CERTIFICATE OF NEED

RESPONSE TO DEFICIENCIES DATED DECEMBER 11, 2015

Eastern Connecticut Health Network, Inc.
Proposed Asset Purchase by
Prospect Medical Holdings, Inc.

OHCA Docket Number: 15-32016-486
Attorney General Docket Number: 15-486-01

December 24, 2015

Eastern Connecticut Health Network
71 Haynes Street
Manchester, CT 06040
860.533.3414
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December 24, 2015

Via Hand Delivery

Office of the Attorney General
55 Elm Street
P.O. Box 120
Hartford, Connecticut 06141-0120
Attn: Gary W. Hawes, Assistant Attorney General

Office of Health Care Access
Department of Public Health
410 Capitol Avenue
Hartford, Connecticut 06134
Attn: Steven W. Lazarus, Health Care Analyst

Re: Eastern Connecticut Health Network, Inc.
Proposed Asset Purchase by Prospect Medical Holdings, Inc.
OHCA Docket Number: 15-32016-486
Attorney General Docket Number: 15-486-01

Dear Mr. Hawes and Mr. Lazarus:

Eastern Connecticut Health Network, Inc. and Prospect Medical Holdings, Inc. (the "Applicants") hereby submit the enclosed responses to the completeness question issued by the Office of the Attorney General and the Office of Health Care Access in a letter dated December 11, 2015.

At your request, one (1) hard copy and one (1) electronic copy have been provided to each Office.

If you have any questions or need anything further, please feel free to contact me at (860) 533-3429. Thank you for your assistance in this matter.

Sincerely,

Dennis P. McConville
Senior Vice President and Chief Strategy Officer

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List of Exhibits

On December 11, 2015, Eastern Connecticut Health Network ("ECHN") and Prospect Medical Holdings ("PMH" and, together with ECHN, the "Applicants") received correspondence from the Office of the Attorney General ("OAG") and the Office of Health Care Access ("OHCA") requesting additional clarification for certain deficiencies identified in the Applicants' Response to Completeness Questions ("Response") submitted on November 23, 2015. The Applicants' response to the deficiencies identified on December 11, 2015 has been provided below:

1. On page 2148 of the Response, Applicants state that ECHN is expected to secure a bank loan for $5 million dollars to cover costs of planned capital projects. With respect to this $5million dollar loan and the referenced capital projects, please answer the following:

   a) Clarify whether the $5 million is intended to be expended exclusively on the behavioral health expansion at RGH mentioned on page 2149 or additional planned capital projects, and, if the latter, identify the projects and estimated expenditure amounts.

      Response:

      The $5 million is intended to be expended exclusively on the behavioral health expansion at RGH.

   b) Elaborate on the specific types of behavioral health conditions the behavioral unit at RGH expects to treat and whether this unit will be utilized for inpatient or outpatient treatment.

      Response:

      The behavioral health unit planned for RGH will be utilized for the inpatient treatment of adults and adolescents with eating disorders.

2. In connection with Response 2(b) at page 2150, relating to the joint ventures in which ECHN has an ownership interest, please respond to the following questions.

   a) Please provide the information on Exhibit A for Connecticut Occupational Partners, LLC.

      Response:

      The joint venture valuations are only applicable to the entities that generate income. Connecticut Occupational Medicine Partners, LLC ("COMP") provides management

services for the occupational health programs of its member hospitals[1] and does not generate revenue for the organization or its members.

b) If a joint venture cannot be transferred to PMH, the parties contemplate that ECHN will issue a note to PMH, in an amount equal to the value of that joint venture. The note would be secured by ECHN's interest in the joint venture and payable from future distributions from the joint venture. If the joint venture fails or it does not generate sufficient funds to enable the note to be repaid, will ECHN have any liability?

Response:

Significant progress has been made to prepare all of the referenced joint ventures for transfer at closing, and therefore the parties do not at this time anticipate that a promissory note will actually be required. ECHN has already obtained all of the necessary third party consents to transfer ECHN's interest in all those joint ventures that require regulatory approval, and is actively securing the necessary consents for all others. For these reasons, ECHN expects to be in a position to transfer its interests in the joint ventures before closing, in which case a promissory note will not be necessary.

In an abundance of caution and in order to eliminate the possibility of disruption to the transaction, however, the parties have also agreed to address the unlikely event that a joint venture interest could not be transferred by providing for a loan from PMH to ECHN, secured by a promissory note, in an amount equal to the deduction made from the purchase price due to the fact that such joint venture interest could not be transferred at closing. This promissory note would be payable from and secured by future distributions from the non-transferred joint venture and would be further secured by ECHN's interests in such joint venture (to the extent permissible under Connecticut law and the joint venture agreement). Any unsecured liability theoretically remaining to ECHN under the promissory note would be addressed in the same manner as ECHN's other post-closing liabilities in accordance with applicable law. An indemnity reserve that will be funded using proceeds from the asset sale will be set up as a vehicle to settle ECHN's post-closing liabilities.

3. The Applicants state in page 2158 of the Response that PMH has established an independent practice association in Connecticut, Prospect Provider Group CT-ECHN, LLC ("PPGCTE") and a preferred provider network/health system risk taking entity, Prospect Health Services, CT, Inc. ("PHS"), and that physicians currently represented by Eastern Connecticut

[1] Member hospitals of COMP include Manchester Memorial Hospital, Bristol Hospital, Saint Francis Hospital and Medical Center, Johnson Memorial Medical Center and Western Connecticut Health Network.

Individual Provider Group, Inc. ("ECIPG") will make individual decisions about whether to participate in PPGCTE. Please respond to the following questions regarding these entities:

a) Will ECIPG be dissolved after the Closing?

Response:

ECIPG is a separately incorporated nonstock corporation and a 50% member of ECHN's Eastern Connecticut Physician Hospital Organization (ECPHO). As ECIPG is a separate and independent entity from ECHN, decisions regarding the future of ECIPG will be made by the members of ECIPG.

b) If ECIPG physicians do not elect to join PPGCTE, will they still have privileges at the Hospitals?

Response:

Physicians apply independently for hospital medical staff membership and privileges. Acceptance to the Hospitals' medical staff is not contingent upon an individual physician's group affiliation. ECIPG physicians that do not join PPGCTE will still have privileges at the Hospitals following the proposed asset purchase of ECHN by PMH (the "Asset Purchase"), assuming that the physicians continue to meet the membership qualification criteria outlined in Article 3 of ECHN's Medical Staff Bylaws. PMH does not have any plans to change the membership qualification criteria for the Hospitals following the Asset Purchase.

Furthermore, it should be noted that PMH welcomes the affiliation of independent physicians, including physicians who are not part of PMH's owned physician network to have privileges at its hospitals.

Section 3.2 of ECHN's Medical Staff Bylaws which outlines the general qualifications for Medical Staff membership has been included as **Exhibit Q**.

4. On pages 2158-2159 of the Response, Applicants identify two types of physicians that participate in the PMH physician network, fully contracted physicians ("FCP") and those identified as operating under a Memorandum of Understanding ("MOU"). Please elaborate on the differences between the two categories of physicians. In the detailed response, please clarify the following:

a) The typical scenarios in which a physician chooses to be an MOU affiliated physician versus an FCP;

Response:

MOUs are entered into on an emergent basis or on an as needed basis. It is not unusual for a patient, on an emergent or urgent basis, to choose a physician (primary care or specialist) who is not part of PMH's network. Rather than require the patient to find an in-network physician, PMH typically negotiates one time rates with that physician by entering into MOUs. If the physician provides services within PMH's geographic service area, PMH would invite the physician to join PMH's network. Some physicians will choose to become part of the PMH network and some decide otherwise.

b) Any differences in the types or frequency of services an MOU physician would provide versus an FCP;

Response:

As stated in the response to Question 4a above, MOUs are typically entered into on an emergent or urgent basis. Typically, an MOU physician's service would be limited to a particular patient.

c) The typical circumstance where an MOU physician's service would be limited to a particular patient.

