	65.6	62.5	1.14
α-β-Blocker[b]	26.7	26.2	1.03
Cardioselective β-blocker[c]	43.3	41.6	1.07
DHP calcium channel blocker	51.2	48.2	1.13
Loop diuretic	13.2	12.7	1.05
Nitrate	15.5	16.0	0.96
Vasodilator[d]	23.4	22.4	1.06
Statin	36.1	34.2	1.09
Antidiabetic agents			
Insulin	27.7	28.3	0.97
Sulfonylurea	11.7	11.5	1.02
Thiazolidinedione	9.4	8.7	1.08
Gastrointestinal agents			
Metoclopramide	18.4	18.5	0.99
Promethazine	11.7	11.7	1.00
Antiulcer agents			
H_2 antagonist	12.1	12.2	0.99
Proton pump inhibitor	45.4	44.2	1.05
Other agents			
β-Agonist	15.8	16.2	0.97
Anticonvulsant	19.8	19.8	1.00
Levothyroxine	9.1	9.3	0.97
Opioid analgesic	58.4	59.4	0.96
Selective serotonin reuptake inhibitor	16.1	16.3	0.98

Note: By medication class.

Abbreviations: ACE, angiotensin-converting enzyme; ARB, angiotensin receptor blocker; DHP, dihydropyridine; H_2, histamine type 2; OR, odds ratio.

[a]Crude OR of 1 or more fills for DaVita Rx enrollees versus matched controls.

[b]Carvedilol and labetalol.

[c]Acebutolol, atenolol, betaxolol, bisoprolol, esmolol, metoprolol, and nebivolol.

[d]Hydralazine and minoxidil.

2006, DaVita Rx implemented features to improve medication access, including no-cost delivery to the dialysis facility or home (as permitted by law); waived copayments for patients who receive the Medicare Part D low-income subsidy; and refill management. In the case of refill management, an algorithm alerts patients of upcoming refills and patients confirm need. DaVita Rx later added services to reduce medication-related problems and increase adherence, including proactive medication list reviews, especially at enrollment, and telephonic medication therapy management (upon patient request) with clinical pharmacists trained in dialysis patient care. The program also provided assistance in obtaining prior authorization for prescriptions and comparing Medicare Part D plan features, including formulary composition. Administrative services potentially are important because plans that lack familiarity with dialysis patients may use acquisition barriers that limit access to dialysis-related medications.[28] Part D plan sponsors also may offer medication therapy management services to dialysis patients, although the level of services varies.[29] However, such services are not coordinated with dialysis treatment.

Rates of hospital admissions ranged from 2%-7% lower in DaVita Rx enrollees versus matched control patients, and corresponding rates of hospital days ranged from 6%-14% lower. These associations are qualitatively similar to effects reported by Pai et al[17] in a small trial (n = 104 hemodialysis patients) of bimonthly clinical pharmacist care consisting of medication list reviews, identification and resolution of medication-related problems, and both patient and provider education. We found that relative rates of hospitalization were homogeneous across causes of admission, in contrast to our expectation that rates of admission due to infection would not be associated with pharmacy program enrollment. Dialysis-related infections usually are treated with intravenous antibiotics administered during dialysis. Furthermore, DaVita Rx enrollees are advised to fill oral antibiotic prescriptions at retail pharmacies to avoid mail delivery delays. Interestingly, we found that enrollees were less likely to be dispensed oral antibiotics. These observations warrant further analysis, including studies of detailed causes of admission and readmission and of unmeasured sources of confounding (eg, facility practices) that might underlie lower infection risk. Because of the influence of hospitalization on economic outcomes, studies of relative Medicare costs also are warranted.

We found that medications most commonly filled by DaVita Rx enrollees were for bone and mineral disorder, pain, cardiovascular disease, and acid reflux. Enrollees were much more likely than control patients to fill cinacalcet and phosphate-binder prescriptions

and modestly more likely to fill antihypertensive agent prescriptions. Randomized trials suggest that cinacalcet and calcium channel blockers lower the risk of cardiovascular events in hemodialysis patients, and observational evidence suggests that phosphate binders lower the risk of death.[30-32] Thus, protective associations we found may be mediated by differences in medication use between DaVita Rx enrollees and control patients.

This study has several limitations. First, patients were not randomly assigned to receive DaVita Rx services. We used matching to control measured differences and restricted analyses to patients with dual eligibility to reduce confounding by unmeasured socioeconomic factors, but we cannot eliminate the possibility of confounding by other unmeasured factors (eg, self-care behaviors). Second, associations in as-treated analyses may be biased because of informative censoring by DaVita Rx disenrollment. It is reasonable to speculate that medication adherence was lower for patients who stopped using DaVita Rx services than for patients who continued. In tandem with the high incidence of disenrollment, this possibility suggests that associations in later follow-up intervals should be interpreted with caution. Third, we lacked data regarding use of DaVita Rx services, thereby precluding identification of individual components that were most closely correlated with outcomes. In particular, we lacked data regarding site of medication delivery (ie, facility or home), and data regarding medication therapy management services provided to control patients. Further analysis of potential mechanisms underlying the observed associations is needed before policy decisions are made.

Dialysis patients likely experience more fragmentation in medication-related services and care today than they did before implementation of Medicare Part D in 2006 and the ESRD prospective payment system in 2011. In this study, receipt of integrated pharmacy services was associated with lower rates of death and hospitalization in hemodialysis patients with dual eligibility. The Affordable Care Act established the Centers for Medicare & Medicaid Services (CMS) Innovation Center to improve health care outcomes at reduced costs.[33] CMS is interested in testing innovative models to achieve these goals. The evolving ESRD prospective payment system and related Quality Incentive Program for outpatient dialysis facilities can be leveraged to encourage more cost-effective management of drugs in the future. This study provides a foundation for further clinical and economic outcomes research regarding coordination of medication-related services for dialysis patients.

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Appendix 20

Corporate Integrity Agreement

EX-10.1 2 d807612dex101.htm EX-10.1

Exhibit 10.1

CORPORATE INTEGRITY AGREEMENT
BETWEEN THE
OFFICE OF INSPECTOR GENERAL
OF THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
AND
DAVITA HEALTHCARE PARTNERS INC.

I. PREAMBLE

DaVita HealthCare Partners Inc. and its U.S. wholly-owned and partially-owned subsidiaries and joint ventures in which DaVita HealthCare Partners Inc. owns an interest that provide dialysis services, whether directly or indirectly owned by DaVita HealthCare Partners Inc., with the exception of the joint ventures listed in Appendix E (collectively "DaVita") hereby enters into this Corporate Integrity Agreement (CIA) with the Office of Inspector General (OIG) of the United States Department of Health and Human Services (HHS) to promote compliance with the statutes, regulations, and written directives of Medicare, Medicaid, and all other Federal health care programs (as defined in 42 U.S.C. § 1320a-7b (f)) (Federal health care program requirements). Contemporaneously with this CIA, DaVita is entering into a Settlement Agreement with the United States.

II. TERM AND SCOPE OF THE CIA

A. The period of the compliance obligations assumed by DaVita under this CIA shall be five years from the effective date of this CIA ("CIA Period"). The "Effective Date" shall be the date on which the final signatory of this CIA executes this CIA. Each one-year period, beginning with the one-year period following the Effective Date, shall be referred to as a "Reporting Period."

B. Sections VII, X, and XI shall expire no later than 120 days after OIG's receipt of: (1) DaVita's final Annual Report, or (2) any additional materials submitted by DaVita pursuant to OIG's request, whichever is later.

C. The scope of this CIA shall be governed by the following definitions:

1. "Arrangements" shall mean every arrangement or transaction that involves, directly or indirectly, the offer, payment, solicitation, or receipt of anything of value, and is between DaVita Dialysis and any actual or potential source of health care business or referrals to DaVita Dialysis or any actual or potential recipient of health care business or referrals from DaVita Dialysis. The term "source of health care business or referrals" shall mean any individual or entity that refers, recommends, arranges for,

orders, leases, or purchases any good, facility, item, or service for which payment may be made in whole or in part by a Federal health care program, and the term "recipient of health care business or referrals" shall mean any individual or entity: (1) to whom DaVita Dialysis refers an individual for the furnishing or arranging for the furnishing of any item or service; or (2) from whom DaVita Dialysis purchases, leases, or orders or arranges for or recommends the purchasing, leasing, or ordering of any good, facility, item, or service for which payment may be made in whole or in part by a Federal health care program.

2. "Arrangements Covered Persons" includes each Covered Person who is involved with the development, approval, management, negotiation, execution, implementation, or review of DaVita Dialysis's Arrangements. This definition does not include Facility Administrators whose sole involvement with Arrangements consists of working with Health Care Providers in implementing an Arrangement with DaVita Dialysis.

3. "Business Courtesies" means meals, gifts, and other gratuities, excluding educational and promotional materials.

4. "Certifying Executive" means each Covered Person who is an officer, president, general manager, vice president, group senior vice president, division vice president, or other Covered Person whose position is equivalent to or above a division vice president.

5. "Clinic Covered Persons" means all Covered Persons employed at a DaVita Dialysis clinic except the Facility Administrators.

6. "Compliance Program Review" means the review performed by the Compliance Advisor in accordance with Appendix A.

7. "Covered Executive" means each Covered Person who is an officer, president, senior vice president, or other Covered Person whose position is equivalent to or above a senior vice president.

8. "Covered Persons" includes:

a. all owners of DaVita who are natural persons (other than shareholders who: (1) have an ownership interest of less than 5% and (2) acquired the ownership interest through public trading or in connection with the operation of employee incentive programs);

b. all officers, directors, and employees of DaVita who are responsible for or work for DaVita Dialysis;

c. all contractors, subcontractors, agents, and other persons who provide patient care items or services or who perform billing or coding functions on behalf of DaVita Dialysis, excluding vendors whose sole connection with DaVita is selling or otherwise providing medical supplies or equipment to DaVita and who do not bill the Federal health care programs for such medical supplies or equipment; and

d. all domestic dialysis clinic Joint Venture Partners and Medical Directors.

Notwithstanding the above, this term does not include part-time or per diem employees, contractors, subcontractors, agents, and other persons (other than Medical Directors) who are not reasonably expected to work more than 160 hours during a Reporting Period, except that any such individuals shall become "Covered Persons" at the point when they work more than 160 hours during a Reporting Period. This term also does not include contractors, subcontractors, agents, and other persons (other than Medical Directors) who only provide diagnostic services, facility services and supplies, home medical equipment, laboratory services, pharmacy services, and transportation and ambulance services.

9. "DaVita Dialysis" means DaVita's domestic dialysis business and clinics, and all DaVita functions that provide support to DaVita's domestic dialysis business and clinics, excluding IT personnel other than IT personnel who develop software and systems, employee benefits personnel, and facility services personnel who provide administrative support for DaVita's corporate business offices.

10. "Executive Financial Recoupment Program" means the financial recoupment program required by Appendix D that puts at risk of forfeiture and recoupment an amount equivalent to up to three years of annual performance pay (*e.g.*, annual bonus, plus long-term incentives) for a Covered Executive who is discovered to have been involved in any significant misconduct.

11. "Focus Arrangements" means every Arrangement that is between DaVita Dialysis and any Health Care Provider and involves, directly or indirectly, the offer, payment, or provision of anything of value. Notwithstanding the foregoing, "Focus Arrangements" shall not include:

a. single patient agreements, stat lab agreements, or transfer agreements that DaVita Dialysis enters into with a hospital or related corporate entity, or

b Business Courtesies extended by DaVita Dialysis, except those Business Courtesies extended by Certifying Employees, DaVita Dialysis business development personnel, and DaVita Dialysis Regional Operations Directors.

12. "Health Care Provider" means: (1) any individual nephrologist or physician practice; (2) any hospital or related corporate entity that is or has entered into a Letter of Intent with DaVita Dialysis to become a Joint Venture Partner; or (3) any joint venture in which DaVita owns an interest that provides dialysis services, whether directly or indirectly owned by DaVita.

13 "Joint Venture De Novo" means any transaction in which DaVita partners with a Health Care Provider to establish and jointly own one or more new dialysis clinics or programs prior to Medicare certification.

14. "Joint Venture Partner" means a Health Care Provider who owns a percentage, directly or indirectly, whether through shares, membership interests, or other ownership means, of a DaVita Dialysis clinic or holding company that owns an interest in a DaVita Dialysis clinic.

15. "Medical Director" means a nephrologist or nephrology practice that provides the medical director services required by Medicare regulations (*e.g.*, 42 C.F.R. § 494.150) to a DaVita Dialysis clinic.

16. "Multi-Specialty Practice" means a physician practice group that includes physicians who practice in general medicine/primary care and/or more than one specialty area. If physicians who specialize in nephrology are included in the Multi-Specialty Practice, they must represent less than 20% of the practice group's physician members.

17. "Partial Acquisition" means any transaction in which DaVita acquires a direct or indirect interest of less than 100% in one or more dialysis clinics or programs.

18. "Partial Divestiture" means any transaction in which the ownership interest held directly or indirectly by DaVita in one or more dialysis clinics or programs is reduced, but remains greater than 0%.

19. "Risk Determination" means: (a) the Independent Monitor's decision regarding whether the proposed Focus Arrangement presents a low risk or a high risk of violating the laws and regulations governing the Federal health care programs, including the False Claims Act and the Anti-Kickback Statute; or (b) the Independent Monitor's determination that he or she is unable to make such a conclusion.

20. "Subject Joint Venture Clinics" means the joint venture clinics listed in Appendix B to this CIA.

21. "Valuation Methodologies" means the collections of processes used to price a Focus Arrangement, including the template financial models used in those processes, standards concerning the methodology for calculating and documenting the inputs to those models when customized to specific transactions, and procedures for evaluating the output from those models.

III. CORPORATE INTEGRITY OBLIGATIONS

DaVita shall establish and maintain a Compliance Program that includes the following elements:

A. Chief Compliance Officer and Management Compliance Committee

1. *Chief Compliance Officer*. DaVita has appointed a Covered Person to serve as its Chief Compliance Officer and shall maintain a Chief Compliance Officer for the CIA Period. The Chief Compliance Officer shall be responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements set forth in this CIA and with Federal health care program requirements. The Chief Compliance Officer shall be a member of senior management of DaVita, shall report directly to the Chief Executive Officer of DaVita and the Chairman of the Compliance Committee of the Board of Directors of DaVita (the "Board"), shall make periodic (at least quarterly) reports regarding compliance matters directly to the Compliance Committee of the Board of Directors ("Board Compliance Committee"), and shall be authorized to report on such matters to the Board or the Board Compliance Committee at any time. Written documentation of the Chief Compliance Officer's reports to the Board Compliance Committee shall be made available to OIG upon request. The Chief Compliance Officer shall not be or be subordinate to the Chief Legal Officer or Chief Financial Officer or have any responsibilities that involve acting in any capacity as legal counsel or supervising legal counsel functions for DaVita. The Chief Compliance Officer shall be responsible for monitoring the day-to-day compliance

activities engaged in by DaVita Dialysis as well as for any reporting obligations created under this CIA. Any noncompliance job responsibilities of the Chief Compliance Officer shall be limited and must not interfere with the Chief Compliance Officer's ability to perform the duties outlined in this CIA.

DaVita shall report to OIG, in writing, any changes in the identity or position description of the Chief Compliance Officer, or any actions or changes that would affect the Chief Compliance Officer's ability to perform the duties necessary to meet the obligations in this CIA, within five days after such a change.

2. *Management Compliance Committee*. DaVita has appointed and shall maintain for the CIA Period a Management Compliance Committee. The Management Compliance Committee shall, at a minimum, include the Chief Compliance Officer and other members of DaVita Dialysis's senior management necessary to meet the requirements of this CIA (*e.g.*, senior executives of DaVita Dialysis Corporate Development, billing, clinical, human resources, audit, and operations). The Chief Compliance Officer shall chair the Management Compliance Committee, and the Management Compliance Committee shall support the Chief Compliance Officer in fulfilling his/her responsibilities (*e.g.*, shall assist in the analysis of DaVita Dialysis's risk areas and shall oversee monitoring of internal and external audits and investigations). The Management Compliance Committee shall meet at least quarterly. The minutes of the Management Compliance Committee meetings shall be made available to OIG upon request.

DaVita shall report to OIG, in writing, any changes in the composition of the Management Compliance Committee, or any actions or changes that would affect the Management Compliance Committee's ability to perform the duties necessary to meet the obligations in this CIA, within 15 days after such a change.

3. *Board of Directors Compliance Obligations*. The Board Compliance Committee shall be responsible for the review and oversight of matters related to compliance with Federal health care program requirements and the obligations of this CIA. The Board Compliance Committee is currently comprised solely of independent (*i.e.*, non-executive) members and shall continue to be comprised solely of independent members for the CIA Period. The Board Compliance Committee has now and shall maintain for the CIA Period the ability to retain, at its sole discretion, outside compliance counsel.

The Board Compliance Committee shall, at a minimum, be responsible for the following:

a. The Board Compliance Committee shall meet at least quarterly to review and oversee DaVita Dialysis's

Compliance Program, including, but not limited to, the performance of the Chief Compliance Officer, Management Compliance Committee, and the Compliance Department.

b. The Board Compliance Committee shall meet at least quarterly in executive session with the Chief Compliance Officer.

c. The Board Compliance Committee shall, within 90 days of the second anniversary of the Effective Date, retain a person or entity who meets the qualifications set forth in Appendix A as its Compliance Advisor. Beginning with the third Reporting Period of the CIA, the Compliance Advisor shall review the effectiveness of DaVita Dialysis's Compliance Program and Risk Assessment and Mitigation Process for DaVita Dialysis (Compliance Program Review) and provide the Board with a Compliance Program Review Report for the remaining Reporting Periods of the CIA. The Board shall consider the Compliance Program Review Report as part of its review and assessment of DaVita Dialysis's Compliance Program.

d. The Board Compliance Committee shall, for each Reporting Period of the CIA, adopt a resolution, signed by each member of the Board Compliance Committee summarizing its review and oversight of DaVita Dialysis's compliance with Federal health care program requirements and the obligations of this CIA.

