

DAVITA HEALTHCARE PARTNERS INC.

Form 10-K

March 01, 2013

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-K

For the Fiscal Year Ended December 31, 2012

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

Commission File Number: 1-14106

DAVITA HEALTHCARE PARTNERS INC.

2000 16th Street

Denver, Colorado 80202

Telephone number (303) 405-2100

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Delaware
(State of incorporation)

51-0354549
(I.R.S. Employer)

Identification No.)

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

Class of Security:
Common Stock, \$0.001 par value

Registered on:
New York Stock Exchange

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

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

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

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

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

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

Large accelerated filer ☒ Accelerated filer ☐

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

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

As of June 29, 2012, the number of shares of the Registrant's common stock outstanding was approximately 94.5 million shares and the aggregate market value of the common stock outstanding held by non-affiliates based upon the closing price of these shares on the New York Stock Exchange was approximately \$9.3 billion.

As of January 31, 2013, the number of shares of the Registrant's common stock outstanding was approximately 105.5 million shares and the aggregate market value of the common stock outstanding held by non-affiliates based upon the closing price of these shares on the New York Stock Exchange was approximately \$12.2 billion.

Documents incorporated by reference

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Portions of the Registrant's proxy statement for its 2013 annual meeting of stockholders are incorporated by reference in Part III of this Form 10-K.

PART I

Item 1. Business

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

Overview of DaVita HealthCare Partners Inc.

With our recent acquisition of HealthCare Partners Holdings, LLC (HCP) on November 1, 2012, we believe the Company is well positioned to capitalize on anticipated trends in U.S. healthcare, including our continued growth opportunities in dialysis care services as well as growth in managed healthcare services, especially to the Medicare-eligible population.

As a result of the acquisition, the Company now primarily operates two major lines of business and, to a lesser extent, various other ancillary services and strategic initiatives, which includes our international dialysis operations. Our largest line of business is our U.S. dialysis and related lab services business, which is a leading provider of kidney dialysis services in the U.S. for patients suffering from chronic kidney failure, also known as end stage renal disease (ESRD). Our other major line of business is HCP, which is a patient- and physician-focused integrated health care delivery and management company with nearly three decades of providing coordinated, outcomes-based medical care in a cost-effective manner.

On November 1, 2012 we completed our acquisition of HCP pursuant to an Agreement and Plan of Merger dated May 20, 2012, whereby HCP became a wholly-owned subsidiary of the Company. HCP is one of the country's largest operators of medical groups and physician networks generating approximately \$2.4 billion in annual revenues and approximately \$488 million in operating income for the year ended December 31, 2011. The operating results of HCP are included in our consolidated financial results from November 1, 2012.

The total consideration paid at closing for all of the outstanding common units of HCP was approximately \$4.70 billion, which consisted of \$3.64 billion in cash, net of cash acquired, and 9,380,312 shares of our common stock valued at approximately \$1.06 billion. The total acquisition consideration is subject to a post-closing working capital adjustment. The acquisition agreement also provides that as further consideration, we will pay the common unit holders of HCP a total of up to \$275 million in cash if certain performance targets are achieved by HCP in 2012 and 2013.

In conjunction with the acquisition, we amended our Senior Secured Credit Agreement (the Credit Agreement) to allow for additional borrowings of \$3.0 billion and also issued new senior notes for \$1.25 billion, all of which was used to finance the acquisition, pay-off a portion of our and HCP's existing debt, and to pay fees and expenses.

For financial information about our reportable segments please read Note 24 Segment Reporting to the consolidated financial statements included in this report.

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 for patients suffering from chronic kidney failure or ESRD. As of December 31, 2012, we provided dialysis and administrative services through a network of 1,954 outpatient dialysis centers in the U.S. throughout 44 states

and the District of Columbia, serving a total of approximately 153,000 patients. We also provide acute inpatient dialysis services in approximately 970 hospitals and related laboratory services throughout the U.S. Our U.S. dialysis and related lab services business accounted for approximately 86% of our 2012 consolidated net revenues. On a pro-forma basis, our U.S. dialysis and related lab services business net revenues for fiscal 2012 would have represented approximately 68% of our consolidated net revenues assuming HCP was acquired on January 1, 2012. All references in this document to dialysis and related lab services refer only to our U.S. dialysis and related lab services business.

HealthCare Partners business

HCP is a patient- and physician-focused integrated health care delivery and management company with nearly three decades of providing coordinated, outcomes-based medical care in a cost-effective manner. Through capitation contracts with some of the nation's leading health plans, as of December 31, 2012 HCP had approximately 724,000 current members under its care in southern California, central and south Florida, and southern Nevada. Of these, approximately 201,000 individuals were patients enrolled in Medicare Advantage. The remaining approximately 523,000 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. Additionally, HCP operates in its New Mexico market under a fee-for-service reimbursement structure. In addition to its managed care business, during the year ended December 31, 2012, HCP provided care in all markets to over 530,000 patients whose health coverage is structured on a fee-for-service basis, including patients enrolled through traditional Medicare and Medicaid programs, preferred provider organizations and other third-party payors. On a pro-forma basis, HCP's business net revenues for fiscal 2012 would have represented approximately 26% of our consolidated net revenues assuming HCP was acquired on January 1, 2012.

The patients of HCP's associated physicians, physician groups and independent practice associations (IPAs) benefit from an integrated approach to medical care that places the physician at the center of patient care. As of December 31, 2012, HCP delivered services to its members via a network of over 2,000 associated group and other network primary care physicians, 145 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.

Ancillary services and strategic initiatives businesses

As of December 31, 2012, our ancillary services and strategic initiatives consisted primarily of pharmacy services, infusion therapy services, disease management services, vascular access services, ESRD clinical research, physician services, direct primary care and our international dialysis operations. Our ancillary services and strategic initiatives, including our international operations but excluding discontinued operations, accounted for approximately 8% of our consolidated net revenues for the year ended December 31, 2012, and relate primarily to our core business of providing kidney care services. On a pro-forma basis, our ancillary services and strategic initiatives net revenues for fiscal 2012 would have represented approximately 6% of our consolidated net revenues assuming HCP was acquired on January 1, 2012.

The dialysis and related lab services business

Industry overview

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

According to United States Renal Data System, there were approximately 415,000 ESRD dialysis patients in the U.S. in 2010 and the underlying ESRD dialysis patient population has grown at an approximate compound rate of 4.0% from 2000 to 2010, the latest period for which such data is available. The growth rate is attributable to the aging of the population, increased incidence rates for diseases that cause kidney failure such as diabetes and hypertension, lower mortality rates for dialysis patients and growth rates of minority populations with higher than average incidence rates of ESRD.

Since 1972, the federal government has provided health care coverage for ESRD patients under the Medicare ESRD program regardless of age or financial circumstances. ESRD is the first and only disease state eligible for Medicare coverage both for dialysis and dialysis-related services and for all benefits available under the Medicare program. For patients with Medicare coverage, all ESRD payments for dialysis treatments are made under a single bundled payment rate. See page 6 for further details.

Although Medicare reimbursement limits the allowable charge per treatment, it provides industry participants with a relatively predictable and recurring revenue stream for dialysis services provided to patients without commercial insurance. For the year ended December 31, 2012, approximately 90% of our total dialysis patients were under government-based programs, with approximately 79% of our dialysis patients under Medicare and Medicare-assigned plans.

Treatment options for ESRD

Treatment options for ESRD are dialysis and kidney transplantation.

Dialysis options

Hemodialysis

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

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

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

Peritoneal dialysis

Peritoneal dialysis uses the patient's peritoneal or abdominal cavity to eliminate fluid and toxins and is typically performed at home. The most common methods of peritoneal dialysis are continuous ambulatory peritoneal dialysis (CAPD), and continuous cycling peritoneal dialysis (CCPD). Because it does not involve

going to an outpatient dialysis center three times a week for treatment, peritoneal dialysis is an alternative to hemodialysis for patients who are healthier, more independent and desire more flexibility in their lifestyle. However, peritoneal dialysis is not a suitable method of treatment for many patients, including patients who are unable to perform the necessary procedures and those at greater risk of peritoneal infection.

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

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

Kidney transplantation

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

Dialysis and related lab services we provide

Outpatient hemodialysis services

As of December 31, 2012, we operated or provided administrative services through a network of 1,954 outpatient dialysis centers in the U.S. that are designed specifically for outpatient hemodialysis. In 2012, our overall network of U.S. outpatient dialysis centers increased by 145 primarily as a result of acquisitions and the opening of new centers, net of center closures and divestitures, representing a total increase of approximately 8.0%.

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

Under Medicare regulations, we cannot promote, develop or maintain any kind of contractual relationship with our patients that would directly or indirectly obligate a patient to use or continue to use our dialysis services, or that would give us any preferential rights other than those related to collecting payments for our services. Our total patient turnover which is based upon all causes averaged approximately 30% per year for the last two years. However, in 2012, the overall number of patients to whom we provided services in the U.S. increased by approximately 8%, primarily from the opening of new centers and acquisitions, continued growth within the industry and lower mortality rates.

Home-based hemodialysis services

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

Hospital inpatient hemodialysis services

As of December 31, 2012, we provided hospital inpatient hemodialysis services, excluding physician services, to patients in approximately 970 hospitals throughout the U.S. We render these services for a contracted per-treatment fee that is individually negotiated with each hospital. When a hospital requests our services, we typically administer the dialysis treatment at the patient's bedside or in a dedicated treatment room in the hospital, as needed. Hospital inpatient hemodialysis services are required for patients as discussed above. In 2012, hospital inpatient hemodialysis services accounted for approximately 4.5% of our total U.S. dialysis treatments.

ESRD laboratory services

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

Management services

We currently operate or provide management and administrative services to 25 outpatient dialysis centers located in the U.S. in which we either own a minority equity investment or are wholly-owned by third parties. These services are provided pursuant to management and administrative services agreements. Management fees are established by contract and are recognized as earned typically based on a percentage of revenues or cash collections generated by the outpatient dialysis centers.

Quality care

We employ 239 clinical service teammates in our dialysis and related lab services business. The primary focus of this group is assuring and facilitating processes that aim to achieve superior clinical outcomes at our centers.

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

Sources of revenue concentrations and risks

Our dialysis and related lab services business net revenues represent approximately 86% of our consolidated net revenues for the year ended December 31, 2012, with the balance of our revenues from HCP and our ancillary services and strategic initiatives which also includes our international dialysis operations. On a pro-forma basis, our dialysis and related lab services business net revenues for fiscal 2012 would have represented approximately 68% of our consolidated net revenues assuming HCP was acquired on January 1, 2012. Our dialysis and related lab services revenues are derived primarily from our core business of providing kidney dialysis services, the administration of pharmaceuticals, related laboratory services and to a lesser extent management fees generated from providing management and administrative services to certain outpatient dialysis centers, as discussed above.

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

The following table summarizes our U.S. dialysis and related lab services revenues by source for the year ended December 31, 2012:

	Revenue percentages
Medicare and Medicare-assigned plans	59%
Medicaid and Medicaid-assigned plans	5%
Other government-based programs	2%
Total government-based programs	66%
Commercial (including hospital inpatient dialysis services)	34%
Total dialysis and related lab services revenues	100%

The following table summarizes our U.S. dialysis and related lab services revenues by modality for the year ended December 31, 2012:

	Revenue percentages
Outpatient hemodialysis centers	80%
Peritoneal dialysis and home-based hemodialysis	15%
Hospital inpatient hemodialysis	5%
Total dialysis and related lab services revenues	100%

Medicare revenue

For patients with Medicare coverage, all ESRD payments for dialysis treatments are made under a single bundled payment rate which provides a fixed payment rate to encompass all goods and services provided during the dialysis treatment, including pharmaceuticals that were historically separately reimbursed to the dialysis providers, such as Epogen® (EPO), vitamin D analogs and iron supplements, irrespective of the level of pharmaceuticals administered or additional services performed. Most lab services that used to be paid directly to laboratories are also included in the bundled payment. The bundled payment rate is also adjusted for certain patient characteristics, a geographic usage index and certain other factors.

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

On November 1, 2011, the Centers for Medicare & Medicaid Services (CMS) issued the final ESRD PPS rule for 2012, which increased the base rate by 2.1%, representing a market basket increase of 3.0% less a productivity adjustment of 0.9%.

On November 9, 2012, CMS issued the final ESRD PPS rule for 2013. The base rate will increase by 2.3%, resulting from a market basket increase of 2.9% less a productivity adjustment of 0.6%. This increase in the ESRD PPS base rate could be reduced by the Budget Control Act of 2011 sequestration, discussed below. The final rule implements the reduction in bad debt payments to dialysis facilities (as well as to all other providers eligible for bad debt payments) mandated under the Middle Class Tax Extension and Job Creation Act of 2012 and adds new quality reporting measures.

On December 7, 2012, the U.S. General Accountability Office (GAO) released a letter report entitled "End-Stage Renal Disease: Reduction in Drug Utilization Suggests Bundled Payment is Too High". The GAO found ESRD drug utilization in 2011 was about 23% lower, on average, than it was in 2007. This was primarily the result of a decline in EPO usage. The GAO concluded the bundled payment rate was excessive given the changes in ESRD drug utilization. Because the Department of Health and Human Services (HHS) claimed it did not have authority to rebase the bundled payment rate, GAO recommended Congress should require the Secretary of HHS to take such action.

Subsequently, on January 1, 2013, Congress passed the American Taxpayer Relief Act of 2012 which includes a provision that incorporates the GAO's recommendations. This Act directs CMS to compare the utilization of drugs and biologicals (EPO and other former composite drugs) from 2007 (before the ESRD PPS) to the utilization after the implementation of the ESRD PPS in 2012 and adjust the ESRD PPS rate to account for reductions in utilization of these drugs. The adjustment also must account for the most current data on average sales prices and changes in prices for drugs reflected in the ESRD market basket percentage increase. The adjustment would apply to services furnished on or after January 1, 2014, which could significantly reduce the Medicare reimbursements we receive under the bundle payment system. The Congressional Budget Office (CBO) projected budget savings of approximately \$5 billion over ten years. In addition, GAO is required to produce an updated report to later than December 31, 2015.

As a result of the Budget Control Act of 2011 and subsequent activity in Congress, the federal government is faced with a \$1.2 trillion sequester (across-the-board spending cuts) in discretionary programs. In particular, Medicare providers face a maximum of a 2% reduction in reimbursements in fiscal year 2013. Under the American Taxpayer Relief Act of 2012, the sequester was postponed until March 1, 2013. Should Congress fail to act by that date, the sequestration will take effect. The across-the-board cuts pursuant to the sequester will likely have an adverse affect on our revenues, earnings and cash flows.

In addition, under the original ESRD PPS statute and regulations, beginning January 1, 2014, certain oral-only ESRD drugs (currently paid separately to pharmacies under Medicare Part D) would have been included in the ESRD bundled payment to dialysis facilities. Under the American Taxpayer Relief Act of 2012, the inclusion of oral-only medications in the bundled rate will be delayed until January 1, 2016. Inadequate pricing could have a significant negative financial impact on our dialysis facilities given the volume and value of these drugs.

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

Medicare pays 80% of the amount set by the Medicare system for each covered dialysis treatment. The patient is responsible for the remaining 20%. In most cases, a secondary payor, such as Medicare supplemental insurance, a state Medicaid program or a commercial health plan, covers all or part of these balances. Some patients, who do not qualify for Medicaid but otherwise cannot afford secondary insurance, can apply for premium payment assistance from charitable organizations through a program offered by the American Kidney Fund. We and other dialysis providers support the American Kidney Fund and similar programs through voluntary contributions. If a patient does not have secondary insurance coverage, we are generally unsuccessful in our efforts to collect from the patient the 20% portion of the ESRD composite rate that Medicare does not pay. However, we are able to recover some portion of this unpaid patient balance from Medicare through an established cost reporting process by identifying these Medicare bad debts on each center's Medicare cost report. As noted above, the Middle Class Tax Extension and Job Creation Act of 2012 mandated reductions in the amount of Medicare bad debt that dialysis centers may recover. These reductions begin in 2013 and increase in 2014.

Certain operating expenditures, such as labor and supply costs, are subject to inflation, and without a compensating inflation-based increase in the bundled payment rate system, could significantly impact our operating results.

Medicaid revenue

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

Commercial revenue

Before a patient becomes eligible to have Medicare as their primary payor for dialysis services, a patient's commercial insurance plan, if any, is responsible for payment of such dialysis services. Although commercial payment rates vary, average commercial payment rates are generally significantly higher than Medicare rates. The payments we receive from commercial payors generate nearly all of our profits. Payment methods from commercial payors include a single lump-sum per treatment, referred to as bundled rates, and in some cases separate payments for treatments and pharmaceuticals, if used as part of the treatment, referred to as fee for service rates. Commercial payment rates are the result of negotiations between us and insurers or third-party administrators. Our out-of-network payment rates are on average higher than in-network payment rates. In 2012, we continued 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. These contracts typically contain annual price escalator provisions. We are continuously in the process of negotiating agreements with our commercial payors and if our negotiations result in overall commercial rate reductions in excess of our commercial 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, we could experience a decrease in the number of patients covered under commercial insurance plans.

Approximately 34% of our dialysis and related lab services revenues and approximately 10% of our dialysis patients were associated with commercial payors for the year ended December 31, 2012. Our commercial patients as a percentage of our total dialysis patients declined in 2012 and 2011, but the actual number of commercial patients has increased during these same periods. Less than 1% of our dialysis and related lab services revenues are due directly from patients. No single commercial payor accounted for more than 10% of total dialysis and related lab services revenues for the year ended December 31, 2012.

Revenue from EPO and other pharmaceuticals

Approximately 5% of our total dialysis and related lab services revenues for the year ended December 31, 2012 are associated with the administration of physician-prescribed pharmaceuticals that are separately billable, which help improve clinical outcomes when included with the dialysis treatment. These pharmaceuticals include EPO, vitamin D analogs and iron supplements.

EPO is an erythropoiesis stimulating agent (ESA), genetically-engineered form of a naturally occurring protein that stimulates the production of red blood cells. EPO is used in connection with all forms of dialysis to treat anemia, a medical complication most ESRD patients experience. The administration of EPO, when separately billable, accounted for approximately 3% of our dialysis and related lab services revenues for the year ended December 31, 2012.

The percentage of revenue that we generate from separately billable pharmaceuticals as a result of operating under Medicare's single bundled payment rate system, continue to decline, whereby pharmaceuticals, including EPO, are included in a single bundled payment. In addition, we also continue to enter into some commercial contracts covering certain patients that also pay us under a single bundled rate for all dialysis services provided to these patients.

EPO is produced by a single manufacturer, Amgen. Any interruption of supply or product cost increases could adversely affect our operations. In 2012 and 2011, we experienced an increase in the unit cost of EPO. In December 2012 we entered into an amendment to our agreement with Amgen that makes non-material changes to certain terms of the agreement for the period from January 1, 2013 through December 31, 2013. Under the terms of the original agreement before the amendment, we were required to purchase EPO in amounts necessary to meet no less than 90% of our requirements of ESAs and are still required to do so after 2013. In addition, all of the other conditions as specified in the original agreement entered into in November 2011 still apply.

Since late 2006, there has been significant media discussion and government scrutiny regarding anemia management practices in the U.S., which has created confusion and concern in the nephrology community. In late 2006, the U.S. House of Representatives Ways and Means Committee held a hearing on the issue of the utilization of ESAs, which include EPO, and in 2007, the Food and Drug Administration (FDA) required changes to the labeling of EPO and Aranesp® to include a black box warning, the FDA's strongest form of warning label. An FDA advisory panel on ESA use met in October 2010, which meeting was similar to the prior meeting held in 2007 in that there was significant discussion and concern about the safety of ESAs. The panel concluded it would not recommend a change in ESA labeling. However, the FDA is not bound by the panel's recommendation. In June 2011, the FDA required that the black box warning be slightly revised and also include more conservative dosing recommendations for patients with CKD. In addition, in June 2011, CMS opened a National Coverage Analysis (NCA), for ESAs. Further, in January 2011, CMS convened a meeting of the Medicare Evidence Development and Coverage Advisory Committee (MEDCAC), to evaluate evidence for the pending NCA. In June 2011, CMS determined not to issue a national coverage determination for ESAs due to a lack of available evidence to establish coverage criteria or limitations.