Response:

Please see the response to Question 4a above.

5. On page 2162 of the Response and at Exhibit F, Applicants provided a summary of performance metrics for Prospect Health Services in Texas. With respect to this summary, please address the following:

a) Explain what differentiates an acute patient versus a non-acute patient.

Response:

An acute patient is typically in need of hospital services. Non-acute patients do not require hospital services but may require a lower level of care such as a skilled nursing facility or a board and care home[2].

[2] "Board and care" refers to nonmedical community-based residential settings that house two or more unrelated adults and provide some services such as meals, medication supervision or reminders, organized activities, transportation, or help with bathing, dressing and other activities of daily living.
Source: https://aspe.hhs.gov/report/description-board-and-care-facilities-operators-and-residents

b) Whether this Exhibit includes Medicare Advantage Performance patients only and the meaning of the term "Seniors".

Response:

Seniors are Medicare Advantage enrollees. The Exhibit is in reference of Medicare Advantage patients.

c) Explain what the Goals identified in the top right corner of the Exhibit signify.

Response:

The Goals identified in the top right corner of the Exhibit signify patient bed days per thousand members by payor class.

d) Applicants stated with respect to the trends in Texas that they were "encouraging and positive, but show room for improvement." Please specifically identify those areas needing improvement and explain the specific strategies being implemented to address these deficiencies.

Response:

The immediate areas that PMH is looking to improve are reducing admission and re-admission rates. PMH plans to reduce such rates through (i) further physician training and patient education; and (ii) dedicated approach to PMH's medical management programs for high risk patients with significant co-morbidities at home which entail the following:

- 24/7 direct telephonic access
- Identification of patient "admission drivers" with development of specific action plans
- Patient and family engagement care plans
- Integrated social service coordination for members with psychosocial issues and placement issues
- Integrated behavioral health management
- Disease-specific action plans and self-management
- Advance care planning
- Coordination of ancillary services and physician referrals
- Outpatient palliative care program

- Multidisciplinary team of physicians, nurses, social workers chaplain, and pharmacist available 24/7
- Expedited interventions for Pneumonia, COPD, CHF, Dehydration, and Cellulitis
- Hospital post-discharge follow-up visits within 24hours
- Same day urgent visits
- Phone communication with primary care physician and specialist for intervention
- Telephonic medication therapy management
- Disease management programs (Disease Management & Anticoagulation)
- Post discharge in-home medication therapy management
- Long-term care medication therapy management
- Integrated with inpatient and outpatient clinical teams
- Patient education and assessment of non-adherence

The Objectives of the above programs are to manage symptoms and reduce readmissions with the goal of maximizing care in home.

When high-risk patients with significant co-morbidities are admitted to a hospital, PMH's hospital care management program provides the following:

- Close monitoring of patients by rounding twice per day until patient is discharged
- Medical Director rounds with hospital case manager and hospitalist twice per day until the patient is discharged
- Ability to direct patients from acute setting to skilled nursing facility when appropriate;
- Ability to direct patients from acute setting to early post discharge visits when appropriate; and
- Close collaboration between hospital case manager, skilled nursing facility case manager, pharmacist, nurse practitioner and primary care physician

When high risk patients with significant co-morbidities are in a sub-acute setting, PMH's medical management program provides the following:

- Monitoring of patients by rounding three to five times per week until patient is stable, then two to three times per week
- Physician rounds supplemented by Prospect nurse practitioners
- Medical Director rounds with case managers and physician twice per week; and
- If patient's status deteriorates, transfer to network hospital

6. On page 2149 of the Response, Applicants state that a $5 million planned renovation at RGH which is expected to be completed by September 2016 will result in RGH having the ability to accommodate an additional 30 patients with behavioral health conditions. Additionally, Applicants state that the acquisition of physicians from Mansfield OB/GYN Associates has added demand for OB services. However, in the table on page 2173 of the Response and the subsequent explanation, Applicants state that projected growth for inpatient discharges is attributable to Medical/Surgical discharges and not to the maternity or behavioral health units at either hospital "as both the maternity unit and behavioral health unit are operating at capacity [at MMH] and RGH does not provide either services at the present time. Based on this assumption, discharge volume for maternity, pediatric (newborn) and psychiatric services will remain constant at the levels projected for FY 2016 through FY 2019." Please clarify why the planned behavioral health unit renovation at RGH and the increased demand for OB services do not result in increases FY 2016 through FY 2019 for Inpatient Discharges in maternity patients for MMH (as the hospital's maternity unit apparently has overflow capacity on the Third West unit) and psychiatric patients for RGH.

Response:

The increased demand for maternity and newborn services resulting from the addition of the Mansfield OB/GYN Associates physicians in FY 2015 will be fully realized in FY 2016. The discharge volume for maternity and pediatric patients reported in Table C on page 2170 reflects the expected twelve-month delivery volume for the OB/GYN physicians on ECHN's Medical Staff and assumes no changes to the number of OB/GYN physicians during the projection period.

The planned behavioral health unit renovation at RGH is only in the developmental stages at this time so projections for RGH do not include any of the volumes, revenues or expenses associated with enhancing behavioral health services at RGH.

7. Applicants indicate on page 217 5 of the Response that ECHN has struggled to retain, in particular, primary care providers. Tables E and F on page 2174 of the Application indicates an increase to date in Allied Health Professionals employed in the ECHN Medical Foundation. Please elaborate on the role Applicants envision for AHPs post-closing, addressing specifically:

   a) Whether AHPs will be utilized to compensate for the lack of primary care physicians.

      Response:

      AHPs are already being utilized to compensate for the shortage of primary care physicians across the state. The Applicants expect this practice to continue in the ECHN service area post-closing. It should be noted that PMH has utilized AHPs in other states for many years. AHPs are an essential part of the care delivery system.

   b) Whether AHPs would be eligible to join PPGCTE or the Medical Foundation PMH will utilize post -closing.

      Response:

      AHPs will be eligible to join PPGCTE and the Medical Foundation PMH will utilize post-closing.

   c) Whether AHPs participate as members in any of PMH's existing physician networks and, if not, why not.

      Response:

      AHPs do participate as members of PMH's existing physician networks because the primary care physician shortage experienced in Connecticut is not unique. The use of AHPs to meet the primary care needs of a given community is common nationwide and a practice that PMH incorporates into its CRC model of care to ensure patients are able to receive needed care in the most appropriate and cost-effective setting.

8. On page 2175 of the Response, Applicants indicate that a decline in participants in the ECHN Medical Foundation from 2013 to 2014 was related to a decision to contract with a third party for hospitalist services at both Hospitals. Please indicate whether PMH intends to continue outsourcing hospitalists post-closing.

Response:

PMH will assume the existing contract with Sound Physicians for hospitalist services post-closing. PMH outsources hospitalist services in other states and expects all hospitalists to comply with PMH's utilization and quality criteria and other outcome measures.

9. Referencing Applicants' response to Question 53 of the Application and page 2178 of the Response, please address the following:

   a) Applicants have projected a 1% increase in spending for Community Building Activities through FY 2019. With respect to the screenings and educational programs listed in Exhibit H of the Response, please indicate whether PMH intends to allocate more resources for screenings versus educational programs than is currently the case;

      Response:

      The projected 1% increase in spending for Community Building Activities through FY 2019 is due to inflation and assumes no change in the Medicaid population served or the complement of community benefit programs offered by the Hospitals.