At minimum, the resolution shall include the following language:

"The Compliance Committee of the Board of Directors has made a reasonable inquiry into the operations of DaVita Dialysis's Compliance Program including the performance of the Chief Compliance Officer and the Management Compliance Committee. Based on its inquiry and review, the Board Compliance Committee has concluded that, to the best of its knowledge, DaVita Dialysis has implemented an effective Compliance Program to meet Federal health care program requirements and the obligations of the CIA."

If the Board Compliance Committee is unable to provide such a conclusion in the resolution, the Board Compliance Committee shall include in the resolution a written explanation of the reasons why it is unable to provide the conclusion and the steps it is taking to implement an effective Compliance Program at DaVita Dialysis.

DaVita shall report to OIG, in writing, any changes in the composition or leadership of the Board Compliance Committee, or any actions or changes that would affect the Board Compliance Committee's ability to perform the duties necessary to meet the obligations in this CIA, within 15 days after such a change.

4. *Management Accountability and Certifications*. In addition to the responsibilities set forth in this CIA for all Covered Persons, Certifying Executives are specifically expected to monitor and oversee activities within their areas of authority and shall annually certify that the functional area is compliant with applicable Federal health care program requirements and with the obligations of this CIA. To the extent that a functional area is not covered by the certification of a Certifying Executive, the person in charge of that functional area shall certify.

For each Reporting Period, each Certifying Executive or person in charge of the applicable functional area shall sign a certification that states:

"I have been trained on and understand the compliance requirements and responsibilities as they relate to [functional area], an area under my supervision. My job responsibilities include ensuring compliance with regard to the [functional area] with all applicable Federal health care program laws and regulations, obligations of the Corporate Integrity Agreement, and applicable DaVita HealthCare Partners policies, and I have taken steps to promote such compliance. In the event that I have identified potential issues of noncompliance with these requirements, I have referred all such issues consistent with the processes of DaVita HealthCare Partners for reporting potential misconduct for further review and follow-up. Apart from those referred issues, and any issues of which I have been made aware by DaVita HealthCare Partners' counsel because they have been brought to the attention of OIG, any other relevant government agency or entity, or the CIA Monitor, I am not currently aware of any violations of applicable Federal health care program laws and regulations, obligations of the Corporate Integrity Agreement, or the requirements of the policies of DaVita HealthCare Partners. I understand that this certification is being provided to and relied upon by the United States."

If any Certifying Executive or person in charge of the applicable functional area is unable to provide such a conclusion in the certification, the Certifying Executive or person in charge of the applicable functional area shall provide a written explanation of the reasons why he or she is unable to provide the certification outlined above and the steps being taken to address the issue(s) identified in the written explanation.

B. Written Standards

1. *Code of Conduct*. Prior to the Effective Date, DaVita developed, implemented, and distributed a written Code of Conduct for DaVita Dialysis to all Covered Persons. During the CIA Period, DaVita Dialysis shall make the performance of job responsibilities in a manner consistent with the Code of Conduct an element in evaluating the performance of all employed Covered Persons and shall implement a policy requiring that all contracted Covered Persons perform job responsibilities in a manner consistent with the Code of Conduct. The Code of Conduct shall, at a minimum, set forth:

a. DaVita's commitment to full compliance with all Federal health care program requirements;

b. DaVita's requirement that all of its Covered Persons shall be expected to comply with all Federal health care program requirements and with DaVita's own Policies and Procedures;

c. the requirement that all of DaVita's Covered Persons shall be expected to report to the Chief Compliance Officer, or other appropriate individual designated by DaVita, suspected violations of any Federal health care program requirements or of DaVita's own Policies and Procedures; and

d. the right of all individuals to use the Disclosure Program described in Section III.L, and DaVita's commitment to nonretaliation and to maintain, as appropriate, confidentiality and anonymity with respect to such disclosures.

Within 90 days after the Effective Date, each Covered Person shall certify, in writing or in electronic form, that he or she has received, read, understood, and shall abide by DaVita Dialysis's Code of Conduct. New Covered Persons shall receive the Code of Conduct in hard copy or electronic form and shall complete the required certification within 30 days after becoming a Covered Person or within 90 days after the Effective Date, whichever is later.

DaVita shall periodically review the Code of Conduct to determine if revisions are appropriate and shall make any necessary revisions based on such review. The Code of Conduct shall be distributed in hard copy or electronic form at least annually to all Covered Persons.

2. *Policies and Procedures*. Within 90 days after the Effective Date, DaVita shall implement written Policies and Procedures regarding the operation of its

compliance program for DaVita Dialysis, including the compliance program requirements outlined in this CIA and compliance with Federal health care program requirements. The Policies and Procedures also shall address:

a. 42 U.S.C. § 1320a-7b(b) (Anti-Kickback Statute) and the regulations and other guidance documents related to that statute, and business or financial arrangements or contracts that generate unlawful Federal health care program business in violation of the Anti-Kickback Statute; and

b. the requirements set forth in Section III.D (Compliance with the Anti-Kickback Statute).

Within 90 days after the Effective Date, the Policies and Procedures shall be made available in hard copy or electronic form to all Covered Persons. Appropriate and knowledgeable staff shall be available to explain the Policies and Procedures.

At least annually (and more frequently, if appropriate), DaVita shall assess and update, as necessary, the Policies and Procedures. Within 30 days after the effective date of any revisions, a description of the revisions shall be communicated to all affected Covered Persons and any revised Policies and Procedures shall be made available to all Covered Persons in hard copy or electronic form.

C. Training and Education

1. *General Training*. Within 90 days after the Effective Date, DaVita Dialysis shall provide at least one hour of General Training to each Covered Person, except Clinic Covered Persons. DaVita Dialysis shall provide at least one hour of General Training to Clinic Covered Persons within the first Reporting Period. This training, at a minimum, shall explain DaVita's:

a. CIA requirements; and

b. Compliance Program, including the Code of Conduct.

New Covered Persons shall receive the General Training described above within 30 days after becoming a Covered Person or within 90 days after the Effective Date, whichever is later. New Clinic Covered Persons shall receive General Training within 60 days after they become new Clinic Covered Persons. After receiving the initial General Training described above, each Covered Person shall receive at least one hour of General Training in each subsequent Reporting Period.

2. *Arrangements Training*. Within 90 days after the Effective Date, each Arrangements Covered Person shall receive at least three hours of Arrangements Training, in addition to the General Training required above. The Arrangements Training shall include a discussion of:

a. Arrangements that potentially implicate the Anti-Kickback Statute, as well as the regulations and other guidance documents related to that statute;

b. DaVita Dialysis's policies, procedures, and other requirements relating to Arrangements and Focus Arrangements, including, but not limited to, the Focus Arrangements Tracking System, the internal review and approval process, and the tracking of remuneration to and from sources of health care business or referrals pursuant to Focus Arrangements as required by Section III.D of the CIA;

c. the personal obligation of each individual involved in the development, approval, management, negotiation, execution, implementation, or review of DaVita Dialysis's Arrangements to know the applicable legal requirements and DaVita Dialysis's policies and procedures;

d. the legal sanctions under the Anti-Kickback Statute; and

e. examples of violations of the Anti-Kickback Statute.

New Arrangements Covered Persons shall receive this training within 30 days after the beginning of their employment or becoming Arrangements Covered Persons, or within 90 days after the Effective Date, whichever is later. New Arrangements Covered Persons shall not develop, approve, manage, negotiate, execute, implement, or review DaVita Dialysis's Arrangements until after they have completed the Arrangements Training.

After receiving the initial Arrangements Training described in this Section, each Arrangements Covered Person shall receive at least two hours of Arrangements Training, in addition to the General Training, in each subsequent Reporting Period.

3. *Board Member Training*. Within 90 days after the Effective Date, DaVita shall provide at least two hours of training to each member of the Board of Directors, in addition to the General Training. This training shall address the responsibilities of board members and corporate governance.

New members of the Board of Directors shall receive the Board Member Training described above within 30 days after becoming a member or within 90 days after the Effective Date, whichever is later.

4. *Certification*. Each individual who is required to attend training shall certify, in writing or in electronic form, that he or she has received the required training. The certification shall specify the type of training received and the date received. The Chief Compliance Officer (or designee) shall retain the certifications, along with one copy of all course materials.

5. *Qualifications of Trainer*. Persons preparing or providing the training shall be knowledgeable about the subject area. Persons preparing or providing the Arrangements Training shall have expertise in the Anti-Kickback Statute, as well as the regulations, directives, and guidance related to that law.

6. *Update of Training*. DaVita shall review the training annually and, where appropriate, update the training to reflect changes in Federal health care program requirements, any pertinent issues discovered during internal audits, the Compliance Program Review, the Monitor's findings and reviews, and any other relevant information.

7. *Computer-based Training*. DaVita may provide the training required under this CIA through appropriate computer-based training approaches. If DaVita chooses to provide computer-based training, it shall make available appropriately qualified and knowledgeable staff or trainers to answer questions or provide additional information to the individuals receiving such training.

8. *Training of Medical Directors and Joint Venture Partners*. DaVita Dialysis shall make the General Training described in Section III.C.1 available to all of its Medical Directors and Joint Venture Partners and shall require them to complete it. If, under existing Focus Arrangements, DaVita does not have the authority to require the Medical Directors and Joint Venture Partners to complete the training, it shall use its best efforts to encourage such Medical Directors and Joint Venture Partners to complete the training. The Chief Compliance Officer shall maintain records of all active Medical Directors and Joint Venture Partners who receive training, including the type of training and the date received. These records shall be made available to OIG upon request.

D. Compliance with the Anti-Kickback Statute

DaVita is responsible for ensuring that the following obligations are met:

1. *Selection Process and Selection Criteria.*

a. Within 90 days after the Effective Date, DaVita Dialysis shall develop a process for documenting the selection of Health Care Providers with whom it enters into Focus Arrangements other than Business Courtesies.

The Selection Process for each type of Focus Arrangement shall include:

i. a mechanism by which DaVita Dialysis identifies Health Care Providers for possible selection;

ii. confirmation that each Health Care Provider considered meets designated Selection Criteria, as defined in Section III.D.1.b, below, specific to the type of Focus Arrangement; and

iii. DaVita Dialysis's rationale for choosing the Health Care Provider ultimately selected for entry into a particular Focus Arrangement.

b. Within 90 days after the Effective Date, DaVita Dialysis shall develop criteria to guide its selection of Health Care Providers with whom it enters into Focus Arrangements other than Business Courtesies ("Selection Criteria"). DaVita Dialysis shall develop Selection Criteria for each type of Focus Arrangement that it enters into with Health Care Providers. For joint venture Focus Arrangements, separate Selection Criteria shall be developed for each type of joint venture that DaVita enters into (*e.g.*, Partial Acquisition, Partial Divestiture, Joint Venture De Novo). The Selection Criteria shall relate to a Health Care Provider's eligibility and ability to perform the functions required in connection with each such type of Focus Arrangement, and shall not include a Health Care Provider's ability to refer patients to DaVita.

c. The Monitor shall review and approve the Selection Process and Selection Criteria. During the first two Reporting

Periods, the Monitor also shall prospectively review and approve any modifications or changes to the Selection Process or Selection Criteria. The requirements of this subsection shall apply to the third Reporting Period if OIG exercises its discretion to extend the Monitor's authority pursuant to Section I of Appendix C to the CIA.

d. DaVita Dialysis shall maintain and continue to apply its Selection Process and Selection Criteria throughout the CIA Period.

e. Section III.D.1 and Section III.D.2 shall not apply to Focus Arrangements in which a Health Care Provider contracts with DaVita Dialysis solely for the provision of management services and has no other Focus Arrangements with DaVita Dialysis.

2. *Valuation Methodologies.*

a. Within 90 days after the Effective Date, DaVita Dialysis shall examine the Valuation Methodologies it uses to price each type of Focus Arrangement, except Business Courtesies, and shall revise each such methodology if necessary to comply with the Anti-Kickback Statute and the requirements of this CIA. To the extent no Valuation Methodology exists for a type of Focus Arrangement, except Business Courtesies, that DaVita Dialysis enters into, DaVita Dialysis shall develop a Valuation Methodology to use in pricing that type of Focus Arrangement.

b. DaVita Dialysis shall obtain the Monitor's approval of each required Valuation Methodology, and any changes to those Valuation Methodologies during the first two Reporting Periods, prior to implementation.

c. During the CIA Period, DaVita Dialysis shall consistently apply the approved Valuation Methodologies to value each type of Focus Arrangement.

3. *Focus Arrangements Procedures*. In addition to the Valuation Methodologies, within 90 days after the Effective Date DaVita Dialysis shall examine its procedures and evaluate whether the procedures are reasonably designed to ensure that each existing and new or renewed Focus Arrangement does not violate the Anti-Kickback

Statute and the regulations and guidance related to the Anti-Kickback Statute (Focus Arrangements Procedures), and shall revise those procedures as necessary. These procedures shall include the following:

a. creating and maintaining a centralized tracking system for all existing and new or renewed Focus Arrangements (Focus Arrangements Tracking System);

b. tracking remuneration to and from all parties to Focus Arrangements;

c. tracking investments made by and estimated rates of return received during the CIA Period by all parties to all Partial Acquisition and Partial Divestiture transactions between DaVita Dialysis and a Health Care Provider (if applicable), except for those transactions that are part of the conduct released by the Settlement Agreement entered into between the United States and DaVita contemporaneously with this CIA;

d. tracking services and activities to ensure that parties to the Focus Arrangement are performing the services required under the applicable Focus Arrangement(s) (if applicable);

e. monitoring the use of leased space, medical supplies, medical devices, equipment, or other patient care items to ensure that such use is consistent with the terms of the applicable Focus Arrangement(s) (if applicable);

f. establishing and implementing a written review and approval process for all Focus Arrangements, except Business Courtesies, the purpose of which is to ensure that all new and existing or renewed Focus Arrangements do not violate the Anti-Kickback Statute, and that includes at least the following: (i) a legal review of all Focus Arrangements by counsel with expertise in the Anti-Kickback Statute, (ii) a process for specifying the business need or business rationale for all Focus Arrangements, and (iii) a process for determining and documenting the fair market value of the remuneration specified in the Focus Arrangement;

g. requiring the Chief Compliance Officer to review the Focus Arrangements Tracking System, internal review and approval

process, and other Focus Arrangements Procedures on at least an annual basis and to provide a report on the results of such review to the Board Compliance Committee; and

h. implementing effective responses when suspected violations of the Anti-Kickback Statute are discovered, including disclosing Reportable Events and quantifying and repaying Overpayments pursuant to Sections III.O and III.P when appropriate.

Notwithstanding the foregoing, DaVita shall have until the end of the first Reporting Period to identify and enter in the Focus Arrangements Tracking System all existing Focus Arrangements except (i) center transaction agreements; (ii) Medical Director agreements, (iii) leases, and (iv) consulting agreements; and to enter all data for items or services provided under the existing Focus Arrangements on or after the Effective Date. DaVita is not required to include in its Focus Arrangements Tracking System historical remuneration or performance data for items or services provided under the existing Focus Arrangements prior to the Effective Date.

4. *New or Renewed Arrangements Requirements*. Prior to entering into new Focus Arrangements or renewing (whether by operation of contract or negotiation) existing Focus Arrangements, except Business Courtesies, in addition to complying with the Focus Arrangements Procedures set forth above, DaVita Dialysis shall comply with the following requirements (Focus Arrangements Requirements):

a. ensure that each Focus Arrangement is set forth in writing and signed by DaVita Dialysis and the other parties to the Focus Arrangement;

b. include in the written agreement a requirement that each party to a Focus Arrangement who meets the definition of a Covered Person shall complete at least one hour of training regarding the Anti-Kickback Statute and examples of arrangements that potentially implicate the Anti-Kickback Statute. Additionally, DaVita Dialysis shall provide each party to the Focus Arrangement with a copy of its Code of Conduct and Policies and Procedures related to the Anti-Kickback Statute in hard copy or electronic form;

c. include in the written agreement a certification by the parties to the Focus Arrangement that the parties shall not violate the Anti-Kickback Statute with respect to the performance of the Arrangement; and

d. beginning 120 days from the Effective Date, during the first two Reporting Periods and for the first 120 days of the third Reporting Period, obtain from the Monitor a Risk Determination for each Focus Arrangement. During the first two Reporting Periods and for the first 120 days of the third Reporting Period, DaVita Dialysis shall not enter into or renew a Focus Arrangement until it has received a Risk Determination from the Monitor containing a conclusion that the proposed Focus Arrangement presents a low risk or a high risk of violating the laws and regulations governing the Federal health care programs, including the False Claims Act and the Anti-Kickback Statute. The requirements of this subsection shall apply to the remainder of the third Reporting Period if OIG exercises its discretion under Section I of Appendix C to the CIA to extend the Monitor's authority to make Risk Determinations under Section C of Appendix C to the CIA.

5. *Records Retention and Access*. DaVita Dialysis shall retain and make available to OIG, upon request, the Focus Arrangements Tracking System and all supporting documentation of the Focus Arrangements subject to this Section and, to the extent available, all non-privileged communications related to the Focus Arrangements and the actual performance of the duties under the Focus Arrangements.