The forgoing congressional and agency activities and related actions could result in further restrictions on the utilization and reimbursement for ESAs. Commercial payors have also increasingly examined their administration policies for EPO and, in some cases, have modified those policies. Further changes in labeling of EPO and other pharmaceuticals in a manner that alters physician practice patterns or accepted clinical practices, changes in private and governmental payment criteria, including the introduction of EPO administration policies or the conversion to alternate types of administration of EPO or other pharmaceuticals that result in further decreases in utilization or reimbursement for EPO and other pharmaceuticals, could have a material adverse effect on our revenues, earnings and cash flows.

Physician relationships

An ESRD patient generally seeks treatment at an outpatient dialysis center near his or her home where his or her treating nephrologist has practice privileges. Our relationships with local nephrologists and our ability to meet their needs and the needs of their patients are key factors in the success of our dialysis operations. Approximately 4,600 nephrologists currently refer patients to our outpatient dialysis centers. As is typical in the dialysis industry, one or a few physicians, including the outpatient dialysis center's medical director, usually account for all or a significant portion of an outpatient dialysis center's patient base.

Participation in the Medicare ESRD program requires that dialysis services at an outpatient dialysis center be under the general supervision of a medical director who is a licensed physician. We have engaged physicians or groups of physicians to serve as medical directors for each of our outpatient dialysis centers. At some outpatient dialysis centers, we also separately contract with one or more other physicians to serve as assistant or associate medical directors or to direct specific programs, such as home dialysis training programs. We have contracts with approximately 1,900 individual physicians and physician groups to provide medical director services.

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

Our medical director contracts for our dialysis centers generally include covenants not to compete. Also, when we acquire an outpatient dialysis center from one or more physicians or where one or more physicians own minority interests in our outpatient dialysis centers, these physicians have agreed to refrain from owning interests in other competing outpatient dialysis centers within a defined geographic area for various time periods. These non-compete agreements restrict the physicians from owning or providing medical director services to other outpatient dialysis centers, but do not prohibit the physicians from referring patients to any outpatient dialysis center, including competing centers. Many of these non-compete agreements continue for a period of time beyond expiration of the corresponding medical director agreements, although some expire at the same time as the medical director agreement. Occasionally, we experience competition from a new outpatient dialysis center established by a former medical director following the termination of his or her relationship with us.

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

Government regulation

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

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

Loss or suspension of federal certifications;

Loss or suspension of licenses under the laws of any state or governmental authority from which we generate substantial revenues;

Exclusion from government healthcare programs including Medicare and Medicaid;

Significant reductions or lack of inflation-adjusted increases in payment rates or reduction of coverage for dialysis and ancillary services and related pharmaceuticals;

Fines, damages and monetary penalties for anti-kickback law violations, Stark Law violations, submission of false claims, civil or criminal liability based on violations of law or other failures to meet regulatory requirements;

Claims for monetary damages from patients who believe their protected health information (PHI) has been used or disclosed in violation of federal and state patient privacy laws;

Mandated changes to our practices or procedures that significantly increase operating expenses; or

Refunds of payments received from government payors and government health care program beneficiaries because of any failures to meet applicable requirements.

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

Licensure and certification

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

To date, we have not experienced significant difficulty in maintaining our licenses or our Medicare and Medicaid authorizations. However, we have experienced delays in obtaining certifications from CMS.

CMS continues to study the regulations applicable to Medicare certification to provide dialysis services. On April 15, 2008, CMS issued new regulations for Medicare-certified ESRD facilities to provide dialysis services, referred to as Conditions for Coverage. The Conditions for Coverage were effective October 14, 2008, with some provisions having a phased in implementation date of February 1, 2009. The regulations are patient, quality and outcome focused. Among other things, they establish performance expectations for facilities and staff, eliminate certain procedural requirements, and promote continuous quality improvement and patient safety measures. We have established an interdisciplinary work group that includes a comprehensive auditing process to monitor our continued compliance with the Conditions of Coverage.

Federal anti-kickback statute

The anti-kickback statute contained in the Social Security Act imposes criminal and civil sanctions on persons who receive, make, offer or solicit payments in return for:

The referral of a Medicare or Medicaid patient for treatment;

The ordering or purchasing of items or services that are paid for in whole or in part by Medicare, Medicaid or similar federal and state programs; or

Arranging for or recommending the ordering or purchasing of such items.

Federal criminal penalties for the violation of the anti-kickback statute include imprisonment, fines and exclusion of the provider from future participation in the Medicare and Medicaid programs. Violations of the anti-kickback statute are punishable by imprisonment for up to five years and fines of up to \$25,000 or both. Larger fines can be imposed upon corporations under the provisions of the U.S. Sentencing Guidelines and the Alternate Fines Statute. Individuals and entities convicted of violating the anti-kickback statute are subject to mandatory exclusion from participation in Medicare, Medicaid and other federal healthcare programs for a minimum of five years. Civil penalties for violation of this law include up to \$50,000 in monetary penalties per violation, repayments of up to three times the total payments between the parties and suspension from future participation in Medicare and Medicaid. Court decisions have also held that the statute is violated whenever one of the purposes of remuneration is to induce referrals. The Health Reform Acts amended the anti-kickback statute to lower the standard of proof for the intent requirement that the government must make in order to obtain a conviction. The government does not have to prove that the defendant knew of the existence of the anti-kickback statute or had the specific intent to violate it. In addition, the Health Reform Acts amended the anti-kickback statute to provide that any claims submitted from an arrangement that violates the anti-kickback statute are false claims under the False Claims Act.

The Department of HHS regulations create exceptions or safe harbors for some business transactions and arrangements. Transactions and arrangements structured within these safe harbors are deemed to not violate the anti-kickback statute. A business transaction or arrangement must satisfy every element of a safe harbor to be protected by that safe harbor. Transactions and arrangements that do not satisfy all elements of a relevant safe harbor do not necessarily violate the statute, but can be subject to greater scrutiny by enforcement agencies.

Our medical directors refer patients to our dialysis centers, and these arrangements, by which we pay them for their medical director services, must be in compliance with the federal anti-kickback statute. Among the available safe harbors is one for personal services furnished for fair market value. However, most of our agreements with our medical directors do not satisfy all seven of the requirements of the personal services safe harbor. We believe that because of the nature of our medical directors' duties, it is impossible to satisfy the anti-kickback safe-harbor requirement that services provided under an agreement on a part-time basis must specify the schedule of intervals of service, and their precise length and the exact charge for such intervals. Accordingly, while we believe that our agreements with our medical directors for our dialysis centers satisfy as many of the elements of this safe harbor as we believe is reasonably possible, our arrangements do not qualify for safe harbor protection, as precise scheduling is not possible. We also note that there is little guidance available as to what constitutes fair market value for medical director services. We believe that our agreements do not violate the federal anti-kickback statute; however, since the arrangements do not satisfy all of the requirements for safe harbor protection, these arrangements could be challenged.

We own a controlling interest in numerous U.S. dialysis related joint ventures. For the year ended December 31, 2012, these joint ventures represented approximately 19% of our dialysis and related lab services revenues. In addition, we also own minority equity investments in several other dialysis related joint ventures. Our relationships with physicians and other referral sources relating to these joint ventures are required to comply with the anti-kickback statute. Although there is a safe harbor for certain investment interests in small entities, our joint ventures do not satisfy all of the elements of the safe harbor under the federal anti-kickback statute. Under current law, physician joint ventures are not prohibited but instead require a case-by-case evaluation under the anti-kickback statute. We have structured our joint ventures to satisfy as many safe harbor requirements as we believe are reasonably possible. We believe that these investments are offered on a fair market value basis and provide returns to the physician investors only in proportion to their actual investment in the venture. We believe that our agreements do not violate the federal anti-kickback statute; however, since the arrangements do not satisfy all of the requirements for safe harbor protection, these arrangements could be challenged. In that regard, we have been advised by the attorneys conducting the 2010 U.S. Attorney Physician Relationship Investigation that they believe that the general structure of our joint ventures does not comply with the anti-kickback statute and the False Claims Act. We disagree that our joint venture structure, which we believe is widely used in the dialysis industry and other segments of the healthcare industry substantially in the form that we use it, violates the federal anti-kickback statute or the False Claims Act. However, if our joint ventures are found to be in violation of the anti-kickback statute, the False Claims Act or the Stark Law provisions, we could be required to restructure the joint ventures or refuse to accept referrals for DHS from the physicians with whom the joint venture centers have a financial relationship.

As of December 31, 2012, we lease space for approximately 610 of our dialysis centers from entities in which physicians, hospitals or medical groups hold ownership interests and we sublease space to referring physicians at approximately 210 of our dialysis centers. These arrangements must be in compliance with the anti-kickback statute. We believe that we meet the elements of the safe harbor for space rentals in all material respects.

Some medical directors and other referring physicians may own our common stock. We believe that these interests materially satisfy the requirements of the safe harbor for investments in large publicly traded companies for the anti-kickback statute.

Because we are purchasing and selling items and services in the operation of our centers that may be paid for, in whole or in part, by Medicare or a state healthcare program and because we acquire certain items and services at a discount, we must structure these arrangements in compliance with the federal anti-kickback statute. Subject to certain requirements and limitations, discounts representing reductions in the amounts we are charged for items or services based on arm's-length transactions can qualify for safe harbor protection if we fully and accurately report the discounts in the applicable Medicare cost reports. While some of the safe harbor criteria are subject to interpretation, we believe that our vendor contracts with discount provisions are in compliance with the anti-kickback statute.

Stark Law

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

CMS has adopted implementing regulations under the Stark Law, collectively, Stark Regulations. CMS has not yet adopted implementing regulations regarding application of the Stark Law to Medicaid, but has indicated that it anticipates issuing additional regulations regarding the application of the Stark Law to Medicaid referrals.

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

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

We have entered into several types of financial relationships with referring physicians, including compensation arrangements. We believe that the compensation arrangements under our medical director agreements satisfy the personal services compensation arrangement exception to the Stark Law. While we believe that compensation under our medical director agreements, which is the result of arm's length negotiations, results in fair market value payments for medical director services, an enforcement agency could nevertheless challenge the level of compensation that we pay our medical directors. If the arrangement does not meet a Stark Law exception, we could in the future be required to change our practices, face civil penalties, pay substantial fines, return certain payments received from Medicare and beneficiaries or otherwise experience a material adverse effect as a result of a challenge to payments made pursuant to referrals from these physicians under the Stark Law.

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

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

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

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

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

Fraud and abuse under state law

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

The False Claims Act

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

Knowingly presents or causes to be presented to the federal government, a false or fraudulent claim for payment or approval;

Knowingly makes, uses or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the federal government;

Conspires to defraud the federal government by getting a false or fraudulent claim allowed or paid; or

Knowingly makes, uses or causes to be made or used, a false record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the federal government.

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

The penalties for a violation of the FCA range from \$5,500 to \$11,000 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. The federal government has used the FCA to prosecute a wide variety of alleged false claims and fraud allegedly perpetrated against Medicare and state healthcare programs, including coding errors, billing for services not rendered, the submission of false cost reports, billing for services at a higher payment rate than appropriate, billing under a comprehensive code as well as under one or more component codes included in the comprehensive code and billing for care that is not considered medically necessary. The Health Reform Acts provide that a violation of the federal anti-kickback statute can form the basis for liability under the FCA. Some courts have held that filing claims or failing to refund amounts collected in violation of the Stark Law can form the basis for liability under the FCA. In addition to the provisions of the FCA, which provide for civil enforcement, the federal government can use several criminal statutes to prosecute persons who are alleged to have submitted false or fraudulent claims for payment to the federal government.

The Health Insurance Portability and Accountability Act of 1996

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its implementing privacy and security regulations, as amended by the federal Health Information Technology for Economic and Clinical Health Act (HITECH Act), (collectively referred to as HIPAA), requires us to provide certain protections to patients and their health information under the Protected Health Information, or PHI. HIPAA requires us to afford patients certain rights regarding their PHI, and to limit uses and disclosure of their PHI existing in any media form (electronic and hardcopy). HIPAA also requires us to implement administrative, physical, and technical safeguards with respect to electronic PHI. We believe our HIPAA Privacy and Security Program sufficiently address HIPAA requirements. Penalties for impermissible use or disclosure of PHI were increased by the HITECH Act by imposing tiered penalties of up to \$50,000 per violation and up to \$1.5 million per year for the same type of violation. In addition, if PHI of 500 or more individuals is improperly used or disclosed, we would be required to report the improper use or disclosure to the Department of Health and Human Services, which would post the violation on its website. If there were improper use or disclosure of PHI of more than 500 individuals in the same jurisdiction, we would be required to report the improper use or disclosure to the media. Improper use or disclosure could result in significant fines and reputational damage.

Healthcare reform

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

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

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

On November 26, 2012, HHS issued a proposed rule governing the standards applicable to EHB Bulletins, new definitions, actuarial value requirements and methodology, and published a list of plan benchmark options that states can use to develop EHBs. The rule describes specific coverage requirements that: (i) prohibit discrimination against individuals because of pre-existing or chronic conditions on health plans applicable to EHBs; (ii) ensure network adequacy of essential health providers, and (iii) prohibit benefit designs that limit enrollment and that prohibit access to care for enrollees.

Other regulations

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

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

Capacity and location of our U.S. dialysis centers

We are able to increase our capacity by extending hours at our existing dialysis centers, expanding our existing dialysis centers, relocating our dialysis centers, developing new dialysis centers and by acquiring dialysis centers. The development of a typical outpatient dialysis center by us generally requires approximately \$2.5 million for leasehold improvements, equipment and first-year working capital. Based on our experience, a new dialysis center typically opens within a year after the property lease is signed, normally achieves operating profitability in the second year after certification and normally reaches maturity within three to five years. Acquiring an existing outpatient dialysis center requires a substantially greater initial investment, but profitability and cash flow are generally initially more predictable. To a limited extent, we enter into agreements to provide

management and administrative services to outpatient dialysis centers in which we either own a minority equity investment, or are wholly-owned by third parties in return for management fees, which are typically based on a percentage of revenues or cash collections of the managed operations.

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

	2012	2011	2010	2009	2008
Number of centers at beginning of year	1,809	1,612	1,530	1,449	1,359
Acquired centers	93	170 ⁽¹⁾	41	19	20
Developed centers	70	65	65	78	86
Net change in centers with management and administrative services agreements*	(8)	1		8 ⁽²⁾	1
Sold and closed centers**	(1)	(32) ⁽¹⁾	(10)	(8)	(9)
Closed centers***	(9)	(7)	(14)	(16)	(8)
Number of centers at end of year	1,954	1,809	1,612	1,530	1,449

- (1) In 2011, we acquired 113 dialysis centers and divested a total of 30 centers in connection with our acquisition of DSI Renal Inc. (DSI).
(2) During 2009, we made minority equity investments in 6 centers and we entered into 2 additional management and administrative service agreements.

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

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

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

As of December 31, 2012, we operated or provided administrative services to a total of 1,954 U.S. outpatient dialysis centers. A total of 1,929 such centers are consolidated in our financial statements. Of the remaining 25 unconsolidated U.S. outpatient dialysis centers, we own a minority equity investment in 20 centers and provide management and administrative services to five centers that are wholly-owned by third parties. The locations of the 1,929 U.S. outpatient dialysis centers consolidated in our financial statements at December 31, 2012 were as follows:

State	Centers	State	Centers	State	Centers
California	228	New York	41	Nevada	20
Texas	164	Minnesota	39	Oregon	20
Florida	149	New Jersey	38	Nebraska	15
Georgia	110	Wisconsin	37	Massachusetts	13
Ohio	89	Colorado	35	Mississippi	11
Pennsylvania	84	Kentucky	34	District of Columbia	10
Illinois	74	Arkansas	32	Idaho	9
Michigan	69	Oklahoma	32	Utah	4
North Carolina	65	Louisiana	27	New Mexico	4
Virginia	57	South Carolina	27	West Virginia	4
Tennessee	55	Washington	27	Maine	3
Maryland	54	Arizona	25	South Dakota	3
Indiana	50	Kansas	24	New Hampshire	2
Missouri	50	Connecticut	23	North Dakota	2
Alabama	47	Iowa	22	Rhode Island	1

HealthCare Partners business

Industry overview

U.S. healthcare spending has increased steadily over the past twenty years. These increases have been driven, in part, by the aging population of the baby boomer generation, lack of healthy lifestyle both in terms of exercise and diet, rapidly increasing costs in medical technology and pharmaceutical research, and provider reimbursement structures that may promote volume over quality in a fee-for-service environment. These factors, as well as the steady growth of the U.S. population, have made the healthcare industry a growing market. In 2010, CMS reported that health care accounted for 17.9% of the U.S. economy. According to CMS the increase in health spending, from \$2.3 trillion in 2008 to \$2.5 trillion in 2009, was the largest one-year jump since 1960. Comprising an estimated 14% of the federal budget and more than one-fifth of total national health expenditures in 2010, Medicare is frequently the focus of discussions on how to moderate the growth of both federal spending and health care spending in the U.S.

Growth in Medicare spending is expected to continue due to demographics. According to the U.S. Census Bureau from 1970 through 2011, the overall U.S. population grew 52% while the number of Medicare enrollees grew 130% over that time period. As an increasing number of the baby boomers become eligible for Medicare, the senior market is expected to grow to 79 million by 2030, more than double the number in 2000. UnitedHealth estimates that over the next decade 10,000 people per day will become newly eligible for Medicare. This translates into a Medicare population that makes up approximately 20% of the total U.S. population by the year 2025, compared to less than 16% currently.

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

Managed care health plans were developed, primarily during the 1980s, in an attempt to mitigate the rising cost of providing healthcare benefits to populations covered by traditional health insurance. These managed care health plans enroll members through their employers, under federal Medicare benefits or through state Medicaid programs. As a result of the prevalence of these health plans, many seniors now becoming eligible for Medicare have been interacting with managed care companies through their employers for the last 30 years. Individuals turning 65 now are likely to be far more familiar with the managed care setting than previous Medicare populations. According to the Kaiser Family Foundation, in 2012, Medicare Advantage represents only 27% of total Medicare members, creating a significant opportunity for additional Medicare Advantage penetration of newly eligible seniors.

In an effort to reduce the number of uninsured and to begin to control healthcare expenditures, President Obama signed The Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 (the Health Reform Acts) into law in March 2010, which were affirmed, in substantial part, by the U.S. Supreme Court in June 2012. The Health Reform Acts provide for a reduction of up to 32 million uninsured by 2019, while potentially increasing Medicaid coverage by up to 16 million and net commercial coverage by 16 million. CMS projects that the total number of uninsured Americans will fall to 23 million in 2021 from 47 million in 2011. These previously uninsured Americans and potentially newly eligible Medicaid beneficiaries represent a significant new market opportunity for health plans. We believe that health plans looking to cover these newly eligible individuals under fixed premium arrangements will seek provider arrangements that can effectively manage the cost and quality of the care being provided to these newly eligible individuals.

In 2006, Medicare began to pay Medicare Advantage health plans under a bidding process. Plans bid against county-level benchmarks established by Medicare based on the prior year's Medicare Advantage county payment rate and increased by the projected national growth rate in per capita Medicare spending. Those payment rates were at least as high as per capita fee-for-service Medicare spending in each county and often substantially higher because Congress set floors to raise the lowest rates to stimulate plan growth in areas where plans historically had not found it profitable to enter. If a plan's bid is higher than the benchmark, enrollees pay the difference in the form of a monthly premium. If the bid is lower than the benchmark, the Medicare program retains 25% of the difference as savings and the plan receives 75% as a rebate, which must be returned to enrollees in the form of additional benefits or reduced premiums. Plan payments are also adjusted based on enrollees' risk profiles. The formula for base payment is a combination of the base rate for the enrollee's county of residence, multiplied by the enrollee's risk score.

One of the primary ways in which the Health Reform Acts will fund increased health insurance coverage is through cuts in Medicare Advantage reimbursement. County benchmarks are transitioning to a system in which each county's benchmark in 2017 will be a certain percentage (ranging from 95% to 115%) of fee-for-service. Medicare Payment Advisory Commission (MedPAC) estimated that 2012 Medicare Advantage benchmarks, bids, and payments will average 112%, 98%, and 107% of fee-for-service spending, respectively. As a result, plans on average would have to bid 36% lower than fee-for-service or 43% lower than the Medicare Advantage benchmark for CMS to begin to save money on Medicare Advantage. As result of the transition of county benchmarks to 95% to 115% of fee-for-service, Medicare Advantage benchmarks on average are expected to be reduced to parity with fee-for-service as compared to 112% of fee for-service today. Given that CMS will retain 25% of the difference of any plans bid below benchmark, the overall Medicare Advantage program should realize savings as compared to fee-for-service in 2017, which would result in lower payments to Medicare Advantage plans and to HCP.

