DaVita®

ANNUAL REPORT

2015

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DaVita. | HealthCare Partners.

Dear Stakeholders:

I will first discuss our 2015 results and then provide a few thoughts on the future.

- Dialysis clinical outcomes were once again the best, or among the best, in virtually every category compared to national averages and we significantly advanced our clinical care initiatives,
- We provided solid cash flows,
- We drove solid growth in adjusted operating profits in our Kidney Care division,
- HealthCare Partners (HCP), a DaVita Medical Group, improved adjusted operating income over 2014,
- We announced HCP's entrance into the state of Washington through the acquisition of The Everett Clinic, a leading physician group in the Puget Sound region with a strong national reputation, and
- Medicare Advantage rate cuts and the need to invest in general and administrative infrastructure present headwinds to HCP operating income in 2016.

Clinical Outcomes and Care Initiatives:

DaVita HealthCare Partners and our affiliated physicians collaborated to achieve outstanding clinical outcomes in 2015.

For the 15th consecutive year we continue to drive improvements in our industry-leading clinical outcomes. By the end of the year:

- 73% of our dialysis patients had an arteriovenous fistula placed for dialysis,
- 92% of our dialysis patients had been vaccinated for pneumonia,
- 92% of our dialysis patients had been vaccinated for influenza, and
- 97% of our dialysis patients had achieved a Kt/V of 1.2 or better.

All these results compare quite favorably to those reported publicly for other dialysis providers, especially when adjusted for acuity and other socioeconomic factors.

DaVita dialysis centers led the industry in the new Five-Star Quality Rating System used by the Center for Medicare and Medicaid Services (CMS), with 46% of our facilities receiving a star rating of four or five stars, compared to just 22% of facilities for the rest of the industry. DaVita dialysis centers also led in CMS' End Stage Renal Disease Quality Incentive Program for the second year in a row with the most dialysis centers ranking in the top clinical performance tier.

Our HCP physicians have a strong focus on clinical quality outcomes and patient satisfaction with more than 80% of our Medicare Advantage patients in plans rated four stars or above in the Medicare Advantage Star Rating program.

SCAN Health Plan recognized HCP for the quality of care and service delivered by its medical professionals and staff. Selection is based on HCP's performance score of four stars or higher – on a five-star scale – in areas such as preventive screenings, treatment of chronic conditions and appropriate documentation.

Our quality clinical care not only results in healthier patients, but also drives reductions in total healthcare cost, and therefore significant savings to the U.S. health care system.

Financial:

Adjusted net income in 2015 was $828 million[(1)], or $3.83[(1)] per share, GAAP net income was $270 million, or $1.25 per share.

Cash flow from operations in 2015 was $1.557 billion and free cash flow was $1.056 billion[(1)]. These strong cash flows allowed us to spend $477 million on center developments and acquisitions and $550 million on repurchases of our common stock in 2015.

Growth:

We provided nearly 26.0 million dialysis treatments in 2015, a 4.0% increase from 2014. Our 2015 normalized non-acquired growth was 3.9% year-over-year.

DaVita Rx, the world's largest full-service pharmacy dedicated to serving the unique needs of kidney patients, now provides services for approximately 165,000 patients.

We continued our international expansion. By year-end 2015 we operated 118 clinics in ten countries outside the United States.

Corporate Citizenship:

Being a leader in American healthcare means being a responsible corporate community. The Trilogy of Care—Caring for our patients, each other, and the world—is DaVita HealthCare Partners' vision for social responsibility and is our philosophy for balancing our business responsibilities with our social, economic and environmental ones. For more than a decade, we have had a vision for creating a true community—one that cares for our teammates as well as our patients. This investment in creating a community has inspired our teammates to realize their full potential and to deliver ever-improving quality care to our patients.