E. Notice to Joint Venture Partners and Medical Directors

1. Within 90 days after the Effective Date, DaVita shall send, by first class mail with delivery confirmation, a notice approved by the Monitor to each Joint Venture Partner and Medical Director. Each notice should include the following information, to the extent applicable to the particular recipient:

a. Joint Venture Partners and Medical Directors, and their employees, colleagues, and contractors, are free to refer patients to and treat patients at non-DaVita-owned dialysis clinics;

b. DaVita will not enforce any patient-related non-disparagement or non-solicitation clauses contained in any of their existing agreements with DaVita; and

c. in connection with joint venture clinics formed by Partial Divestitures, DaVita will not enforce the investment non-compete provisions it may have in those joint venture and Medical Director agreements.

2. Within 90 days after the anniversary of the Effective Date in each subsequent Reporting Period, DaVita shall send, by first class mail, postage prepaid with delivery confirmation, the notice described in Section III.E.1 to each Joint Venture Partner and Medical Director. If DaVita changes or revises the wording of the letter, DaVita shall obtain, in the second Reporting Period, the approval of the Monitor and, in subsequent Reporting Periods, the approval of the OIG prior to sending the letter.

F. Unwinding of Subject Joint Venture Clinics

1. During the first Reporting Period, DaVita shall unwind the Subject Joint Venture Clinics. DaVita may unwind the Subject Joint Venture Clinics by:

a. selling its interest in the Subject Joint Venture Clinic, at a price within the range of fair market value, to its nephrologist or nephrology practice partners;

b. purchasing its nephrologist or nephrology practice partners' interest in the Subject Joint Venture Clinic, at a price within the range of fair market value;

c. selling its interest in a Subject Joint Venture Clinic, at a price within the range of fair market value, to an independent third party; or

d. selling the full interest of the Subject Joint Venture Clinic, at a price within the range of fair market value, to an independent third party, which would buy out all Joint Venture Partners.

2. DaVita shall obtain the Monitor's approval for each transaction involved in the unwinding of the Subject Joint Venture Clinics prior to the transaction's closure and/or execution.

3. In the event that DaVita is not able to unwind a Subject Joint Venture Clinic prior to the end of the first Reporting Period, the Monitor may provide a certification that DaVita has acted in good faith to unwind the Subject Joint Venture Clinic. The Monitor shall provide such a certification only if she or he determines that DaVita has actively pursued in good faith all avenues for unwinding the Subject Joint Venture Clinic listed in Section III.F.1 above and that DaVita's failure to complete the unwind is due to circumstances beyond its control. In making this determination, the Monitor may consider the conduct of the other parties to the Subject Joint Venture Clinic.

4. During the term of the CIA, DaVita shall not enter into any Partial Divestitures, unless expressly permitted by Section III.F.5, below.

5. Notwithstanding Section III.F.4 of this CIA, DaVita is expressly permitted to enter into the following:

a. Joint Venture De Novo arrangements;

b. Any joint venture formed by selling a direct or indirect interest in a DaVita dialysis clinic to a Multi-Specialty Practice and/or hospital;

c. Any joint venture formed by selling a direct or indirect interest in a DaVita dialysis clinic to a Multi-Specialty Practice and a nephrologist or nephrology practice;

d. Any joint venture formed by selling a direct or indirect interest in a DaVita dialysis clinic to a hospital and a nephrologist or nephrology practice;

e. Any joint venture formed by selling a direct or indirect interest in a DaVita dialysis clinic to a hospital and a Multi-Specialty Practice and a nephrologist or nephrology practice;

f. Any transaction pursuant to which DaVita is required under the existing agreements related to the joint ventures listed in Appendix F to sell, offer to sell, or otherwise transfer some of its membership interests to another party;

g. Any transaction in which DaVita is required by court order sought and obtained by any independent third party to sell, offer to sell, or otherwise transfer some of its membership interests to another party; or

h. Any transaction consistent with CMS rules or regulations regarding ESRD Seamless Care Organizations (ESCOs).

G. Independent Monitor

1. *Retention of the Independent Monitor*. Within 60 days after the Effective Date, DaVita shall retain the Independent Monitor (Monitor) selected by OIG after consultation with DaVita. The Monitor may retain additional personnel, including, but not limited to, independent consultants, if needed to help meet the Monitor's obligations under this CIA. DaVita shall provide OIG with a copy of the agreement between DaVita and the Monitor, and any agreements between DaVita or the Monitor and any consultants retained by the Monitor. OIG shall have 10 business days to review and provide comment on the agreement(s) prior to final execution.

The Monitor may confer and correspond with DaVita or OIG individually or together. The Monitor and DaVita shall not negotiate or enter into another financial relationship for at least 12 months after the date of OIG's CIA closure letter to DaVita.

2. *Duties of the Monitor*. The Monitor shall perform the tasks and reviews and prepare the reports described in Appendix C of the CIA. The Monitor shall submit all reports simultaneously to OIG and DaVita. The Monitor shall not share draft reports with DaVita.

3. *Retention of Records*. The Monitor shall retain and make available to OIG, upon request, all work papers, supporting documentation, correspondence, and other documents related to the engagement of and work performed by the Monitor.

4. *Resignation or Removal of the Monitor*. The Monitor is not an agent of OIG. However, the Monitor may be removed by OIG at OIG's sole discretion. If the Monitor resigns or is removed prior to the termination of the CIA, DaVita shall retain, within 60 days after selection by OIG, another Monitor with the same functions and authorities. If the Monitor resigns or is removed, all deadlines under Sections III.F and V applicable to the Reporting Period during which the resignation or removal occurs will be tolled until 60 days after OIG selects a new Monitor or DaVita retains the new Monitor, whichever is earlier. No penalties will be applied under Section X for days that are tolled as a result of this Section III.G.4.

5. *Validation Review*. In the event OIG has reason to believe that: (a) the Monitor's work fails to conform to the requirements of this CIA, or (b) the Monitor's findings or review results are inaccurate, OIG may, at its sole discretion, conduct its own review (Validation Review). DaVita shall pay for the reasonable cost of any such review performed by OIG or any of its designated agents. Any Validation Review of reports submitted as part of DaVita's final Annual Report shall be initiated no later than one year after DaVita's final submission (as described in Section II) is received by OIG.

Prior to initiating a Validation Review, OIG shall notify DaVita of its intent to do so and provide a written explanation of why OIG believes such a review is necessary. To resolve any concerns raised by OIG, DaVita may request a meeting with OIG to discuss the matter, present any additional information, and/or propose alternatives to the proposed Validation Review. DaVita agrees to provide any additional information as may be requested by OIG under this Section III.G.5 in an expedited manner. OIG will attempt in good faith to resolve any issues with DaVita prior to conducting a Validation Review. However, the final determination as to whether or not to proceed with a Validation Review shall be made at the sole discretion of OIG.

6. *Responsibilities and Liabilities*. Nothing in this Section III.G or Appendix C to this CIA affects DaVita's responsibilities or liabilities under any criminal, civil, or administrative laws or regulations applicable to any Federal health care program including, but not limited to, the Anti-Kickback Statute.

H. Compliance Audits

1. DaVita Dialysis has established a compliance audit program consisting of four components: annual audits, routine audits, email audits, and metric monitoring. DaVita shall, at a minimum, maintain this compliance audit program for DaVita Dialysis for the CIA Period at the same level of effort as allocated to the compliance audit program in calendar year 2013.

2. DaVita shall ensure that OIG receives a list of annual, routine, and email audits completed or scheduled to be completed by DaVita Dialysis during each Reporting Period no later than 30 days prior to the end of the Reporting Period.

3. The compliance audit program shall not be performed under attorney-client privilege.

I. Risk Assessment and Mitigation Process

Within 90 days after the Effective Date, DaVita shall develop a standardized, centralized process to allow DaVita Dialysis's in-house or outside legal counsel, compliance, and leaders of the relevant functions to: (1) identify and assess the risks associated with DaVita Dialysis's compliance with Federal health care program requirements, the False Claims Act, and the Anti-Kickback Statute; and (2) determine what steps, if any, DaVita Dialysis should take to mitigate the identified risks. DaVita shall maintain the Risk Assessment and Mitigation Process for the duration of the CIA.

J. Compensation

1. *Executive Financial Recoupment Program.* DaVita shall establish no later than December 31, 2014, and shall maintain throughout the CIA Period, a financial recoupment program that puts at risk of forfeiture and recoupment an amount equivalent to up to three years of annual performance pay (*e.g.*, annual bonus, incentives) for a Covered Executive who is discovered to have been involved in any significant misconduct (Executive Financial Recoupment Program). This financial recoupment program shall apply both to Covered Executives who are current DaVita employees and to Covered Executives who are former DaVita employees at the time of a Recoupment Determination. The specific terms and conditions of the Executive Financial Recoupment Program are set forth in Appendix D to this CIA. DaVita shall maintain an Executive Financial Recoupment Program consistent with the terms of Appendix D for at least the duration of the CIA, absent agreement otherwise by OIG.

2. *Compliance Input on Executive Compensation.* The Chief Compliance Officer shall provide information to the Board Compensation Committee that evaluates each Covered Executive's performance, including, but not limited to, the Covered Executive's commitment to compliance, as demonstrated by modeling compliant behavior, leading in a compliant manner, identifying risks and issues, resolving risks and issues in a compliant manner, working with the Compliance Department to address issues, and other compliance-related factors as appropriate. The Board Compensation Committee shall document its decision regarding the consideration given to the information for each Covered Executive in determining annual compensation (*e.g.*, salary, bonuses) and the rationale for its decision. DaVita shall provide copies of the Board Compensation Committee's documentation of its decision and rationale to OIG upon request.

K. Cooperation

Upon reasonable notice, DaVita shall cooperate with all OIG investigations and understands that full cooperation includes: (1) prompt and truthful disclosures to OIG of all matters relating to any Federal or state health care law investigation, prosecution, or other enforcement action relating to the Covered Conduct in the Settlement Agreement entered into between the United States and DaVita contemporaneously with this CIA, including other matters involving possible violations of Federal or state health care law by individuals or entities in the dialysis industry and the medical practice of nephrology; and (2) truthful testimony in any administrative hearing and/or court proceeding. DaVita, upon reasonable notice, will make reasonable efforts to facilitate access to, and encourage the cooperation of, its current and former directors, officers, and employees for interviews and testimony, and will furnish to OIG, upon reasonable request, all documents and records in its possession, custody, or control relating to the Covered Conduct. Section III.K shall not require and shall not be construed as a waiver of any applicable attorney-client or work product privileges.

L. Disclosure Program

DaVita has established and shall continue to maintain a Disclosure Program that includes a mechanism (*e.g.*, a toll-free compliance telephone line) to enable individuals to disclose, to the Chief Compliance Officer or some other person who is not in the disclosing individual's chain of command, any identified issues or questions associated with DaVita Dialysis's policies, conduct, practices, or procedures with respect to a Federal health care program believed by the individual to be a potential violation of criminal, civil, or administrative law. DaVita shall continue to appropriately publicize the existence of the disclosure mechanism (*e.g.*, via periodic e-mails to employees or by posting the information in prominent common areas).

The Disclosure Program shall continue to emphasize a nonretribution, nonretaliation policy, and shall continue to include a reporting mechanism for anonymous communications for which appropriate confidentiality shall be maintained. Upon receipt of a disclosure, the Chief Compliance Officer (or designee) shall continue to gather all relevant information from the disclosing individual. The Chief Compliance Officer (or designee) shall continue to make a preliminary, good faith inquiry into the allegations set forth in every disclosure to ensure that he or she has obtained all of the information necessary to determine whether a further review should be conducted. For any disclosure that is sufficiently specific so that it reasonably: (1) permits a determination of the appropriateness of the alleged improper practice, and (2) provides an opportunity for taking corrective action, DaVita shall continue to conduct an internal review of the allegations set forth in the disclosure and ensure that proper follow-up is conducted.

The Chief Compliance Officer (or designee) shall maintain a disclosure log for DaVita Dialysis, which shall include a record and summary of each disclosure received (whether anonymous or not), the status of the respective internal reviews, and any corrective action taken in response to the internal reviews.

M. Ineligible Persons

1. *Definitions*. For purposes of this CIA:

a. an "Ineligible Person" shall include an individual or entity who:

i. is currently excluded, debarred, suspended, or otherwise ineligible to participate in the Federal health care programs or in Federal procurement or nonprocurement programs; or

ii. has been convicted of a criminal offense that falls within the scope of 42 U.S.C. § 1320a-7(a), but has not yet been excluded, debarred, suspended, or otherwise declared ineligible.

b. "Exclusion Lists" include:

i. the HHS/OIG List of Excluded Individuals/Entities (LEIE) (available through the Internet at http://www.oig.hhs.gov); and

ii. the General Services Administration's System for Award Management (SAM) (available through the Internet at http://www.sam.gov).

2. *Screening Requirements*. DaVita shall continue to ensure that all prospective and current Covered Persons are not Ineligible Persons, by continuing or implementing the following screening requirements.

a. DaVita shall screen all prospective Covered Persons against the Exclusion Lists prior to engaging their services and, as part of the hiring or contracting process, shall require such Covered Persons to disclose whether they are Ineligible Persons.

b. DaVita shall screen all Covered Persons against the Exclusion Lists within 90 days after the Effective Date and thereafter shall screen against the LEIE on a monthly basis and screen against SAM on an annual basis.

c. DaVita shall implement a policy requiring all Covered Persons to disclose immediately any debarment, exclusion, suspension, or other event that makes that person an Ineligible Person.

Nothing in Section III.M affects DaVita's responsibility to refrain from (and liability for) billing Federal health care programs for items or services furnished, ordered, or prescribed by an excluded person. DaVita understands that items or services furnished, ordered, or prescribed by excluded persons are not payable by Federal health care programs and that DaVita may be liable for overpayments and/or criminal, civil, and administrative sanctions for employing or contracting with an excluded person regardless of whether DaVita meets the requirements of Section III.M.

3. *Removal Requirement*. If DaVita has actual notice that a Covered Person has become an Ineligible Person, DaVita shall remove such Covered Person from responsibility for, or involvement with, DaVita's business operations related to the Federal health care programs and shall remove such Covered Person from any position for which the Covered Person's compensation or the items or services furnished, ordered, or prescribed by the Covered Person are paid in whole or in part, directly or indirectly, by Federal health care programs or otherwise with Federal funds at least until such time as the Covered Person is reinstated into participation in the Federal health care programs.

4. *Pending Charges and Proposed Exclusions*. If DaVita has actual notice that a Covered Person is charged with a criminal offense that falls within the scope of 42 U.S.C. §§ 1320a-7(a), 1320a-7(b)(1)–(3), or is proposed for exclusion during the Covered Person's employment or contract term, DaVita shall take all appropriate actions to ensure that the responsibilities of that Covered Person have not and shall not adversely affect the quality of care rendered to any beneficiary, patient, or resident, or any claims submitted to any Federal health care program.

N. Notification of Government Investigation or Legal Proceedings

Within 30 days after discovery, DaVita shall notify OIG, in writing, of any ongoing investigation or legal proceeding known to DaVita conducted or brought by a governmental entity or its agents in the United States involving an allegation that DaVita has committed a crime or has engaged in fraudulent activities. This notification shall include a description of the allegation, the identity of the investigating or prosecuting agency, and the status of such investigation or legal proceeding. DaVita shall also provide written notice to OIG within 30 days after the resolution of the matter, and shall provide OIG with a description of the findings and/or results of the investigation or proceedings, if any.

O. Repayment of Overpayments

1. *Definition of Overpayments*. For purposes of this CIA, an "Overpayment" shall mean the amount of money DaVita Dialysis has received in excess of the amount due and payable under any Federal health care program requirements.

2. *Repayment of Overpayments*.

a. If, at any time, DaVita Dialysis identifies any Overpayment, DaVita Dialysis shall repay the Overpayment to the appropriate payor (*e.g.*, Medicare contractor) within 60 days

after identification of the Overpayment and take remedial steps within 90 days after identification (or such additional time as may be agreed to by the payor) to correct the problem, including preventing the underlying problem and the Overpayment from recurring. If the Overpayment is not yet quantified, within 30 days after identification, DaVita Dialysis shall notify the payor of its efforts to quantify the Overpayment amount along with a schedule of when such work is expected to be completed. Notification and repayment to the payor shall be done in accordance with the payor's policies.

b. Notwithstanding the above, notification and repayment of any Overpayment amount that routinely is reconciled or adjusted pursuant to policies and procedures established by the payor should be handled in accordance with such policies and procedures.

P. Reportable Events

1. *Definition of Reportable Event*. For purposes of this CIA, a "Reportable Event" means anything that involves:

a. a substantial Overpayment to DaVita Dialysis;

b. a matter involving DaVita Dialysis that a reasonable person would consider a probable violation of criminal, civil, or administrative laws applicable to any Federal health care program for which penalties or exclusion may be authorized;

c. DaVita Dialysis's employment of or contracting with a Covered Person who is an Ineligible Person as defined by Section III.M.1.a; or

d. the filing of a bankruptcy petition by DaVita.

A Reportable Event may be the result of an isolated event or a series of occurrences.

2. *Reporting of Reportable Events*. If DaVita determines (after a reasonable opportunity to conduct an appropriate review or investigation of the allegations) through any means that there is a Reportable Event, DaVita shall notify OIG, in writing, within 30 days after making the determination that the Reportable Event exists.

DaVita Dialysis shall not be required to report as a Reportable Event a matter that is the subject of an ongoing investigation or legal proceeding by a government entity or agent previously disclosed under Section III.N, above.

3. *Reportable Events under Section III.P.1.a.* For Reportable Events under Section III.P.1.a, DaVita's report to OIG shall be made within 30 days of the identification of the Overpayment and shall include:

a. a description of the steps taken by DaVita Dialysis to identify and quantify the Overpayment;

b. a complete description of the Reportable Event, including the relevant facts, persons involved, and legal and Federal health care program authorities implicated;

c. a description of DaVita Dialysis's actions taken to correct the Reportable Event; and

d. any further steps DaVita Dialysis plans to take to address the Reportable Event and prevent it from recurring.