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

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

Healthcare reform

The U.S. healthcare system, including the Medicare Advantage program, is subject to a broad array of new laws and regulations as a result of the Health Reform Acts. The Health Reform Acts are considered by some to be the most dramatic change to the U.S. healthcare system in decades. The Supreme Court recently found that the individual mandate to obtain health insurance coverage under this legislation is constitutional and also found that the expanded Medicaid benefit included in the legislation is constitutional if states can opt out of the expanded Medicaid benefit without losing their funding under the current Medicaid program. This legislation made significant changes to the Medicare program and to the health insurance market overall. The Health Reform Acts reflect sweeping legislation that, once fully implemented, may have a significant impact on the U.S. health care system generally and the operations of HCP's business. There are numerous steps required to implement the Health Reform Acts, and Congress may seek to alter or eliminate some of their provisions.

One provision of the Health Reform Acts required CMS to establish a Medicare Shared Savings Program (MSSP) that promotes accountability and coordination of care through the creation of Accountable Care Organizations (ACOs). The program allows certain providers and suppliers (including hospitals, physicians and other designated professionals) to voluntarily form ACOs and work together along with other ACO participants to invest in infrastructure and redesign delivery processes to achieve high quality and efficient delivery of services.

In addition, beginning January 1, 2012, CMS authorized 32 organizations to participate in the Pioneer ACO program, which is similar to, but separate from, the ACOs created under the MSSP regulations. HCP has been designated as a Pioneer ACO in three geographic regions—Florida, California and Nevada. The Pioneer ACO designation is designed for health care organizations and providers, like HCP, that are already experienced in coordinating care for patients across care settings. It allows designated provider groups to move more rapidly from a shared savings payment model to a population-based payment model on a track consistent with, but separate from, the MSSP. The Pioneer ACO program is designed to work in coordination with private payors by aligning provider incentives. This alignment of provider incentives is intended to improve quality and medical outcomes for patients across the ACO, and achieve cost savings for Medicare and patients. As the initial participants for the MSSP, Pioneer ACOs face significant uncertainty. CMS authorized an additional 27 ACOs in April 2012 to begin services April 1, 2012 and an additional 88 ACOs in July 2012 to begin services as of July 1, 2012. See Government regulation below for a discussion of some of these issues.

Payor environment

Government programs

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

Medicare. The Medicare program was established in 1965 and became effective in 1967 as a federally funded U.S. health insurance program for persons aged 65 and older, and it was later expanded to include individuals with ERSD and certain disabled persons, regardless of income or age. Since its formation, Medicare has grown to a \$560 billion program in 2011, covering approximately 48 million Americans and, based on the growing number of eligible beneficiaries and increases in the cost of health care, CMS projects that Medicare program funding will grow to \$1.1 trillion by 2022.

Initially, Medicare was offered only on a fee-for-service basis. Under the Medicare fee-for-service payment system, an individual can choose any licensed physician enrolled in Medicare and use the services of any hospital, health care provider or facility certified by Medicare. CMS reimburses providers, based on a fee schedule, if Medicare covers the service and CMS considers it medically necessary.

Fee-for-service Medicare is paid according to a physician fee schedule (PFS) set each year by CMS in accordance with formulas mandated by Congress. CMS is required to limit the growth in spending under the PFS

by a predetermined sustained growth rate (SGR). If implemented as mandated, the SGR would result in significant payment reductions under the PFS. For 2013 it would be approximately 27%. Every year since 2003, Congress has delayed application of the SGR but we cannot predict whether they will continue to do so. There is pressure for Congress to implement a permanent solution to the SGR reductions. We cannot predict whether the SGR will be repealed or if another formula would be substituted and what form that might take. Repeal of the SGR could be offset by further reductions in Medicare payments.

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

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

Most Medicare beneficiaries have the option to enroll in private health insurance plans that contract with Medicare under the Medicare Advantage program. According to the Kaiser Family Foundation, the share of Medicare beneficiaries in such plans has risen rapidly in recent years; it reached approximately 27% in 2012 from approximately 13% in 2004. Plan costs for the standard benefit package can be significantly lower or higher than the corresponding cost for beneficiaries in the traditional Medicare fee-for-service payment program, but prior to the Health Reform Acts, private plans were generally paid a higher average amount, and they used the additional payments to reduce enrollee cost-sharing requirements, provide extra benefits, and/or reduce Medicare premiums. These enhancements were valuable to enrollees, but also resulted in higher Medicare costs overall and higher premiums for all Medicare Part B beneficiaries and not just those enrolled in Medicare Advantage plans. The Health Reform Acts require that future payments to plans be based on benchmarks in a range of 95% to 115% of local fee-for-service Medicare costs, with bonus amounts payable to plans meeting high quality-of-care standards. In addition, beginning in 2014, health plans offering Medicare Advantage will be required to spend at least 85% of their premium dollars on medical care, the so-called medical loss ratio, or MLR. Since HCP is not a health plan it is not subject to the 85% MLR floor. However, payments that health plans make to HCP will apply in full towards the health plans' 85% MLR requirement. If HCP's administrative costs, combined with a plan's other administrative costs aggregate to more than 15% of the total premium dollars the plan receives, the plan will either be required to reduce its administrative costs or increase the amount expended for MLR.

Medicaid. Medicaid is a federal entitlement program administered by the states that provides health care and long-term care services and support to low-income Americans. Medicaid is funded jointly by the states and the

federal government. The federal government guarantees matching funds to states for qualifying Medicaid expenditures based on each state's federal medical assistance percentage, which is calculated annually and varies inversely with average personal income in the state. Subject to federal rules, each state establishes its own eligibility standards, benefit packages, payment rates and program administration within broad federal statutory and regulatory guidelines. Every state Medicaid program must balance a number of potentially competing demands, including the need for quality care, adequate provider access, and cost-effectiveness. In an effort to improve quality and provide more uniform and cost-effective care, many states have implemented Medicaid managed care programs to improve access to coordinated health care services, including preventative care, and to control health care costs. Under Medicaid managed care programs, a health plan receives capitation payments from the state. The health plan, in turn, arranges for the provision of health care services by contracting with a network of medical providers, such as HCP. HCP has entered into capitation agreements with health plans to manage approximately 80,000 Medicaid managed care members in its southern California and Florida markets.

Commercial payors

According to the Robert Wood Johnson Foundation, in 2009, approximately 61% of non-elderly U.S. citizens received their health care benefits through their employer, which contracted with health plans to administer these health care benefits. Patients enrolled in health plans offered through an employment setting are generally referred to as commercial members. Nationally, commercial health plan enrollment was approximately 166 million as of 2011. Under the Health Reform Acts, beginning in 2014, many uninsured individuals and many individuals who receive their health insurance benefits through small employers may purchase their health care benefits through insurance exchanges in which health plans compete directly for individual or small group members enrollment. HCP derives a significant amount of its revenues from commercial payors; however, these payors represent a disproportionately small share of HCP's operating profits.

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

Capitation and fee-for-service revenue

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

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

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

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

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

Global model. In Florida, HCP contracts directly with health plans under global capitation arrangements that include hospital services because state law permits HCP to assume financial responsibility for both professional and institutional services. In Nevada, HCP also enters into global capitation arrangements to assume financial responsibility for both professional and institutional services, however, according to the Nevada Division of Insurance (NDI), the NDI has not opined on whether it is appropriate for an entity like HCP to enter into global capitation arrangements to assume financial responsibility for the provision of professional and institutional services to either Medicare Advantage enrollees or enrollees of commercial health plans. Nevertheless, NDI representatives are aware of HCP's contracting practices and have not taken any actions to question such practices given the ambiguity in Nevada law and the fact that NDI has no formal opinion on the subject. If NDI were to determine that HCP has been inappropriately taking global risk for institutional and professional services in Nevada without having the necessary Nevada state insurance license to do so, we may be required to obtain such a license to resolve such violations and we could be subject to civil and criminal liability should NDI elect to take actions that it heretofore has been unwilling to do to date. Because of the current global capitation to HCP, and HCP's assumption of nearly the entire professional and institutional risk in Nevada and Florida, HCP's health plan customers function primarily to support HCP in undertaking marketing and sales efforts to enroll members and processing claims in Florida.

Risk-share model. In California, HCP utilizes a capitation model in several different forms. While there are variations specific to each arrangement, HCP generally contracts with health plans to receive a PMPM fee for professional (physician) services and assumes the financial responsibility for professional services only. In some cases, the health plans separately enter into capitation contracts with third parties (typically hospitals) who receive directly a portion of the PMPM fee and assume contractual financial responsibility for institutional (hospital) services. In other cases, the health plan does not pay any portion of the PMPM fee to the hospital, but rather simply administers claims for hospital expenses itself. In both cases, HCP is responsible for managing the care dollars associated with both the professional and institutional services provided for the PMPM fee, but in the case of institutional services and as a result of its managed care-related administrative services agreements with hospitals, HCP recognizes a percentage of the surplus of institutional revenues less institutional expense as HCP revenues and is also responsible for any short-fall in the event that institutional expenses exceed institutional revenues.

Government regulation

In addition to the laws and regulations to which our dialysis and related lab services business is subject, the internal operations of HCP and its contractual relationships with healthcare providers such as hospitals, other healthcare facilities, and healthcare professionals are subject to extensive and increasing regulation by numerous federal, state, and local government entities. These laws and regulations often are interpreted broadly and

enforced aggressively by multiple government agencies, including the Office of Inspector General (OIG), the U.S. Department of Justice, and various state authorities. Many of these laws and regulations are the same as those that impact our dialysis and related lab services business. For example:

HCP's financial relationships with healthcare providers including physicians and hospitals could subject HCP to sanctions and penalties under the federal anti-kickback statute;

The referral of Medicare patients by HCP-associated physicians for the provision of DHS may subject the parties to sanctions and penalties under the federal Stark Law;

HCP's financial relationships and those of its associated physicians may subject the parties to penalties and sanctions under state fraud and abuse law;

HCP's submission of claims to governmental payors such as the Medicare and Medicaid programs for services provided by its associated physicians and clinical personnel may subject HCP to sanction and penalties under the federal FCA; and

HCP's handling of electronic PHI may subject HCP to sanctions and penalties under the federal HIPAA of 1996 and its implementing privacy and security regulations, as amended by the HITECH Act, collectively referred to as HIPAA, and state medical privacy laws which often include penalties and restrictions that are more severe than those which arise under HIPAA.

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

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

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

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

occurred in another state. Therefore, if an HCP-associated physician is licensed in multiple states, sanctions or loss of licensure in one state may result in sanction or the loss of licensure in another state. Professional licensing sanctions may also result in exclusion from participation in governmental healthcare programs, such as Medicare and Medicaid, as well as other third-party programs.

Corporate practice of medicine and fee splitting. Two states in which HCP operates, California and Nevada have laws that prohibit business entities, such as our Company and our subsidiaries, from practicing medicine, employing physicians to practice medicine or exercising control over medical decisions by physicians, known collectively as the corporate practice of medicine. These states also prohibit entities from engaging in certain arrangements, such as fee-splitting, with physicians. In some states these prohibitions are expressly stated in a statute or regulation, while in other states the prohibition is a matter of judicial or regulatory interpretation. In California, a violation of the corporate practice of medicine prohibition constitutes the unlawful practice of medicine, which is a public offense punishable by fines and other criminal penalties. In addition, any physician who participates in a scheme that violates California's corporate practice of medicine prohibition may be punished for aiding and abetting a lay entity in the unlawful practice of medicine. In Nevada, violation of the corporate practice of medicine rules by a lay entity also constitutes the unlawful practice of medicine. This violation is a felony punishable by fines and other criminal penalties. Physicians in Nevada can similarly be punished for aiding and abetting in the unlicensed practice of medicine.

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

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

If we were required to restructure its management arrangements in California or Nevada due to determination that a corporate practice of medicine violation existed, such a restructuring might include revisions of the management services agreements, which might include a modification of the management fee, and/or establishing an alternative structure, such as obtaining a California Knox-Keene license (as described below) or its Nevada equivalent which would permit HCP to contract with a physician network without violating the corporate practice of medicine prohibition.

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

DMHC's Division of Financial Oversight conducts examinations of the fiscal and administrative affairs of licensed HCSPs to protect consumers and providers from potential insolvencies. Financial examination reviews include examinations of cash flow, premium receivables, intercompany transactions and medical liabilities. The examination also ensures that there is adequate tangible net equity (TNE), as determined according to calculations included in the Knox-Keene Act. The TNE regulations for organizations holding a Knox-Keene license vary depending on circumstances, but generally require any licensee to have on hand in cash or cash equivalents a minimum of the greater of (i) \$1 million; (ii) the sum of 2% of the first \$150 million of annualized premium revenues plus 1% of annualized premium revenues in excess of \$150 million; or (iii) the sum of 8% of the first \$150 million of annualized health care expenditures (except those paid on a capitated basis or managed hospital payment basis); plus 4% of the annualized health care expenditures, except those paid on a capitated basis or managed hospital payment basis, which are in excess of \$150 million; plus 4% of annualized hospital expenditures paid on a managed hospital payment basis. In its sole discretion, DMHC may require, as a condition to obtaining or maintaining an HCSP license, that a licensee accept certain contractual undertakings such that the licensee is obligated to maintain TNE in amounts greater than the minimum amount described above. Such contractual undertakings may require 130% or more of TNE to be maintained by a licensee.

The DMHC interprets the Knox-Keene Act to apply to both HCSPs and downstream contracting entities, including provider groups, that enter into global risk contracts with licensed HCSPs. A global risk contract is a health care services contract in which a downstream contracting entity agrees to provide both professional (e.g., medical group) services and institutional (e.g., hospital) services subject to an at-risk or capitated reimbursement methodology. According to DMHC, entities that accept global risk must obtain a restricted or limited Knox-Keene license (limited Knox-Keene license).

Under a limited Knox-Keene license, entities may enter into global risk contracts with other licensed HCSPs. Holders of limited Knox-Keene licenses must comply with the same financial requirements as HCSPs with full licenses, including demonstrating specific levels of TNE, but are granted waivers from meeting marketing and other terms of full Knox-Keene licensure. The consequences of operating without a license include civil penalties, criminal penalties and the issuance of cease and desist orders.

We do not hold a limited Knox-Keene license. Instead of operating under such a license which would allow us to directly enter risk contracts with HCSPs for the provision of both professional and institutional services, HCP utilizes arrangements with hospital and its associated physician organizations. If (i) DMHC were to determine that HCP has been inappropriately taking global risk for institutional and professional services as a result of its various hospital and physician arrangements without having a limited Knox-Keene license or (ii) the California Board of Medicine were to conclude that the current HCP physician arrangements present a violation of the corporate practice of medicine, we may be required to obtain a limited Knox-Keene license to resolve such violations and we could be subject to civil and criminal liability. Alternatively, HCP might voluntarily elect to obtain a limited Knox-Keene license for various reasons including to permit it to contract directly with HCSPs, to simplify its current contractual and financial structure and to facilitate expansion into new markets. If HCP were to obtain a limited Knox-Keene license, certain of the primary impacts would be the TNE requirements described above and additional regulatory oversight.

Although obtaining such a limited Knox-Keene license would ameliorate risks under the Knox-Keene Act and California's corporate practice of medicine prohibition, there are disadvantages associated with obtaining such a license. These disadvantages include: (i) regulatory oversight of operations, (ii) the need to seek approval for all material business changes, (iii) significant requirements to maintain certain TNE levels, and (iv) other operating limitations imposed by the Knox-Keene Act and its regulations.

HCP services

Approximately 88% of HCP's operating revenues for the period November 1, 2012 through December 31, 2012 were derived from multi-year capitation contracts with health plans. Under these contracts, HCP's health plan customers delegate full responsibility for member care to physicians and health care facilities that are part of

HCP's network. In return, HCP receives a PMPM fee for each HCP member. As a result, HCP has financial and clinical accountability for a population of members. In California, HCP does not assume direct financial risk for institutional (hospital) services, but is responsible for managing the care dollars associated with both the professional (physician) and institutional services being provided for the PMPM fee attributable to both professional and institutional services. In those cases and as a result of its managed care-related administrative services agreements with hospitals, HCP recognizes the surplus of institutional revenues less institutional expense as HCP revenues and is also responsible for any short-fall in the event that institutional expenses exceed institutional revenues. In addition to revenues recognized for financial reporting purposes, HCP measures its total care dollars under management which includes the PMPM fee payable to third parties for institutional (hospital) services where HCP manages the care provided to its members by hospitals and other institutional providers, which fees are not included in Generally Accepted Accounting Principles (GAAP) revenues. For the twelve months ended December 31, 2012, HCP's total consolidated operating revenues were \$2.7 billion, total care dollars under management were \$3.6 billion and adjusted operating income was \$524 million.

HCP provides complete medical care through a network of participating physicians and other health care professionals. Through its group model, HCP employs, directly (where permitted by state law) and through its associated physician groups, approximately 455 associated group full-time primary care physicians who practice in clinics that are operated by HCP. Through its IPA model, HCP contracts with approximately 1,800 additional network primary care physicians who provide care for HCP's members in an independent office setting. These physicians are complemented by a network of several thousand specialists and ancillary providers and 145 network hospitals that provide specialty or institutional care to the patients of HCP's associated physicians, physician groups and IPAs.

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

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

A typical fee-for-service primary care physician might treat up to 30 to 40 patients per day. In contrast, HCP group physicians typically see 18 to 20 patients per day, which we believe is a more appropriate benchmark to ensure there is sufficient time to understand all of the patients' clinical needs. HCP care teams, including nurses, engage in outreach to patients in order help monitor the fragile and high risk patients, and help improve adherence to physicians' care plans. During these visits, HCP's physicians, nurses and educators use the time to educate patients and manage their health care needs. The goal of this preventative care delivery model is to keep patients healthy. Education improves self-management and compliance which allows the patient to recognize early signs of their disease and seek appropriate care. We believe this translates into earlier intervention, which in turn leads to fewer emergency room visits, fewer hospital admissions and fewer hospital bed days (the most expensive location for health care). This clinical model seeks to provide early diagnosis of disease or deterioration in a chronic and complex condition and provide preventive care to maintain optimal health and avert unnecessary hospitalization. Clinic-based case managers and hospitalists coordinate with the primary care physicians to ensure that patients are receiving proper care whether they are in the clinic, in the hospital or are not regularly accessing health care. Physicians and case managers encourage patients to regularly visit the clinics in order to enhance their day-to-day health and diagnose any illness or deterioration in condition as early as possible.

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

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

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

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

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

HCP's clinical leadership and associated group and network physicians denote significant effects to ensuring that HCP's members receive the most appropriate care in the most appropriate manner.

HCP is committed to maximizing its patients' satisfaction levels.

HCP has the scale and combined with its strong reputation and high quality patient care, makes it an attractive partner for health plans compared to smaller provider groups that may have a higher risk of default and may not have the same resources to devote to HCP's techniques.

HCP has nearly three decades of experience in managing complex disease cases for its population of patients. As a result, HCP has developed a rich dataset of patient care experiences and outcomes which permits HCP to proactively monitor and intervene in improving the care of its members.

HCP's senior management team possesses substantial experience with the healthcare industry with average experience of nearly 35 years.

Locations of HCP clinics

As of December 31, 2012, HCP operated a total of 184 medical clinics, of which 69 clinics were located in California, 54 clinics were located in Florida, 43 clinics were located in Nevada and 18 clinics were located in New Mexico.

Ancillary services and strategic initiatives business

Ancillary services and strategic initiatives, which include our international dialysis operations, as described below, accounted for approximately 8% of our total consolidated net revenues for the year ended December 31, 2012 excluding the divestiture of HomeChoice Partners that has been reported as discontinued operations for all periods presented. On a pro-forma basis our ancillary services and strategic initiatives net revenues for fiscal 2012 would have represented approximately 6% of our consolidated net revenues assuming HCP was acquired on January 1, 2012 and consist primarily of the following as of December 31, 2012:

Pharmacy services. DaVita Rx is a pharmacy that provides oral medications to DaVita's patients with ESRD. The main objectives of the pharmacy are to improve clinical outcomes by facilitating increased patient compliance and to provide our patients a convenient way to fill their prescription needs by delivering the prescriptions to the center where they are treated. Revenues are recognized as prescriptions are filled and shipped to patients. On January 8, 2013, we entered into an agreement with Fresenius Medical Care (FMC) to provide certain pharmacy services to FMC's Medicare patients in the U.S. beginning in late 2013.