- For the fifth anniversary of the **DaVita Way of Giving** program, teammates at nearly 1,900 DaVita Kidney Care centers and HCP sites directed $2 million of company donations to locally based charities across the United States. The program has donated more than $6 million since it began.
- In 2015, **Bridge of Life**, the primary program of **DaVita Village Trust**, an independent 501(c)(3) nonprofit organization, completed more than 30 international medical missions and over 50 domestic missions and chronic kidney disease screening events. More than 300 DaVita volunteers supported these missions, impacting nearly 17,000 men, women and children in 15 countries.
- More than 550 riders participated in **Tour DaVita**, DaVita's annual 250-mile charity bike ride, which raised $1.2 million to support Bridge of Life. Bridge of Life serves thousands of men, women and children around the world through kidney care, primary care, education and prevention and medically supported camps for kids.
- Because of the efforts of **DaVita Village Green** and DaVita's clinical enterprise and biomedical teams, DaVita dialysis centers are on average using nearly 30 percent fewer gallons of water per dialysis treatment in 2015 than they did in 2010, and we are working towards our goal to reduce energy consumption by 15 percent across our footprint.

We invite you to review our work and be inspired to help change your community. Our 2015 Community Care social responsibility report is available at DaVita.com/communitycare/.

Outlook:

Over the next few years we will face numerous challenges, including government reimbursement pressures, risks associated with government investigations and private lawsuits, uncertainty around health care reimbursement, and the risks arising from driving change and growth at HCP.

We believe our combined enterprise offers exciting levels of clinical quality, service, and consumer/taxpayer savings. Both DaVita Kidney Care and HCP continue to execute on our integrated care mission by partnering with thousands of physicians across the country to lead the transformation of health care delivery.

I offer heartfelt thanks to our 64,000 teammates around the world. Your resilience and tenacity in simultaneously meeting the needs of so many diverse constituencies is remarkable.

Respectfully submitted,

Kent J. Thiry
Chairman and CEO, and
CEO HealthCare Partners

(1) These are non-GAAP amounts. Adjusted net income excludes an estimated non-cash goodwill and other intangible asset impairment charges, an estimated accrual for damages and liabilities associated with our pharmacy business, debt redemption charges and a settlement charge related to the Vainer private civil suit, all after tax. Free cash flow represents net cash provided by operating activities less distributions to noncontrolling interests and capital expenditures for routine maintenance and information technology. For a reconciliation of non-GAAP financial measures to comparable GAAP measures, see our press release dated February 11, 2016 for the fourth quarter and year ended December 31, 2015 results, which is on our website at DavitaHealthCarePartners.com under Investor Relations/Press Releases.

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In the interest of our Stakeholders, we have kept the cost of this Annual Report to a minimum. For additional information about the Company, please visit our website at *www.davita.com* or contact Jim Gustafson at DaVita's corporate address.

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Management's Discussion and Analysis of Financial Condition and Results of Operations

Forward-looking statements

This Annual Report, 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 this Annual Report. We base our forward-looking statements on information currently available to us at the time of this Annual Report, 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.

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 5⅛% 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 6⅝% Senior Notes due 2020 (6⅝% 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 6⅝% 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.

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.

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.

KPMG LLP

Seattle, Washington

February 26, 2016

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.

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.

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.

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.

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		Additional paid-in capital	Retained earnings	Treasury stock		Accumulated other comprehensive income (loss)	Total	
		Shares	Amount			Shares	Amount			
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

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		Additional paid-in capital	Retained earnings	Treasury stock		Accumulated other comprehensive income (loss)	Total	
		Shares	Amount			Shares	Amount			
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

(dollars in thousands, except per share data)

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.

(dollars in thousands, except per share data)

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

(dollars in thousands, except per share data)

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

(dollars in thousands, except per share data)

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.