Within 60 days of identification of the Overpayment, DaVita shall provide OIG with a copy of the notification and repayment (if quantified) to the payor required by Section III.O.2.

4. *Reportable Events under Section III.P.1.b and c*. For Reportable Events under Section III.P.1.b and III.P.1.c, DaVita's report to OIG shall include:

a. a complete description of the Reportable Event, including the relevant facts, persons involved, and legal and Federal health care program authorities implicated;

b. a description of DaVita Dialysis's actions taken to correct the Reportable Event;

c. any further steps DaVita Dialysis plans to take to address the Reportable Event and prevent it from recurring; and

d. if the Reportable Event has resulted in an Overpayment, a description of the steps taken by DaVita Dialysis to identify and quantify the Overpayment.

5. *Reportable Events under Section III.P.1.d*. For Reportable Events under Section III.P.1.d, DaVita's report to OIG shall include documentation of the bankruptcy filing and a description of any Federal health care program authorities implicated.

IV. SUCCESSOR LIABILITY; CHANGES TO BUSINESS UNITS OR LOCATIONS

A. Sale of Business, Business Unit, or Location

In the event that, after the Effective Date, DaVita proposes to sell any or all of its DaVita Dialysis business, business units, or locations (whether through a sale of assets, sale of stock, or other type of transaction) that are subject to this CIA, DaVita shall notify OIG of the proposed sale at least 30 days prior to the sale of the DaVita Dialysis business, business unit, or location. This notification shall include a description of the DaVita Dialysis business, business unit, or location to be sold, a brief description of the terms of the sale, and the name and contact information of the prospective purchaser. This CIA shall be binding on the purchaser of the DaVita Dialysis business, business unit, or location, unless otherwise determined and agreed to in writing by OIG.

B. Change or Closure of Business, Business Unit, or Location

In the event that, after the Effective Date, DaVita changes locations or closes a DaVita Dialysis business, business unit, or location related to the furnishing of items or services that may be reimbursed by Federal health care programs, DaVita shall notify OIG of this fact as soon as possible, but no later than within 30 days after the date of change or closure of the DaVita Dialysis business, business unit, or location.

C. Purchase or Establishment of New Business, Business Unit, or Location

In the event that, after the Effective Date, DaVita purchases or establishes a new DaVita Dialysis business, business unit, or location related to the furnishing of items or services that may be reimbursed by Federal health care programs, DaVita shall notify OIG at least 30 days prior to such purchase or the operation of the new DaVita Dialysis business, business unit, or location. This notification shall include the address of the new DaVita Dialysis business, business unit, or location; phone number; fax number; the location's Medicare and state Medicaid program provider number and/or supplier number(s); and the name and address of each Medicare and state Medicaid program contractor to which DaVita Dialysis currently submits claims. Each new DaVita Dialysis business, business unit, or location and all Covered Persons at each new DaVita Dialysis business, business unit, or location shall be subject to the applicable requirements of this CIA, unless otherwise agreed to in writing by OIG.

V. IMPLEMENTATION, QUARTERLY RESPONSE, AND ANNUAL REPORTS

A. Implementation Report

Within 120 days after the Effective Date, DaVita shall submit a written report to OIG summarizing the status of its implementation of the requirements of this CIA (Implementation Report). The Implementation Report shall, at a minimum, include:

1. the name, address, phone number, and position description of the Chief Compliance Officer required by Section III.A.1, and a summary of other noncompliance job responsibilities the Chief Compliance Officer may have;

2. the names and positions of the members of the Management Compliance Committee required by Section III.A.2;

3. the names of the Board members who are responsible for satisfying the Board of Directors compliance obligations described in Section III.A.3;

4. a copy of DaVita Dialysis's Code of Conduct required by Section III.B.1;

5. the number of individuals required to complete the Code of Conduct certification required by Section III.B.1, the percentage of individuals who have completed such certification, and an explanation of any exceptions (the documentation supporting this information shall be made available to OIG upon request);

6. copies of all Policies and Procedures required by Section III.B.2;

7. the following information regarding each type of training required by Section III.C:

   a. a description of such training, including a summary of the topics covered, the length of sessions, and a schedule of training sessions;

   b. the number of individuals required to be trained, percentage of individuals actually trained, and an explanation of any exceptions.

A copy of all training materials and the documentation supporting this information shall be made available to OIG upon request.

8. a description of: (a) the Selection Process and Selection Criteria required by Section III.D.1; (b) the Valuation Methodologies required by Section III.D.2; (c) the Focus Arrangements Tracking System required by Section III.D.3.a; (d) the internal review and approval process required by Section III.D.3.f; and (e) the tracking and monitoring procedures and other Focus Arrangements Procedures required by Section III.D.3;

9. a copy of the Notices required by Section III.E and a list of the Joint Venture Partners and Medical Directors to whom each Notice was sent;

10. a copy of the engagement letter with the Monitor that DaVita is required to retain by Section III.G;

11. a description of the Disclosure Program required by Section III.L;

12. a description of the process by which DaVita fulfills the requirements of Section III.M regarding Ineligible Persons;

13. a list of all of DaVita Dialysis's offices and joint venture dialysis clinics (including locations and mailing addresses); the corresponding name under which each joint venture dialysis clinic is doing business; the corresponding phone numbers and fax numbers; each joint venture clinic's Medicare and state Medicaid program provider number(s) and/or supplier number(s); and the name and address of each Medicare and state Medicaid program contractor to which DaVita Dialysis currently submits claims;

14. a description of DaVita's corporate structure, including identification of any parent and sister companies, subsidiaries, and their respective lines of business;

15. a description of DaVita's Executive Financial Recoupment Program implemented pursuant to Section III.J.1; and

16. the certifications required by Section V.D.

B. Quarterly Response Reports

Within 30 days after receipt of the Monitor's Quarterly Reports, DaVita shall submit its Quarterly Response Report to OIG and the Monitor containing:

1. its response to the Monitor's findings and recommendations;

2. its corrective action plans; and

3. the certifications required by Section V.D.

C. Annual Reports

DaVita shall submit to OIG annually a report with respect to the status of, and findings regarding, DaVita Dialysis's compliance activities for each of the five Reporting Periods (Annual Report). Each Annual Report shall include, at a minimum:

1. any change in the identity, position description, or other noncompliance job responsibilities of the Chief Compliance Officer; any change in the membership of the Management Compliance Committee described in Section III.A; and any change in the leadership or composition of the Board Compliance Committee;

2. the dates of each report made by the Chief Compliance Officer to the Board (written documentation of such reports shall be made available upon request);

3. the Board resolution required by Section III.A.3;

4. a summary of any changes or amendments to DaVita Dialysis's Code of Conduct required by Section III.B.1 and the reason for such changes, along with a copy of the revised Code of Conduct;

5. the number of individuals required to complete the Code of Conduct certification required by Section III.B.1, the percentage of individuals who have completed such certification, and an explanation of any exceptions (the documentation supporting this information shall be made available to OIG upon request);

6. copies of the Policies and Procedures required by Section III.B.2, and a summary of the reasons for any significant changes or amendments. DaVita shall provide a "redlined" copy of any revised Policy or Procedure at OIG's request;

7. the following information regarding each type of training required by Section III.C:

a. a copy of all training materials, the length of the training sessions, and a schedule of training sessions; and

b. the number of individuals required to complete the initial and annual training, the percentage of individuals who actually completed the initial and annual training, and an explanation of any exceptions.

The documentation to support this information shall be made available to OIG upon request.

8. a description of: (a) any changes to the Focus Arrangements Tracking System required by Section III.D.3.a; (b) any changes to the internal review and approval process required by Section III.D.3.f; and (c) any changes to the tracking and monitoring procedures and other Focus Arrangements Procedures required by Section III.D.3;

9. a copy of documents related to the Selection Process and Selection Criteria required by Section III.D.1 and, in each of the third through fifth Reporting Periods, an explanation of any modifications or changes to, or deviations from, the Selection Process or Selection Criteria made during the applicable Reporting Period;

10. DaVita Dialysis's response to the reports prepared pursuant to Section H of Appendix C to the CIA, along with corrective action plan(s) related to any issues raised by the reports;

11. a summary of Reportable Events (as defined in Section III.P) identified during the Reporting Period and the status of any corrective action relating to all such Reportable Events;

12. a report of the aggregate Overpayments that DaVita Dialysis has returned to the Federal health care programs. Overpayment amounts shall be broken down into the following categories: inpatient Medicare, outpatient Medicare, Medicaid (report each applicable state separately, if applicable), and other Federal health care programs. Overpayment amounts that are routinely reconciled or adjusted pursuant to policies and procedures established by the payor do not need to be included in this aggregate Overpayment report;

13. a summary of the disclosures in the disclosure log required by Section III.L that: (a) relate to Federal health care programs, or (b) involve allegations of conduct that may involve illegal remunerations in violation of the Anti-Kickback Statute (the complete disclosure log shall be made available to OIG upon request);

14. any changes to the process by which DaVita fulfills the requirements of Section III.M regarding Ineligible Persons;

15. a summary describing any ongoing investigation or legal proceeding required to have been reported pursuant to Section III.N. The summary shall include a description of the allegation, the identity of the investigating or prosecuting agency, and the status of such investigation or legal proceeding;

16. a description of all changes to the most recently provided list of DaVita Dialysis's locations (including addresses) as required by Section V.A.13; the corresponding name under which each location is doing business; the corresponding phone numbers and fax numbers; each location's Medicare and state Medicaid program provider number(s) and/or supplier number(s); and the name and address of each Medicare and state Medicaid program contractor to which DaVita currently submits claims;

17. a description of any changes to DaVita's Executive Financial Recoupment Program;

18. a copy of the annual report to the Board concerning DaVita's Executive Financial Recoupment Program, as required by Appendix D; and

19. the certifications required by Section V.D.

The third and subsequent Annual Reports shall also include:

20. the Compliance Program Review Report; and

21. a summary and description of any and all current and prior engagements and agreements between DaVita and the Compliance Advisor, if different from what was submitted under Section A of Appendix A to the CIA.

The first Annual Report shall be received by OIG no later than 90 days after the end of the first Reporting Period. Subsequent Annual Reports shall be received by OIG no later than the anniversary date of the due date of the first Annual Report.

D. Certifications

1. *Certifying Executives*. In each Annual Report, DaVita shall include the certifications of Certifying Executives as required by Section III.A.4.

2. *Compliance Officer and Chief Executive Officers*. The Implementation Report and each Quarterly Response and Annual Report shall include certifications by the Chief Compliance Officer, Chief Executive Officer of DaVita Dialysis, and Chief Executive Officer of DaVita that:

a. to the best of his or her knowledge, except as otherwise described in the report, DaVita is in compliance with all of the requirements of this CIA;

b. to the best of his or her knowledge, DaVita has implemented procedures reasonably designed to ensure that all Focus Arrangements do not violate the Anti-Kickback Statute, including the Focus Arrangements Procedures required in Section III.D of the CIA;

c. to the best of his or her knowledge, DaVita has fulfilled the requirements for new and renewed Focus Arrangements under Section III.D.4 of the CIA; and

d. he or she has reviewed the report and has made reasonable inquiry regarding its content and believes that the information in the report is accurate and truthful.

3. *Chief Financial Officer*. The first Annual Report shall include a certification by the Chief Financial Officer that, to the best of his or her knowledge, DaVita has complied with its obligations under the Settlement Agreement: (a) not to resubmit to any Federal health care program payors any previously denied claims related to the Covered Conduct addressed in the Settlement Agreement, and not to appeal any such denials of claims; (b) not to charge to or otherwise seek payment from federal or state payors for unallowable costs (as defined in the Settlement Agreement); and (c) to identify and adjust any past charges or claims for unallowable costs.

E. Designation of Information

DaVita shall clearly identify any portions of its submissions that it believes are trade secrets, or information that is commercial or financial and privileged or confidential, and therefore potentially exempt from disclosure under the Freedom of Information Act (FOIA), 5 U.S.C. § 552. DaVita shall refrain from identifying any information as exempt from disclosure if that information does not meet the criteria for exemption from disclosure under FOIA.

VI. NOTIFICATIONS AND SUBMISSION OF REPORTS

Unless otherwise stated in writing after the Effective Date, all notifications and reports required under this CIA shall be submitted to the following entities:

OIG: Administrative and Civil Remedies Branch
Office of Counsel to the Inspector General
Office of Inspector General
U.S. Department of Health and Human Services
Cohen Building, Room 5527
330 Independence Avenue, SW
Washington, DC 20201
Telephone: 202.619.2078
Facsimile: 202.205.0604

DaVita: Jeanine Jiganti
Chief Compliance Officer
DaVita HealthCare Partners Inc.
2000 16th Street
Denver, CO 80202
Telephone: 303.876.7401
Facsimile: 877.873.8029

Unless otherwise specified, all notifications and reports required by this CIA may be made by certified mail, overnight mail, hand delivery, or other means, provided that there is proof that such notification was received. For purposes of this requirement, internal facsimile confirmation sheets do not constitute proof of receipt. Upon request by OIG, DaVita may be required to provide OIG with an electronic copy of each notification or report required by this CIA in searchable portable document format (pdf), in addition to a paper copy.

VII. OIG INSPECTION, AUDIT, AND REVIEW RIGHTS

In addition to any other rights OIG may have by statute, regulation, or contract, OIG or its duly authorized representative(s) may examine and/or request copies of DaVita's books, records, and other documents and supporting materials and/or conduct on-site reviews of DaVita's headquarters and any of DaVita Dialysis's locations for the purpose of verifying and evaluating: (a) DaVita's compliance with the terms of this CIA; and (b) DaVita Dialysis's compliance with the requirements of the Federal health care programs. The documentation described above shall be made available by DaVita to OIG or its duly authorized representative(s) at all reasonable times for inspection, audit, and/or reproduction. Furthermore, for purposes of this provision, OIG or its duly authorized representative(s) may interview any of DaVita's Covered Persons who

consent to be interviewed at the individual's place of business during normal business hours or at such other place and time as may be mutually agreed upon between the individual and OIG. DaVita shall assist OIG or its duly authorized representative(s) in contacting and arranging interviews with such individuals upon OIG's request. DaVita's Covered Persons may elect to be interviewed with or without a representative of DaVita present.

VIII. DOCUMENT AND RECORD RETENTION

DaVita shall maintain for inspection all documents and records relating to DaVita Dialysis's reimbursement from the Federal health care programs and to DaVita's compliance with this CIA for six years (or longer if otherwise required by law) from the Effective Date.

IX. DISCLOSURES

Consistent with HHS's FOIA procedures, set forth in 45 C.F.R. Part 5, OIG shall make a reasonable effort to notify DaVita prior to any release by OIG of information submitted by DaVita pursuant to its obligations under this CIA and identified upon submission by DaVita as trade secrets, or information that is commercial or financial and privileged or confidential, under the FOIA rules. With respect to such releases, DaVita shall have the rights set forth at 45 C.F.R. § 5.65 (d).

X. BREACH AND DEFAULT PROVISIONS

DaVita is expected to fully and timely comply with all of its CIA obligations.

A. Stipulated Penalties for Failure to Comply with Certain Obligations

As a contractual remedy, DaVita and OIG hereby agree that failure to comply with certain obligations as set forth in this CIA may lead to the imposition of the following monetary penalties (hereinafter referred to as "Stipulated Penalties") in accordance with the following provisions.

1. A Stipulated Penalty of $2,500 (which shall begin to accrue on the day after the date the obligation became due) for each day DaVita fails to establish and implement any of the following obligations as described in Sections III and IV:

a. a Chief Compliance Officer;

b. a Management Compliance Committee;

c. the Board of Directors compliance obligations;

d. a written Code of Conduct;

e. written Policies and Procedures;

f. the training of Covered Persons, Arrangements Covered Persons, and Board Members;

g. the Selection Process and Selection Criteria, Valuation Methodologies, Focus Arrangements Procedures, and/or Focus Arrangements Requirements described in Section III.D;

h. the Notice to Joint Venture Partners and Medical Directors;

i. the unwinding of the Subject Joint Venture Clinics, except to the extent covered by a Monitor's certification as described in Section III.F.3;

j. the Executive Financial Recoupment Program;

k. the Compliance Input on Executive Compensation;

l. a Disclosure Program;

m. Ineligible Persons screening and removal requirements;

n. notification of government investigations or legal proceedings in the United States;

o. repayment by DaVita Dialysis of Overpayments;

p. reporting of Reportable Events; and

q. disclosure of changes to business units or locations.

2. A Stipulated Penalty of $2,500 (which shall begin to accrue on the day after the date the obligation became due) for each day DaVita fails to engage and use a Compliance Advisor, as required in Section III.A.3 and Appendix A.

3. A Stipulated Penalty of $2,500 (which shall begin to accrue on the day after the date the obligation became due) for each day DaVita fails to engage and use an Independent Monitor, as required in Section III.G and Appendix C.

4. A Stipulated Penalty of $2,500 (which shall begin to accrue on the day after the date the obligation became due) for each day DaVita fails to submit the Implementation Report or any Quarterly Response Reports or Annual Reports to OIG in accordance with the requirements of Section V by the deadlines for submission.

5. A Stipulated Penalty of $2,500 (which shall begin to accrue on the day after the date the obligation became due) for each day DaVita fails to submit a Compliance Program Review Report in accordance with the requirements of Section III.A.3 and Appendix A.

6. A Stipulated Penalty of $2,500 (which shall begin to accrue on the day after the date the obligation became due) for each day the Independent Monitor fails to submit a Quarterly or Annual Report in accordance with the requirements of Section III.G and Appendix C.

7. A Stipulated Penalty of $1,500 for each day DaVita fails to grant access as required in Section VII. (This Stipulated Penalty shall begin to accrue on the date DaVita fails to grant access.)