Infusion therapy services. HomeChoice Partners (HomeChoice) provides comprehensive personalized infusion therapy services to patients typically in their own homes as a cost-effective alternative to inpatient hospitalization. Intravenous and nutritional support therapies are typically managed by registered and/or board-certified professionals including pharmacists, nurses and dieticians in collaboration with the patient's physician in support of the patient's ongoing health care needs. Revenues are recognized in the period when infusion therapy services are provided. See *Divestiture of HomeChoice Partners Inc.* for further details regarding the divestiture of this business on February 1, 2013.

Disease management services. VillageHealth provides advanced care management services to health plans and government agencies for employees/members diagnosed with CKD or ESRD. Through a combination of clinical coordination, medical claims analysis and information technology, we endeavor to assist our customers and patients in obtaining superior renal health care and improved clinical outcomes, as well as helping to reduce overall medical costs. Revenues are typically based upon an established contract fee and are recognized as earned over the contract period and can include additional fees for cost savings recognized by certain customers. In 2012, VillageHealth operated a Medicare Advantage ESRD Special Needs Plan in partnership with a payor that works with CMS to provide ESRD patients full service health care. We are at risk for all medical costs of the program in excess of the capitation payments. We also completed the final reconciliation calculation for a Chronic Kidney Disease (CKD)/ESRD demonstration program that was terminated in April 2011. Based on the May 2012 final reconciliation report prepared for CMS, we retained a portion of our management fee.

for program enrollees relating to CKD and ESRD disease states for one managed group but also had to refund our management fees to CMS for other managed group as certain Medicare cost savings targets were not met.

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

ESRD clinical research programs. DaVita Clinical Research conducts research trials principally with dialysis patients and provides administrative support for research conducted by DaVita-associated nephrology practices. Revenues are based upon an established fee per study, as determined by contract with drug companies and other sponsors and are recognized as earned according to the contract terms.

Physician services. DaVita Nephrology Partners offers practice management and administrative services to physicians who specialize in nephrology under management and administrative services agreements. Practice management and administrative services typically include operations management, IT support, billing and collections, credentialing and coding, and other support functions. Management fees generated from providing practice management and administrative services to physician practices are recognized as earned typically based upon cash collections generated by the practices.

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

International dialysis operations

As of December 31, 2012, we operated or provided administrative services to a total of 36 outpatient dialysis centers located in eight countries outside of the U.S. serving approximately 2,200 patients. Our international dialysis operations are still in a start-up phase in which we have been developing and acquiring dialysis centers in various strategic markets, since the commencement of our international operations during the fourth quarter of 2011. Our overall net revenues generated from our international operations were not material to our consolidated results during 2012. Our international operations are included as a component of our ancillary services and strategic initiatives.

The table below summarizes the number and locations of our international outpatient dialysis centers.

	2012	2011
Number of centers at beginning of year	11	
Acquired centers	13	8
Developed centers	9	
Managed centers	3	3
Number of centers end of year	36	11

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

China	2
Singapore	2
Malaysia	3
Saudi Arabia	3
Germany	4
Poland	5
Portugal	4
India	13
	36

Competition

U.S. and International dialysis competition

The U.S. dialysis industry has consolidated significantly over time but still remains highly competitive, particularly in terms of acquiring existing outpatient dialysis centers. We continue to face increased competition in the U.S. dialysis industry from large and medium-sized providers who compete directly with us for the acquisition of dialysis businesses, relationships with physicians to act as medical directors and for individual patients. 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. Acquisitions, developing new outpatient dialysis centers, patient retention and physician relationships are an important part of our growth strategy and our business could be adversely affected if we are not able to continue to make acquisitions on reasonable terms, experience significant patient attrition to our competitors and are not able to maintain or establish new relationships with physicians. Competition for qualified physicians to act as medical directors and for inpatient dialysis services agreements with hospitals is also intense. Occasionally, we have also experienced competition from former medical directors or referring physicians who have opened their own dialysis centers. In addition, we experience competitive pressures in connection with negotiating contracts with commercial healthcare payors.

The two largest dialysis companies, Fresenius Medical Care (Fresenius), and our company, account for approximately two-thirds of outpatient dialysis patients in the U.S. with our company serving approximately 34% of the total outpatient dialysis patients. Approximately 46% of the centers not owned by us or Fresenius are owned or controlled by hospitals or non-profit organizations. Hospital-based and non-profit dialysis units typically are more difficult to acquire than physician-owned centers. 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.

Fresenius also manufactures a full line of dialysis supplies and equipment in addition to owning and operating outpatient dialysis centers. This may give them cost advantages over us because of their ability to manufacture their own products. However, Fresenius has been one of our largest suppliers of dialysis products. In January 2010, we entered into an agreement with Fresenius which committed us to purchase a certain amount of dialysis equipment, parts and supplies from them through 2013. In addition, in August 2006 in connection with the DVA Renal Healthcare acquisition, we also entered into a product supply agreement with Gambro Renal Products that requires us to purchase a certain amount of our hemodialysis non-equipment product supplies, such as dialyzers, at fixed prices through 2015. Our purchases of products in these categories generally offered by both Fresenius and Gambro Renal Products represent approximately 5% of our total U.S. dialysis operating expenses. During 2012, we purchased hemodialysis products and supplies from Gambro Renal Products representing approximately 3% of our total U.S. dialysis operating expenses.

HCP's competition

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

Corporate compliance program

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

Assessing and identifying risks for existing and new businesses, such as HCP;

Increasing, through training and education, the awareness of our teammates and affiliated professionals of the necessity of complying with all applicable laws, regulations and company policies and procedures;

Auditing and monitoring the activities of our operating units and business support functions on a regular basis to identify potential instances of noncompliance in a timely manner; and

Ensuring that we take steps to resolve instances of noncompliance or to address areas of potential noncompliance as promptly as we become aware of them.

We have a code of conduct that each of our teammates and affiliated professionals must follow and we have a confidential toll-free hotline for teammates and patients to report potential instances of noncompliance. Our Chief Compliance Officer administers the compliance program. The Chief Compliance Officer reports directly to our Chief Operating Officer and to the Compliance Committee of our Board of Directors.

Insurance

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

Teammates

As of December 31, 2012, we employed approximately 53,400 teammates:

Licensed professional staff (physicians, nurses and other healthcare professionals)	22,000
Other patient care and center support staff and laboratory personnel	21,900
Corporate, billing and regional administrative staff	9,500

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

Item 1A. Risk Factors.

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

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

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

Approximately 34% of our dialysis and related lab services revenues for the year ended December 31, 2012 were generated from patients who have commercial payors as the primary payor. The majority of these patients have insurance policies that pay us on terms and at rates that are generally significantly higher than Medicare rates. The payments we receive from commercial payors generate nearly all of our profit and all of our nonacute dialysis profits come from commercial payors. We continue to experience downward pressure on some of our commercial payment rates and it is possible that commercial payment rates could be materially lower in the future. The downward pressure on commercial payment rates is a result of general conditions in the market, recent and future consolidations among commercial payors, increased focus on dialysis services and other factors.

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

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

Our revenue levels are sensitive to the percentage of our patients with higher-paying commercial insurance coverage. A patient's insurance coverage may change for a number of reasons, including changes in the patient's or a family member's employment status. Currently, for a patient covered by an employer group health plan, Medicare generally becomes the primary payor after 33 months, or earlier, if the patient's employer group health plan coverage terminates. When Medicare becomes the primary payor, the payment rate we receive for that

patient shifts from the employer group health plan rate to the lower Medicare payment rate. We have seen an increase in the number of patients who have government-based programs as their primary payors which we believe is largely a result of improved mortality and recent economic conditions which have a negative impact on the percentage of patients covered under commercial insurance plans. To the extent there are sustained or increased job losses in the U.S., independent of whether general economic conditions might be improving, we could experience a continued decrease in the number of patients covered under commercial plans. We could also experience a further decrease if changes to the healthcare regulatory system result in fewer patients covered under commercial plans or an increase of patients covered under more restrictive commercial plans with lower reimbursement rates. In addition, our continuous process of negotiations with commercial payors under existing or potentially new agreements could result in a decrease in the number of patients under commercial plans to the extent that we cannot reach agreement with commercial payors on rates and other terms, resulting in termination or non-renewals of existing agreements or our inability to enter into new ones. If there is a significant reduction in the number of patients under higher-paying commercial plans relative to government-based programs that pay at lower rates, it would have a material adverse effect on our revenues, earnings and cash flows.

Changes in the structure of, and payment rates under the Medicare ESRD program, including the American Taxpayer Relief Act of 2012, the Budget Control Act of 2011 and other healthcare reform initiatives, could substantially reduce our revenues, earnings and cash flows.

Approximately 49% of our dialysis and related lab services revenues for the year ended December 31, 2012 was generated from patients who have Medicare as their primary payor. For patients with Medicare coverage, all ESRD payments for dialysis treatments are made under a single bundled payment rate which provides a fixed payment rate to encompass all goods and services provided during the dialysis treatment, including pharmaceuticals that were historically separately reimbursed to the dialysis providers, such as Epogen (EPO), vitamin D analogs and iron supplements, irrespective of the level of pharmaceuticals administered or additional services performed. Most lab services that used to be paid directly to laboratories are also included in the bundled payment. The bundled payment rate is also adjusted for certain patient characteristics, a geographic usage index and certain other factors.

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

with regard to the expanded list of case-mix adjusters, 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.

under the original ESRD Prospective Payment System (PPS) statute and regulations, beginning January 1, 2014, certain oral-only ESRD drugs (currently paid separately to pharmacies under Medicare Part D) would have been included in the ESRD bundled payment to dialysis facilities. Under the American Taxpayer Relief Act of 2012, the inclusion of oral-only medications will be delayed until January 1, 2016. It remains unclear how CMS will price the oral-only drugs for inclusion in the ESRD bundle in 2016. Inadequate pricing could have a significant negative financial impact on our dialysis facilities given the volume and value of these drugs.

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.

as a result of the Budget Control Act of 2011 and subsequent activity in Congress, the federal government is faced with a \$1.2 trillion sequester (across-the-board spending cuts) in discretionary programs. In particular, Medicare providers face a maximum of no more than a 2% reduction in reimbursements in fiscal year 2013. Under the American Taxpayer Relief Act of 2012, the sequester was postponed until March 1, 2013. Should Congress fail to act by that date, the sequestration will take effect. The across-the-board cuts pursuant to the sequester could adversely affect our revenues, earnings and cash flows.

we may not be able to comply with the CMS rules related to the bundled payment system as processes and systems are modified substantially to capture all required data. To the extent we are not able to adequately bill and collect for certain payment adjusters and are not able to offset the mandated reductions in reimbursement or if we face regulatory enforcement actions and penalties as a result of alleged improper billing of governmental programs, it could have a material adverse effect on our revenues, earnings and cash flows.

the American Taxpayer Relief Act of 2012 mandates that the CMS Secretary reduce dialysis payments beginning in January 2014 to reflect the Secretary's estimate of changes in patient utilization data from 2007 to 2012 for ESAs, other drugs and biologicals that would have been paid for separately under the composite rate system, and laboratory services that would have been paid for separately under the composite rate system. Oral-only drugs are excluded. The Secretary must also use the most recently available data on average sales prices and changes in prices for drugs and biological reflected in the ESRD market basket percentage increase factor. Additionally, the legislation delayed the implementation of oral-only ESRD-related drugs until January 1, 2016, and requires the Secretary to monitor bone and mineral metabolism with respect to the implementation of these drugs, but it does not expressly link monitoring to the ESRD Quality Incentive Program or QIP. Finally, it requires the Secretary to conduct an analysis of the case-mix adjusters and make appropriate revisions to the bundled payment system no later than January 1, 2016.

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 and cash flows." For additional details about the establishment, implementation and changes to the ESRD PPS, the current bundled payment system, see Part I, Item 1, of this report under the sub-caption "Medicare revenue" under the caption "Sources of revenue" concentration and risks.

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

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

In March 2012, the HHS issued two final rules related to the establishment of health care insurance exchanges due to be operating by 2014 that will provide a marketplace for eligible individuals to purchase health care insurance. We believe the establishment of health care insurance exchanges could result in a reduction in patients covered by commercial insurance or an increase of patients covered through the exchanges under more restrictive commercial plans with lower reimbursement rates. To the extent that the implementation of such exchanges results in a reduction in patients covered by commercial insurance or a reduction in reimbursement rates for our services from commercial and/or government payors, our revenues, earnings and cash flows could be adversely affected.

The law requires that all non-grandfathered individual and small group health plans sold in a state, including plans sold through state exchanges, cover EHBs in ten general categories. The scope of the benefits is intended to equal the scope of benefits under a typical employer plan. In December 2011, the Center for Consumer Information and Insurance Oversight published an Essential Health Benefits Bulletin describing the approach it was taking regarding the implementation of the EHB Bulletin requirement. For the two year transition period (from 2014 through 2015) the law requires states to define an EHB benchmark plan that must be covered by plans in the state. States that do not define an EHB benchmark plan must use the small group plan with the

largest enrollment in the state. On November 26, 2012, HHS issued a proposed rule governing the standards applicable to EHB Bulletins, new definitions, actuarial value requirements and methodology, and published a list of plan benchmark options that states can use to develop EHBs. The rule describes specific coverage requirements that: (i) prohibit discrimination against individuals because of pre-existing or chronic conditions on health plans applicable to EHBs; (ii) ensure network adequacy of essential health providers, and (iii) prohibit benefit designs that limit enrollment and that prohibit access to care for enrollees. The proposed rule raises several issues that could impact the Company. To date, 47 states and the District of Columbia have chosen EHB Bulletin benchmark plans. Few state EHBs specifically include dialysis benefits. We believe that these current benchmark plans do in fact provide coverage for dialysis services, even if such services are not explicitly specified in the benchmark plans. However, the proposed rule gives issuers flexibility to define services within the 10 benefit categories set forth in the law, to substitute services within the same category and to design health plans in ways that could limit the number of treatments an individual may receive, or to restrict his or her provider network.

The law prohibits issuers from discriminating against individuals. However, the issuer would be permitted to vary premiums within the limits, and the rule does not explain how anti-discrimination provisions will be monitored and enforced. Our U.S. dialysis business, as a member of the Kidney Care Council, has submitted comments to HHS regarding the proposed rule. If HHS fails to include dialysis services explicitly as an EHB, it could adversely affect revenues as patients currently covered by commercial payors move to exchanges which then could require that individuals purchasing coverage on the exchange look to public payors to cover ESRD services.

In October 2011, CMS issued a final rule concerning the MSSP established by the health care reform legislation, which under the statute was required to be implemented no later than January 1, 2012. The MSSP, which is now operational, provides financial incentives to health care providers and suppliers that work together to furnish coordinated, high-quality care to Medicare beneficiaries through ACOs. Approximately 250 ACOs have been formed throughout the country.

The CMS Center for Innovation (Innovation Center) is in various stages of development in working with various healthcare providers to implement ACOs and other innovative models of care for Medicare and Medicaid beneficiaries. We are currently uncertain of the extent to which these models of care, including ACOs, Bundled Payments for Care Improvement Initiative (which is scheduled to begin in the spring of 2013), the Comprehensive Primary Care Initiative, the Duals Demonstration, or other models, will impact the health care market. Our U.S. dialysis business may choose to participate in one or several of these models either as a partner with other providers or independently. We are currently seeking a renal specific coordinated care pilot with the Innovation Center. Even if we do not participate in these programs, some of our patients may be assigned to a program, in which case the quality and cost of care that we furnish will be included in an ACOs or other programs calculations regardless of our participation in the program. As new models of care emerge, we may be at risk for losing our Medicare patient base, which would have a materially adverse effect on our revenues, earnings and cash flow. Furthermore, other initiatives in the government or private sector may arise, including the development of models similar to ACOs, IPAs and integrated delivery systems or evolutions of those concepts which could adversely impact our business.

In addition, the health care reform legislation introduced severe penalties for the knowing and improper retention of overpayments collected from government payors. As a result, we made initial significant investments in additional resources to accelerate the time it takes to identify and process overpayments and we may be required to make additional investments in the future. Acceleration in our ability to identify and process overpayments could result in us refunding overpayments to government or other payors sooner than we have in the past, which could have a material adverse effect on our operating cash flows. The failure to return identified overpayments within the specified time frame is now a violation of the federal FCA. Additionally, the American Taxpayer Relief Act of 2012 extended the look-back period for returning overpayments by two years.

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

Effective March 2011, CMS instituted screening procedures and a \$500 enrollment fee for providers enrolling and re-enrolling in government health care programs. A provider is subject to screening upon initial enrollment and each time the provider re-validates its enrollment application. Screening includes verification of enrollment information and review of various federal databases to ensure the provider has valid tax identification, NPI numbers and is not excluded from participation in federal and state healthcare programs. We expect this screening process to delay the Medicare contractor approval process, potentially causing a delay in reimbursement. The enrollment fee is also applicable upon initial enrollment, re-validation, and each time an existing provider adds a new facility location. This fee is an additional expense that must be paid for each center every three years and could be more significant if other government and commercial payors follow this trend. Ultimately, we anticipate the new screening and enrollment requirements will require additional personnel and financial resources and will potentially delay the enrollment and revalidation of our centers which in turn will delay payment.

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

There are numerous steps required to implement the broad healthcare reform legislation adopted by Congress, and Congress may seek to alter or eliminate some of the provisions described above. Numerous legal challenges have also been raised to the healthcare reform legislation that could alter or eliminate certain provisions. The United States Supreme Court reviewed state actions challenging the constitutionality of the health insurance mandate and the Medicaid expansion program. The Court upheld the mandate under Congress' taxing power and upheld the Medicaid expansion program. However, the Court found that the federal government cannot withhold all of a state's Medicaid funding for the state's failure or refusal to expand its Medicaid program as contemplated by the reform legislation, effectively leaving the Medicaid expansion decision up to the individual states. Several states have announced they do not intend to expand their Medicaid programs. Further, various health insurance reform proposals are also emerging at the state level. There is a considerable amount of uncertainty as to the prospective implementation of the federal healthcare reform legislation and what similar measures might be enacted at the state level. The enacted reforms as well as future legislative changes could have a material adverse effect on our results of operations, including lowering our reimbursement rates and increasing our expenses.

The health care reform legislation added several new tax provisions that, among other things, impose various fees and excise taxes, and limit compensation deductions for health insurance providers and their affiliates. On December 28, 2012, the Internal Revenue Service posted a proposed regulation that outlines the federal Executive branch's stance on several key issues surrounding the employer mandate, including the determination of applicable large employer rules for determining full-time employees and rules for determining whether an employer is subject to penalties. These rules could negatively impact our cash flow and tax liabilities.

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

Approximately 17% of our dialysis and related lab services revenues for the year ended December 31, 2012 was generated from patients who have state Medicaid or other non-Medicare government-based programs, such as Medicare-assigned plans or the VA, as their primary coverage. As state governments and governmental

organizations face increasing budgetary pressure, we may in turn face reductions in payment rates, delays in the timing of payments, limitations on eligibility or other changes to the applicable programs. For example, some programs, such as certain state Medicaid programs and the VA, have recently considered, proposed or implemented rate reductions.

On December 17, 2010, the Department of Veterans Affairs (VA) published a final rule in which it materially changed the payment methodology and ultimately the amount paid for dialysis services furnished to veterans in non-VA centers such as ours. In the final rule, the VA adopted the bundled payment system implemented by Medicare and estimated a reduction of 39% in payments for dialysis services to veterans at non-VA centers. Approximately 2% of our dialysis and related lab services revenues for the year ended December 31, 2012 was generated by the VA. The VA payment methodology will have a significant negative impact on our revenues, earnings and cash flows as a result of the reduction in rates or as a result of the decrease in the number of VA patients we serve. We recently executed contractual agreements with the VA and there is some uncertainty as to when this rule will take effect for the patients covered by these contracts. While at this time the contracts remain in force, these agreements provide for the right of the VA to terminate the agreement without cause on short notice. Further, patients who are not covered by the contractual arrangements will likely be reimbursed at Medicare rates beginning with the date of implementation of the rule. If the VA proceeds with payment rate reductions or fails to renew our existing contracts, we might have to cease accepting patients under this program and could even be forced to close centers.