(dollars in thousands, except per share data)

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)

(dollars in thousands, except per share data)

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	December 31, 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 6⅝% Senior Notes due 2020 (6⅝% 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 6⅝% 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

(dollars in thousands, except per share data)

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:

Derivatives designated as cash flow hedges	Amount of gains (losses) recognized in OCI on interest rate swap and cap agreements — Years ended December 31, 2015	2014	2013	Location of (losses) gains reclassified from accumulated OCI into income	Amount of gains (losses) reclassified from accumulated OCI into income — Years ended December 31, 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.

(dollars in thousands, except per share data)

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.

(dollars in thousands, except per share data)

A combined summary of the status of the Company's stock-settled awards under the 2011 Plan, including base shares for stock-settled stock appreciation rights and stock-settled stock unit awards is as follows:

	Year ended December 31, 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

(dollars in thousands, except per share data)

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

(dollars in thousands, except per share data)

	Total	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
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.

(dollars in thousands, except per share data)

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

	Year ended December 31,		
	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

(dollars in thousands, except per share data)

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.

(dollars in thousands, except per share data)

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
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

Consolidating Statements of Income

	DaVita HealthCare Partners Inc.	Guarantor Subsidiaries	Non-Guarantor Subsidiaries	Consolidating Adjustments	Consolidated Total
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

(dollars in thousands, except per share data)

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

(dollars in thousands, except per share data)

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

(dollars in thousands, except per share data)

29. Supplemental data (unaudited)

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

Condensed Consolidating Statements of Income

	Consolidated Total	Physician Groups	Unrestricted Subsidiaries	Company and Restricted Subsidiaries[1]
For the year ended December 31, 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

(dollars in thousands, except per share data)

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

Risk Factors

This Annual Report 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 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, 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.

Selected Financial Data

The following financial and operating data should be read in conjunction with "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.

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

	High	Low
Year ended December 31, 2014:		
1st quarter	$ 69.81	$ 62.74
2nd quarter	72.95	67.12
3rd quarter	74.94	70.44
4th quarter	78.07	72.03

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 "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

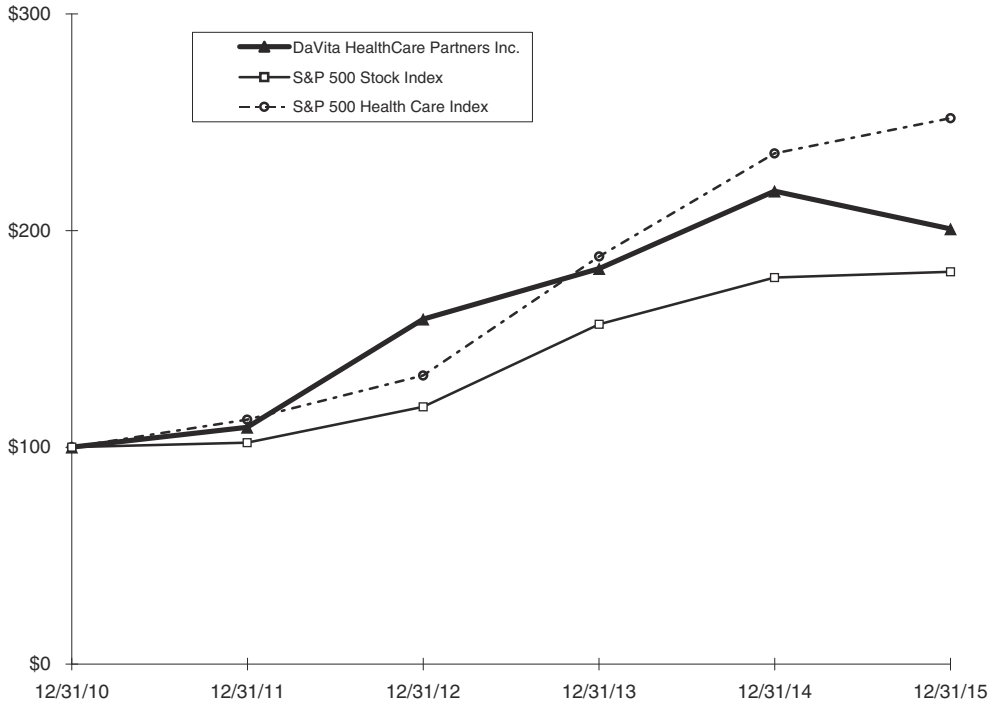
our common stock for $249 million, or an average price of $67.61 per share, during January 2016. As a result of these transactions, there was approximately $259 million available under our current Board authorizations for additional share repurchases. These share repurchase authorizations have no expiration 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.