8. A Stipulated Penalty of $50,000 for each false certification submitted by or on behalf of DaVita as part of its Implementation Report, Quarterly Response Report, Annual Report, additional documentation to a report (as requested by the OIG), or otherwise required by this CIA.

9. A Stipulated Penalty of $1,000 for each day DaVita fails to comply fully and adequately with any obligation of this CIA. OIG shall provide notice to DaVita stating the specific grounds for its determination that DaVita has failed to comply fully and adequately with the CIA obligation(s) at issue and steps DaVita shall take to comply with the CIA. (This Stipulated Penalty shall begin to accrue 10 days after DaVita receives this notice from OIG of the failure to comply.) A Stipulated Penalty as described in this Subsection shall not be demanded for any violation for which OIG has sought a Stipulated Penalty under Subsections 1–8 of this Section.

B. Timely Written Requests for Extensions

DaVita may, in advance of the due date, submit a timely written request for an extension of time to perform any act or file any notification or report required by this CIA. Notwithstanding any other provision in this Section, if OIG grants the timely written request with respect to an act, notification, or report, Stipulated Penalties for failure to perform the act or file the notification or report shall not begin to accrue until one day after DaVita fails to meet the revised deadline set by OIG. Notwithstanding any other provision in this Section, if OIG denies such a timely written request, Stipulated

Penalties for failure to perform the act or file the notification or report shall not begin to accrue until three days after DaVita receives OIG's written denial of such request or the original due date, whichever is later. A "timely written request" is defined as a request in writing received by OIG at least five days prior to the date by which any act is due to be performed or any notification or report is due to be filed.

C. Payment of Stipulated Penalties

1. *Demand Letter*. Upon a finding that DaVita has failed to comply with any of the obligations described in Section X.A and after determining that Stipulated Penalties are appropriate, OIG shall notify DaVita of: (a) DaVita's failure to comply; and (b) OIG's exercise of its contractual right to demand payment of the Stipulated Penalties. (This notification shall be referred to as the "Demand Letter.")

2. *Response to Demand Letter*. Within 10 days after the receipt of the Demand Letter, DaVita shall either: (a) cure the breach to OIG's satisfaction and pay the applicable Stipulated Penalties; or (b) request a hearing before an HHS administrative law judge (ALJ) to dispute OIG's determination of noncompliance, pursuant to the agreed upon provisions set forth below in Section X.E. In the event DaVita elects to request an ALJ hearing, the Stipulated Penalties shall continue to accrue until DaVita cures, to OIG's satisfaction, the alleged breach in dispute. Failure to respond to the Demand Letter in one of these two manners within the allowed time period shall be considered a material breach of this CIA and shall be grounds for exclusion under Section X.D.

3. *Form of Payment*. Payment of the Stipulated Penalties shall be made by electronic funds transfer to an account specified by OIG in the Demand Letter.

4. *Independence from Material Breach Determination*. Except as set forth in Section X.D.1.c, these provisions for payment of Stipulated Penalties shall not affect or otherwise set a standard for OIG's decision that DaVita has materially breached this CIA, which decision shall be made at OIG's discretion and shall be governed by the provisions in Section X.D, below.

D. Exclusion for Material Breach of this CIA

1. *Definition of Material Breach*. A material breach of this CIA means:

a. a failure by DaVita to report a Reportable Event, take corrective action, and make the appropriate refunds, as required in Section III.P;

b. repeated or flagrant violations of the obligations under this CIA, including, but not limited to, the obligations addressed in Section X.A;

c. a failure to respond to a Demand Letter concerning the payment of Stipulated Penalties in accordance with Section X.C;

d. a failure to engage and use a Compliance Advisor in accordance with Section III.A.3 and Appendix A; or

e. a failure to engage and use an Independent Monitor in accordance with Section III.G and Appendix C.

2. *Notice of Material Breach and Intent to Exclude*. The parties agree that a material breach of this CIA by DaVita constitutes an independent basis for DaVita's exclusion from participation in the Federal health care programs. Upon a determination by OIG that DaVita has materially breached this CIA and that exclusion is the appropriate remedy, OIG shall notify DaVita of: (a) DaVita's material breach, and (b) OIG's intent to exercise its contractual right to impose exclusion. (This notification shall be referred to as the "Notice of Material Breach and Intent to Exclude.")

3. *Opportunity to Cure*. DaVita shall have 30 days from the date of receipt of the Notice of Material Breach and Intent to Exclude to demonstrate to OIG's satisfaction that:

a. DaVita is in compliance with the obligations of the CIA cited by OIG as being the basis for the material breach;

b. the alleged material breach has been cured; or

c. the alleged material breach cannot be cured within the 30-day period, but that: (i) DaVita has begun to take action to cure the material breach, (ii) DaVita is pursuing such action with due diligence, and (iii) DaVita has provided to OIG a reasonable timetable for curing the material breach.

4. *Exclusion Letter*. If, at the conclusion of the 30-day period, DaVita fails to satisfy the requirements of Section X.D.3, OIG may exclude DaVita from participation in the Federal health care programs. OIG shall notify DaVita in writing of its determination to exclude DaVita. (This letter shall be referred to as the "Exclusion Letter.") Subject to the Dispute Resolution provisions in Section X.E, below, the exclusion shall go into effect 30 days after the date of DaVita's receipt of the Exclusion

Letter. The exclusion shall have national effect. Reinstatement to program participation is not automatic. After the end of the period of exclusion, DaVita may apply for reinstatement by submitting a written request for reinstatement in accordance with the provisions at 42 C.F.R. §§ 1001.3001–.3004.

E. Dispute Resolution

1. *Review Rights*. Upon OIG's delivery to DaVita of its Demand Letter or of its Exclusion Letter, and as an agreed-upon contractual remedy for the resolution of disputes arising under this CIA, DaVita shall be afforded certain review rights comparable to the ones that are provided in 42 U.S.C. § 1320a-7(f) and 42 C.F.R. Part 1005 as if they applied to the Stipulated Penalties or exclusion sought pursuant to this CIA. Specifically, OIG's determination to demand payment of Stipulated Penalties or to seek exclusion shall be subject to review by an HHS ALJ and, in the event of an appeal, the HHS Departmental Appeals Board (DAB), in a manner consistent with the provisions in 42 C.F.R. § 1005.2 –1005.21. Notwithstanding the language in 42 C.F.R. § 1005.2(c), the request for a hearing involving Stipulated Penalties shall be made within 10 days after receipt of the Demand Letter and the request for a hearing involving exclusion shall be made within 25 days after receipt of the Exclusion Letter.

2. *Stipulated Penalties Review*. Notwithstanding any provision of Title 42 of the United States Code or Title 42 of the Code of Federal Regulations, the only issues in a proceeding for Stipulated Penalties under this CIA shall be: (a) whether DaVita was in full and timely compliance with the obligations of this CIA for which OIG demands payment; and (b) the period of noncompliance. DaVita shall have the burden of proving its full and timely compliance and the steps taken to cure the noncompliance, if any. OIG shall not have the right to appeal to the DAB an adverse ALJ decision related to Stipulated Penalties. If the ALJ agrees with OIG with regard to a finding of a breach of this CIA and orders DaVita to pay Stipulated Penalties, such Stipulated Penalties shall become due and payable 20 days after the ALJ issues such a decision unless DaVita requests review of the ALJ decision by the DAB. If the ALJ decision is properly appealed to the DAB and the DAB upholds the determination of OIG, the Stipulated Penalties shall become due and payable 20 days after the DAB issues its decision.

3. *Exclusion Review*. Notwithstanding any provision of Title 42 of the United States Code or Title 42 of the Code of Federal Regulations, the only issues in a proceeding for exclusion based on a material breach of this CIA shall be:

a. whether DaVita was in material breach of this CIA;

b. whether such breach was continuing on the date of the Exclusion Letter; and

c. whether the alleged material breach could not have been cured within the 30-day period, but that: (i) DaVita had begun to take action to cure the material breach within that period; (ii) DaVita has pursued and is pursuing such action with due diligence; and (iii) DaVita provided to OIG within that period a reasonable timetable for curing the material breach and DaVita has followed the timetable.

For purposes of the exclusion herein, exclusion shall take effect only after an ALJ decision favorable to OIG, or, if the ALJ rules for DaVita, only after a DAB decision in favor of OIG. DaVita's election of its contractual right to appeal to the DAB shall not abrogate OIG's authority to exclude DaVita upon the issuance of an ALJ's decision in favor of OIG. If the ALJ sustains the determination of OIG and determines that exclusion is authorized, such exclusion shall take effect 20 days after the ALJ issues such a decision, notwithstanding that DaVita may request review of the ALJ decision by the DAB. If the DAB finds in favor of OIG after an ALJ decision adverse to OIG, the exclusion shall take effect 20 days after the DAB decision. DaVita shall waive its right to any notice of such an exclusion if a decision upholding the exclusion is rendered by the ALJ or DAB. If the DAB finds in favor of DaVita, DaVita shall be reinstated effective on the date of the original exclusion.

4. *Finality of Decision*. The review by an ALJ or DAB provided for above shall not be considered to be an appeal right arising under any statutes or regulations. Consequently, the parties to this CIA agree that the DAB's decision (or the ALJ's decision if not appealed) shall be considered final for all purposes under this CIA.

XI. EFFECTIVE AND BINDING AGREEMENT

DaVita and OIG agree as follows:

A. This CIA shall become final and binding on the date the final signature is obtained on the CIA.

B. This CIA constitutes the complete agreement between the parties and may not be amended except by written consent of the parties to this CIA.

C. OIG may agree to a suspension of DaVita's obligations under this CIA based on a certification by DaVita that it is no longer providing health care items or services that will be billed to any Federal health care program and that it does not have any ownership or control interest, as defined in 42 U.S.C. § 1320a-3, in any entity that bills any Federal health care program. If DaVita is relieved of its CIA obligations, DaVita will be required to notify OIG in writing at least 30 days in advance if DaVita plans to resume providing health care items or services that are billed to any Federal

health care program or to obtain an ownership or control interest in any entity that bills any Federal health care program. At such time, OIG shall evaluate whether the CIA will be reactivated or modified.

D. The undersigned DaVita signatories represent and warrant that they are authorized to execute this CIA. The undersigned OIG signatories represent that they are signing this CIA in their official capacities and that they are authorized to execute this CIA.

E. This CIA may be executed in counterparts, each of which constitutes an original and all of which constitute one and the same CIA. Facsimiles of signatures shall constitute acceptable, binding signatures for purposes of this CIA.

ON BEHALF OF DAVITA

/s/ Jeanine Jiganti	10/21/14
JEANINE JIGANTI Chief Compliance Officer DaVita HealthCare Partners Inc.	DATE
/s/ Kim Rivera	10/21/14
KIM RIVERA Chief Legal Officer DaVita HealthCare Partners Inc.	DATE
/s/ Paul E. Kalb	10/22/14
PAUL E. KALB, M.D. Partner, Sidley Austin LLP	DATE
/s/ Jaime L.M. Jones	10/22/14
JAIME L.M. JONES Partner, Sidley Austin LLP	DATE

ON BEHALF OF THE OFFICE OF INSPECTOR GENERAL
OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROBERT K. DECONTI Assistant Inspector General for Legal Affairs Office of Inspector General U.S. Department of Health and Human Services	10/22/14 DATE
LAURA E. ELLIS Senior Counsel	10/22/14 DATE
KAITLYN L. DUNN Associate Counsel	10/22/14 DATE

APPENDIX A

COMPLIANCE ADVISOR

This Appendix contains the requirements relating to the Compliance Advisor required by Section III.A.3 of the CIA.

A. Compliance Advisor Engagement

1. The Board Compliance Committee shall engage an independent individual or entity (Compliance Advisor) that possesses the qualifications set forth in Section B, below, to perform the Compliance Program Review. The Compliance Advisor shall conduct the review in a professionally independent and objective fashion, as set forth in Section D. Within 15 days after engaging the Compliance Advisor, the Board Compliance Committee shall provide OIG with: (a) the identity, address, and phone number of the Compliance Advisor; (b) a copy of the engagement letter; (c) information to demonstrate that the Compliance Advisor has the qualifications outlined in Section B, below; (d) a summary and description of any and all current and prior engagements and agreements between DaVita and the Compliance Advisor; and (e) a certification from the Compliance Advisor that it meets the independence requirements of Section D, below. Within 30 days after OIG receives this information or any additional information submitted by the Board Compliance Committee in response to a request by OIG, whichever is later, OIG will notify the Board Compliance Committee if the Compliance Advisor is unacceptable. Absent notification from OIG that the Compliance Advisor is unacceptable, the Board Compliance Committee may continue to engage the Compliance Advisor.

2. If the Board Compliance Committee engages a new Compliance Advisor during the term of the CIA, that Compliance Advisor shall also meet the requirements of this Appendix. If a new Compliance Advisor is engaged, the Board Compliance Committee shall submit the information identified in Section A. 1, above, within 15 days of engagement of the Compliance Advisor. Within 30 days after OIG receives this information or any additional information submitted by the Board Compliance Committee at the request of OIG, whichever is later, OIG will notify the Board Compliance Committee if the Compliance Advisor is unacceptable. Absent notification from OIG that the Compliance Advisor is unacceptable, the Board Compliance Committee may continue to engage the Compliance Advisor.

B. Compliance Advisor Qualifications

The Compliance Advisor shall:

1. have expertise in health care compliance and in the general requirements applicable to dialysis providers of the Federal health care program(s) from which DaVita Dialysis seeks reimbursement; and

2. have sufficient staff with the expertise described in Section B.l and sufficient resources to conduct the Compliance Program Review on a timely basis.

C. Compliance Advisor Responsibilities

The Compliance Advisor shall:

1. create a work plan for each Reporting Period's Compliance Program Review and submit the work plan to OIG for comment before beginning the Compliance Program Review;

2. perform the annual Compliance Program Review;

3. respond to all OIG inquiries in a prompt, objective, and factual manner;

4. retain and make available to OIG, upon request, all work papers, supporting documentation, correspondence, and other documents related to the engagement of and work performed by the Compliance Advisor; and

5. prepare timely, clear, and well-written reports.

D. Compliance Advisor Independence and Objectivity

To ensure that the Compliance Program Reviews are conducted in a professionally independent and objective fashion, the Compliance Advisor shall not have a relationship to DaVita, or to its officers, directors, employees, or agents, that would cause a reasonable person to question the Compliance Advisor's impartiality.

E. Compliance Advisor Removal/Termination

1. *The Board Compliance Committee and Compliance Advisor*. If the Board Compliance Committee terminates the Compliance Advisor or if the Compliance Advisor withdraws from the engagement during the term of the CIA, the Compliance

Advisor must submit a notice explaining its reasons for termination or the reason for withdrawal to OIG no later than 30 days after termination or withdrawal. The Board Compliance Committee must engage a new Compliance Advisor in accordance with Section A of this Appendix within 60 days of termination or withdrawal of the Compliance Advisor.

2. *OIG Removal of the Compliance Advisor.* In the event OIG has reason to believe the Compliance Advisor does not possess the qualifications described in Section B, is not independent and objective as set forth in Section D, or has failed to carry out its responsibilities in performing the Compliance Program Review as set forth in Section C, OIG may, at its sole discretion, require the Board Compliance Committee to engage a new Compliance Advisor in accordance with Section A of this Appendix. The Board Compliance Committee must engage a new Compliance Advisor within 60 days of termination of the Compliance Advisor.

Prior to requiring the Board Compliance Committee to engage a new Compliance Advisor, OIG shall notify the Board Compliance Committee of its intent to do so and provide a written explanation of why OIG believes such a step is necessary. To resolve any concerns raised by OIG, the Board Compliance Committee may present additional information regarding the Compliance Advisor's qualifications, independence, or performance of its responsibilities. OIG will attempt in good faith to resolve any differences regarding the Compliance Advisor with the Board Compliance Committee prior to requiring the Board Compliance Committee to terminate the Compliance Advisor. However, the final determination as to whether or not to require the Board Compliance Committee to engage a new Compliance Advisor shall be made at the sole discretion of OIG.