      As discussed in the Applicants' response to deficiencies Question 53d on page 2179, PMH will reevaluate the healthcare needs of the community with input from the Local Boards as part of its overall planning process post-closing and expects to prioritize capital projects and service improvements based on hospital and community needs. Plans to address the priority needs in ECHN's service area, including the allocation of resources for screenings and educational programs, will be developed post-closing once the priority needs have been confirmed or identified.

   b) Certain screening programs identified in Exhibit H had low utilization rates. Please elaborate how PMH intends to increase community utilization of those screening programs specifically, and screening programs, generally, in coordination with the planned 1% increase in spending year over year.

      Response:

      The projected increase in spending for Community Building Activities is due to inflation and not a result of an increase in screening frequency or community utilization. As stated in the Applicant's response to Question 22 on page 73 of the CON application submitted on October 13, 2015, PMH will continue to focus efforts on improving population health and will utilize its experience and knowledge in population health management to incorporate best-practice recommendations for disease prevention, early detection screenings and treatment options. PMH

recognizes the importance of screening in overall population health; thus specific plans to increase community utilization of screening programs will be developed post-closing pending the confirmation or identification of the communities' priority needs.

10. For those Community Health Improvement Services and Community Benefit Operations programs identified on pages 2183-2185 of the Response, please indicate which programs PMH intends to continue funding post -closing and whether any material changes in funding are expected for any of the programs listed.

Response:

PMH is committed to maintaining ECHN's current policies on community volunteer services and community benefits. Specific plans related to community benefit program offerings will be developed post-closing pending the confirmation or identification of the communities' priority needs.

11. Please explain the role, purpose and function of the Nurse and Survivorship Navigator Program listed on page 2183 of the Response.

Response:

Oncology nurse navigators assist patients and their caregivers by supporting the coordination of care in both inpatient and outpatient settings. Some examples include the management of symptoms, referrals to other specialists, the scheduling of tests and treatments, and referrals for homecare services.

The survivorship navigator is a licensed clinical social worker available to assist patients and their families with financial, insurance and disability concerns resulting from their illness. Some examples of assistance provided by the survivorship navigator include documenting advance directives, smoking cessation, supportive counseling, and referrals to community agencies. The survivorship navigator also provides supervision of ECHN's integrative medicine program.

The women's health nurse navigator oversees ECHN's Breast Care Collaborative which ensures prompt and efficient transition of care for women with suspicious or benign findings following a diagnostic breast exam, mammography or breast biopsy. The navigator is responsible for community and physician education, screening and prevention events and serves as the clinical nurse navigator for the Early Detection Program.

The Commission on Cancer, which is a department of the American College of Surgeons, requires community cancer centers to have both nurse navigators and survivorship programs to receive national accreditation and meet best practice standards. PMH is committed to maintaining ECHN's current policies on community volunteer services and community benefits and will expects to maintain the existing accreditation levels of services currently offered by ECHN and its affiliates.

12. In reference to Exhibit M, page 2381 of the Response, the Patient Experience survey indicates patient satisfaction levels for Hollywood Community Hospital of Hollywood and Los Angeles Community Hospital well below the national average. Please elaborate on the factors causing these results and detail what policy, programs and procedures PMH has implemented to increase patient satisfaction levels at these hospitals.

Response:

PMH believes that a significant factor in the patient satisfaction scores at Los Angeles Community Hospital and Southern California Hospital at Hollywood are primarily due the age of the physical plant.

Some of the upgrades that are planned for 2016 at Los Angeles Community Hospital include the following:

- ER remodel;
- Beautification of OB areas;
- Upgrades to ICU and CCU;
- Modernization of elevators;
- Beautification of the lobby;
- Better signage; and
- Beautification of radiology areas.

Some of the upgrades that PMH is planning for 2016 at Southern California Hospital at Hollywood include the following:

- Upgrades to ICU and CCU;
- Beautification of the lobby areas;
- Better signage; and
- Modernization of elevators.

In addition to the projects described above, we are re-dedicating new hospital leaders to improve all quality and patient satisfaction scores at all California hospitals. We expect that the new leaders will adopt proven measures to increase patient satisfaction, such as patient rounding with a focus on communication with patients.

13. Please provide clarification as to whether the amounts provided on Table 8, Exhibit B, page 2209, are actual or estimated and if amounts were submitted as of 9/30/15 or 11/4/15.

Response:

The amounts provided on Table 8, Exhibit B, page 2210 are the actual amounts for 09/30/2015 based on the unaudited financials updated as of 11/4/2015. The actual amounts for Table 8 will not be considered final until the FY 2015 audited financials have been through all audit review levels and presented to ECHN's Audit Committee.

14. Please provide documentation that supports PMH's available funds in excess of $110 million and its generation of $7.5 million in free cash flow per month as of September 30, 2015, as stated on page 2192.

Response:

Please refer to **Exhibit R** for the documentation that supports PMH's available funds.

15. In reference to PMH's Capital Investments and Cost Savings Table, Exhibit L, page 2327, address the following:

a) What do the amounts listed under the columns Profitability, Liquidity and Solvency represent (e.g. total margin, operating margin, EBITDA, cash and cash equivalents, net assets, stock holder's equity, etc.)? Provide documentation that supports the data, for example, calculation methodology, etc. and the measurement period that applies to each of the entries;

Response:

The data provided for Exhibit L are on a standalone company basis. Profitability for each entity is measured by EBITDA for the entity (subject to the footnotes in Exhibit L), on a standalone basis. EBITDA was calculated pursuant Generally Accepted Accounting Principles ("GAAP") the fiscal year ending September 30, 2015.

Liquidity is calculated by measuring the working capital for each entity. The formula for working capital is: current assets less current liabilities for each entity as of September 30, 2015.

Finally, solvency is measured by stockholders equity for each entity as of fiscal year ended September 30, 2015. Stock holders' equity is measured by GAAP.

b) As previously requested in Question 37(b), for each of the five entities, elaborate on how the cost savings listed were the result of economies of scale inherent of a larger organization;

Response:

All hospitals acquired by PMH become part of PMH's purchasing programs for supplies and drugs. Under PMH's contracts, higher volume of purchases by PMH as an organization results in lower prices for supplies and drugs. All acquired hospitals benefit from such realized savings. Furthermore, PMH as an organization, because of its growing size, has hired employees with subject matter expertise in operations of hospitals. Such personnel are made available to all PMH hospitals. As such, our hospitals save on hiring consultants.

c) The table shows references to footnotes labeled as "(g)" and "(h)" but the information related to these footnotes is missing. Please provide the missing information.

Response:

Please see **Exhibit S** for the revision of Exhibit L showing the footnotes for (g) and (h) that were inadvertently left off the previously provided version of the exhibit.

16. In reference to the Revised Financial Worksheets (C), Exhibit I, pages 2312-2317 and related assumptions, for ECHN, MMH and RGH, explain the following:

a) The factors driving the gains in incremental gross patient revenue for each entity;

Response:

Gross patient revenue for ECHN, MMH and RGH is expected to increase in FY 2017 through FY 2019 "without the CON" as a result of fee schedule adjustments made in connection with changes to managed care agreements. Additional gains in gross patient revenue are anticipated "with the CON" as a result of incremental volume increases.

b) The positive net income "without the CON" in FY 2019 for MMH and RGH; and

Response:

The positive net income achieved in FY 2019 "without the CON" is due the cumulative effect of annual increases in net patient revenue anticipated as a result of improved managed care contracts and ECHN's continuous efforts to manage expenses and control costs at the Hospitals and other ECHN facilities.

c) The reductions in "other operating revenue" between FY 2014 actual and FY 2015 projected for each entity.

Response:

The other operating revenue amount in FY 2014 includes realized gains from the one-time transfer of ECHN's investment portfolio from volatile, high-risk stock investments to more conservative, fixed-income investments.