Stock Price Performance

The following graph shows a comparison of our cumulative total returns, the standard & Poor's 500 Stock Index and the S&P 500 Health Care Index. The graph assumes that the value of an investment in our common stock and in each such index was $100.00 on December 31, 2010 and that all dividends have been reinvested.

The comparison in the graph below is based solely on historical data and is not intended to forecast the possible future performance of our common stock.

COMPARISON OF FIVE-YEAR CUMULATIVE TOTAL RETURN AMONG DAVITA HEALTHCARE PARTNERS INC., S&P 500 STOCK INDEX, S&P 500 HEALTH CARE INDEX



	12/31/10	12/31/11	12/31/12	12/31/13	12/31/14	12/31/15
DaVita HealthCare Partners Inc.	$100.0	$109.1	$159.1	$182.4	$218.0	$200.6
S&P 500 Stock Index	$100.0	$102.1	$118.5	$156.8	$178.3	$180.8
S&P 500 Health Care Index	$100.0	$112.7	$132.9	$188.0	$235.6	$251.9

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.

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CORPORATE INFORMATION

World Headquarters
DaVita HealthCare Partners Inc.
2000 16th St.
Denver, CO 80202
Tel (303) 405-2100/(888) 484-7505
Fax (303) 405-2200
DaVitaHealthCarePartners.com

Independent Registered
Public Accounting Firm
KPMG LLP
Seattle, Washington

Stock Registrar and Transfer Agent
Computershare
P.O. Box 43006
Providence, RI 02940-3006
Toll Free Number 877.889.2012
Hearing Impaired 800.231.5469
www.computershare.com/investor

Annual Meeting of Stockholders
Monday, June 20, 2016
DaVita HealthCare Partners
2000 16th St.
Denver, CO 80202

Common Stock Listing
New York Stock Exchange (NYSE)
Symbol: DVA

Form 10-K Request
For a free copy of DaVita Healthcare Partners' annual report on Form 10-K for the year ended December 31, 2015, please send a written request to Jim Gustafson, Vice President of Investor Relations, at DaVita HealthCare Partners' corporate address.

Corporate governance guidelines, Code of Ethics and Board Committee Charters are located at DaVitaHealthCarePartners.com.

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University of North Carolina at Chapel Hill

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Centers for Disease Control and Prevention

Former Administrator
Centers for Medicare & Medicaid Services

Kent J. Thiry
Chairman and Chief Executive Officer,
DaVita HealthCare Partners, and
Chief Executive Officer, HealthCare Partners

Roger J. Valine
Former President and Chief Executive Officer
Vision Service Plan

SECTION 16 OFFICERS

Kent J. Thiry
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DaVita HealthCare Partners, and
Chief Executive Officer, HealthCare Partners

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Chief Executive Officer, Kidney Care

Michael D. Staffieri
Chief Operating Officer, Kidney Care

Dennis L. Kogod
President, HealthCare Partners, and
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Interim Chief Financial Officer
and Chief Accounting Officer

Jeanine M. Jiganti
Chief Compliance Officer

Kathleen A. Waters
Chief Legal Officer

LeAnne M. Zumwalt
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DaVita®

WORLD HEADQUARTERS
DaVita HealthCare Partners
2000 16th St.
Denver, CO 80202
Phone: (303) 405-2100
info@davita.com

DAVITAHEALTHCAREPARTNERS.COM

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