State Medicaid programs are increasingly adopting Medicare-like bundled payment systems, but sometimes these payment systems are poorly defined and could include all drugs (even those oral-only drugs that Medicare will not include in the bundled payment until 2014) and are implemented without any claims processing infrastructure, or patient or facility adjusters. If these payment systems are implemented without any adjusters and claims processing changes, Medicaid payments will be substantially reduced and the costs to submit such claims may increase. 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. These Medicaid payment and enrollment changes, along with similar changes to other non-Medicare government programs could reduce the rates paid by these programs for dialysis and related services, delay the timing of payment for services provided, and further limit eligibility for coverage which could adversely affect our revenues, earnings and cash flows.

Changes in clinical practices, payment rates or regulations impacting EPO and other pharmaceuticals could reduce our revenues, earnings and cash flows.

Historically, Medicare and most Medicaid programs paid for EPO outside of the composite rate. This separate payment has long been the subject of discussions regarding appropriate dosing and payment in an effort to reduce escalating expenditures for EPO. Since January 1, 2011, Medicare has bundled EPO into the prospective payment system such that dosing variations will not change the amount paid to a dialysis facility. Although some Medicaid programs and other payors suggest movement towards a bundled payment system inclusive of EPO, some non-Medicare payors continue to pay for EPO separately from the treatment rate. The administration of EPO and other pharmaceuticals that are separately billable accounted for approximately 5% of our dialysis and related lab services revenues for the year ended December 31, 2012, with EPO alone accounting for approximately 3% of our dialysis and related lab services revenues for the same period. Changes in physician clinical practices that result in further decreased utilization of prescribed pharmaceuticals or changes in payment rates for those pharmaceuticals could reduce our revenues, earnings and cash flows.

Since late 2006, there has been significant media discussion and government scrutiny regarding anemia management practices in the U.S. which has created confusion and concern in the nephrology community. In late 2006, the U.S. House of Representatives Ways and Means Committee held a hearing on the issue of the utilization of erythropoiesis stimulating agents (ESAs), which include EPO, and in 2007, the FDA required changes to the labeling of EPO and Aranesp® to include a black box warning, the FDA's strongest form of warning label. In June 2011, the FDA required that the black box warning be slightly revised and also include

more conservative dosing recommendations for patients with CKD. In addition, in 2011, CMS opened a national coverage analysis (NCA) for ESAs that could have resulted in a national coverage determination potentially impacting payments for ESAs in anemia treatment. CMS subsequently determined in 2011 not to issue a national coverage determination for ESAs due to a lack of available evidence to establish coverage criteria or limitations. However, we cannot predict whether CMS might open a NCA for ESAs in the future and, if so, what the potential outcome might be.

The forgoing congressional and agency activities and related actions could result in further restrictions on the utilization and reimbursement for ESAs. Commercial payors have also increasingly examined their administration policies for EPO and, in some cases, have modified those policies. Further changes in labeling of EPO and other pharmaceuticals in a manner that alters physician practice patterns or accepted clinical practices, changes in private and governmental payment criteria, including the introduction of EPO administration policies or the conversion to alternate types of administration of EPO or other pharmaceuticals that result in further decreases in utilization of EPO for patients covered by commercial payors or increased utilization of EPO for patients for whom the cost of EPO is included in a bundled reimbursement rate, or further decreases in reimbursement for EPO and other pharmaceuticals that are not included in a bundled reimbursement rate, could have a material adverse effect on our revenues, earnings and cash flows.

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

In November 2011, we entered into a seven year Sourcing and Supply Agreement with Amgen USA Inc. Under the agreement we committed to purchase EPO in amounts necessary to meet no less than 90% of our requirements for ESAs. The agreement replaces in its entirety the prior one-year supply agreement between us and Amgen that expired on December 31, 2011. As long as we meet certain conditions, the agreement limits Amgen's ability to unilaterally decide to increase the price for EPO. Future increases in the cost of EPO without corresponding increases in payment rates for EPO from commercial payors and without corresponding increases in the Medicare bundled rate could have a material adverse effect on our earnings and cash flows and ultimately reduce our income. Our agreement with Amgen for EPO provides for discounted pricing and rebates for EPO. Some of the rebates are subject to various conditions including but not limited to future pricing levels of EPO by Amgen and data submission by us. In addition, the rebates are subject to certain limitations. We cannot predict whether, over the seven year term of the agreement, we will continue to receive the rebates for EPO that we have received in the past, or whether we will continue to achieve the same levels of rebates within that structure as we have historically achieved. In the initial years of the agreement, however, the total rebate opportunity is less than what was provided in the agreement that expired at the end of 2011, however, the opportunity for us to earn discounts and rebates increases over the term of the agreement. Factors that could impact our ability to qualify for rebates provided for in our agreement with Amgen in the future include, but are not limited to, our ability to track certain data elements. We cannot predict whether we will be able to meet the applicable qualification requirements for receiving rebates. Failure to meet certain targets and earn the specified rebates could have a material adverse effect on our earnings and cash flows. In 2012, we experienced an increase in our overall EPO unit costs. In December 2012 we entered into an amendment to our agreement with Amgen that makes non-material changes to certain terms of the agreement for the period from January 1, 2013 through December 31, 2013. Under the terms of the original agreement before the amendment, we were required to purchase EPO in amounts necessary to meet no less than 90% of our requirements of ESAs and are still required to do so after 2013. In addition, all of the other conditions as specified in the original agreement entered into in November 2011 still apply.

We are the subject of a number of inquiries by the federal government and two private civil suits, any of which could result in substantial penalties or awards against us, imposition of certain obligations on our practices and procedures, exclusion from future participation in the Medicare and Medicaid programs and, in certain cases, criminal penalties.

We are the subject of a number of inquiries by the federal government. We have received subpoenas or other requests for documents from the federal government in connection with the Vainer private civil suit, the

2010 U.S. Attorney physician relationship investigation, the 2011 U.S. Attorney physician relationship investigation and the 2011 U.S. Attorney Medicaid investigation. Certain current and former members of the Board, executives and other teammates have been subpoenaed to testify before the grand jury in Colorado related to the 2011 U.S. Attorney physician relationship investigation.

With respect to the Vainer and the Turner-Hooks private civil suits, after investigation, the government did not intervene and is not actively pursuing either of these private civil suits. (See Part I, Item 3, of this report under the caption "Legal Proceedings" for additional details regarding these matters). In each of these private civil suits, a relator filed a complaint against us in federal court under the *qui tam* provisions of the FCA and pursued the claims independently after the government declined to intervene. The parties are engaged in active litigation in the Vainer private civil suit, and the Company was recently served with the complaint in the Turner-Hooks private civil suit.

We are cooperating with the OIG and those offices of the U.S. Attorney pursuing the matters mentioned above and are producing the requested records. Although it is uncertain whether or when proceedings might be initiated by the federal government, the scope of such proceedings or when these matters may be resolved, it is not unusual for investigations such as these to continue for a considerable period of time through the various phases of document and witness requests and on-going discussions with regulators. Responding to the subpoenas or investigations and defending ourselves in the private civil suits will continue to require management's attention and significant legal expense. Any negative findings could result in substantial financial penalties or awards against us, imposition of certain obligations on our practices and procedures, exclusion from future participation in the Medicare and Medicaid programs and, in certain cases, criminal penalties. It is possible that criminal proceedings may be initiated against us in connection with investigations by the federal government, including the 2011 U.S. Attorney physician relationship investigation. To our knowledge, no proceedings have been initiated by the federal government against us at this time.

Continued inquiries from various governmental bodies with respect to our utilization of EPO and other pharmaceuticals will require management's attention, cause us to incur significant legal expense and could result in substantial financial penalties against us, repayment 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.

In response to clinical studies which identified risks in certain patient populations related to the utilization of EPO and other ESAs, i.e., Aranesp®, and in response to changes in the labeling of EPO and Aranesp®, there has been substantial media attention and government scrutiny resulting in hearings and legislation regarding pharmaceutical utilization and reimbursement. Although we believe our anemia management practices and other pharmaceutical administration practices have been compliant with existing laws and regulations, as a result of the current high level of scrutiny and controversy, we may be subject to increased inquiries from a variety of governmental bodies and claims by third parties. Additional inquiries from or audits by various agencies and claims by third parties with respect to these issues would continue to require management's attention and significant legal expense and any negative findings could result in substantial financial penalties or repayments, imposition of certain obligations on our practices and procedures and the attendant financial burden on us to comply, or exclusion from future participation in the Medicare and Medicaid programs, and could have a material adverse effect on our revenues, earnings and cash flows.

If we fail to adhere to all of the complex government regulations that apply to our business, we could suffer severe consequences that would substantially reduce our revenues, earnings, cash flows and stock price.

Our dialysis operations are subject to extensive federal, state and local government regulations, including Medicare and Medicaid payment rules and regulations, federal and state anti-kickback laws, the Stark Law physician self-referral prohibition and analogous state referral statutes, Federal Acquisition Regulations, the FCA and federal and state laws regarding the collection, use and disclosure of patient health information and the

storage, handling and administration of pharmaceuticals. The Medicare and Medicaid reimbursement rules related to claims submission, enrollment and licensing requirements, cost reporting, and payment processes impose complex and extensive requirements upon dialysis providers. A violation or departure from any of these requirements may result in government audits, lower reimbursements, significant fines and penalties, the potential loss of certification and recoupments or voluntary repayments.

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

We endeavor to comply with all of the requirements for receiving Medicare and Medicaid payments, to structure all of our relationships with referring physicians to comply with state and federal anti-kickback laws and physician self-referral law (Stark Law), and for storing, handling and administering pharmaceuticals. However, the laws and regulations in these areas are complex, require considerable resources to monitor and implement and are subject to varying interpretations. For example, if an enforcement agency were to challenge the level of compensation that we pay our medical directors or the number of medical directors whom we engage, we could be required to change our practices, face criminal or civil penalties, pay substantial fines or otherwise experience a material adverse effect as a result of a challenge to these arrangements. In addition, amendments to the FCA impose severe penalties for the knowing and improper retention of overpayments collected from government payors. These amendments could subject our procedures for identifying and processing overpayments to greater scrutiny. We have made significant investments in additional resources to decrease the time it takes to identify and process overpayments and we may be required to make additional investments in the future. An acceleration in our ability to identify and process overpayments could result in us refunding overpayments to government or other payors sooner than we have in the past. A significant acceleration of these refunds could have a material adverse effect on our operating cash flows. Additionally, amendments to the federal anti-kickback statute in the health reform law make anti-kickback violations subject to FCA prosecution, including *qui tam* or whistleblower suits.

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

Suspension or termination of our participation in government payment programs;

Refunds of amounts received in violation of law or applicable payment program requirements;

Loss of required government certifications or exclusion from government payment programs;

Loss of licenses required to operate health care facilities or administer pharmaceuticals in some of the states in which we operate;

Reductions in payment rates or coverage for dialysis and ancillary services and related pharmaceuticals;

Fines, damages or monetary penalties for anti-kickback law violations, Stark Law violations, FCA violations, civil or criminal liability based on violations of law, or other failures to meet regulatory requirements;

Enforcement actions by governmental agencies and/or claims for monetary damages by patients who believe PHI has been used or disclosed or not properly safeguarded in violation of federal or state patient privacy laws, including the federal HIPAA of 1996;

Mandated changes to our practices or procedures that significantly increase operating expenses;

Imposition of and compliance with Corporate Integrity Agreements that could subject us to ongoing audits, reporting, increased scrutiny of our billing and business practices and potential additional fines;

Termination of relationships with medical directors; and

Harm to our reputation, which could impact our business relationships, ability to obtain financing and access to new opportunities.

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

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

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

As of December 31, 2012, we owned a controlling interest in numerous dialysis-related joint ventures, which represented approximately 19% of our U.S. dialysis and related lab services revenues for the year ended December 31, 2012. In addition, we also owned minority equity investments in several other dialysis related joint ventures. We anticipate that we will continue to increase the number of our joint ventures. Many of our joint ventures with physicians or physician groups also have the physician owners providing medical director services to those centers or other centers we own and operate. Because our relationships with physicians are governed by the federal anti-kickback statute, we have sought to structure our joint venture arrangements to satisfy as many safe harbor requirements as we believe are reasonably possible. However, our joint venture arrangements do not satisfy all elements of any safe harbor under the federal anti-kickback statute (and possibly the Stark Law). The subpoena and related requests for documents we received from the U.S. Attorney's Office for the Eastern District of Missouri in the 2005 U.S. Attorney investigation, the OIG's Office in Dallas in the 2010 U.S. Attorney physician relationship investigation and the U.S. Attorney's Office for the District of Colorado in the 2011 U.S. Attorney physician relationship investigation, included requests for documents related to our joint ventures. We have been advised by the U.S. Department of Justice that it is conducting civil and grand jury investigations into our financial relationships with physicians, including our joint ventures generally. We have been advised by the attorneys conducting the civil investigation that they believe that the general structure of our joint ventures does not comply with the anti-kickback statute and the False Claims Act. We disagree that our joint venture structure, which we believe is widely used in the dialysis industry and other segments of the healthcare industry substantially in the form that we use it, violates the federal anti-kickback statute or the False Claims Act. However, if our joint ventures are found to be in violation of the anti-kickback statute, the False Claims Act or the Stark Law provisions, we could be required to restructure the joint ventures or refuse to accept referrals for DHS from the physicians with whom the joint venture centers have a financial relationship.

We also could be required to repay amounts received by the joint ventures from Medicare and certain other payors to the extent that these arrangements are found to give rise to prohibited referrals, and we could be subject to monetary penalties, exclusion from government healthcare programs and, if criminal proceedings are brought against us, criminal penalties. If our joint venture centers are subject to any of these penalties, we could suffer severe consequences that would have a material adverse effect on our revenues, earnings and cash flows.

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

There are significant estimating risks associated with the amount of dialysis and related lab services revenues and related refund liabilities that we recognize in a reporting period. The billing and collection process is complex due to ongoing insurance coverage changes, geographic coverage differences, differing interpretations of contract coverage, and other payor issues. Determining applicable primary and secondary coverage for approximately 153,000 U.S. patients at any point in time, together with the changes in patient coverage that occur each month, requires complex, resource-intensive processes. Errors in determining the correct coordination of benefits may result in refunds to payors. Revenues associated with Medicare and Medicaid programs are also subject to estimating risk related to the amounts not paid by the primary government payor that will ultimately be collectible from other government programs paying secondary coverage, the patient's commercial health plan secondary coverage or the patient. Collections, refunds and payor retractions typically continue to occur for up to three years and longer after services are provided. We generally expect our range of U.S. dialysis and related lab services revenues estimating risk to be within 1% of net revenues for the segment, which can represent as much as 5% of dialysis operating income. If our estimates of dialysis and related lab services revenues and related refund liabilities are materially inaccurate, it could impact the timing and the amount of our revenues recognition and have a significant impact on our operating results.

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

Our ancillary services and strategic initiatives currently include pharmacy services, disease management services, vascular access services, ESRD clinical research programs, physician services, direct primary care and our international dialysis operations. We expect to add additional service offerings and pursue additional strategic initiatives in the future as circumstances warrant, which could include healthcare services not related to dialysis. Many of these initiatives require or would require investments of both management and financial resources and can generate significant losses for a substantial period of time and may not become profitable. There can be no assurance that any such strategic initiative will ultimately be successful. Any significant change in market conditions, or business performance, or in the political, legislative or regulatory environment, may impact the economic viability of any of these strategic initiatives. For example, during 2011 and 2012, several of our strategic initiatives generated net operating losses and some are expected to generate net operating losses in 2013 and beyond. If any of our ancillary services or strategic initiatives, including our international dialysis operations, do not perform as planned, we may incur a material write-off or an impairment of our investment, including goodwill, in one or more of these activities or we could incur significant termination costs if we were to exit a certain line of business. As an example, during the second quarter of 2011 we recorded a goodwill impairment charge of \$24 million related to our infusion therapy business, as a result of a decrease in the implied fair value of goodwill below its carrying amount.

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

We believe that physicians prefer to have their patients treated at dialysis centers where they or other members of their practice supervise the overall care provided as medical director of the center. As a result, the primary referral source for most of our centers is often the physician or physician group providing medical director services to the center. Neither our current nor former medical directors have an obligation to refer their patients to our centers. If a medical director agreement terminates, whether before or at the end of its term, and a new medical director is appointed, it may negatively impact the former medical director's decision to treat his or her patients at our center. If we are unable to enforce noncompetition provisions contained in the terminated

medical director agreements, former medical directors may choose to provide medical director services for competing providers or establish their own dialysis centers in competition with ours. Also, if the quality of service levels at our centers deteriorates, it may negatively impact patient referrals and treatment volumes.

Our medical director contracts are for fixed periods, generally three to ten years, and at any given time a large number of them could be up for renewal at the same time. Medical directors have no obligation to extend their agreements with us, and there are a number of factors, including opportunities presented by our competitors or different affiliation models in the changing healthcare environment, such as an increase in the number of physicians becoming employed by hospitals, that could negatively impact their decisions to extend their agreements with us. In addition, we may take actions to restructure existing relationships or take positions in negotiating extensions of relationships to assure compliance with the anti-kickback statute, Stark Law and other similar laws. These actions also could negatively impact the decision of physicians to extend their medical director agreements with us or to refer their patients to us. If the terms of any existing agreement are found to violate applicable laws, we may not be successful in restructuring the relationship which could lead to the early termination of the agreement, or cause the physician to stop referring patients to our dialysis centers. If a significant number of physicians were to cease referring patients to our dialysis centers, whether due to regulatory or other reasons, then our revenues, earnings and cash flows would be substantially reduced.

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

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

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

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

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

Our business is labor intensive, and our results are subject to variations in labor-related costs, productivity and the number of pending or potential claims against us related to labor and employment practices. If political

efforts at the national and local level result in actions or proposals that increase the likelihood of union organizing activities at our facilities or if union organizing activities increase for other reasons, or if labor and employment claims, including the filing of class action suits, trend upwards, our operating costs could increase and our employee relations, productivity, earnings and cash flows could be adversely affected.

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

We are continuously performing upgrades to our billing systems and expect to continue to do so in the near term. In addition, we continuously work to improve our billing and collections performance through process upgrades, organizational changes and other improvements. We may experience difficulties in our ability to successfully bill and collect for services rendered as a result of these changes, including a slow-down of collections, a reduction in the amounts we expect to collect, increased risk of retractions from and refunds to commercial and government payors, an increase in our provision for uncollectible accounts receivable and noncompliance with reimbursement regulations. The failure to successfully implement the upgrades to the billing and collection systems and other improvements could have a material adverse effect on our revenues, cash flows and operating results.

Our ability to effectively provide the services we offer could be negatively impacted if certain of our suppliers are unable to meet our needs or if we are unable to effectively access new technology, which could substantially reduce our revenues, earnings and cash flows.

We have significant suppliers that are either the sole or primary source of products critical to the services we provide, including Amgen, Baxter Healthcare Corporation, NxStage Medical, Inc. and others or to which we have committed obligations to make purchases including Gambro Renal Products and Fresenius. If any of these suppliers are unable to meet our needs for the products they supply, including in the event of a product recall, or shortage, and we are not able to find adequate alternative sources, or if some of the drugs that we purchase are not reimbursed or not adequately reimbursed by commercial payors or through the bundled payment rate by Medicare, our revenues, earnings and cash flows could be substantially reduced. In addition, the technology related to the products critical to the services we provide is subject to new developments and may result in superior products. If we are not able to access superior products on a cost-effective basis or if suppliers are not able to fulfill our requirements for such products, we could face patient attrition which could substantially reduce our revenues, earnings and cash flows.

Risks related to HCP:

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

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

The healthcare business is heavily regulated and changes in laws, regulations, or government programs could have a material impact on HCP;

Failure to comply with complex governmental regulations could have severe consequences to HCP, including, without limitation, exclusion from governmental payor programs like Medicare and Medicaid;

HCP could become the subject of governmental investigations, claims, and litigation;

HCP may be unable to continue to make acquisitions or to successfully integrate such acquisitions into its business, and such acquisitions may include liabilities of which HCP was not aware; and

As a result of the broad scope of HCP's medical practice, HCP is exposed to medical malpractice claims, as well as claims for damages and other expenses, that may not be covered by insurance for which adequate limits of insurance coverage may not be available.