APPENDIX B

SUBJECT JOINT VENTURE CLINICS

1. Llano Dialysis, LLC ("East Bay"), a joint venture consisting of five dialysis clinics:

   - Oakland Peritoneal Dialysis Center and Oakland Peritoneal At Home, Oakland, CA
     National Provider Identifier – 1568699882
     Medicaid Provider Number – 1568699882

   - Vallejo Dialysis, Vallejo, CA
     National Provider Identifier – 1265669444
     Medicaid Provider Number – 1265669444

   - San Pablo Dialysis, San Pablo, CA
     National Provider Identifier – 1790912970
     Medicaid Provider Number – 1790912970

   - El Cerrito Dialysis, El Cerrito, CA
     National Provider Identifier – 1063649242
     Medicaid Provider Number – 1063649242

2. University Dialysis Center, LLC, a joint venture consisting of one dialysis clinic:

   - University Dialysis Center, Sacramento, CA
     National Provider Identifier – 1154415982
     Medicaid Provider Number – CDC52549G

3. Shadow Dialysis, LLC, a joint venture consisting of one dialysis clinic:

   - Antelope Dialysis Center, Citrus Heights, CA
     National Provider Identifier – 1780836684
     Medicaid Provider Number – 1780836684

4. Doves Dialysis, LLC, a joint venture consisting of one dialysis clinic:

   - Carmel Mountain Dialysis, San Diego, CA
     National Provider Identifier – 1669788980
     Medicaid Provider Number – 1669788980

5. Animas Dialysis, LLC, a joint venture consisting of two dialysis clinics:

   - Doctors Dialysis of East Los Angeles, Los Angeles, CA
     National Provider Identifier – 1083853667
     Medicaid Provider Number – 1083853667

   - Doctors Dialysis Center of Montebello, Montebello, CA
     National Provider Identifier – 1568601789
     Medicaid Provider Number – 1568601789

6. MountainWest Dialysis Services, LLC, a joint venture consisting of seven dialysis clinics:

   - Lakewood Crossing Dialysis, Lakewood, CO
     National Provider Identifier – 1437310109
     Medicaid Provider Number – 56325398

   - Longmont Dialysis Center, Longmont, CO
     National Provider Identifier – 1336301860
     Medicaid Provider Number – 11485884

   - Lakewood Dialysis Center and Lakewood at Home, Lakewood, CO
     National Provider Identifier – 1063673739
     Medicaid Provider Number – 20733283

   - Thornton Dialysis Center, Thornton, CO
     National Provider Identifier – 1154582831
     Medicaid Provider Number – 12089273

   - Boulder Dialysis Center, Boulder, CO
     National Provider Identifier – 1154582823
     Medicaid Provider Number – 86187589

   - Arvada Dialysis Center, Arvada, CO
     National Provider Identifier – 1609037373
     Medicaid Provider Number – 45706794

   - Mile High Home Dialysis PD, Lakewood, CO
     National Provider Identifier – 1508026436
     Medicaid Provider Number – 36032395

7. South Central Florida Dialysis Partners, LLC ("IMS/St. Cloud"), a joint venture consisting of four dialysis clinics:

- Celebration Dialysis, Celebration, FL
  National Provider Identifier – 1043287550
  Medicaid Provider Number – 000044200

- Hunters Creek Dialysis and Hunters Creek at Home, Orlando, FL
  National Provider Identifier – 1801864459
  Medicaid Provider Number – 000092700

- Kissimmee Dialysis, Kissimmee, FL
  National Provider Identifier – 1609843010
  Medicaid Provider Number – 000039800

- St. Cloud Dialysis, St. Cloud, FL
  National Provider Identifier – 1245410091
  Medicaid Provider Number – 892801100

8. Bright Dialysis, LLC, a joint venture consisting of one dialysis clinic:

- Bright Dialysis, Fort Pierce, FL
  National Provider Identifier – 1316179062
  Medicaid Provider Number – 001826000

9. Central Kentucky Dialysis Centers, LLC, a joint venture consisting of one dialysis clinic:

- Woodland Dialysis Center, Elizabethtown, KY
  National Provider Identifier – 1861452302
  Medicaid Provider Number – 7100011990

10. Columbus-RNA-DaVita, LLC, a joint venture consisting of three dialysis clinics:

- Columbus Dialysis, Columbus, OH
  National Provider Identifier – 1073787248
  Medicaid Provider Number – 2908241

- Columbus East Dialysis, Columbus, OH
  National Provider Identifier – 1952575128
  Medicaid Provider Number – 2911497

- Columbus Downtown Dialysis, Columbus, OH
  National Provider Identifier – 1528232790
  Medicaid Provider Number – 2955477

11. Wauseon Dialysis, LLC, a joint venture consisting of one dialysis clinic:

- Wauseon Dialysis Center, Wauseon, OH
  National Provider Identifier – 1306010228
  Medicaid Provider Number – 2911522

APPENDIX C

RESPONSIBILITIES OF THE INDEPENDENT MONITOR

A. Review of Selection Process and Selection Criteria, Valuation Methodologies, and Notice

1. *Selection Process and Selection Criteria Review*. During the first two Reporting Periods, the Monitor shall review and approve the Selection Process and Selection Criteria required by Section III.D. 1 of the CIA, and any subsequent modifications or changes to the Selection Process and Selection Criteria.

2. *Valuation Methodologies Review*. During the first two Reporting Periods, the Monitor shall review and approve each Valuation Methodology required by Section III.D.2 of the CIA, and any subsequent modifications or changes to those Valuation Methodologies. In conducting this review, the Monitor shall ensure that the Valuation Methodologies:

a. provide for application of the same methodologies for calculating and documenting inputs when valuing each type of Focus Arrangement; and

b. conform to standards commonly used and accepted by accountants and valuation experts.

3. *Notice to Joint Venture Partners and Medical Directors Review*. The Monitor shall review and approve each type of Notice required by Section III.E of the CIA.

a. The Monitor shall ensure that each type of Notice clearly and adequately informs all Joint Venture Partners and Medical Directors that:

i. Joint Venture Partners, Medical Directors, and their employees, colleagues, and contractors are free to refer patients to and treat patients at non-DaVita-owned dialysis clinics;

ii. DaVita will not enforce any patient-related non-disparagement or non-solicitation clauses contained in any of their existing agreements with DaVita; and

iii. in connection with joint venture clinics formed by Partial Divestitures, DaVita will not enforce the investment non-compete provisions it may have in the applicable joint venture agreements and Medical Director agreements.

b. The Monitor shall review and approve any changes or revisions DaVita makes to the wording of the Notice in the second Reporting Period before DaVita sends the Notice to its Joint Venture Partners and Medical Directors.

B. Oversight of Unwinding of Subject Joint Venture Clinics

The Monitor shall oversee DaVita's unwinding of the Subject Joint Venture Clinics as required by Section III.F of the CIA.

1. The Monitor shall review and approve each transaction required to unwind the Subject Joint Venture Clinic to ensure that it conforms to the requirements set forth in Section III.F of the CIA.

2. The Monitor shall review and approve prior to execution any "seller's non-competes" with the Joint Venture Partners who were party to a Subject Joint Venture Clinic to ensure that such clauses or agreements:

   a. do not contain patient-related non-disparagement or non-solicitation language; and

   b. do not restrict the nephrologist or nephrology practice's ability to refer patients to or treat patients at a non-DaVita- owned dialysis clinic.

C. Oversight of DaVita Dialysis Focus Arrangements

The Monitor:

1. Beginning 120 days from the Effective Date, during the first two Reporting Periods and for the first 120 days of the third Reporting Period, shall prospectively evaluate all Focus Arrangements, except Business Courtesies, that DaVita Dialysis proposes to enter into with Health Care Providers.

   a. The Monitor shall determine whether DaVita Dialysis properly applied the appropriate Valuation Methodology, as required by Section III.D.2 of the CIA.

   b. The Monitor shall determine whether the Health Care Provider was selected consistent with DaVita Dialysis's Selection Process and Selection Criteria, as applicable and required by Section III.D.l of the CIA.

   c. The Monitor shall inform DaVita Dialysis and OIG of: (1) the Risk Determination, and (2) the Monitor's basis for the Risk Determination.

2. For the first two Reporting Periods, shall review and evaluate:

   a. DaVita's corporate managerial and governance structure overseeing and executing DaVita Dialysis's selection, negotiation, and implementation of Focus Arrangements with, and compensation of, Health Care Providers;

   b. the Focus Arrangement Procedures required by Section III.D.3;

   c. DaVita Dialysis's compliance with the Focus Arrangement Requirements set forth in Section III.D.4; and

   d. DaVita's compliance program in relation to DaVita Dialysis's selection, negotiation, and implementation of Focus Arrangements with, and compensation of, Health Care Providers, including, but not limited to, training and education, policies and procedures, risk assessment, and auditing.

3. For the first two Reporting Periods, may retrospectively review, in his or her discretion, any payments made under a new or renewed Focus Arrangement to determine whether the payments comply with the laws governing the Federal health care programs, including the False Claims Act and the Anti-Kickback Statute.

4. For the first two Reporting Periods, may retrospectively review, in his or her discretion, any payments made under a Focus Arrangement existing on or before the Effective Date if the Monitor receives, identifies, or discovers information that suggests the payments do not comply with the laws governing the Federal health care programs, including the False Claims Act and the Anti-Kickback Statute, except for conduct released by the Settlement Agreement entered into between the United States and DaVita contemporaneously with this CIA. In the event of a disagreement between the Monitor and DaVita as to whether the Monitor has a basis to review under this Section C.4, the OIG shall, in its sole discretion, determine whether a basis to review exists.

D. Arrangements Review

1. For the third, fourth, and fifth Reporting Periods, the Monitor shall conduct the Arrangements Review. The Arrangements Review shall consist of two components: a systems review and a transactions review. The Monitor shall perform all components of each Arrangements Review. If there are no material changes to DaVita Dialysis's systems, processes, policies, and procedures relating to Arrangements after the end of the second Reporting Period, the Arrangements Systems Review shall be performed for the fourth Reporting Period. If DaVita Dialysis materially changes the Arrangements systems, processes, policies, and procedures during the third or fifth Reporting Periods, the Monitor shall perform an Arrangements Systems Review of the material changes for the Reporting Period in which such changes were made in addition to conducting the systems review for the fourth Reporting Period. The Arrangements Transactions Review shall be performed annually for the third, fourth, and fifth Reporting Periods.

2. *Arrangements Systems Review*. The Arrangements Systems Review shall be a review of DaVita Dialysis's systems, processes, policies, and procedures relating to the initiation, review, approval, and tracking of Arrangements. Specifically, the Monitor shall review the following:

a. DaVita Dialysis's systems, policies, processes, and procedures with respect to creating and maintaining a centralized tracking system for all existing and new and renewed Focus Arrangements (Focus Arrangements Tracking System), including a detailed description of the information captured in the Focus Arrangements Tracking System;

b. DaVita Dialysis's systems, policies, processes, and procedures for tracking remuneration to and from all parties to Focus Arrangements;

c. DaVita Dialysis's systems, policies, processes, and procedures for tracking services and activities to ensure that parties to the Focus Arrangement are performing the services required under the applicable Focus Arrangement(s) (if applicable);

d. DaVita Dialysis's systems, policies, processes, and procedures for monitoring the use of leased space, medical supplies, medical devices, equipment, or other patient care items to ensure that such use is consistent with the terms of the applicable Focus Arrangement(s) (if applicable);

e. DaVita Dialysis's systems, policies, processes, and procedures for initiating Focus Arrangements, including those policies that: (1) govern the Selection Process and Selection Criteria and the calculation and application of Valuation Methodologies, (2) identify the individuals with authority to initiate a Focus Arrangement, and (3) specify the business need or business rationale required to initiate a Focus Arrangement;

f. DaVita Dialysis's systems, policies, processes, and procedures for the internal review and approval of all Focus Arrangements, including those policies that identify the individuals required to approve each type or category of Focus Arrangement entered into by DaVita Dialysis, the internal controls designed to ensure that all required approvals are obtained, and the processes for ensuring that all Focus Arrangements are subject to a legal review by counsel with expertise in the Anti-Kickback Statute;

g. the Chief Compliance Officer's annual review of and reporting to the Board Compliance Committee on the Focus Arrangements Tracking System; DaVita Dialysis's internal review and approval process; and other Focus Arrangements systems, policies, processes, and procedures;

h. DaVita Dialysis's systems, policies, processes, and procedures for implementing effective responses when

suspected violations of the Anti-Kickback Statute are discovered, including disclosing Reportable Events and quantifying and repaying Overpayments when appropriate; and

i. DaVita Dialysis's systems, policies, processes, and procedures for ensuring that all new and renewed Focus Arrangements comply with the Focus Arrangements Requirements set forth in Section III.D.4 of the CIA.

3. *Arrangements Transactions Review*. The Arrangements Transactions Review shall consist of a review by the Monitor of 100 randomly selected Focus Arrangements that were entered into or renewed by DaVita Dialysis during the Reporting Period. The Monitor shall assess whether DaVita Dialysis has complied with Section III.D of the CIA with respect to the selected Focus Arrangements.

The Monitor's assessment with respect to each Focus Arrangement that is subject to review shall include:

a. verifying that the Health Care Provider(s) involved in the Focus Arrangement was selected consistent with DaVita Dialysis's Selection Process and Selection Criteria (if applicable);

b. verifying that the Focus Arrangement is maintained in DaVita Dialysis's centralized tracking system in a manner that permits the Monitor to identify the parties to the Focus Arrangement and the relevant terms of the Focus Arrangement (*i.e.*, the items/services/equipment/space to be provided, the amount of compensation, the effective date, the expiration date, etc.);

c. verifying that the remuneration related to the Focus Arrangement was determined using the appropriate Valuation Methodology;

d. verifying that the Focus Arrangement was subject to the internal review and approval process (including both a legal and business review) and obtained the necessary approvals, and that such review and approval is appropriately documented;

e. verifying that the remuneration related to the Focus Arrangement is properly tracked;

f. verifying that the services and activities are properly tracked and reviewed by DaVita Dialysis, and that the parties to the Focus Arrangement are performing the services required under the applicable Focus Arrangement (if applicable);

g. verifying that the use of leased space, medical supplies, medical devices, equipment, and other patient care items is properly monitored by DaVita Dialysis, and that such use is consistent with the terms of the applicable Focus Arrangement (if applicable); and

h. verifying that the Focus Arrangement satisfies the Focus Arrangements Requirements of Section III.D.4 of the CIA.

E. Compliance Audit Review

The Monitor shall conduct an annual review of annual, routine, and email compliance audits conducted of DaVita Dialysis.

1. OIG shall select three annual audits and one routine audit of DaVita Dialysis for the Monitor's review.

2. The Monitor shall select a statistically valid random sample of three email audits from the universe comprised of all email audits completed during the Reporting Period.

3. For each of the audits selected, the Monitor shall:

a. review the protocol and methodology of the audit to assess whether it was designed in a manner that sufficiently and effectively audits the issue;

b. review the work papers, including all records and references relied upon by DaVita Dialysis, to assess whether DaVita Dialysis relied on the relevant laws, regulations, and program guidance, and whether the work papers, records, and references reviewed support the findings reached by DaVita Dialysis; and

c. to the extent the Monitor finds that DaVita Dialysis's findings are unsupported or incorrect, provide the Monitor's findings and the Monitor's support for those findings.

F. Independent Investigations

During the first two Reporting Periods, the Monitor may, in his or her discretion, conduct an independent investigation of any complaint, concern, or report that the Monitor receives from any source concerning a probable violation of criminal, civil, or administrative laws applicable to any Federal health care program for which penalties or exclusion may be authorized, where:

1. such conduct is alleged to be by any member of the Board of Directors, officer, or Certifying Executive of DaVita;

2. such conduct allegedly has been approved or sanctioned by the DaVita Dialysis Compliance or Legal personnel;

3. the Monitor has concerns about the integrity or adequacy of DaVita's investigation; or

4. the Monitor otherwise believes, and OIG agrees, that DaVita Dialysis cannot effectively investigate the complaint, concern, or report,

except for conduct released by the Settlement Agreement entered into between the United States and DaVita contemporaneously with this CIA. The Monitor shall report its findings from any independent investigation conducted pursuant to this Section F to both DaVita and OIG. The Monitor shall complete any independent investigation begun but not completed during the first two Reporting Periods.

G. Quarterly Reports

1. The Quarterly Reports shall include, but shall not be limited to:

a. the Monitor's findings and recommendations to DaVita based on the work performed by the Monitor under Sections A, B, C, E, and F, above;

b. a list of the Subject Joint Venture Clinics unwound each quarter, a description of the terms of each transaction, and the Monitor's rationale for approving the transactions required to accomplish the unwinding;

c. a list of the Focus Arrangements reviewed each quarter, the Risk Determination for each of the listed Focus Arrangement, and the basis for each Risk Determination;

d. a list of the Focus Arrangements that DaVita Dialysis entered into each quarter, the Risk Determination for each of the listed Focus Arrangements, and the basis for each Risk Determination; and

e. the Monitor's evaluation of corrective actions taken by DaVita Dialysis based on the Monitor's findings and recommendations.

2. The Monitor shall submit via overnight delivery Quarterly Reports covering the first two Reporting Periods and the first 120 days of the third Reporting Period, with the first Quarterly Report due 30 days after the first quarter of the first Reporting Period. The last Quarterly Report shall be due 30 days after the first quarter of the third Reporting Period.

3. The Monitor may provide written recommendations to DaVita in between the Quarterly Reports, provided that the recommendations are simultaneously sent to OIG and included in the subsequent Quarterly Report. DaVita shall include its response and corrective action plans in its corresponding Quarterly Response Report.

4. With each Quarterly Report, the Monitor shall include a certification, signed by the Monitor, stating that the individuals who assisted in fulfilling the oversight obligations required by Sections A, B, C, E, and F, above, possessed the professional competence necessary to perform the work.

H. Annual Reports

The Monitor shall submit via overnight delivery each Annual Report no later than 80 days after the end of the Reporting Period for which the review was performed. With each individual review report, the Monitor shall include a certification, signed by the Monitor, stating that the individuals who worked on the review possessed the professional competence necessary to perform the work.

1. *Compliance Audit Review Report*. The Compliance Audit Review Report shall contain:

a. For each audit reviewed:

i. a description of the audit's objective, protocol, methodology, and results;

ii. the Monitor's assessment of DaVita Dialysis's performance of the audit, including the identification of any issues or deficiencies with the protocol and/or methodology, and any unsupported or incorrect findings; and

iii. to the extent DaVita Dialysis's findings are unsupported or incorrect, the Monitor's findings and the Monitor's justification for those findings.

b. The Monitor's observations and recommendations concerning:

i. the strengths and weaknesses of DaVita Dialysis's performance of the audits;

ii. any improvements to DaVita Dialysis's compliance audit program to address specific problems or weaknesses identified through the Compliance Audit Review; and

iii. other improvements that could strengthen DaVita Dialysis's compliance audit program.

2. *Arrangements Systems Review Report.* The Monitor shall prepare a report based upon each Arrangements Systems Review performed. The Arrangements Systems Review Report shall include the following information:

a. a description of the documentation (including policies) reviewed and personnel interviewed;

b. a detailed description of DaVita Dialysis's systems, policies, processes, and procedures relating to the items identified in Section D.2.a–i above;

c. findings and supporting rationale regarding weaknesses in DaVita Dialysis's systems, policies, processes, and procedures relating to Arrangements described in Section D.2.a–i above; and

d. recommendations to improve DaVita Dialysis's systems, policies, processes, or procedures relating to Arrangements described in Section D.2.a–i above.