17. In reference to PMH'S credit rating and the revolving line of credit with Morgan Stanley information provided on page 2191 of the Response, address the following:

a) Provide the specific time period (e.g. month, quarter) associated with the credit ratings referenced for PMH; and

Response:

Please see **Exhibit T** for the most recent credit rating reports for PMH.

b) Provide the total amount available and principal amount related to the credit line. Elaborate on the ability to retain this funding once the engagement with Morgan Stanley and PMH concludes "within the next year" as indicated on page 2206 of the Response.

Response:

Please see Note 8 on page 47 of PMH's consolidated financial statements attached hereto as **Exhibit U** which states that the total amount available under the credit line is $40 million. It is anticipated that the credit line will either remain the same or increase next year due to PMH's positive financial performance.

18. On page 2194 of the Response, the Applicants indicated that PMH's FY 2015 financial statements, reflecting twelve months of financial activity, are not available and that a copy will be provided once they have been received and publicly disclosed. In reference to this

response, please provide an estimate for when the copy of the audited financial statements will be available.

Response:

The FY 2015 consolidated financial statements for PMH are now available and have been provided as **Exhibit U**.

19. On page 2195 of the Response, the Applicants indicated that the Other Operating Revenue Detail report, Exhibit J, submission was corrected to reflect the removal of the amount for "Public Support" in the "with CON" scenario. Please define what encompasses "Public Support."

Response:

Public Support includes the unrestricted charitable donations that ECHN, as a non-profit entity, receives through the ECHN Community Healthcare Foundation, Inc. The post-closing for-profit entity will not receive any charitable support.

20. In reference to the California Quality Assurance Fee (SB 239) program referred to on page 2192, elaborate on the impact on PMH's future ability to support the cost of this proposal and future capital needs for MMH and RGH in excess of the $75 million, without the additional dollar amounts generated by this program in the form of revenue and cash receipts.

Response:

The Quality Assurance Fee program has been part of California law for the past eight years and will be part of California law for the next six years. PMH fully expects the extension of the program after six years. In the next six years, PMH expects an increase in its portion of the net Quality Assurance Fees. Furthermore, PMH is a profitable and growing company with access to capital. As such, we expect to be able to support this proposal to meet the needs of ECHN for the foreseeable future. It should be noted that in 2014, due to a delay in payment of Quality Assurance Fees, PMH did not receive any funds for the program, but was able to meet all of its commitments to close on $70 million of transactions.

RESPONSE TO DEFICIENCIES (DECEMBER 11, 2015)

EXHIBITS

RESPONSE TO DEFICIENCIES (DECEMBER 11, 2015)

EXHIBIT Q – Section 3.2 ECHN's Medical Staff Bylaws

ARTICLE THREE: MEMBERSHIP

3.1 NATURE OF MEMBERSHIP

Membership on the Medical Staff is a privilege that is granted by the Board after considering the recommendations of the Medical Staff, and that shall be extended only to professionally competent Practitioners who continuously comply with and meet the qualifications, standards, and requirements set forth in these bylaws, the rules and regulations of the Medical Staff, and other Medical Staff policies, including the directives and policies of the MEC and the other Medical Staff committees. Appointment to and membership on the Medical Staff shall not confer on the Staff member any Clinical Privileges. A member of the Medical Staff shall only have Clinical Privileges if specifically granted by the Board in accordance with these bylaws.

An individual who fails to satisfy the membership qualifications, standards and requirements is ineligible to apply. A determination of eligibility shall be made prior to submitting the application to the Credentials Committee. A determination of ineligibility does not entitle the individual to the provisions of Article Twelve of these bylaws.

3.2 GENERAL QUALIFICATIONS

Each Practitioner who seeks or enjoys Staff membership shall, at the time of appointment and continuously thereafter, demonstrate to the satisfaction of the Medical Staff and the Board, through documentation and other evidence, the following:

3.2-1 LICENSURE

A currently valid unrestricted license issued by the State of Connecticut to practice medicine, osteopathy, dentistry, or podiatry and have never had such a license to practice revoked by any state licensing agency and currently valid federal and state registrations to prescribe controlled substances except where the Practitioner demonstrates that such registration is not required in order to exercise the Practitioner's current or requested Clinical Privileges.

3.2-2 PERFORMANCE

(a) Professional education, training, experience, current competence, and clinical results documenting a continuing ability to provide optimally achievable patient care services given the resources locally available.

(b) With regard to board certification, all applicants to the Medical Staff, with the exception of general dentists, at the time of being granted Privileges, shall:

(1) Have completed a residency accredited by the Accreditation Council for Graduate Medical Education, the American

Osteopathic Association, the American Dental Association, or the Council on Podiatric Medical Education; or by a program with a reciprocity agreement with the American Board of Medical Specialties or American Osteopathic Association.

3.2-2 (b) (2) If not certified by a board that is a member of the American Board of Medical Specialties, by a board recognized by the American Board of Medical Specialties, by the American Osteopathic Association, by a board recognized by the American Osteopathic Association, by the American Podiatric Medical Association, or by the American Dental Association (limited to the American Board of Oral and Maxillofacial Surgery) be admissible for certification and become certified within the lesser of (i) the period of eligibility as defined by the respective board, or (ii) five years after initial appointment to the Medical Staff. Certification by the Royal College of Physicians and Surgeons of Canada may be accepted based upon a waiver recommended by the MEC and approved by the Board. The boards listed in this section shall be the sole means for certification requirement.

Furthermore, Staff members whose board certificates bear an expiration date shall successfully complete recertification no later than three years following such date. Failure to obtain board certification or recertification shall result in automatic termination of all Privileges accorded to such member and termination of such Practitioner's Staff membership. However, the requirements to obtain board certification and/or recertification are not made retroactive for those Staff members who, prior to obtaining membership on the Medical Staff, had been members of the Medical Staff of MMH continuously since July 1, 1988 or had been members of the Medical Staff of RGH continuously since May 1, 1996.

3.2-3 ATTITUDE

A willingness and capability, based on current attitude and evidence of performance, to work with and relate to other Staff members, members of other health disciplines, the Network Hospitals' management, and employees, visitors, and the community in general, in a cooperative, professional manner conducive to the maintenance of an environment appropriate to quality patient care. The behavior of members of and applicants for membership on the Medical Staff and AHPs constitutes an essential component of professional activity and personal relationships within the Network Hospitals. Civil deportment fosters an environment conducive to excellent patient care. Accordingly, in addition to the other qualifications set forth in this Article Three, all members of Medical Staff and AHPs at all times shall demonstrate an ability to interact on a professional basis with members of the Staff, patients, and others and to behave in a professional and civil manner. This requirement is not in any way intended to

interfere with a Staff member or AHP's privileges: (1) to express opinions freely and to support positions whether or not they are in dispute with those of other Staff members; (2) to engage in honest differences of opinion with respect to diagnosis and treatment or basic program development that are debated in appropriate forums; or (3) to engage in the good faith criticism of others. The following types of behavior, however, which constitute some examples of an inability to interact on a professional basis with others or to behave in a professional and civil manner, are deemed unacceptable for members of the Medical Staff and AHPs:

- Conduct that reasonably could be characterized as sexual and/or racial harassment;
- Threats of physical assault or actual physical assault, harassment, or the placing of others in fear by engaging in threatening behavior;
- The unnecessary and unjustifiable use of loud, profane, or abusive language directed toward Staff members, patients, or others;
- Unnecessary and unjustifiable rude or abusive behavior;
- Written or oral statements that constitute the intentional expression of falsehoods or constitute deliberately disparaging statements made with a reckless disregard for their truth or for the reputation and feelings of others.

Furthermore, all members of the Medical Staff shall demonstrate a willingness and capability, based on current attitude and evidence of performance, to:

(a) Participate equitably in the discharge of Staff obligations appropriate to Staff membership category; and

(b) Adhere to generally recognized standards of professional ethics.