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

Substantially all of HCP's revenue is derived from PMPM fees paid by health plans under capitation agreements with HCP or its associated physician groups. In Florida and, a significant portion in Nevada, HCP contracts directly with health plans under global capitation arrangements to assume financial responsibility for both professional and institutional services. In California, HCP utilizes a capitation model in several different forms. While there are variations specific to each arrangement, HCPAMG generally contracts with health plans to receive a PMPM fee for professional services and assumes the financial responsibility for professional services only. In some cases, the health plans separately enter into capitation contracts with third parties (typically hospitals) who receive directly a PMPM fee and assume contractual financial responsibility for hospital services. In other cases, the health plan does not pay any portion of the PMPM fee to the hospital, but rather administers claims for hospital expenses itself. In both scenarios, HCP enters into managed care-related administrative services agreements or similar arrangements with those third parties (hospitals) under which HCP agrees to be responsible for utilization review, quality assurance, and other managed care-related administrative functions and claim payments. As compensation for such administrative services, HCP is entitled to share a percentage of the amount by which the institutional capitation revenue exceeds institutional expenses; any such risk-share amount to which HCP is entitled is recorded as medical revenues and HCP is also responsible for any short-fall in the event that institutional expenses exceed institutional revenues.

To the extent that members require more care than is anticipated, aggregate fixed Per Member Per Month (PMPM) amounts, or capitation payments, may be insufficient to cover the costs associated with treatment. If medical expenses exceed estimates, except in very limited circumstances, HCP will not be able to increase the PMPM fee received under these risk agreements during their then-current terms.

If HCP or its associated physician groups enter into capitation contracts or other risk sharing arrangements with unfavorable economic terms, or a capitation contract is amended to include unfavorable terms, HCP could, directly or indirectly through its contracts with its associated physician groups, suffer losses with respect to such contract. Since HCP does not negotiate with CMS or any health plan regarding the benefits to be provided under their Medicare Advantage plans, HCP often has just a few months to familiarize itself with each new annual package of benefits it is expected to offer.

Changes in HCP's or its associated physician groups' ratio of medical expense to revenue can create significant changes in HCP's financial results. Accordingly, the failure to adequately predict and control medical expenses and to make reasonable estimates and maintain adequate accruals for incurred but not reported claims, may have a material adverse effect on HCP's financial condition, results of operations or cash flows.

Historically, HCP's and its associated physician groups' medical expenses as a percentage of revenue have fluctuated. Factors that may cause medical expenses to exceed estimates include:

the health status of members;

higher than expected utilization of new or existing healthcare services or technologies;

an increase in the cost of healthcare services and supplies, including pharmaceuticals, whether as a result of inflation or otherwise;

changes to mandated benefits or other changes in healthcare laws, regulations, and practices;

periodic renegotiation of provider contracts with specialist physicians, hospitals, and ancillary providers;

periodic renegotiation of contracts with HCP's associated primary care physicians;

changes in the demographics of the participating members and medical trends;

contractual or claims disputes with providers, hospitals, or other service providers within a health plan's network;

the occurrence of catastrophes, major epidemics, or acts of terrorism; and

plans with declining premiums.

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

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

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

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

Under most of HCP's and its associated physician groups' capitation agreements with health plans, the health plan is generally permitted to modify the benefit and risk obligations and compensation rights from time to time during the terms of the agreements. If a health plan exercises its right to amend its benefit and risk obligations and compensation rights, HCP and its associated physician groups are generally allowed a period of time to object to such amendment. If HCP or its associated physician group so objects, under some of the risk agreements, the relevant health plan may terminate the applicable agreement upon 60 to 90 days written notice. Depending on the health plan at issue and the amount of revenue associated with the health plan's risk agreement, the renegotiated terms or termination may have a material adverse effect on HCP's and DaVita's future revenues and profitability.

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

Some states have laws that prohibit business entities, such as HCP, from practicing medicine, employing physicians to practice medicine, exercising control over medical decisions by physicians (also known collectively as the corporate practice of medicine) or engaging in certain arrangements, such as fee-splitting, with physicians.

In some states these prohibitions are expressly stated in a statute or regulation, while in other states the prohibition is a matter of judicial or regulatory interpretation. Of the four states in which HCP currently operates, California and Nevada prohibit the corporate practice of medicine.

In California and Nevada, HCP operates by maintaining long-term contracts with its associated physician groups which are each owned and operated by physicians and which employ or contract with additional physicians to provide physician services. Under these arrangements, HCP provides management services, receives a management fee for providing non-medical management services, does not represent that it offers medical services, and does not exercise influence or control over the practice of medicine by the physicians or the associated physician groups.

In addition to the above management arrangements, HCP has certain contractual rights relating to the orderly transfer of equity interests in certain of its associated California and Nevada physician groups through succession agreements and other arrangements with their physician equityholders. However, such equity interests cannot be transferred to or held by HCP or by any non-professional organization. Accordingly, neither HCP nor HCP's subsidiaries directly own any equity interests in any physician groups in California and Nevada. In the event that any of these associated physician groups fails to comply with the management arrangement or any management arrangement is terminated and/or HCP is unable to enforce its contractual rights over the orderly transfer of equity interests in its associated physician groups, such events could have a material adverse effect on HCP's business, financial condition or results of operations.

HCP may be required to restructure its relationship with its associated physician groups if HCP's management services agreements with such associated physician groups or HCP's succession agreements and other related arrangements with equityholders of any such associated physician groups are deemed invalid under prohibitions against the corporate practice of medicine in California and Nevada.

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

In light of the above, it is possible that a state regulatory agency or a court could determine that HCP's agreements with physician equityholders of certain managed California and Nevada associated physician groups as described above, either independently or coupled with the management services agreements with such associated physician groups, confer impermissible control over the business and/or medical operations of such associated physician groups, that the management fee payable under such arrangements results in profit sharing or that HCP is the beneficial owner of the associated physician groups' equity interests in violation of the corporate practice of medicine doctrine. If there were a determination that a corporate practice of medicine violation existed or exists, these arrangements could be deemed invalid, potentially resulting in a loss of revenues and an adverse effect on results of operations derived from such associated physician groups. In addition, HCP's California and Nevada associated physician groups and HCP, as well as those physician equity holders of associated physician groups who are subject to succession agreements with HCP, could be subject to criminal or civil penalties or an injunction for practicing medicine without a license or aiding and abetting the unlicensed practice of medicine.

A determination that a corporate practice of medicine violation existed could also force a restructuring of HCP's management arrangements with associated physician groups in California and/or Nevada. Such a restructuring might include revisions of the management services agreements, which might include a modification of the management fee, and/or establishing an alternative structure, such as obtaining a California Knox-Keene license (a managed care plan license issued pursuant to the California Knox-Keene Health Care Service Plan Act of 1975 (the Knox-Keene Act)) or its Nevada equivalent, which would permit HCP to contract with a physician network without violating the corporate practice of medicine prohibition. There can be no assurance that such a restructuring would be feasible, or that it could be accomplished within a reasonable time frame without a material adverse effect on HCP's operations and financial results.

If HCP's agreements or arrangements with any physician equityholder(s) of associated physicians, physician groups, or IPAs are deemed invalid under state law, including laws against the corporate practice of medicine, or Federal Law, or are terminated as a result of changes in state law, or if there is a change in accounting standards by the Financial Accounting Standards Board (FASB) or the interpretation thereof affecting consolidation of entities, it could impact HCP's consolidation of total revenues derived from such associated physician groups.

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

If HCP's associated physician groups are not able to satisfy the California Department of Managed Health Care's financial solvency requirements, HCP's associated physicians groups could become subject to sanctions and HCP's ability to do business in California could be limited or terminated.

The California DMHC has instituted financial solvency regulations. The regulations are intended to provide a formal mechanism for monitoring the financial solvency of capitated physician groups. Under the regulations, HCP's associated physician groups are required to, among other things:

Maintain, at all times, a minimum cash-to-claims ratio (where cash-to-claims ratio means the organization's cash, marketable securities, and certain qualified receivables, divided by the organization's total unpaid claims liability). The regulation currently requires a cash-to-claims ratio of 0.75.

Submit periodic reports to the DMHC containing various data and attestations regarding performance and financial solvency, including incurred but not reported calculations and documentation, and attestations as to whether or not the organization was in compliance with the Knox-Keene Act requirements related to claims payment timeliness had maintained positive tangible net equity (i.e., at least \$1.00), and had maintained positive working capital (i.e., at least \$1.00).

In the event that a physician organization is not in compliance with any of the above criteria, the organization would be required to describe in a report submitted to the DMHC the reasons for non-compliance and actions to be taken to bring the organization into compliance. Further, under these regulations, the DMHC can make public some of the information contained in the reports, including, but not limited to, whether or not a particular physician organization met each of the criteria. In the event HCP or its associated physician groups are not able to meet certain of the financial solvency requirements, and fail to meet subsequent corrective action plans, HCP's associated physicians groups could be subject to sanctions, or limitations on, or removal of, its or their ability to do business in California.

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

A significant portion of HCP's revenue is directly or indirectly derived from the monthly premium payments paid by CMS to health plans for medical services provided to Medicare Advantage enrollees. As a result, HCP's results of operations are, in part, dependent on government funding levels for Medicare Advantage

programs. Any changes that limit or reduce Medicare Advantage reimbursement levels, such as reductions in or limitations of reimbursement amounts or rates under programs, reductions in funding of programs, expansion of benefits without adequate funding, elimination of coverage for certain benefits, or elimination of coverage for certain individuals or treatments under programs, could have a material adverse effect on HCP.

The Health Reform Acts contain a number of provisions that negatively impact Medicare Advantage plans, including the following:

Medicare Advantage benchmarks for 2011 were frozen at 2010 levels. Beginning in 2012, Medicare Advantage benchmark rates are being phased down from current levels to levels that are between 95% and 115% of fee-for-service costs, depending on a plan's geographic area. Medicare advantage plans receiving certain quality ratings by CMS will be eligible for bonus rate increases.

Rebates received by Medicare Advantage plans that underbid based on payment benchmarks will be reduced, with larger reductions for plans failing to receive certain quality ratings.

The Secretary of the HHS is granted explicit authority to deny Medicare Advantage plan bids that propose significant increases in cost sharing or decreases in benefits.

Beginning in 2014, Medicare Advantage plans with medical loss ratios below 85% will be required to pay a rebate to the Secretary of HHS. The Secretary of HHS will halt enrollment in any plan failing to meet this ratio for three consecutive years, and terminate any plan failing to meet the ratio for five consecutive years. If an HCP-contracting Medicare Advantage plan experiences a limitation on enrollment or is otherwise terminated from the Medicare Advantage program, HCP may suffer materially adverse consequences to its business or financial condition.

Since January 1, 2011, cost-sharing for certain series (such as chemotherapy and skilled nursing care) has been limited to the cost-sharing permitted under the original fee-for-service Medicare program.

Prescription drug plans are now required to cover all drugs on a list developed by the Secretary of HHS, and the Medicare part D premium subsidy for high-income beneficiaries has been reduced by 25%.

Beginning in 2014, CMS is required to increase coding intensity adjustments for Medicare Advantage plans, which is expected to reduce CMS payments to Medicare Advantage plans, which in turn will likely reduce the amounts payable to HCP and its associated physicians, physician groups, and IPA's under its capitation agreements.

In addition to the above, the Health Reform Acts establish a new Independent Payment Advisory Board (IPAB) to recommend ways to reduce Medicare spending if the increase in Medicare costs per capita exceeds certain targets, which will be implemented unless Congress passes alternative legislation that achieves the same savings. The Health Reform Acts mandate that if targets are not met, the IPAB's recommendations are to include ways to reduce payments to Medicare Advantage plans and Medicare Part D prescription drug plans related to administrative expenses (including profits) and performance bonuses. Also, the Budget Control Act of 2011 (BCA) mandates a 2% decrease in Medicare Advantage spending in order to bring Medicare spending for Medicare Advantage beneficiaries more in line with Medicare fee-for-service spending. Additional steps could be taken by government agencies and plan providers to further restrict, directly or indirectly, the reimbursements available to plan service providers like HCP.

Finally, it is possible that the impact of the Health Reform Acts could cause a reduction in enrollment in Medicare Advantage plans, which, in turn, would reduce HCPs revenues and net income. For example, the Congressional Budget Office expects that, after reaching a high of 26% participation in Medicare Advantage plans in 2013, such participation will decline to 17% in 2020. The CBO predicts that this, together with other changes under the Health Reform Act, will result in reductions in Medicare Advantage spending by CMS of up to an aggregate of \$131.9 billion over 10 years.

Although the Health Reform Acts provide for reductions in payments to Medicare Advantage plans, the Health Reform Acts also provide for bonus payments to Medicare Advantage plans rated four or five stars based on quality measures. In November 2011, CMS announced a three-year demonstration project with an alternative bonus structure that awards bonuses to plans with three or more stars. The GAO and MedPAC have criticized the demonstration project. If Congress acts to curb the CMS initiated bonus structure, HCP's revenues would decrease.

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

For the period November 1, 2012 through December 31, 2012, 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 these and other health plans. Each health plan may immediately terminate any of HCP's contracts and/or any individual credentialed physician upon the occurrence of certain events. They may also amend the material terms of the contracts under certain circumstances. Failure to maintain the contracts on favorable terms, for any reason, would materially and adversely affect HCP's results of operations and financial condition. A material decline in the number of members could also have a material adverse effect on HCP's results of operations.

Notwithstanding each health plan's and HCP's current shared interest in providing service to HCP's members who are enrolled in the subject health plans, the health plans may have different and, at times, opposing economic interests from those of HCP. The health plans provide a wide range of health insurance services across a wide range of geographic regions, utilizing a vast network of providers. As a result, they and HCP may have different views regarding the proper pricing of services and/or the proper pricing of the various service providers in their provider networks, the cost of which HCP bears to the extent that the services of such service providers are utilized. These health plans may also have different views than HCP regarding the efforts and expenditures that they, HCP, and/or other service providers should make to achieve and/or maintain various quality ratings. In addition, several health plans have purchased or announced their intent to purchase provider organizations. If health plans with which HCP contracts make significant purchases, they may not continue to contract with HCP or contract on less favorable terms or seek to prevent HCP from acquiring or entering into arrangements with certain providers. Similarly, as a result of changes in laws, regulations, consumer preferences, or other factors, the health plans may find it in their best interest to provide health insurance services pursuant to another payment or reimbursement structure. In the event HCP's interests diverge from the interests of the health plans, HCP may have limited recourse or alternative options in light of its dependence on these health plans. There can be no assurances that HCP will continue to find it mutually beneficial to work with the health plans. As a result of various restrictive provisions that appear in some of the managed care agreements with health plans, HCP may, at times, have limitations on its ability to cancel an agreement with a particular health plan and immediately thereafter contract with a competing health plan with respect to the same service area.

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

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

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

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

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

Reductions in the quality ratings of the health plans HCP serves could have an adverse effect on its results of operations, financial condition, and/or cash flow.

As a result of the Health Reform Acts, HCP anticipates that the level of reimbursement each health plan receives from CMS will be dependent, in part, upon the quality rating of the Medicare plan that such health plan serves. Such ratings are expected to impact the percentage of any cost savings rebate and any bonuses earned by such health plan. Since a significant portion of HCP's revenue for 2012 is expected to be calculated as a percentage of CMS reimbursements received by these health plans with respect to HCP members, reductions in the quality ratings of a health plan that HCP serves could have an adverse effect on its results of operations, financial condition, and/or cash flows. In addition, CMS has announced its intention to terminate any plan that has a rating of less than three stars for three consecutive years. Medicare Advantage plans with five stars are permitted to conduct enrollment throughout the year and enrollees in plans with 4.5 or fewer stars are permitted to change plans during the year. None of the plans with which HCP contracts are five star plans. Given each health plan's control of its plans and the many other providers that serve such plans, HCP believes that it will have limited ability to influence the overall quality rating of any such plan. Accordingly, since low quality ratings can potentially lead to the termination of a plan that HCP serves, HCP may not be able to prevent the potential termination of a contracting plan or a shift of patients to other plans based upon quality issues which could, in turn, have an adverse effect on HCP's results of operations, financial condition, and/or cash flows.

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

HCP, on behalf of itself and its associated physicians, physician groups and IPAs, submits to health plans claims and encounter data that support the risk adjustment factor, or RAF, scores attributable to members. These RAF scores determine, in part, the revenue to which the health plan and, in turn, HCP is entitled for the provision

of medical care to such members. The data submitted to CMS by each health plan is based on medical charts and diagnosis codes prepared and submitted by HCP. Each health plan generally relies on HCP to appropriately document and support such RAF data in HCP's medical records. Each health plan also relies on HCP to appropriately code claims for medical services provided to members. HCP may periodically review medical records and may find inaccurate or unsupported coding or otherwise inaccurate records. Erroneous claims and erroneous encounter records and submissions could result in inaccurate PMPM fee revenue and risk adjustment payments, which may be subject to correction or retroactive adjustment in later periods. This corrected or adjusted information may be reflected in financial statements for periods subsequent to the period in which the revenue was recorded. HCP might also need to refund a portion of the revenue that it received, which refund, depending on its magnitude, could damage its relationship with the applicable health plan and could have a material adverse effect on HCP's results of operations, financial condition or cash flows.

CMS audits Medicare Advantage plans for documentation to support RAF-related payments for members chosen at random. The Medicare Advantage plans ask providers to submit the underlying documentation for members that they serve. It is possible that claims associated with members with higher RAF scores could be subject to more scrutiny in a CMS audit. HCP has experienced increases in RAF scores attributable to its members, and thus there is a possibility that a Medicare Advantage plan may seek repayment from HCP as a result of CMS payment adjustments to the Medicare Advantage plan. The plans also may hold HCP liable for any penalties owed to CMS for inaccurate or unsupported RAF scores provided by HCP.

CMS has indicated that, starting with payment year 2011, payment adjustments will not be limited to RAF scores for the specific Medicare Advantage enrollees for which errors are found but may also be extrapolated to the entire Medicare Advantage plan subject to a particular CMS contract. Although CMS has described its audit process as plan-year specific and has stated that it will not extrapolate audit results for plan years prior to 2011.

CMS has not specifically stated that payment adjustments as a result of one plan year's audit will not be extrapolated to prior plan years. There can be no assurance that a health plan will not be randomly selected or targeted for review by CMS or that the outcome of such a review will not result in a material adjustment in HCP's revenue and profitability, even if the information HCP submitted to the plan is accurate and supportable. Since the CMS rules, regulations, and statements regarding this audit program are still not well defined and, in some cases, have not been published in final form, there is also a risk that CMS may adopt new rules and regulations that are inconsistent with their existing rules, regulations, and statements.

A failure to estimate incurred but not reported medical expense accurately could adversely affect HCP's profitability.

Patient care costs include estimates of future medical claims that have been incurred by the patient but for which the provider has not yet billed HCP. These claim estimates are made utilizing actuarial methods and are continually evaluated and adjusted by management, based upon HCP's historical claims experience and other factors, including an independent assessment by a nationally recognized actuarial firm. Adjustments, if necessary, are made to medical claims expense when the assumptions used to determine HCP's claims liability changes and when actual claim costs are ultimately determined.

Due to the inherent uncertainties associated with the factors used in these estimates and changes in the patterns and rates of medical utilization, materially different amounts could be reported in HCP's financial statements for a particular period under different conditions or using different, but still reasonable, assumptions. It is possible that HCP's estimates of this type of claim may be inadequate in the future. In such event, HCP's results of operations could be adversely impacted. Further, the inability to estimate these claims accurately may also affect HCP's ability to take timely corrective actions, further exacerbating the extent of any adverse effect on HCP's results.

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

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

As a result of the direct and indirect impacts of the Health Reform Acts, many Medicare beneficiaries may decide that an original fee-for-service Medicare program is more attractive than a Medicare Advantage plan. As a result, enrollment in the health plans HCP serves may decrease.

Managed care companies offer alternative products such as regional preferred provider organizations (PPOs) and private fee-for-service plans. Medicare PPOs and private fee-for-service plans allow their patients more flexibility in selecting physicians than Medicare Advantage health plans, which typically require patients to coordinate care with a primary care physician. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 has encouraged the creation of regional PPOs through various incentives, including certain risk corridors, or cost reimbursement provisions, a stabilization fund for incentive payments, and special payments to hospitals not otherwise contracted with a Medicare Advantage plan that treat regional plan enrollees. The formation of regional Medicare PPOs and private fee-for-service plans may affect HCP's relative attractiveness to existing and potential Medicare patients in their service areas.

The payments for the local and regional Medicare Advantage plans are based on a competitive bidding process that may indirectly cause a decrease in the amount of the PMPM fee or result in an increase in benefits offered.

The annual enrollment process and subsequent lock-in provisions of the Health Reform Acts may adversely affect HCP's level of revenue growth as it will limit the ability of a health plan to market to and enroll new Medicare beneficiaries in its established service areas outside of the annual enrollment period.