3. *Arrangements Transactions Review Report*. The Monitor shall prepare a report based on each Arrangements Transactions Review performed. The Arrangements Transactions Review Report shall include the following information:

a. *Review Methodology*

i. Review Protocol. A detailed narrative description of the procedures performed and a description of the sampling unit and universe utilized in performing the procedures for the sample reviewed.

ii. Sources of Data. A full description of the documentation and other information, if applicable, relied upon by the Monitor in performing the Arrangements Transactions Review.

iii. Supplemental Materials. The Monitor shall request all documentation and materials required for its review of the Focus Arrangements selected as part of the Arrangements Transactions Review, and DaVita Dialysis shall furnish such documentation and materials to the Monitor prior to the Monitor initiating its review of the Focus Arrangements. If the Monitor accepts any supplemental documentation or materials from DaVita Dialysis after the Monitor has completed its initial review of the Focus Arrangements (Supplemental Materials), the Monitor shall identify in the Arrangements Transactions Review Report the Supplemental Materials, the date the Supplemental Materials were accepted, and the relative weight the Monitor gave to the Supplemental Materials in its review. In addition, the Monitor shall include a narrative in the Arrangements Transactions Review Report describing the process by which the Supplemental Materials were accepted and the Monitor's reasons for accepting the Supplemental Materials.

2. *Review Findings*. The Arrangements Transactions Review Report shall include the Monitor's findings with respect to each of the items set forth in Section D.3.a-h, above. In addition, the Monitor shall identify in the Arrangements Transactions Review Report any Focus Arrangement(s) reviewed that a reasonable person would consider a probable violation of the Anti-Kickback Statute, along with the Monitor's basis for reaching that conclusion. The Arrangements Transactions Review Report also shall include observations, findings, and recommendations on possible improvements to DaVita Dialysis's systems, policies, processes, and procedures in place to ensure that all Focus Arrangements comply with the Focus Arrangements Procedures and Focus Arrangements Requirements.

I. Extension of Certain Independent Monitor Responsibilities

OIG may, in its sole discretion, determine that the Monitor should continue to perform his or her responsibilities under Sections A, B, C, F, and G of this Appendix for the full third Reporting Period. If the OIG exercises this discretion, the requirements of Section D of this Appendix shall be tolled for the third Reporting Period.

APPENDIX D

EXECUTIVE FINANCIAL RECOUPMENT PROGRAM

DaVita shall establish and maintain throughout the term of the CIA a financial recoupment program that puts at risk of forfeiture and recoupment an amount equivalent to up to three years of annual performance pay (e.g., annual bonus, plus long-term incentives) for a Covered Executive who is discovered to have been involved in any significant misconduct (Executive Financial Recoupment Program). This financial recoupment program shall apply to Covered Executives who are either current DaVita employees or who are former DaVita employees at the time of a Recoupment Determination.

A. Existing Commitments. Pursuant to DaVita's existing Board-approved clawback policy (the "Clawback Policy"), if the Board of Directors of DaVita (the "Board") determines that any fraud or intentional misconduct by an executive officer or director was a significant contributing factor to the Company having to restate all or a portion of its consolidated financial statements, the Board may (i) require reimbursement of any bonus or incentive compensation paid to such executive or director, (ii) cause the cancellation of restricted stock unit awards and outstanding stock appreciation rights or stock options granted to such executive officer or director, and (iii) seek reimbursement of any gains realized that are attributable to such awards. These actions may be taken if (a) the amount of incentive compensation was calculated based on the achievement of certain financial results that were subsequently reduced due to a financial statement restatement, (b) the executive officer or director engaged in any fraud or intentional misconduct that was a significant contributing factor to the need for the restatement and (c) the amount of the bonus or incentive compensation that would have been awarded to the officer had the financial results been properly reported would have been lower than the amount actually awarded. Under the Clawback Policy, the Company may not seek to recover bonuses or incentive or equity-based compensation paid or which vests more than three years prior to the date the applicable financial statement restatement is disclosed. In addition, pursuant to the terms of certain awards made under the DaVita Healthcare Partners Inc. 2011 Incentive Award Plan (the "LTI Plan"), an award shall terminate, and the Company may seek repayment of gains realized by a recipient of such an award, if the recipient of the award (w) breaches certain restrictive covenants contained in the award, (x) is convicted of a felony, (y) is adjudicated by a court of competent jurisdiction to have committed an act of fraud or dishonesty resulting or intending to result directly or indirectly in personal enrichment at the expense of DaVita, or (z) is excluded from participating in any Federal health care program (the "Award Provisions" and, together with the Clawback Policy, the "Existing Commitments").

If DaVita discovers any employee misconduct that would implicate the forfeitures described in this paragraph, it will evaluate the situation and make a determination about

whether any forfeiture, and the terms of such forfeiture, will be implemented. DaVita reserves the right to amend the Existing Commitments in order to implement any changes required by rules that may be adopted by the Securities and Exchange Commission and the New York Stock Exchange pursuant to the Dodd-Frank Act relating to clawback policies.

B. New Commitments. In addition to the compensation forfeiture provisions of the Existing Commitments already in place with respect to annual bonuses and other forms of incentive compensation, no later than December 31, 2014, DaVita shall modify and supplement the provisions of its annual bonus plan and any plans and programs that provide for the award of long-term incentives (i.e., awards that have vesting dates later than the one year anniversary of the grant date), whether based on or settled in cash or equity, and whether under the LTI Plan or any other plan or program (collectively, the "LTI Program") and any employment agreements, as appropriate, by imposing the following eligibility and repayment conditions on future bonuses and LTI Program awards, as well as establishing the mandatory tolling remedy and additional remedies described below (collectively, "New Commitments") to all Covered Executives. The New Commitments shall apply prospectively to Covered Executives beginning with the 2015 bonus plan year and LTI Program awards (bonuses earned in 2015 and paid out in 2016 and LTI awards granted in 2015).

1. *Covered Executive Bonus Eligibility and Repayment Conditions*. DaVita shall implement an eligibility and repayment condition on annual bonuses designed to survive both the payment of the bonus and the separation of a Covered Executive's employment. This will allow DaVita, as a consequence of a Triggering Event as defined below in Section C, to pursue repayment from the Covered Executive of all or any portion of the bonus monies paid to the Covered Executive. To the extent permitted by controlling law, these bonus eligibility and repayment conditions will survive the payment of the Covered Executive's bonus and the separation of the Covered Executive's employment for a period of three years from the payment of the bonus for the plan year.

Consistent with a Recoupment Determination, as defined below in Section D, DaVita shall endeavor to collect repayment of any bonus from the Covered Executive through reasonable and appropriate means according to the terms of its bonus plan (or employment agreement, as the case may be) and to the extent permitted by controlling law of the relevant jurisdiction. If necessary to collect the repayment, DaVita shall file suit against the Covered Executive unless good cause exists not to do so. For purposes of the Executive Financial Recoupment Program, "good cause" shall include, but not be limited to, a financial inability on the part of the Covered Executive to repay any recoupment amount or DaVita's inability to bring such a suit under the controlling law of the relevant jurisdiction.

2. *LTI Program Awards.* DaVita shall implement, in all long-term incentive awards that vest in three or more years, a right to clawback any unvested equity or target cash value if a Triggering Event occurred within three years after the issuance of the award. In the event the long-term incentive award vesting is less than three years, DaVita shall implement a right to seek recoupment or forfeiture, as the situation requires, of the portion of the award that has vested and/or been paid or otherwise monetized by the Covered Executive within three years from the grant date. This right is designed to survive the issuance of the awards in the event the award vests in less than three years and to survive the separation of a Covered Executive's employment. This will allow DaVita, as a consequence of a Triggering Event as defined below in Section C, to compel disgorgement by the Covered Executive of all or any portion of the award granted to the Covered Executive, including all unvested awards and payments made to, or value realized by, the Covered Executive. This will also provide that, as a consequence of a Triggering Event, DaVita may pursue repayment by a Covered Executive who is a former employee of all or any portion of the last three years' worth of share option and restricted share grants that became vested and were paid during the Covered Executive's last years of employment and following termination of employment.

To the extent permitted by controlling law, these eligibility and repayment conditions shall survive vesting and payment for a period of three years from the Covered Executive's employment termination date. Consistent with a Recoupment Determination, DaVita shall endeavor to collect repayment of these LTI Program awards from the Covered Executive through reasonable and appropriate means and to the extent permitted by controlling law of the applicable jurisdiction. If necessary to collect the repayment, DaVita shall file suit against the Covered Executive unless good cause exists not to do so.

3. *Tolling Remedy*. To the extent permitting by controlling law, for the three years during which the bonus eligibility and repayment conditions exist, if DaVita reasonably anticipates that a Triggering Event has occurred pursuant to Section C of this Appendix, and DaVita has recoupment rights remaining under Sections B.l and B.2 of this Appendix, DaVita shall have the right to notify the Covered Executive that those rights shall be tolled and thereby extended for an additional three years or until the Recoupment Committee determines that a Triggering Event has not occurred, whichever is earlier, to the extent permitted by applicable controlling law.

4. *Additional Remedies*. If, after expiration of the time period specified in Sections B.l and B.2, above, the Recoupment Committee determines that a Triggering Event occurred, DaVita shall make a determination as to whether to pursue available remedies (e.g., filing suit against the Covered Executive) existing under statute or common law to the extent available.

C. Triggering Events

1. DaVita shall revise, as necessary, its bonus plan and LTI Program requirements (and employment agreements, if applicable) to provide that a Covered Executive will be ineligible for an annual bonus or LTI Program award upon discovery of significant misconduct, which shall include violations of a significant DaVita policy, applicable regulations, or law.

2. *Definition of Triggering Event*. The eligibility and repayment conditions described above shall be triggered upon a Recoupment Determination that finds:

a. significant misconduct (e.g., violation of a significant DaVita policy, or applicable regulations or law) by the Covered Executive that, if discovered prior to payment, would have made the Covered Executive ineligible for an annual bonus or LTI Program award in that program year or subsequent program years; or

b. significant misconduct by subordinate employees in the business unit over which the Covered Executive had responsibility that does not constitute an isolated occurrence and which the Covered Executive knew or should have known was occurring that, if discovered prior to payment, would have made the Covered Executive and/or employees in question ineligible for an annual bonus or LTI Program award in that program year or subsequent program years.

D. Administration of Recoupment Program. DaVita shall engage in a standardized, formal process to determine, in its sole discretion, whether a Triggering Event has occurred and, if so, the extent of bonus monies, LTI Program awards, and deferred compensation that are subject to repayment or forfeiture by the Covered Executive, and the most appropriate method for securing recoupment of relevant monies previously paid to or value realized by a Covered Executive. The findings and conclusions resulting from this process shall be referred to as the "Recoupment Determination."

1. *Initiation*. DaVita shall initiate the Recoupment Determination process upon: (1) discovery of potential significant misconduct that may rise to the level of a Triggering Event, or (2) written notification by a United States federal government agency to the Chief Compliance Officer of DaVita of a situation that may rise to the level of a Triggering Event and gives rise (or may give rise) to liability relating to Federal health care programs. This written notification shall either identify the Covered

Executive(s) potentially at issue or provide information (e.g., a description of the alleged misconduct and the applicable time period) to allow DaVita to identify the Covered Executive and alleged misconduct.

2. *Recoupment Committee*. The Recoupment Determination shall be made by a committee of senior executives headed by the Chief Compliance Officer (Recoupment Committee). In the event a Recoupment Determination must be made with respect to a member of the Recoupment Committee, it shall be made by the Board Compliance Committee.

3. *Timeline for Recoupment Determination Process*. DaVita shall initiate the Recoupment Determination process within 30 days after discovery by DaVita or notification, pursuant to Section D.l of this Appendix, of a potential Triggering Event. Absent extraordinary reasons, DaVita shall reach a Recoupment Determination within 90 days after initiation of the determination process.

In connection with making its Recoupment Determination, the Recoupment Committee or appropriate Delegate (as defined below), pursuant to implementing policies and procedures, shall:

a. undertake an appropriate and substantive review or investigation of the facts and circumstances associated with the Triggering Event or any written notifications about potential Triggering Events received pursuant to Section D.l, above;

b. make written findings regarding the facts and circumstances associated with the Triggering Event and any written notifications about potential Triggering Events received pursuant to Section D.l, above; and

c. set forth in writing its determinations (and the rationale for such determinations) about:

   i. whether a Triggering Event occurred;

   ii. the extent of bonus monies, LTI Program award payments made or value realized, or deferred compensation that will be subject to forfeiture and/or repayment by the Covered Executive;

iii the means that will be followed to implement the forfeiture and/or secure the recoupment of performance pay from the Covered Executive; and

iv the timetables under which DaVita will implement the forfeiture and/or attempt to recoup the performance pay.

For purposes of this section, a "Delegate" shall refer to the DaVita personnel to whom the Recoupment Committee has delegated one or more of its required tasks in furtherance of the Executive Financial Recoupment Program.

E. Reporting. The Recoupment Committee shall provide annual reports to the Board (or an appropriate committee thereof) about: (1) the number and circumstances of any Triggering Events that occurred during the preceding year and any written notifications about potential Triggering Events received pursuant to Section D.l, above; (2) a description of any Recoupment Determinations made during the preceding year (including any decision to require or not require forfeiture/recoupment from any Covered Executives, the amount and type of any forfeiture/recoupment, the means for collecting any recoupment, and the rationale for such decisions); and (3) a description of the status of any forfeitures and/or recoupments required under prior Recoupment Determinations that were not fully completed in prior years.

The Recoupment Committee shall also provide annual reports to the OIG about: (1) the number and circumstances of any Triggering Events that occurred during the preceding year and any written notifications about potential Triggering Events received pursuant to Section D.l, above; (2) a summary description of any Recoupment Determinations made during the preceding year (including any decision to require or not require forfeiture/recoupment from any Covered Executives, the amount and type of any forfeiture/recoupment, the method for collecting any recoupment, and the rationale for such decisions); and (3) a description of the status of any forfeitures and/or recoupments required under prior Recoupment Determinations that were not fully completed in prior years.

DaVita shall maintain all of the forfeiture and recoupment commitments set forth in Sections A–E above for at least the CIA Period.

APPENDIX E

EXCLUDED JOINT VENTURES

A. Conditions

In exchange for OIG's agreement that the joint ventures listed below ("Excluded Joint Ventures") will be excluded as parties to the CIA, DaVita agrees to the following:

1. During the CIA Period, each of the dialysis clinics that is owned and operated by the Excluded Joint Ventures will be managed pursuant to a Management Services Agreement with DaVita Dialysis, and all individuals and entities who provide items or services to the Excluded Joint Ventures will be considered Covered Persons to the same extent that individuals and entities who provide items or services to joint ventures that are parties to the CIA qualify as Covered Persons.

2. DaVita shall fulfill the obligations of Section III.P of the CIA (Reportable Events) for any Reportable Event that occurs at a dialysis clinic owned by an Excluded Joint Venture.

3. DaVita shall notify OIG of any sale of its interest in an Excluded Joint Venture or closure of any dialysis clinic that is owned and operated by the Excluded Joint Venture to the same extent as it is required to notify OIG of changes to DaVita Dialysis business units or locations under Section IV of the CIA.

4. OIG shall be able to exercise its rights under Section VII of the CIA to inspect DaVita's books, records, and other documents and supporting materials related to and/or conduct on-site reviews at the dialysis clinics owned and operated by the Excluded Joint Ventures for the purpose of determining DaVita's compliance with the CIA and DaVita Dialysis's compliance with the requirements of the Federal health care programs.

5. Section X of the CIA shall apply to DaVita for any violations of the CIA by DaVita or DaVita Dialysis that involve or occur at an Excluded Joint Venture.

B. List of Excluded Joint Ventures

1. Bluegrass Dialysis, LLC

2. DVA Healthcare Southwest Ohio, LLC

3. DVA/Washington University Healthcare of Greater St. Louis, LLC
4. Fields Dialysis, LLC
5. Greater Los Angeles Dialysis Center, LLC
6. ISD Lees Summit LLC, f/k/a DSI Lees Summit LLC
7. ISD Plainfield, LLC, f/k/a DSI Plainfield, LLC
8. Ohio River Dialysis, LLC
9. Physicians Dialysis of Houston, LLP
10. Pittsburgh Dialysis Partners, LLC
11. River Valley Dialysis, LLC
12. Southcrest Dialysis, LLC
13. UT Southwestern DVA Healthcare, LLP

APPENDIX F

JOINT VENTURES EXCEPTED FROM THE PARTIAL DIVESTITURE BAN

1. Basin Dialysis, LLC
2. Bluegrass Dialysis, LLC
3. Borrego Dialysis, LLC
4. Carroll County Dialysis Facility Limited Partnership
5. Cimarron Dialysis, LLC
6. DVA Healthcare – Southwestern Ohio, LLC
7. DVA Healthcare of New London, LLC
8. DVA Healthcare of Norwich, LLC
9. DVA Healthcare of Tuscaloosa, LLC (f/k/a REN Centers of Tuscaloosa, LLC)
10. Fields Dialysis, LLC
11. Green Desert Dialysis, LLC
12. Grosse Pointe Dialysis LLC & Medical Director Agreement for the Grosse Pointe Dialysis Center
13. Joshua Dialysis, LLC
14. Lockhart Dialysis, LLC
15. Longworth Dialysis. LLC
16. Mountain West Dialysis Services LLC
17. Ohio River Dialysis, LLC
18. River Valley Dialysis, LLC (f/k/a Greater Ohio River Dialysis, LLC)

19. Roose Dialysis, LLC
20. Routt Dialysis, LLC
21. Star Dialysis, LLC
22. Total Renal Care of North Carolina, LLC
23. TRC-Four Corners Dialysis Clinics, LLC
24. Tustin Dialysis Center, LLC
25. UT Southwestern DVA Healthcare, LLP
26. Valley Springs Dialysis, LLC

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 8-K

CURRENT REPORT
Pursuant to Section 13 or 15(d) of the
Securities Exchange Act of 1934

Date of Report (date of earliest event reported): October 22, 2014

DAVITA HEALTHCARE PARTNERS INC.
(Exact name of registrant as specified in its charter)

Delaware	1-14106	No. 51-0354549
(State or other jurisdiction of incorporation)	(Commission File Number)	(IRS Employer Identification No.)