3.2-4 DISABILITY

To be free of, or have under adequate control, any significant physical or behavioral impairment that interferes with, or presents a significant possibility of interfering with, the Practitioner's ability to perform the Privileges requested or granted.

3.2-5 PROFESSIONAL LIABILITY INSURANCE

Professional liability insurance is not less than the minimum amount, as determined from time to time by resolution of the Board. Medico-Administrative Officers with no Clinical Privileges shall be exempt from this requirement.

RESPONSE TO DEFICIENCIES (DECEMBER 11, 2015)

EXHIBIT R – PMH Free Cash Flow

Prospect Medical Holdings
Free Cash Flow
FYE 9/30/2015

Operating Income	$	108,060,000
Change in WC (Increase)	$	34,374,000
Taxes Paid	$	(35,778,000)
Net Change in PP&E	$	(10,863,000)
Free Cash Flow	$	95,793,000
Average Monthly Free cash Flow	**$**	**7,982,750**

RESPONSE TO DEFICIENCIES (DECEMBER 11, 2015)

EXHIBIT S – PMH Capital Investments and Cost Savings Table (Exhibit L Revision)

Table from Question 37a - Capital Investments and Cost Savings Table

Hospital	Investments since Acquistion	Describe Improvements in Financial Performance: Profitability	Liquidity	Solvency	Cost Savings
Los Angeles Community Hospital at Bellflower	$ 3,646,633	N//A (a)	N/A (a)	N/A (a)	N/A (a)
Foothill Regional Medical Center	$ 7,912,807	N/A (a)	N/A (a)	N/A (a)	N/A (a)
Our Lady of Fatima Hospital	$ 11,321,376 (f)	$ 15,184,000 (g)	$ 4,976,828 (c)	$ 67,475,613 (c)	Marginal Cost per day reduced to $1,493 from $1,542 (d)
Roger Williams Medical Center	$ 11,321,376 (f)	$ 15,184,000 (g)	$ 4,976,828 (c)	$ 67,475,613 (c)	Marginal Cost per day reduced to $2,271 from $2,263 (d)
Nix Health System	$ 33,350,077	$ 20,867,000 (h)	$ 15,882,118	$ 63,789,134	Total Costs per day decreased to $1,444 from $1,584 (e)

(a) Both Los Angeles Community Hospital at Bellflower (Bellflower) and Foothill Regional Medical Center (Foothill) were closed prior to PMH acquisition
Bellflower re-opened in July 2015 and Foohill re-opened in September 2015. Both facilities were purchased in May 2014.

(b) Los Angeles Community Hospital at Bellflower is under common corporate ownership structure and license as Los Angeles Community Hospital and
Los Angeles Community Hospital at Norwalk. As such, liquidity and solvency for this campus includes financial information for all three campuses combined

(c) The profitability, liquidity and solvency of Our Lady of Fatima and Roger Williams Medical Center are reported on a consoldiated basis for the CharterCARE system
Prior to the acquisition, the liquidity of CharterCARE system was approximately a negative $2.5 million
Profitability is measured on an EBITDA basis and reported on a consolidated basis for the CharterCARE system

(d) Measured from June 2014 to May 2015

(e) Measured from Dember 2011 to September 2015. Prior to acquisition Nix did not compute Marginal cost per day.

(f) Total capital investment in Our Lay of Fatima and Roger Williams Medical Center (which comprise CharterCARE) is reported on a combined basis.
In addition to the amount already spent, we have committed to spend $20 million in addtion to what has already been spent
on (i) cancer center; (ii) Digestive Diseases Center; (iii) Emergency Department and (iv) physician practice acquisitions.

(g) Profitability based on a consolidated EBITDA basis and adjusted for corporate allocation for nine months endedf 6/30/2015.
Our Lady of Fatima Hospital and Roger Williams Medical Center are part of CharterCARE system
EBITDA of CharterCARE as of 3/31/2013 (one year prior to acquisition) was $7,146,000

(h) Profitablilty reported on an EBITDA basis adjusted for corporate allocations for year ended 9/30/2014.
EBITDA of Nix for 12/31/2011 was $18,774,000.

RESPONSE TO DEFICIENCIES (DECEMBER 11, 2015)

EXHIBIT T – Credit Rating Reports for PMH

MOODY'S
INVESTORS SERVICE

Rating Action: Moody's upgrades Prospect Medical's CFR to B1 from B2; outlook is stable

Global Credit Research - 09 Jul 2015

New York, July 09, 2015 -- Moody's Investors Service upgraded the Corporate Family Rating of Prospect Medical Holdings, Inc. (Prospect) to B1 from B2. The company's Probability of Default Rating was also upgraded to B1-PD from B2-PD and the rating on Prospect's senior secured notes was upgraded to B1 from B2. The rating outlook is stable.

The ratings upgrade primarily reflects Moody's expectation of operational improvements at the company's existing and newly acquired hospitals that will contribute to earnings growth and improved cash flow. Moody's expects Prospect to sustain debt to EBITDA below 4 times over the next twelve to eighteen months.

The following ratings were upgraded

Corporate Family Rating to B1 from B2

Probability of Default Rating to B1-PD from B2-PD

Senior secured notes due 2019 to B1 (LGD 3) from B2 (LGD 4)

The outlook is stable.

RATINGS RATIONALE

Prospect's B1 Corporate Family Rating reflects the company's moderate scale, its high financial leverage, its high concentration in only a few markets, and its significant reliance on California and Texas Medicaid programs. Moody's anticipates that Prospect will remain acquisitive beyond the transactions the company has already announced in New Jersey and Connecticut in order to gain scale and improve geographic diversification. Moody's expects Prospect to generate EBITDA and cash flow growth from both existing and soon-to-be-acquired hospitals. Further, Moody's anticipates that Prospect will use internally generated cash and limit the use of incremental debt to fund future growth so that leverage remains below 4.0 times.

The stable outlook reflects Moody's expectation that Prospect's leverage will remain moderately high but will benefit from near term hospital acquisitions that will be funded with internally generated cash. Moody's also expects that Prospect will maintain good liquidity, despite capital commitments at newly acquired facilities, due to improvement in operating cash flow.

Given Prospect's relatively small size and considerable concentration in only a few markets, Moody's does not anticipate an upgrade of the ratings in the near term. However, over the longer term, the ratings could be upgraded if the company can increase scale and enhance revenue and earnings diversification. Further, the ratings could be upgraded if Prospect maintains debt to EBITDA at around 3.0 and maintains a measured approach towards debt funded acquisitions or shareholder initiatives.

The ratings could be downgraded if operational or integration challenges cause a significant deterioration in financial metrics or the company undertakes a material debt funded acquisition or shareholder distribution. More specifically, ratings could be downgraded if Moody's expects debt to EBITDA to be sustained above 4.0 times or if liquidity weakens.

The principal methodology used in these ratings was Global Healthcare Service Providers published in December 2011. Other methodologies used include Loss Given Default for Speculative-Grade Non-Financial Companies in the U.S., Canada and EMEA published in June 2009. Please see the Credit Policy page on www.moodys.com for a copy of these methodologies.

Headquartered in Los Angeles, California, Prospect Medical Holdings, Inc. provides health care services through a network of 13 acute care and behavioral hospitals located in California, Texas and Rhode Island. Through its Medical Group business unit, the company provides administrative management of health care services to

independent physician organizations that cover over 300,000 members through a network of primary care doctors and specialists. Prospect recognized revenues of approximately $1.2 billion in the twelve months ended March 31, 2015. The company is owned by private equity firm Leonard Green & Partners L.P. and members of the company's management team.