Commencing in 2012, CMS will allow Medicare beneficiaries who are enrolled in a Medicare Advantage plan with a quality rating of 4.5 stars or less to enroll in a 5 star rated Medicare Advantage plan at any time during the benefit year. None of the plans HCP serves are 5-star rated. Therefore, HCP may face a competitive disadvantage in recruiting and retaining Medicare beneficiaries.

In addition to the competitive threats intrinsic to the Medicare programs, competition among health plans and among healthcare providers may also have a negative impact on HCP's profitability. For example, HCP's Existing Geographic Regions have become increasingly attractive to health plans that may compete with HCP, including the health plans with which HCP and its associated physicians, physician groups, and IPAs currently compete. HCP may not be able to continue to compete profitably in the healthcare industry if additional competitors enter the same market. If HCP cannot compete profitably, the ability of HCP to compete with other service providers that contract with competing health plans may be substantially impaired. Similarly, HCP's Existing Geographic Regions have also become increasingly attractive to HCP's competitors due to the large populations of Medicare beneficiaries. HCP may not be able to continue to compete effectively if additional competitors enter the same regions.

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

A disruption in HCP's healthcare provider networks could have an adverse effect on HCP's operations and profitability.

In any particular service area, healthcare providers or provider networks could refuse to contract with HCP, demand higher payments, or take other actions that could result in higher healthcare costs, disruption of benefits

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

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

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

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

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

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

The Health Reform Acts establish a Medicare shared savings program for Accountable Care Organizations (ACOs), which took effect in January 2012. Under the MSSP, the Secretary of HHS may contract with eligible organizations, including group medical practices, to be accountable for the quality, cost and overall care of Medicare beneficiaries assigned to an ACO. Participating ACOs that meet specified quality performance standards will be eligible to share in any savings below a specified benchmark amount. The Secretary of HHS is also authorized, but not required, to use capitation payment models with ACOs. The continued development and expansion of ACOs will have an uncertain impact on HCP's revenue and profitability.

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

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

California hospitals may terminate their agreements with HCPAMG or reduce the fees they pay to HCP.

In California, HCPAMG maintains significant hospital arrangements designed to facilitate the provision of coordinated hospital care with those services provided to members by HCPAMG and its associated physicians, physician groups, and IPAs. Through contractual arrangements with certain key hospitals, HCPAMG provides utilization review, quality assurance, and other management services related to the provision of patient care services to members by the contracted hospitals and downstream hospital contractors. In the event that any one of these key hospital agreements is amended in a financially unfavorable manner or is otherwise terminated, such events could have a material adverse effect on HCP's financial condition, and results of operations.

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

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

Changes in the rates or methods of third-party reimbursements may adversely affect HCP operations.

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

Medicare program reimbursements for physician services as well as other services to Medicare beneficiaries who are not enrolled in Medicare Advantage plans are based upon the fee-for-service rates set forth in the Medicare Physician Fee Schedule, which relies, in part, on a target-setting formula system called the SGR. Each year, on January 1st, the Medicare program updates the Medicare Physician Fee Schedule reimbursement rates. Many private payors use the Medicare Physician Fee Schedule to determine their own reimbursement rates. Based on the SGR, the annual fee schedule update is adjusted to reflect the comparison of actual expenditures to target expenditures. Because one of the factors for calculating the SGR is linked to the growth in the U.S. gross

domestic product (GDP), the SGR formula may result in a negative payment update if growth in Medicare beneficiaries' use of services exceeds GDP growth, a situation which has occurred every year since 2002 and the reoccurrence of which HCP cannot predict.

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

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

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

Congress has a strong interest in reducing the federal debt, which may lead to new proposals designed to achieve savings by altering payment policies. The BCA established a Joint Select Committee on Deficit Reduction, which had the goal of achieving a reduction in the federal debt level of at least \$1.2 trillion. As a result of the Joint Select Committee's failure to draft a proposal by the BCA's deadline, automatic cuts in various federal programs (excluding cuts to Medicaid by including cuts to Medicare provider reimbursement in an amount not to exceed 2%) were scheduled to commence on January 1, 2013. However, as a result of the enactment of ATRA on January 2, 2013, any such cuts were delayed until March 1, 2013 so as to allow Congress to consider whether to allow sequestration to place or replace it with other cuts in federal spending and/or higher taxes.

At this time, it is unclear whether the sequestration will be preempted by further Congressional action effective on or before March 1, 2013. If sequestration is not preempted by such Congressional action prior to March 1, 2013, it is unknown as to how the resulting federal program cost reductions may be applied to the various Medicare healthcare programs, including physician reimbursement. If sequestration is preempted, it is unknown whether the intervening Congressional action will impose lesser or greater cuts than required under the BCA. In addition, certain Congressional members have stated that the automatic federal spending cuts under the BCA are insufficient to achieve the BCA's goals of reducing federal spending and, in turn, the federal deficit. Such members have said that the way to achieve these additional cuts is to implement changes to federal entitlement programs, such as Medicare. Therefore it is not possible at this time to estimate what impact, if any, the BCA cuts or other federal Medicare provider reimbursement cuts will have on HCP's business or results of operations.

Because governmental healthcare programs generally reimburse on a fee schedule basis rather than on a charge-related basis, HCP generally cannot increase its revenues from these programs by increasing the amount it charges for its services. Moreover, if HCP's costs increase, HCP may not be able to recover its increased costs from these programs. Government and private payors have taken and may continue to take steps to control the cost, eligibility for, use, and delivery of healthcare services as a result of budgetary constraints, cost containment pressures and other reasons. HCP believes that these trends in cost containment will continue. These cost containment measures, and other market changes in non-governmental insurance plans have generally restricted HCP's ability to recover, or shift to non-governmental payors, any increased costs that HCP experiences. HCP's business and financial operations may be materially affected by these developments.

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

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

HCP's failure to successfully implement and maintain all of its systems could have a material adverse effect on its business, financial condition, and results of operations. For example, HCP's failure to successfully operate its billing systems could lead to potential violations of healthcare laws and regulations. If HCP is unable to handle its claims volume, or if HCP is unable to pay claims timely, HCP may become subject to a health plan's corrective action plan or de-delegation until the problem is corrected, and/or termination of the health plan's agreement with HCP. This could have a material adverse effect on HCP's operations and profitability. In addition, if HCP's claims processing system is unable to process claims accurately, the data HCP uses for its incurred but not received (IBNR) estimates could be incomplete and HCP's ability to accurately estimate claims liabilities and establish adequate reserves could be adversely affected. Finally, if HCP's management information systems are unable to function in compliance with applicable state or federal rules and regulations, including, without limitation, medical information confidentiality laws such as the Health Insurance Portability and Accountability Act of 1996, or HIPAA, possible penalties and fines as a result of this lack of compliance could have a material adverse effect on HCP's financial condition, and results of operations.

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

HCP must comply with numerous federal and state laws and regulations governing the collection, dissemination, access, use, security and privacy of PHI, including HIPAA and its implementing privacy and security regulations, as amended by the federal HITECH Act and collectively referred to as HIPAA. In the event that HCP's non-compliance with existing or new laws and regulations related to PHI results in privacy or security breaches, HCP could be subject to monetary fines, civil suits, civil penalties or criminal sanctions and requirements to disclose the breach publicly.

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

Due to potential decreased availability of healthcare through private employers, the number of patients who are uninsured or participate in governmental programs may increase. The Health Reform Acts will increase the participation of individuals in the Medicaid program in states that elect to participate in the expanded Medicaid

coverage. A shift in payor mix from managed care and other private payors to government payors or the uninsured may result in a reduction in the rates of reimbursement or an increase in uncollectible receivables or uncompensated care, with a corresponding decrease in net revenue. Changes in the eligibility requirements for governmental programs such as the Medicaid program under the Health Reform Acts and state decisions on whether to participate in the expansion of such programs also could increase the number of patients who participate in such programs or the number of uninsured patients. Even for those patients who remain with private insurance, changes in those programs could increase patient responsibility amounts, resulting in a greater risk for uncollectible receivables. These factors and events could have a material adverse effect on HCP's business, financial condition, and results of operations.

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

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

requiring HCP to change its products and services;

increasing the regulatory, including compliance, burdens under which HCP operates, which, in turn, may negatively impact the manner in which HCP provides services and increase HCP's costs of providing services;

adversely affecting HCP's ability to market its products or services through the imposition of further regulatory restrictions regarding the manner in which plans and providers market to Medicare Advantage enrollees; or

adversely affecting HCP's ability to attract and retain members.

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

We may engage in acquisitions, mergers or dispositions, which may affect our results of operations, debt-to-capital ratio, capital expenditures or other aspects of our business.

We may engage in acquisitions, mergers or dispositions, which may affect our results of operations, debt-to-capital ratio, capital expenditures, or other aspects of our business. There can be no assurance that we will be able to identify suitable acquisition targets or merger partners or that, if identified, we will be able to acquire these targets on acceptable terms or agree to terms with merger partners. There can also be no assurance that we will be successful in completing any acquisitions, mergers or dispositions that we might be considering or announce, or integrating any acquired business into our overall operations or operate them successfully as stand-alone businesses, or that any such acquired business will operate profitably or will not otherwise adversely impact our results of operations. Further, we cannot be certain that key talented individuals at the business being acquired will continue to work for us after the acquisition or that they will be able to continue to successfully manage or have adequate resources to successfully operate any acquired business.

HCP operates in a different line of business from our historical business. We may face challenges managing HCP as a new business and may not realize anticipated benefits.

As a result of the HCP transaction, we are now significantly engaged in a new line of business. We may not have the expertise, experience, and resources to pursue all of our businesses at once, and we may be unable to successfully operate all businesses in the combined Company. The administration of HCP will require implementation of appropriate operations, management, and financial reporting systems and controls. We may experience difficulties in effectively implementing these and other systems. The management of HCP will require the focused attention of our management team, including a significant commitment of its time and resources. The need for management to focus on these matters could have a material and adverse impact on our

revenues and operating results. If the HCP operations are less profitable than we currently anticipate or we do not have the experience, the appropriate expertise, or the resources to pursue all businesses in the combined company, the results of operations and financial condition may be materially and adversely affected.

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

As a private company, HCP has not been subject to the requirements of the Securities Exchange Act of 1934, as amended, with respect to internal control over financial reporting, and for a period of time after the consummation of the HCP transaction our management evaluation and auditor attestation regarding the effectiveness of our internal control over financial reporting will be permitted to exclude the operations of HCP. The integration of HCP into our internal control over financial reporting has required and will continue to require significant time and resources from our management and other personnel and will increase our compliance costs. If we fail to successfully integrate these operations into our internal control over financial reporting, our internal control over financial reporting may not be effective. Failure to achieve and maintain an effective internal control environment could have a material adverse effect on our ability to accurately report our financial results and the market's perception of our business and our stock price. In addition, if HCP's internal control over financial reporting were found to be ineffective, the integrity of HCP's past financial reporting could be adversely impacted.

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

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

The market price of our common stock may be affected by factors different from those affecting the shares of our common stock prior to consummation of the HCP transaction.

Our historical business differs substantially from that of HCP. Accordingly, the results of operations of the combined company and the market price of our common stock may be affected by factors different from those that previously affected the independent results of operations of each of the Company and HCP.

If we are not able to continue to make acquisitions, or maintain an acceptable level of non-acquired growth, or if we face significant patient attrition to our competitors or a reduction in the number of our medical directors or associated physicians, it could adversely affect our business.

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

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

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

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

Although we generally seek indemnification from the sellers of businesses we acquire for matters that are not properly disclosed to us, we are not always successful. We have limited indemnification rights in connection with matters affecting HCP. In addition, even in cases where we are able to obtain indemnification, we may discover liabilities greater than the contractual limits, the amounts held in escrow for our benefit (if any), or the financial resources of the indemnifying party. In the event that we are responsible for liabilities substantially in excess of any amounts recovered through rights to indemnification or alternative remedies that might be available to us, or any applicable insurance, we could suffer severe consequences that would substantially reduce our earnings and cash flows or otherwise materially and adversely affect our business.

Expansion of our operations to and offering our services in markets outside of the U.S. subjects us to political, economical, legal, operational and other risks that could adversely affect our business, results of operations and cash flows.

We are continuing an expansion of our operations by offering our services outside of the U.S., which increases our exposure to the inherent risks of doing business in international markets. Depending on the market, these risks include, without limitation, those relating to:

changes in the local economic environment;

political instability, armed conflicts or terrorism;

social changes;

intellectual property legal protections and remedies;

trade regulations;

procedures and actions affecting approval, production, pricing, reimbursement and marketing of products and services;

foreign currency;

repatriating or moving to other countries cash generated or held abroad, including considerations relating to tax-efficiencies and changes in tax laws;

export controls;

lack of reliable legal systems which may affect our ability to enforce contractual rights;

changes in local laws or regulations;

potentially longer ramp-up times for starting up new operations and for payment and collection cycles;

financial and operational, and information technology systems integration; and

failure to comply with U.S. or local laws that prohibit us or our intermediaries from making improper payments to foreign officials for the purpose of obtaining or retaining business.

Additionally, some factors that will be critical to the success of our international business and operations will be different than those affecting our domestic business and operations. For example, conducting international operations requires us to devote significant management resources to implement our controls and systems in new markets, to comply with local laws and regulations and to overcome the numerous new challenges inherent in managing international operations, including those based on differing languages, cultures and regulatory environments, and those related to the timely hiring, integration and retention of a sufficient number of skilled personnel to carry out operations in an environment with which we are not familiar.

We anticipate expanding our international operations through acquisitions of varying sizes or through organic growth, which could increase these risks. Additionally, though we might invest material amounts of capital and incur significant costs in connection with the growth and development of our international operations, there is no assurance that we will be able to operate them profitably anytime soon, if at all. As a result, we would expect these costs to be dilutive to our earnings over the next several years as we start-up or acquire new operations.

These risks could have a material adverse effect on our financial condition, results of operations and cash flows.

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

We have substantial debt outstanding, we incurred a substantial amount of additional debt in connection with the HCP transaction and we may incur additional indebtedness in the future. The high level of our indebtedness, among other things, could:

make it difficult for us to make payments on our debt securities;

increase our vulnerability to general adverse economic and industry conditions;

require us to dedicate a substantial portion of our cash flow from operations to payments on our indebtedness, thereby reducing the availability of our cash flow to fund working capital, capital expenditures, acquisitions and investments and other general corporate purposes;

limit our flexibility in planning for, or reacting to, changes in our business and the markets in which we operate;

place us at a competitive disadvantage compared to our competitors that have less debt; and

limit our ability to borrow additional funds.

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

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

The borrowings under our Senior Secured Credit Facilities are guaranteed by a substantial portion of our direct and indirect wholly-owned domestic subsidiaries and are secured by a substantial portion of DaVita HealthCare Partners Inc.'s and its guarantors' assets.

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

A portion of our outstanding debt bears interest at variable rates. We are subject to LIBOR-based interest rate volatility from a floor of 1.50% to a cap of 4.00% on \$1,250 million notional amounts of our Term Loan B outstanding debt as a result of several interest rate cap agreements that were entered into in January 2011. The remaining \$465 million of outstanding debt on the Term Loan B is subject to LIBOR-based interest rate volatility above a floor of 1.50%. At December 31, 2012, we were also subject to LIBOR-based interest rate volatility above a floor of 1.00% on \$1,650 million of outstanding debt associated with our Term Loan B-2. At December 31, 2012, we were also subject to LIBOR-based interest rate volatility on Term Loan A-3 totaling \$1,350 million. Our Term Loan A is also subject to LIBOR-based interest rate volatility but as a result of our swap agreements the LIBOR-based variable component of our interest rate is economically fixed at December 31, 2012.

We also have approximately \$350 million of additional borrowings available of which approximately \$115 million was committed for outstanding letters of credit, under our Senior Secured Credit Facilities that are subject to LIBOR-based interest rate volatility and a line of credit of approximately \$16 million related to HCP with \$1 million committed for our outstanding letter of credit. We may also incur additional variable rate debt in the future. Increases in interest rates would increase our interest expense of the variable portion of our indebtedness, which could negatively impact our earnings and cash flow and our ability to service our indebtedness which would be particularly significant in the event of rapid and substantial increases in interest rates.

At December 31, 2012, if interest rates were to hypothetically increase by 100 basis points it would increase our interest expense by approximately \$6.7 million, which increase relates to our Term Loan A-3 that is subject to LIBOR-based interest rate volatility and our Term Loan B-2 that is subject to LIBOR-based interest rate volatility above a floor of 1.00%. See Item 3 Quantitative and Qualitative Disclosures about Market Risk for more information.

We may be subject to liability claims for damages and other expenses not covered by insurance that could reduce our earnings and cash flows.

Our operations and how we manage the Company may subject the Company, as well as its officers and directors to whom the Company owes certain defense and indemnity obligations, to litigation and liability for damages. Our business, profitability and growth prospects could suffer if we face negative publicity or we pay damages or defense costs in connection with a claim that is outside the scope or limits of coverage of any applicable insurance coverage, including claims related to adverse patient events, contractual disputes, professional and general liability, and directors' and officers' duties. In addition, we have received several notices of claims from commercial payors and other third parties related to our historical billing practices and the

historical billing practices of the centers acquired from Gambro Healthcare and other matters related to their settlement agreement with the Department of Justice. Although the ultimate outcome of these claims cannot be predicted, an adverse result with respect to one or more of these claims could have a material adverse effect on our financial condition, results of operations, and cash flows. We currently maintain insurance coverage for those risks we deem are appropriate to insure against and make determinations about whether to self-insure as to other risks or layers of coverage. However, a successful claim, including a professional liability, malpractice or negligence claim which is in excess of any applicable insurance coverage, or that is subject to our self-insurance retentions, could have a material adverse effect on our earnings and cash flows.

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

the collapse or insolvency of our insurance carriers;

further increases in premiums and deductibles;

increases in the number of liability claims against us or the cost of settling or trying cases related to those claims; and

an inability to obtain one or more types of insurance on acceptable terms, if at all.

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

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

Most of our outstanding employee stock-based compensation awards include a provision accelerating the vesting of the awards in the event of a change of control. We also maintain a change of control protection program for our employees who do not have a significant number of stock awards, which has been in place since 2001, and which provides for cash bonuses to the employees in the event of a change of control. Based on the market price of our common stock and shares outstanding on December 31, 2012, these cash bonuses would total approximately \$459 million if a change of control transaction occurred at that price and our Board of Directors did not modify this program. These change of control provisions may affect the price an acquirer would be willing to pay for our Company.

We are also subject to Section 203 of the Delaware General Corporation Law that, subject to exceptions, would prohibit us from engaging in any business combinations with any interested stockholder, as defined in that section, for a period of three years following the date on which that stockholder became an interested stockholder.

These provisions may discourage, delay or prevent an acquisition of our Company at a price that our stockholders may find attractive. These provisions could also make it more difficult for our stockholders to elect directors and take other corporate actions and could limit the price that investors might be willing to pay for shares of our common stock.

Item 1B. Unresolved Staff Comments.

None.

Item 2. Properties.

For our U.S. dialysis and related lab service business, we own the land and buildings for 25 of our outpatient dialysis centers. We also own the buildings for six other outpatient dialysis centers and the building at one of our Florida labs and we own two separate land parcels and sublease a total of five properties to third-party tenants. In addition, we also own the land and building for our new corporate headquarters. Our remaining outpatient dialysis centers are located on premises that we lease.

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

Our leases for our dialysis and related lab services and for HCP generally cover periods from five to fifteen years and typically contain renewal options of five to ten years at the fair rental value at the time of renewal. Our leases are generally subject to periodic consumer price index increases, or contain fixed escalation clauses. Our outpatient dialysis centers range in size from approximately 500 to 33,000 square feet, with an average size of approximately 7,100 square feet. HCP's clinics range in size from approximately 300 to 172,000 square feet, with an average size of approximately 10,900 square feet.