2000 16th Street
Denver, CO 80202
(Address of principal executive offices including Zip Code)

(303) 405-2100
(Registrant's telephone number, including area code)

Not applicable
(Former name or former address, if changed since last report)

Check the appropriate box below if the Form 8-K filing is intended to simultaneously satisfy the filing obligation of the registrant under any of the following provisions:

☐ Written communications pursuant to Rule 425 under the Securities Act (17 CFR 240.425)

☐ Soliciting material pursuant to Rule 14a-12 under the Exchange Act (17 CFR 240.14a-12)

☐ Pre-commencement communications pursuant to Rule 14d-2(b) under the Exchange Act (17 CFR 240.14d-2(b))

☐ Pre-commencement communications pursuant to Rule 13e-4(c) under the Exchange Act (17 CFR 240.13e-4(c))

Item 1.01. Entry into a Material Definitive Agreement.

On October 22, 2014, DaVita HealthCare Partners Inc. (the "Company") entered into a final settlement agreement (the "Settlement Agreement") with the United States of America, acting through the United States Department of Justice and on behalf of the Office of Inspector General of the Department of Health and Human Services (the "OIG"), the Defense Health Agency on behalf of TRICARE, through its General Counsel (collectively, the "United States") and relator David Barbetta, to resolve the pending 2010 and 2011 U.S. Attorney Physician Relationship Investigations. Under the Settlement Agreement, the Company will pay $350 million plus accrued interest from February 8, 2014, at the rate of 2.25% per annum to the United States, plus a civil forfeiture of $39 million (together, the "Settlement Payment"). In addition, the Company has agreed in principle to a settlement of certain state Medicaid claims in the amount of $11.5 million plus interest. The Company had previously announced an agreement in principle in these matters and had accrued an estimated loss contingency reserve of $397 million. In the third quarter of 2014, the Company increased the reserve from $397 million to $414 million.

Under the Settlement Agreement, the United States agrees to release the Company from any civil or administrative monetary liability arising from allegations that the Company caused the submission of claims to the federal health care programs that were ineligible for reimbursement due to certain violations of the Anti-Kickback Statute in connection with certain of its dialysis center joint venture arrangements. Additionally, under the Settlement Agreement the United States and the relator agree to dismissal of the civil action filed by the relator under the qui tam provisions of the False Claims Act, and the OIG agrees, conditioned upon the Company's full payment of the Settlement Payment, to release its permissive exclusion rights and to refrain from instituting proceedings to exclude the Company or any Company affiliates from participating in Medicare, Medicaid or other Federal health care programs.

The Settlement Agreement reflects the Company's disagreement with the United States' claims and contains no admissions of facts or liability on the part of the Company. The Settlement Payment does not include the payment of the relator's expenses, costs and attorney's fees, the amount of which remain under negotiation. The United States has also informed the Company that it has declined to proceed with any criminal charges in connection with this matter.

In connection with the resolution of this matter, and in exchange for the OIG's agreement not to exclude the Company from participating in the federal health care programs, the Company has entered into a five-year corporate integrity agreement (the "Corporate Integrity Agreement") with the OIG. The Corporate Integrity Agreement, a copy of which is attached as Exhibit 10.1 hereto, requires that the Company maintain certain elements of its compliance programs and imposes certain expanded compliance-related requirements during the term of the Corporate Integrity Agreement. Among these requirements are the following:

- Establishment of specific procedures to track and ensure compliance of relationships between its domestic dialysis business and referral sources with the Anti-Kickback Statute.
- Retention of an independent monitor to perform duties under the Corporate Integrity Agreement, which include pre-review and oversight of proposed relationships between its domestic dialysis business and certain referral sources.
- Supplementing the Company's current executive compensation clawback program to specifically address certain compliance-related matters.
- Cooperation with future investigations by the OIG.

In addition to the foregoing, the Corporate Integrity Agreement includes ongoing monitoring, reporting, certification, records retention and training obligations, the formal allocation of certain oversight responsibility to the Board's Compliance Committee, the creation of a Management Compliance Committee and the retention of an independent compliance advisor to the Board.

The Corporate Integrity Agreement also contains certain business restrictions related to a subset of the Company's joint venture arrangements. Pursuant to these obligations, the Company has agreed to: (1) unwind 11 joint venture transactions that were created through partial divestitures to or partial acquisitions from Nephrologists and that cover 26 of the Company's 2,119 clinics; (2) not enter into certain types of partial divestiture joint venture transactions with nephrologists during the term of the Corporate Integrity Agreement and (3) certain other restrictions.

In the event of a breach of the Corporate Integrity Agreement, the Company could become liable for payment of certain stipulated penalties, or could be excluded from participation in federal health care programs. The costs associated with compliance with the Corporate Integrity Agreement could be substantial and may be greater than we currently anticipate.

The foregoing descriptions of the Corporate Integrity Agreement is qualified in its entirety by the full terms of that agreement, which is attached as Exhibit 10.1 hereto and incorporated herein by reference.

Item 7.01. Regulation FD Disclosure.

On October 22, 2014, the Company issued a press release titled "DaVita Kidney Care Finalizes DOJ Settlement." A copy of the press release is attached hereto as Exhibit 99.1.

The information contained in Item 7.01 of this Current Report on Form 8-K (including Exhibit 99.1 attached hereto) is being furnished and shall not be deemed to be "filed" for the purposes of Section 18 of the Securities Exchange Act of 1934, as

amended (the "Exchange Act"), or otherwise subject to the liabilities of that section and shall not be incorporated by reference in any filing under the Securities Act of 1933, as amended, or the Exchange Act, except as shall be expressly set forth by specific reference in such filing.

Item 9.01. Financial Statements and Exhibits.

(d) Exhibits.

Exhibit No.	Description
10.1	Corporate Integrity Agreement, dated as of October 22, 2014, by and among the Office of Inspector General of the Department of Health and Human Services and DaVita HealthCare Partners Inc.
99.1	Press Release dated October 22, 2014 announcing the registrant's entry into a settlement agreement and corporate integrity agreement.

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned hereunto duly authorized.

DAVITA HEALTHCARE PARTNERS INC.

Date: October 23, 2014

By: /s/ Kim M. Rivera
Kim M. Rivera
Chief Legal Officer

EXHIBIT INDEX

Exhibit No.	Description
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99.1	Press Release dated October 22, 2014 announcing the registrant's entry into a settlement agreement and corporate integrity agreement.

EX-99.1 3 d807612dex991.htm EX-99.1

Exhibit 99.1



PRESS RELEASE

DaVita Kidney Care Finalizes DOJ Settlement

Resolves all Pending Issues Regarding Joint Ventures in Question

DENVER (Oct. 22, 2014) – DaVita Kidney Care, a division of DaVita HealthCare Partners Inc. (NYSE: DVA) today announced it has finalized its comprehensive settlement with the U.S. Department of Justice and certain other federal agencies into allegations of improperly structured joint ventures with certain physician partners.

As announced in February of this year, DaVita Kidney Care will be subject to a Corporate Integrity Agreement and an independent monitor to oversee certain future joint ventures. The agreement also includes a repayment to the government and a provision requiring executive certification of quarterly and annual compliance reports.

The following statement is attributable to DaVita Kidney Care:

We are pleased to announce a civil resolution of the government's thorough review of our joint venture practices that covered more than a decade's worth of transactions. Patient care was never at issue, nor were billing or payment practices.

We are proud of our commitment to compliance over our 15-year history. We have worked incredibly hard to get things right and it is our belief there was no intentional wrongdoing.

We believe this settlement is the right thing for our teammates, partners and shareholders. It allows us to move forward with heightened clarity and transparency, both with regulators and our physician partners. As part of the settlement we will undo 11 joint venture transactions covering 26 of our 2,119 clinics.

We thank our teammates and physicians for their uninterrupted dedication in providing the highest quality care in the industry to the nearly 170,000 kidney care patients we serve in the U.S. This commitment is reflected in the government's recent annual Quality Improvement Program report card which shows DaVita leading the industry in all quality indicators measured.

About DaVita Kidney Care

DaVita Kidney Care is a division of DaVita HealthCare Partners Inc. a Fortune 500(r) company that, through its operating divisions, provides a variety of health care services to patient populations throughout the United States and abroad. A leading provider of dialysis services in the United States, DaVita Kidney Care treats patients with chronic kidney failure and end stage renal disease. DaVita Kidney Care strives to improve patients' quality of life by innovating clinical care, and by offering integrated treatment plans, personalized care teams and convenient health-management services. As of June 30, 2014, DaVita Kidney Care operated or provided administrative services at 2,119 outpatient dialysis centers located in the United States serving approximately 168,000 patients. The company also operated 84 outpatient dialysis centers located in 10 countries outside the United States. DaVita Kidney Care supports numerous

programs dedicated to creating positive, sustainable change in communities around the world. The company's leadership development initiatives and social responsibility efforts have been recognized by Fortune, Modern Healthcare, Newsweek and WorldBlu. For more information, please visit DaVita.com.

Contact Information

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News Releases

DaVita Kidney Care Announcement Regarding Atlanta Lawsuit

Company nears settlement of longstanding private case

DENVER, May 4, 2015 /PRNewswire/ -- DaVita Kidney Care, a division of DaVita HealthCare Partners Inc. (NYSE: DVA) and a leading provider of kidney care services, today announced the next step in an agreement in principle for a settlement in an Atlanta-based case, which previously was announced on April 15. The lawsuit was brought by private attorneys regarding allegations of medication wastage from 2003 to 2010.

"We should be held to high standards of accountability," said Javier Rodriguez, CEO of DaVita Kidney Care. "Our 67,000 teammates across 11 countries look forward to putting this behind us. We can now renew our focus on collaborating with regulators to avoid situations like this going forward."

"Although we believe strongly in the merits of our case, we decided it was in our stakeholders' best interests to resolve it," said Chief Legal Officer for DaVita HealthCare Partners Kim Rivera. "The potential mandatory penalties for being found in the wrong in even a small percentage of instances were simply too large."

"Our current compliance program is already much more comprehensive than what we had five to 10 years ago," said Chief Compliance Officer for DaVita HealthCare Partners Jeanine Jiganti. "We will use this experience to take our effectiveness to a whole new level going forward."

DaVita Kidney Care thanks its teammates and physicians for their dedication to providing the highest quality kidney care to the more than 170,000 patients they serve. This commitment to their patients is reflected in the government's two key scoring reports: The Quality Incentive Plan and the Five-Star Rating System. DaVita Kidney Care is the clear national leader in kidney care clinical outcomes, outperforming the industry in both.

About DaVita Kidney Care

DaVita Kidney Care is a division of DaVita HealthCare Partners Inc., a Fortune 500® company that, through its operating divisions, provides a variety of health care services to patient populations throughout the United States and abroad. A leading provider of dialysis services in the United States, DaVita Kidney Care treats patients with chronic kidney failure and end stage renal disease. DaVita Kidney Care strives to improve patients' quality of life by innovating clinical care, and by offering integrated treatment plans, personalized care teams and convenient health-management services. As of March 31, 2015, DaVita Kidney Care operated or provided administrative services at 2,197 outpatient dialysis centers located in the United States serving approximately 174,000 patients. The company also operated 93 outpatient dialysis centers located in 10 countries outside the United States. DaVita Kidney Care supports numerous programs dedicated to creating positive, sustainable change in communities around the world. The company's leadership development initiatives and social responsibility efforts have been recognized by Fortune, Modern Healthcare, Newsweek and WorldBlu. For more information, please visit DaVita.com.

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Logo - http://photos.prnewswire.com/prnh/20140318/DC85712LOGO

SOURCE DaVita Kidney Care

Appendix 21

DaVita Top Clinical Outcomes

Press Release April 2018

DaVita News

DaVita Continues to Improve Patient Care, Leads in Five-Star Quality Ratings

Company earns its most ever three-, four- and five-star rated centers

DENVER, April 27, 2018 /PRNewswire/ -- DaVita Kidney Care, a division of DaVita Inc. (NYSE: DVA) and a leading provider of kidney care services in the United States, today announced it has led the industry for the fourth year by meeting or exceeding Medicare standards in the Centers for Medicare & Medicaid Services (CMS) Five-Star Quality Rating System (Five-Star).

DaVita's focus on helping improve patients' health and quality of life is demonstrated in this year's Five-Star ratings, where the company has more three, four and five star centers than it has ever had in the history of the program. The results mark DaVita's best quality performance in the program to date.

"The entire kidney care community has come together through Five-Star to raise the bar on quality year over year," said Javier Rodriguez, CEO for DaVita Kidney Care. "It's time to honor our collective success—and our commitment to clinical improvement—in the best interest of our patients and their families."

The broader kidney care community has also continued to improve with an increase in the number of dialysis centers receiving a three-, four- or five-star quality rating by 10 percent since 2016. Other meaningful improvements have been demonstrated in publicly reported clinical quality measures, including:

- 3 percent improvement in dialysis adequacy, which measures how well dialysis removes waste from the blood.
- 8 percent improvement in bloodstream infections, which are one of the leading causes of hospitalizations among dialysis patients.

"Improved clinical quality means patients have greater access to better care. That is the real victory of Five-Star," said Allen R. Nissenson, M.D., FACP, chief medical officer for DaVita Kidney Care. "DaVita continues to evolve our patient-centered clinical programs to deliver optimal care so our patients have a better chance of staying home with loved ones and friends instead of being in and out of the hospital."

All center ratings can be found on the Dialysis Facility Compare website.

To learn more about DaVita Kidney Care's commitment to quality, visit DaVita.com/Five-Star.

About DaVita Kidney Care

DaVita Kidney Care is a division of DaVita Inc., a Fortune 500® company, that through its operating divisions provides a variety of health care services to patient populations throughout the United States and abroad. A leading provider of dialysis services in the United States, DaVita Kidney Care treats patients with chronic kidney failure and end stage renal disease. DaVita Kidney Care strives to improve patients' quality of life by innovating clinical care, and by offering integrated treatment plans, personalized care teams and convenient health-management services. As of Dec. 31, 2017,

DaVita Kidney Care operated or provided administrative services at 2,510 outpatient dialysis centers located in the United States serving approximately 198,000 patients. The company also operated 237 outpatient dialysis centers located in 11 countries outside the United States. DaVita Kidney Care supports numerous programs dedicated to creating positive, sustainable change in communities around the world. The company's leadership development initiatives and social responsibility efforts have been recognized by Fortune, Modern Healthcare, Newsweek and WorldBlu. For more information, please visit DaVita.com.

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SOURCE DaVita Kidney Care

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http://pressreleases.davita.com/2018-04-27-DaVita-Continues-to-Improve-Patient-Care-Leads-in-Five-Star-Quality-Ratings

Appendix 22

Non-Binding Contractor’s Estimate

AXIOM
NORTHWEST CONSTRUCTION INC.

DaVita Dialysis Auburn - TI

Request for Budget Proposal - May 2018

GSF
11,500

Division	*Description*		*SHELL Bid Amounts*	*LIFE SAFETY Bid Amounts*	*TI Bid Amounts*	*Costs*	*Costs/SF*
1	General Requirements		-	-	114,795.00	114,795.00	9.98
2	Site Work		-		-	-	-
3	Concrete		-		76,420.00	76,420.00	6.65
4	Masonry		-		-	-	-
5	Metals		-		-	-	-
6	Wood and Plastics		-		242,865.00	242,865.00	21.12
7	Moisture Protection		-		15,080.00	15,080.00	1.31
8	Doors and Windows		-		102,900.00	102,900.00	8.95
9	Finishes		-		385,975.00	385,975.00	33.56
10	Specialties		-	-	83,200.00	83,200.00	7.23
11	Equipment		-		-	-	-
12	Furnishings		-		-	-	-
13	Special Construction		-		-	-	-
14	Conveying Systems		-		-	-	-
15	Mechanical		-	-	504,900.00	504,900.00	43.90
16	Electrical		-	-	167,200.00	167,200.00	14.54
	Subtotal		**$ -**	**$ -**	**$ 1,693,335.00**	**$ 1,693,335.00**	**$ 147.25**
	Taxes and Insurance	3.5%	-	-	59,266.73	59,266.73	5.15
	Overhead and Markup	8%	-	-	140,208.14	140,208.14	12.19
	Total Direct Cost		**$ -**	**$ -**	**$ 1,892,809.86**	**$ 1,892,809.86**	**$ 164.59**
*	***WA State Sales Tax Code 1732***	10.0%	-	-	189,280.99	189,280.99	16.46
	Total Cost		**$ -**	**$ -**	**$ 2,082,090.85**	**$ 2,082,090.85**	**$ 181.05**

*

Tax rates are subject to change and will be charged at the rate set by the WA State Dept of Revenue at the time of billing.

NOTICE: This Budget Owned By Axiom Northwest Construction, Inc and the attachments hereto, if any, may contain privileged and/or confidential information. It is intended only for use by the named addressee(s).

If you are not the intended recipient of this Budget or are not associated with this job, you are hereby notified that any examination, distribution or copying of this Budget and the attachments hereto, if any, is strictly prohibited.

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As of 5/31/201812:39 PM