REGULATORY DISCLOSURES

For ratings issued on a program, series or category/class of debt, this announcement provides certain regulatory disclosures in relation to each rating of a subsequently issued bond or note of the same series or category/class of debt or pursuant to a program for which the ratings are derived exclusively from existing ratings in accordance with Moody's rating practices. For ratings issued on a support provider, this announcement provides certain regulatory disclosures in relation to the rating action on the support provider and in relation to each particular rating action for securities that derive their credit ratings from the support provider's credit rating. For provisional ratings, this announcement provides certain regulatory disclosures in relation to the provisional rating assigned, and in relation to a definitive rating that may be assigned subsequent to the final issuance of the debt, in each case where the transaction structure and terms have not changed prior to the assignment of the definitive rating in a manner that would have affected the rating. For further information please see the ratings tab on the issuer/entity page for the respective issuer on www.moodys.com.

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Research Update:

Prospect Medical Holdings Inc. 'B' Corporate Credit Rating Affirmed; Senior Secured Notes Raised To 'B' (Recovery: '4')

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Shannan R Murphy, Boston 6175308337; shannan.murphy@standardandpoors.com

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Table Of Contents

Research Update:

Prospect Medical Holdings Inc. 'B' Corporate Credit Rating Affirmed; Senior Secured Notes Raised To 'B' (Recovery: '4')

Overview

- Los Angeles-based health care services provider Prospect Medical Holdings Inc. has expanded EBITDA meaningfully in 2015, reflecting the impact of its 2014 acquisitions and the positive impact of health care coverage expansion.
- We are affirming our 'B' corporate credit rating on Prospect.
- We are raising our rating on Prospect's senior secured notes to 'B' from 'B-' and revising our recovery rating on this debt to '4' from '5', indicating our expectations for average (30% to 50%; at the low end of the range) recovery for bondholders in the event of payment default.
- The rating outlook is stable, reflecting our view that EBITDA margins will remain broadly stable, with improving margins at acquired hospitals offset by persistent, industrywide pressure from reimbursement headwinds.

Rating Action

On Sept. 21, 2015, Standard & Poor's Ratings Services affirmed its 'B' corporate credit rating on Los Angeles-based health care services provider Prospect Medical Holdings Inc. The rating outlook is stable.

At the same time, we raised our rating on Prospect's senior secured notes to 'B' from 'B-' and revised our recovery rating on this debt to '4' from '5'. The '4' recovery rating indicates our expectations for recovery at the low end of the average (30% to 50%) range for bondholders in the event of payment default.

Rationale

The ratings affirmation on Prospect follows several quarters of strong EBITDA growth, reflecting the impact of significant acquisitions completed in 2014, as well as high-single digit same-facility growth in the company's hospital and medical group portfolio, despite a continued high level of competition in Prospect's key markets.

Prospect operates a network of 13 hospitals and related primary-care clinics in Southern California, Texas, and Rhode Island. The company also operates a Medical Group segment that manages the provision of physician services on behalf of health maintenance organization (HMO) customers. While the medical

group segment provides some business diversity, this business also has significant exposure to government reimbursement pressures in the Medicare Advantage program.

We view Prospect's business as geographically concentrated, with the majority of revenues coming from very competitive urban markets in California and Texas. While recent acquisitions in Rhode Island and pending acquisitions in New Jersey and Connecticut will contribute modest geographic diversity, the company still has very significant exposure to the California Hospital Fee Program and other disproportionate share subsidy programs, which at times has contributed to meaningful volatility in the timing of cash flows relative to peers. We expect this factor to continue over time. We view Prospect's EBITDA margins as below average, which in part reflects the company's government-focused payor mix (excluding capitation revenues, the company derives over 55% of revenues from Medicare and Medicaid), as well as acquisitions of underperforming hospital facilities. These factors are only partially offset by our view that Prospect's strategic focus as a cost-efficient provider of coordinated care will aid the company's growth as health care services providers make the eventual transition away from fee-for-service reimbursement and toward payments based on quality and efficiency of care. Collectively, these factors support our assessment of a "vulnerable" business risk profile.

We expect Prospect to generate over 50% revenue growth in fiscal 2015 and high-single-digit revenue growth in 2016, reflecting the impact of acquisitions as well as low- to mid-single-digit same-facility revenue growth. We expect EBITDA margins to remain broadly stable, with improving margins at acquired hospitals offset by persistent, industrywide pressure from reimbursement headwinds. As a result of EBITDA growth, we expect Prospect to generate about $50 million in discretionary cash flow in 2016, which we expect the company will allocate toward acquisitions.

Despite recent improvement in credit measures, we continue to assess Prospect's financial risk profile as "aggressive". Following the completion of several acquisitions in 2014, leverage has declined to below 4x at June 30, 2015, from over 5x at Dec. 31, 2014. While leverage should remain at the stronger end of the range for an aggressive financial risk profile, we expect funds from operations (FFO) to debt to remain in the mid-to-high teens, consistent with the financial risk descriptor. The company's financial sponsor ownership, somewhat aggressive acquisition strategy, and history of debt-funded dividends are key considerations supporting our financial risk assessment, as we believe the company's financial policies are likely to tolerate modest increases to leverage versus current levels. We expect Prospect to pursue hospital acquisitions to diversify and grow its business over the next few years, and we believe the company may increase leverage to finance this strategy.

Liquidity

We assess Prospect's liquidity as "adequate". We expect sources of liquidity to exceed uses by over 1.2x in 2015, and that sources would exceed uses even if EBITDA declined by 15%. Our liquidity assessment is constrained at "adequate" because we do not believe the company could withstand a high-impact, low-probability event without refinancing.

Principal liquidity sources:

- About $40 million of cash at June 30, 2015;
- About $40 million of availability on the company's $60 million revolving credit facility; and
- About $80 million to $90 million in expected 2015 FFO.

Principal liquidity uses:

- About $40 million in capital expenditures; and
- Some investment in working capital in 2015.

Outlook

The rating outlook on Prospect Medical Holdings Inc. is stable. Standard & Poor's Ratings Services expects over 50% revenue growth in 2015, driven primarily by acquisitions. We expect EBITDA margins to remain broadly stable, with improving margins at acquired hospitals offset by persistent, industrywide pressure from reimbursement headwinds. We expect leverage and cash flow metrics to be at the strong end of the range for an "aggressive" financial risk profile, and believe reasonable levels of profitability provide moderate downside cushion to the rating.

Downside scenario

We could lower our rating if Prospect's financials deteriorate to the point where leverage rises above 5x, or if the company stops generating positive free cash flow. We believe this could occur if margins decline about 450 basis points below our expectations. Sharp cuts to disproportionate share payment programs or Medicare reimbursement without offsetting factors could, in our view, cause this to occur. Leverage could also increase above 5x if the company becomes meaningfully more acquisitive. Assuming no acquired EBITDA, we estimate that the company has about $300 million in debt capacity at the existing rating.

Upside scenario

We could raise our rating if the company's acquisition strategy results in better business diversity over time. Specifically, we could consider a higher rating if the company's exposure to California declines, as we would likely view better geographic diversity (and less exposure to California's provider fee programs) as consistent with a stronger business risk assessment and raise the rating accordingly.