The following is a summary of our business, administrative offices, laboratories and pharmacies:

Office	Location	Square Feet	Expiration
U.S. Dialysis and related lab service and other ancillary business:			
Corporate Headquarters	Denver, CO	240,000	Owned
Corporate Headquarters	Denver, CO	70,000	2018
Administrative Office	Vernon Hills, IL	33,000	2015
Administrative Office	Norfolk, VA	20,000	2015
Administrative Office	Washington, DC	5,000	2013
Administrative Office	Tempe, AZ	4,000	2016
Administrative Office	Centennial, CA	23,000	2018
Business Office	El Segundo, CA	61,000	2013
Business Office	Tacoma, WA	201,000	2013 through 2021
Business Office	Malvern, PA	120,000	2022
Business Office	Brentwood, TN	95,000	2021
Business Office	Franklin, TN	10,000	2014
Business Office	Irvine, CA	65,000	2015
Business Office	Federal Way, WA	187,000	2023
DaVita Rx	Orlando, FL	17,000	2013
DaVita Rx	Coppell, TX	121,000	2019
DaVita Rx	San Bruno, CA	7,000	2015
Laboratory	DeLand, FL	40,000	Owned
Laboratory Warehouse and Office	DeLand, FL	68,000	2013 through 2015
Laboratory	Ft. Lauderdale, FL	43,000	2013
Laboratory Office	Miami, FL	1,000	2014
HCP s business:			
Business Office	El Segundo, CA	11,000	2016
Business Office	Rochester, NY	4,000	2016
Business Office	Chicago, IL	4,000	2015
Business Office	Boston, MA	4,000	2017
Business Office	Costa Mesa, CA	5,000	2016
Administrative Office	St. Petersburg, FL	36,000	2020
Administrative Office	Ft. Lauderdale, FL	2,000	2017
Administrative Office	Orlando, FL	2,000	2013
Administrative Office	Fort Harrison, FL	3,000	2018
Administrative Office	Costa Mesa, CA	27,000	2013
Administrative Office	Irvine, CA	9,000	2014
Administrative Office	Arcadia, CA	16,000	2019
Administrative Office	Las Vegas, NV	37,000	2013 through 2016
Administrative Office	Torrance, CA	95,000	2015 through 2021
Administrative Office	Los Angeles, CA	46,000	2013 through 2021
Administrative Office	Albuquerque, NM	30,000	2017

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

Item 3. Legal Proceedings.

Inquiries by the Federal Government and Certain Related Civil Proceedings

2005 U.S. Attorney Investigation: In March 2005, we received a subpoena from the U.S. Attorney's Office for the Eastern District of Missouri in St. Louis. The subpoena required production of a wide range of documents relating to our operations, including documents related to, among other things, pharmaceutical and other services provided to patients, relationships with pharmaceutical companies, and financial relationships with physicians and joint ventures. The subpoena covers the period from December 1, 1996 through March 2005. In October 2005, we received a follow-up request for additional documents related to specific medical director and joint venture arrangements. In February 2006, we received an additional subpoena for documents, including certain patient records relating to the administration and billing of Epogen® (EPO). In May 2007, we received a request for documents related to durable medical equipment and supply companies owned and operated by us. We cooperated with the inquiry and have produced the requested documents. The subpoenas were issued in connection with a joint civil and criminal investigation. It was possible that criminal proceedings could be initiated against us in connection with this investigation. Until recently, we had not received a communication from the St. Louis U.S. Attorney's Office on this matter for nearly three years. In early October 2012, we announced that the government closed its investigation without filing any charges, without demanding any payments and without seeking any changes in Company policies.

Woodard Private Civil Suit: In February 2007, we received a request for information from the Office of Inspector General, U.S. Department of Health and Human Services, or OIG, for documents relating to EPO claims submitted to Medicare. In August 2007, we received a subpoena from the OIG seeking similar documents. The requested documents relate to services provided from 2001 to 2004 by a number of our dialysis centers. The request and subpoena were sent from the OIG's offices in Houston and Dallas, Texas. We cooperated with the inquiry and have produced all previously requested documents to date. We were contacted by the U.S. Attorney's Office for the Eastern District of Texas, which stated that this was a civil investigation related to EPO claims. On July 6, 2009, the U.S. District Court for the Eastern District of Texas lifted the seal on the civil *qui tam* complaint related to these previous requests for information. We were subsequently served with a complaint by the relator, Ivey Woodard, purportedly on behalf of the federal government, under the *qui tam* provisions of the federal False Claims Act. The government did not intervene and is not actively pursuing this matter. The relator has been pursuing the claims independently and the parties have been engaged in active litigation. The complaint contains allegations relating to our EPO practices for the period from 1992 through 2010 and seeks monetary damages and civil penalties as well as costs and expenses. The court has ruled that claims earlier than 1996 are beyond the statute of limitations. We believe that there is some overlap between the subject of this complaint and the review of EPO utilization in the 2005 U.S. Attorney investigation described above. We publicly disclosed on July 3, 2012 that we had reached an agreement in principle to settle all allegations relating to claims arising out of this matter. In connection with this settlement, we incurred costs and expenses totaling \$86 million that consists of \$55 million for the settlement plus attorney fees and related expenses. In December 2012, the settlement was finalized and the case was dismissed.

Vainer Private Civil Suit: In December 2008, we received a subpoena for documents from the OIG relating to the pharmaceutical products Zemplar, Hectorol, Venofer, Ferrlecit and EPO, as well as other related matters. The subpoena covered the period from January 2003 to December 2008. We were in contact with the U.S. Attorney's Office for the Northern District of Georgia and the U.S. Department of Justice in Washington, DC, since November 2008 relating to this matter, and were advised that this was a civil inquiry. On June 17, 2009, we learned that the allegations underlying this inquiry were made as part of a civil complaint filed by individuals and brought pursuant to the *qui tam* provisions of the federal False Claims Act. On April 1, 2011, the U.S. District Court for the Northern District of Georgia ordered the case to be unsealed. At that time, the Department of Justice and U.S. Attorney's Office filed a notice of declination stating that the U.S. would not be intervening and not pursuing the relators' allegation in litigation. On July 25, 2011, the relators, Daniel Barbir and Dr. Alon Vainer, filed their amended complaint in the U.S. District Court for the Northern District of Georgia, purportedly on behalf of the federal government. The allegations in the complaint relate to the drug administration practices

for our dialysis and related lab services operations for Vitamin D and iron agents for a period from 2003 through 2010. The complaint seeks monetary damages and civil penalties as well as costs and expenses. We are vigorously defending this matter and intend to continue to do so. We can make no assurances as to the time or resources that will be needed to devote to this litigation or its final outcome.

2010 U.S. Attorney Physician Relationship Investigation: In May 2010, we received a subpoena from the OIG's office in Dallas, Texas. The civil subpoena covers the period from January 1, 2005 to May 2010, and seeks production of a wide range of documents relating to our dialysis and related lab services, including documents related to, among other things, financial relationships with physicians and joint ventures, and whether those relationships and joint ventures comply with the federal anti-kickback statute and the False Claims Act. Some of the requested documents overlap with documents requested pursuant to the subpoena in the 2011 U.S. Attorney Physician Relationship Investigation described below. We are cooperating with the government and are producing the requested documents. However, we have been advised by the attorneys conducting this civil investigation that they believe that the general structure of our joint ventures does not comply with the anti-kickback statute and the False Claims Act. We disagree that our joint venture structure, which we believe is widely used in the dialysis industry and other segments of the healthcare industry substantially in the form that we use it, violates the federal anti-kickback statute or the False Claims Act. This investigation will continue to require management's attention and significant legal expense, and we can make no assurances as to the final outcome.

2011 U.S. Attorney Physician Relationship Investigation: In August 2011, we announced we had learned that the U.S. Attorney's Office for the District of Colorado would be looking into certain activities of our dialysis business in connection with information being provided to a grand jury. This investigation relates to our relationships with physicians, including our joint ventures, and whether those relationships and joint ventures comply with the federal anti-kickback statute, and appears to overlap, at least in part, with the 2010 U.S. Attorney Physician Relationship Investigation described above. We have received a number of subpoenas for documents covering the period from January 2006 to November 2012, and we have produced and continue to produce documents in response to those subpoenas and other requests. In addition, certain current and former members of the Board, executives and other teammates have received subpoenas to testify before the grand jury. It is possible that criminal proceedings may be initiated against us in connection with this investigation. This investigation will continue to require management's attention and significant legal expense, and we can make no assurances as to the final outcome.

2011 U.S. Attorney Medicaid Investigation: In October 2011, we announced that we would be receiving a request for documents, which could include an administrative subpoena from the Office of Inspector General for the U.S. Department of Health and Human Services. Subsequent to our announcement of this 2011 U.S. Attorney Medicaid Investigation, we received a request for documents in connection with the inquiry by the U.S. Attorney's Office for the Eastern District of New York. The request relates to payments for infusion drugs covered by Medicaid composite payments for dialysis. We believe this inquiry is civil in nature. We do not know the time period or scope. We understand that certain other providers that operate dialysis clinics in New York may be receiving or have received a similar request for documents. We are cooperating with the government and are producing the requested documents.

Clark Shareholder Derivative Civil Suit: As we previously disclosed, on August 7, 2012, a shareholder derivative lawsuit was filed in the U.S. District Court for the District of Colorado against certain current and former directors and executives of the Company and against the Company, as nominal defendant. The complaint alleges, among other things, that certain of our current and past officers and directors breached fiduciary duties to the Company relating to the previously disclosed inquiries by the federal government and *qui tam* proceedings described above. On October 12, 2012, the parties filed a joint motion to stay the case for an indefinite period as in the best interests of the Company and to conserve judicial resources. On October 19, 2012, the Court denied the stay motion but ordered that the case be administratively closed, subject to being reopened upon a showing of good cause by any party.

Turner-Hooks Private Civil Suit: In January 2013, we were served with a civil complaint filed by a former patient, Laura Turner-Hooks, and brought pursuant to the *qui tam* provisions of the federal False Claims Act purportedly on behalf of the federal government. On November 13, 2012, the U.S. District Court for the Eastern District of Michigan ordered the case to be unsealed. At that time, the Department of Justice and U.S. Attorney's Office filed a notice of declination stating that the U.S. would not be intervening *and not* pursuing the relator's allegation in litigation. The relator's complaint, originally filed in July 2011, states that she was a patient at a single dialysis facility in Michigan and that we allegedly violated the federal False Claims Act by providing treatments at the facility that failed to comply with the standard of care required under federal healthcare programs. The complaint seeks monetary damages and civil penalties as well as costs and expenses. We intend to vigorously defend this action.

Except for the private civil complaints filed by the relators as described above, to our knowledge, no proceedings have been initiated against us at this time in connection with any of the inquiries by the federal government. Although we cannot predict whether or when proceedings might be initiated or when these matters may be resolved, it is not unusual for inquiries such as these to continue for a considerable period of time through the various phases of document and witness requests and on-going discussions with regulators. Responding to the subpoenas or inquiries and defending the Company in the relator proceedings will continue to require management's attention and significant legal expense. Any negative findings in the inquiries or relator proceedings could result in substantial financial penalties or awards against us, exclusion from future participation in the Medicare and Medicaid programs and, to the extent criminal proceedings may be initiated against us, possible criminal penalties. At this time, we cannot predict the ultimate outcome of these inquiries, or the potential outcome of the relators' claims (except as described above), or the potential range of damages, if any.

Other

We have received several notices of claims from commercial payors and other third parties related to historical billing practices and claims against DVA Renal Healthcare (formerly known as Gambro Healthcare), a subsidiary of the Company, related to historical Gambro Healthcare billing practices and other matters covered by its 2004 settlement agreement with the Department of Justice and certain agencies of the U.S. government. We have received no further indication that any of these claims are active, and some of them may be barred by applicable statutes of limitations. To the extent any of these claims might proceed, we intend to defend against them vigorously; however, we may not be successful and these claims may lead to litigation and any such litigation may be resolved unfavorably. At this time, we cannot predict the ultimate outcome of this matter or the potential range of damages, if any.

A wage and hour claim, which has been styled as a class action, is pending against us in the Superior Court of California. We were served with the complaint in this lawsuit in April 2008, and it has been amended since that time. The lawsuit, as amended, alleges that we failed to provide meal periods, failed to pay compensation in lieu of providing rest or meal periods, failed to pay overtime, and failed to comply with certain other California Labor Code requirements. In September 2011, the court denied the plaintiffs' motion for class certification. Plaintiffs have appealed that decision. We intend to continue to vigorously defend against these claims. Any potential settlement of these claims is not anticipated to be material to our consolidated financial statements.

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

In addition to the foregoing, we are subject to claims and suits, including from time to time, contractual disputes and professional and general liability claims, as well as audits and investigations by various government entities, in the ordinary course of business. We believe that the ultimate resolution of any such pending proceedings, whether the underlying claims are covered by insurance or not, will not have a material adverse effect on our financial condition, results of operations or cash flows.

Item 4. Mine Safety Disclosures.

Not applicable.

PART II

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

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

	High	Low
Year ended December 31, 2012:		
1st quarter	\$ 90.17	\$ 77.13
2nd quarter	98.21	80.23
3rd quarter	103.61	94.80
4th quarter	114.98	103.44
Year ended December 31, 2011:		
1st quarter	\$ 85.51	\$ 69.07
2nd quarter	89.17	82.70
3rd quarter	89.36	62.67
4th quarter	76.81	60.64

The closing price of our common stock on January 31, 2012 was \$115.41 per share. According to Computershare, our registrar and transfer agent, as of January 31, 2012, there were 10,422 holders of record of our common stock. We have not declared or paid cash dividends to holders of our common stock since 1994. We have no current plans to pay cash dividends and we are restricted from paying dividends under the terms of our Senior Secured Credit Facilities and the indentures governing our senior notes. Also, see the heading "Liquidity and capital resources" under

Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations and the notes to our consolidated financial statements.

Stock Repurchases

The following table summarizes our repurchases of our common stock during the fourth quarter of 2012:

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)
Oct 1 - Dec 31, 2012				\$ 358.2

- (1) On November 3, 2010, the Board of Directors authorized \$800 million for repurchases of our common stock. This stock repurchase program has no expiration date. We are authorized to make purchases from time to time in the open market or in privately negotiated transactions, depending upon market conditions and other considerations. However, we are subject to share repurchase limitations under the terms of the Senior Secured Credit Facilities and the indentures governing our senior notes.

Item 6. Selected Financial Data.

The following financial and operating data should be read in conjunction with Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations and our consolidated financial statements filed as part of this report. The following table presents selected consolidated financial and operating data for the periods indicated. Effective January 1, 2012 we were required to present our provision for uncollectible accounts related to patient service revenues as a deduction from our patient service revenues, which changed the classification of our provision for uncollectible accounts related to patient service revenues. Effective January 1, 2009, we were required to present consolidated net income attributable to us and to noncontrolling interests on the face of the consolidated statement of income, which changed the presentation of minority interests (noncontrolling interests) in our consolidated statements of income. 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 and noncontrolling interests.

On November 1, 2012, we completed our acquisition of HCP whereby HCP became a wholly-owned subsidiary of the Company. The total consideration paid at closing for all of the outstanding common units of HCP was approximately \$4.70 billion, which consisted of \$3.64 billion in cash, net of cash acquired, and 9,380,312 share of our common stock valued at approximately \$1.06 billion. The total acquisition consideration is subject to a post-closing working capital adjustment. In addition, the acquisition agreement also provides that as further consideration, we will pay the common unit holders of HCP a total of up to \$275 million in cash if certain performance targets are achieved by HCP in 2012 and 2013. The operating results of HCP are included in our consolidated results beginning November 1, 2012.

	2012	2011	Year ended December 31,			2008
			2010	2009		
(in thousands, except share data)						
Income statement data:						
Net revenues	\$ 8,186,280	\$ 6,731,806	\$ 6,219,610	\$ 5,898,801	\$ 5,474,600	
Operating expenses and charges(1)	6,889,196	5,577,093	5,225,802	4,964,120	4,607,797	
Operating income	1,297,084	1,154,713	993,808	934,681	866,803	
Debt expense	(288,554)	(241,090)	(181,607)	(185,755)	(224,716)	
Debt refinancing and redemption charges	(10,963)		(74,382)			
Other income, net	3,737	2,982	3,419	3,706	12,410	
Income from continuing operations before income taxes	1,001,304	916,605	741,238	752,632	654,497	
Income tax expense	359,845	325,292	258,874	276,099	234,213	
Income from continuing operations	641,459	591,313	482,364	476,533	420,284	
Income from operations of discontinued operations, net of tax(2)	(222)	(13,162)	1,855	3,226	1,036	
Loss on disposal of discontinued operations, net of tax(2)		(4,756)				
Net income	\$ 641,237	\$ 573,395	\$ 484,219	\$ 479,759	\$ 421,320	
Less: Net income attributable to noncontrolling interests	(105,220)	(95,394)	(78,536)	(57,075)	(47,160)	
Net income attributable to DaVita HealthCare Partners Inc.	\$ 536,017	\$ 478,001	\$ 405,683	\$ 422,684	\$ 374,160	
Basic income from continuing operations per share attributable to DaVita HealthCare Partners Inc.(2)	\$ 5.58	\$ 5.25	\$ 3.98	\$ 4.05	\$ 3.53	
Diluted income from continuing operations per share attributable to DaVita HealthCare Partners Inc.(2)	\$ 5.47	\$ 5.14	\$ 3.92	\$ 4.03	\$ 3.50	
Weighted average shares outstanding:(3)						
Basic	96,018,000	94,658,000	101,504,000	103,604,000	105,149,000	
Diluted	97,971,000	96,532,000	103,059,000	104,168,000	105,940,000	
Ratio of earnings to fixed charges(4)	3.17:1	3.39:1	3.43:1	3.56:1	3.00:1	
Balance sheet data:						
Working capital	\$ 860,620	\$ 1,128,492	\$ 1,698,509	\$ 1,255,580	\$ 965,233	
Total assets	16,018,596	8,903,808	8,114,424	7,558,236	7,286,083	
Long-term debt	8,326,534	4,417,624	4,233,850	3,532,217	3,622,421	

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Total DaVita HealthCare Partners Inc. shareholders equity(3)	3,763,137	2,141,075	1,978,422	2,135,066	1,767,747
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- (1) Operating expenses and charges in 2012 include \$85,837 for a legal settlement and related expenses, and \$30,753 of transaction expenses associated with the acquisition of HCP.
- (2) Income from operations of discontinued operations, net of tax includes the operations of HomeChoice which was divested on February 1, 2013. The income from operations of discontinued operations in 2011 also includes \$24 million of a non-cash goodwill impairment charge related to this business. In addition, 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. In addition, 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 periods presented. In addition, the operating results for the historical DSI divested centers are reflected as discontinued operation in our consolidated financial statements beginning September 1, 2011.
- (3) Share repurchases consisted of 3,794,686 shares of common stock for \$323,348 in 2011, 8,918,760 shares of common stock for \$618,496 in 2010, 2,902,619 shares of common stock for \$153,495 in 2009, and 4,788,881 shares of common stock for \$232,715 in 2008. Shares issued in connection with stock awards were 1,260,259 in 2011, 1,771,384 in 2010, 2,104,304 in 2009 and 1,314,074 in 2008.
- (4) 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. Fixed charges include debt expense (interest expense and the write-off and amortization of deferred financing costs), the estimated interest component of rental expense on operating leases, and capitalized interest.

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

Forward-looking statements

This Management's Discussion and Analysis of Financial Condition and Results of Operations contain statements that are forward-looking statements within the meaning of the federal securities laws. This Annual Report on Form 10-K contains forward-looking statements within the meaning of the federal securities laws. All statements that do not concern historical facts are forward-looking statements and include, among other things, statements about our expectations, beliefs, intentions and/or strategies for the future. These forward-looking statements include statements regarding our future operations, financial condition and prospects, expectations for treatment growth rates, revenue per treatment, expense growth, levels of the provision for uncollectible accounts receivable, operating income, cash flow, operating cash flow, estimated tax rates, capital expenditures, the development of new dialysis centers and dialysis center acquisitions, government and commercial payment rates, revenue estimating risk and the impact of our level of indebtedness on our financial performance, including earnings per share, and incorporation of HCP's operating results into the Company's consolidated operating results. These statements involve substantial known and unknown risks and uncertainties that could cause our actual results to differ materially from those described in the forward-looking statements, including, but not limited to, risks resulting from the concentration of profits generated by the continued downward pressure on average realized payment rates from, and a reduction in the number of patients under higher-paying commercial payor plans, which may result in the loss of revenues or patients, a reduction in, government payment rates under the Medicare ESRD program or other government-based programs, the impact of health care reform legislation that was enacted in the U.S. in March 2010, changes in pharmaceutical or anemia management practice patterns, payment policies, or pharmaceutical pricing, legal compliance risks, including our continued compliance with complex government regulations, current or potential investigations by various government entities and related government or private-party proceedings, 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 any acquisitions, mergers or dispositions that we might be considering or announce, or to integrate