

Ms. Stabrawa,

My name is Roddy Boyd and I'm the founder and editor of the [Southern Investigative Reporting Foundation](#), an investigative reporting non-profit 501c3 based in Wilmington, N.C. To learn more about myself and the board of directors, please go [here](#); to read some press clippings, please go [here](#). Per SIRFs practice, all reporting centers on publicly filed documents, although I certainly have spoken to current and former employees.

I'm writing an article on DaVita that will look at its leverage to the AKF, specifically the amount of its earnings that are derived from this channel. The springboard for this was Kent Thiry's remark at this year's Capital Market's Day where he told an analyst "It's not in your best interests for us to provide information" about the estimated percentage of earnings coming from the AKF HIPP program. Please consider all responses on the record and it would be helpful if you could reply by Monday evening.

1. Based on your documents, it appears that at least 40%-45% of your Kidney Care unit's EBIT is from the AKF. I attached the model and as hopefully evident, all data is from publicly-filed sources or comes from conservative assumptions, i.e. \$DVA filings state that the dialysis patient populace grows at 3.8% annually, thus at 6/30/17 I estimated your patient base at 1.9% greater than 513,940 or 523,700.

2.. Given Thiry's remarks at the RW Baird conference that the AKF relationship is fully legal, why is it not in shareholders best interests to provide an answer to the analysts question? (excerpt attached)

3. In the 2Q CC, JJ Rodriguez statement to the Goldman Sachs analyst appears to be misleading, given that the motion wasn't denied; only the "emergency" nature of it wasn't granted. Why did he say that? Will the company publicly clarify it? Is DaVita now in compliance with Aetna's request? (excerpt attached)

4. This is a 2012 [National Bureau of Economic Research](#) study by professors from Northwestern and Harvard that found average spending for DaVita and Fresenius patients rose about 50% from 2005 to 2009, to about \$120,000 annually. Spending for dialysis patients in Medicare rose about 20% during that time, but reached only about \$60,000 a year. Does DaVita have a comment on this? What explains the cost differential?

5. Has DaVita fully withdrawn all support for ACA Marketplace purchased commercial insurance plans?

6. If DaVita cannot break even on Medicare coverage of between \$230-\$290 per treatment, given that 7/8 of your patient base is on it, is it fair to conclude that the rollout/acquisition-driven strategy is going to stop?

7. What is the relationship between political dynamics and commercial reimbursement rates that Thiry has alluded to?

8. At the J.P. Morgan San Francisco conference in January, at the end of the Q&A there's a "hot mic" episode (around 23:30 mark) where Thiry says the issue

of treatment reimbursement rates is driven by A) historical pricing and in several instances B) "outlier" contracts that are so high above the market that certain payors have "decided to go the mat" rather than negotiate and C) that "there are still some" contracts like this in place. Is this still his view?

Thank you for your time and attention,

Roddy Boyd