Ratings Score Snapshot

Corporate Credit Rating B/Stable/--

Business risk: Vulnerable
- Country risk: Very low
- Industry risk: Intermediate
- Competitive position: Vulnerable

Financial risk: Aggressive
- Cash flow/Leverage: Aggressive

Anchor: b

Modifiers
- Diversification/Portfolio effect: Neutral (no impact)
- Capital structure: Neutral (no impact)
- Financial policy: FS-5 (no additional impact)
- Liquidity: Adequate (no impact)
- Management and governance: Fair (no impact)
- Comparable rating analysis: Neutral (no impact)

SACP: B

Recovery Analysis

Key analytical factors

- We have reassessed our view of Prospect's likely emergence enterprise value following a default given the company's recent acquisitions.
- Our issue-level rating on Prospect's senior secured notes is now 'B', with a recovery rating of '4', indicating our expectation for average (30% to 50%; at the low end of the range) recovery on this debt in the event of payment default.
- Prospect's capital structure includes a $60 million revolver, $425 million in senior secured notes, and approximately $13 million in capital leases. We do not rate the revolver.
- In our default scenario, we assumed the company would be reorganized, and valued the company on a going-concern basis using a 4.0x multiple of our projected emergence EBITDA. This multiple is below that of peers and reflects Prospect's reliance on various disproportionate share subsidy programs.
- We estimate that for the company to default, EBITDA would need to decline significantly, representing a meaningful adverse change to reimbursement or a loss of key customers in the group medical business.

Simulated default assumptions

- Simulated year of default: 2018.
- EBITDA at emergence: $61 million.

- EBITDA multiple: 4.0x.

Simplified waterfall

- Net enterprise value (after 5% admin. costs): $230 million
- Valuation split in % (obligors/nonobligors): 100/0
- Priority claims: $13 million
- ----------
- Collateral value available to revolver lenders: $181 million
- Revolver debt (with a first-out provision): $53 million
- --Recovery expectations: N/A
- Collateral value available to secured creditors: $164 million
- Secured first-lien debt: $443 million
- --Recovery expectations: 30% to 50% [low end of the range]

Notes: All debt amounts include six months of prepetition interest. N/A--Not applicable.

Related Criteria And Research

Related Criteria

- Criteria - Corporates - General: Methodology And Assumptions: Liquidity Descriptors For Global Corporate Issuers, Dec. 16, 2014
- Criteria - Corporates - Industrials: Key Credit Factors For The Health Care Services Industry, April 16, 2014
- General Criteria: Group Rating Methodology, Nov. 19, 2013
- Criteria - Corporates - General: Corporate Methodology: Ratios And Adjustments, Nov. 19, 2013
- Criteria - Corporates - General: Corporate Methodology, Nov. 19, 2013
- General Criteria: Methodology: Management And Governance Credit Factors For Corporate Entities And Insurers, Nov. 13, 2012
- Criteria - Corporates - Recovery: Criteria Guidelines For Recovery Ratings On Global Industrials Issuers' Speculative-Grade Debt, Aug. 10, 2009

Ratings List

Ratings Affirmed

Prospect Medical Holdings Inc.		
Corporate Credit Rating	B/Stable/--	
Upgraded; Recovery Rating Revised		
	To	**From**
Prospect Medical Holdings Inc.		
Senior Secured	B	B-
Recovery Rating	4L	5

Complete ratings information is available to subscribers of RatingsDirect at www.globalcreditportal.com and at www.spcapitaliq.com. All ratings affected by

RESPONSE TO DEFICIENCIES (DECEMBER 11, 2015)

EXHIBIT U – Consolidated Financial Statements for PMH

Prospect Medical Holdings, Inc.

Consolidated Financial Statements

For the Years Ended
September 30, 2015 and 2014

The report accompanying these financial statements was issued by BDO USA, LLP, a Delaware limited liability partnership and the U.S. member of BDO International Limited, a UK company limited by guarantee.

Prospect Medical Holdings, Inc.

Consolidated Financial Statements

For the Years Ended September 30, 2015 and 2014

Prospect Medical Holdings, Inc.

Contents

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Independent Auditor's Report

Board of Directors
Prospect Medical Holdings, Inc.
Los Angeles, California

We have audited the accompanying consolidated financial statements of Prospect Medical Holdings, Inc. (the "Company"), which comprise the consolidated balance sheets as of September 30, 2015 and 2014, and the related consolidated statements of income, statements of stockholder's equity (deficit), and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Prospect Medical Holdings, Inc. and its subsidiaries as of September 30, 2015 and 2014, and the results of their operations and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

BDO USA, LLP

December 10, 2015

Consolidated Financial Statements

Prospect Medical Holdings, Inc.

Consolidated Balance Sheets
(in thousands except par value and share amounts)

September 30,	2015	2014
Assets		
Current assets		
Cash and cash equivalents	$ 65,606	$ 39,072
Restricted cash	4,585	4,976
Restricted investments	1,266	642
Patient accounts receivable, net of allowance for doubtful accounts of $52,707 and $49,727	139,696	123,733
Due from government payers	41,586	42,518
Other receivables	6,821	15,947
Inventories	12,294	10,448
Hospital fee program receivable	32,285	-
Prepaid expenses and other current assets	17,889	14,374
Total current assets	322,028	251,710
Property, improvements and equipment, net	240,337	229,474
Deferred financing costs, net	7,233	9,457
Deferred income taxes, net	11,865	1,165
Goodwill	162,296	158,864
Intangible assets, net	29,162	35,274
Other assets	9,930	8,234
Total assets	$ 782,851	$ 694,178

See accompanying notes to the consolidated financial statements.

Prospect Medical Holdings, Inc.

Consolidated Balance Sheets
(in thousands except par value and share amounts)

September 30,	2015	2014
Liabilities and Stockholder's Equity (Deficit)		
Current liabilities:		
Accrued medical claims and other healthcare costs payable	$ 53,531	$ 39,314
Accounts payable and other accrued liabilities	102,936	88,218
Accrued salaries, wages and benefits	57,432	53,808
Hospital fee program liability	15,022	2,806
Due to government payers	27,078	26,584
Income taxes payable, net	15,110	5,879
Revolving line of credit	20,000	20,000
Current portion of capital leases	2,905	4,691
Current portion of long-term debt	135	133
Other current liabilities	2,168	1,659
Total current liabilities	296,317	243,092
Long-term debt, net of current portion	422,700	421,755
Deferred income taxes, net	-	3,308
Malpractice reserves	6,632	4,590
Capital leases, net of current portion	9,296	10,463
Asset retirement obligations	4,583	4,310
Other long-term liabilities	6,883	7,866
Total liabilities	746,411	695,384
Commitments, contingencies and subsequent event		
Stockholder's equity (deficit):		
Common stock, $0.01 par value; 100 shares authorized, issued and outstanding at September 30, 2015 and 2014	1	1
Additional paid-in capital	20,037	18,457
Retained earnings (accumulated deficit)	6,158	(28,481)
Total stockholder's equity (deficit) attributable to Prospect Medical Holdings, Inc.	26,196	(10,023)
Non-controlling interests	10,244	8,817
Total stockholder's equity (deficit)	36,440	(1,206)
Total liabilities and stockholder's equity (deficit)	$ 782,851	$ 694,178

See accompanying notes to the consolidated financial statements.

Prospect Medical Holdings, Inc.

Consolidated Statements of Income
(in thousands)

For the Years Ended September 30,	2015	2014
Revenues:		
Net Hospital Services revenues	$ 1,047,517	$ 619,809
Provision for bad debts	(44,087)	(32,945)
Net Hospital Services revenues less provision for bad debts	1,003,430	586,864
Medical Group revenues	333,238	253,980
Net Global Risk Management revenues	3,440	-
Other revenues	5,436	13,672
Total net revenues	1,345,544	854,516
Operating Expenses:		
Hospital operating expenses	788,366	449,742
Medical Group cost of revenues	224,028	185,342
Global Risk Management cost of revenues	3,119	-
General and administrative	193,997	133,056
Depreciation and amortization	34,374	23,580
Total operating expenses	1,243,884	791,720
Operating income from unconsolidated joint venture	6,400	3,356
Operating income	108,060	66,152
Other (income) expense:		
Interest expense and amortization of deferred financing costs, net	42,063	41,437
Adjustment to (Gain on) bargain purchase	319	(4,817)
Other expense	230	419
Total other (income) expense, net	42,612	37,039
Income before income taxes	65,448	29,113
Income tax provision	31,146	10,561
Net income	34,302	18,552
Net income attributable to non-controlling interests	(337)	(463)
Net income attributable to Prospect Medical Holdings, Inc.	$ 34,639	$ 19,015

See accompanying notes to the consolidated financial statements.

Prospect Medical Holdings, Inc.

Consolidated Statements of Stockholder's Equity (Deficit)
(in thousands except share amounts)

	Number of Common Shares	Common Stock	Additional Paid-in Capital	Retained Earnings (Accumulated Deficit)	Prospect Medical Holdings, Inc. Stockholder's Equity (Deficit)	Non-controlling Interests	Total Stockholder's Equity (Deficit)
Balance at September 30, 2013	100	$ 1	$ 15,334	$ (47,496)	$ (32,161)	$ 120	$ (32,041)
Stock-based compensation	-	-	2,673	-	2,673	-	2,673
Investment in Chaparral Medical Group (see Note 1)	-	-	450	-	450	-	450
Non-controlling interest attributed to PCC Seller (see Note 4)	-	-	-	-	-	9,160	9,160
Net income	-	-	-	19,015	19,015	(463)	18,552
Balance at September 30, 2014	100	1	18,457	(28,481)	(10,023)	8,817	(1,206)
Options exercised	-	-	396	-	396	-	396
Stock-based compensation	-	-	1,184	-	1,184	-	1,184
Non-controlling interest attributed to PCC Seller (see Note 4)	-	-	-	-	-	1,764	1,764
Net income	-	-	-	34,639	34,639	(337)	34,302
Balance at September 30, 2015	100	$ 1	$ 20,037	$ 6,158	$ 26,196	$ 10,244	$ 36,440

See accompanying notes to the consolidated financial statements.

Prospect Medical Holdings, Inc.

Consolidated Statements of Cash Flows
(in thousands)

For the Years Ended September 30,	2015	2014
Operating activities		
Net income	$ 34,302	$ 18,552
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	34,374	23,580
Amortization of deferred financing costs, net	2,223	2,218
Amortization of original issue discount and premium, net	1,080	992
Provision for bad debts	44,087	32,945
Deferred income taxes, net	(14,008)	(8,111)
Stock-based compensation	1,184	2,673
Undistributed earnings from equity method investments	(135)	(178)
Loss on disposal of assets	271	-
Adjustment to (Gain on) bargain purchase	319	(4,817)
Gain on sale of equity method investment	(296)	-
Changes in operating assets and liabilities, net of business combinations:		
Patient accounts receivable and other receivables	(53,076)	(50,596)
Due to/from government payers, net	1,426	(8,827)
Prepaid expenses and other current assets	901	(1,682)
Hospital fee program receivable	(32,285)	18,895
Inventories	(1,839)	(814)
Hospital fee program liability and deferred revenue	12,216	(5,803)
Income taxes payable/receivable, net	9,289	6,899
Deposits and other assets	(660)	1,338
Accrued medical claims and other healthcare costs payable	14,217	8,962
Accounts payable and other accrued liabilities	21,235	16,177
Net cash provided by operating activities	74,825	52,403
Investing activities		
Purchases of property, improvements and equipment	(37,502)	(50,107)
Cash paid for acquisitions, net of cash received and working capital adjustments	(1,740)	(58,300)
Proceeds from sale of property and improvements	987	-
Proceeds from sale of equity method investment	1,233	-
Cash paid for equity method investments	(1,880)	-
Cash paid for investment in Chaparral Medical Group, Inc. (see Note 1)	-	(1,100)
Change in note receivable (net)	70	66
Increase in restricted investments	(624)	(5)
Net cash used in investing activities	(39,456)	(109,446)

Prospect Medical Holdings, Inc.

Consolidated Statements of Cash Flows (Continued)
(in thousands)

For the Years Ended September 30,	2015	2014
Financing activities		
Borrowings on line of credit, net	-	20,000
Repayments of long-term debt	(133)	(176)
Repayments of capital leases	(4,935)	(5,435)
Proceeds from exercise of stock options	396	-
Cash paid for deferred financing costs, net	-	(50)
Change in restricted cash	391	(2,676)
Repayments of insurance premium financing	(4,554)	(1,863)
Net cash (used in) provided by financing activities	(8,835)	9,800
Increase (decrease) in cash and cash equivalents	26,534	(47,243)
Cash and cash equivalents, beginning of year	39,072	86,315
Cash and cash equivalents, end of year	$ 65,606	$ 39,072
Supplemental disclosure of cash flow information		
Interest paid	$ 38,099	$ 37,608
Income taxes paid, net	$ 35,778	$ 12,004
Schedule of non-cash investing and financing activities		
Equipment acquired under capital leases	$ 1,999	$ 2,028
Insurance premium financed	$ 4,472	$ 1,842
Long-term liability assumed from acquisition of PCC (see Note 4)	$ -	$ 6,440
Partial satisfaction of long-term liability assumed from acquisition of PCC (see Note 4)	$ 1,446	$ -

See accompanying notes to the consolidated financial statements.

1. Organization

Prospect Medical Holdings, Inc. ("Prospect" or the "Company" or the "Parent Entity") is a Delaware corporation and a wholly-owned indirect subsidiary of Ivy Holdings Inc. ("Ivy Holdings").

The Company's operations are currently organized into four primary reportable segments: Hospital Services, Medical Group, Global Risk Management and Corporate, as discussed below.

The Global Risk Management segment is a new segment in Prospect's operations and commenced operations during the year ended September 30, 2015. The Global Risk Management segment includes Prospect Health Plan, Inc. ("PHP") with operations in California, Prospect Health Services TX, Inc. ("PHSTX") with operations in Texas, Prospect Health Services RI, Inc. ("PHSRI") with operations in Rhode Island, and Coordinated Regional Care Group, Inc. ("CRCG") with operations in various states. PHP, PHSTX, and PHSRI have entered into global capitation arrangements with certain third-party health plans and manage the provision of care for members in coordination with the Hospital Services and Medical Group segments.

Hospital Services Segment

The Company owns 13 acute care and behavioral hospitals and multi-level elder care facilities in Southern California, the Greater San Antonio, Texas region, and Rhode Island with a total of 2,258 licensed beds, and a network of specialty and primary care clinics, through its subsidiaries, Southern California Healthcare System, Inc. ("SCHS"), Alta Los Angeles Hospitals, Inc. ("Alta Los Angeles Hospitals"), Alta Newport Hospital, Inc., Prospect Hospital Holdings, LLC ("Nix Health"), and Prospect CharterCARE, LLC ("PCC") (collectively, the "Hospital Services segment"). The Hospital Services segment subsidiaries are wholly-owned by Prospect, except for PCC, in which Prospect has an 85% interest (see Note 4).

Effective May 6, 2014, Prospect acquired substantially all of the assets and associated real estate of Newport Specialty Hospital, which was subsequently renamed Foothill Regional Medical Center ("FRMC"), through Prospect's newly created subsidiary, Alta Newport Hospital, Inc., and Bellflower Medical Center (subsequently renamed Los Angeles Community Hospital at Bellflower or "LACH Bellflower") through Prospect's subsidiary Alta Los Angeles Hospitals, Inc. FRMC, located in Tustin, California, was substantially closed in 2013 except for its pediatric sub-acute unit. LACH Bellflower, located in Bellflower, California, was closed in 2013 and was non-operational when acquired by the Company. Bellflower opened its 32-bed voluntary adult behavioral health unit during July 2015. Prospect intends to fully reopen both facilities, including maintaining the FRMC pediatric sub-acute unit.

Effective June 20, 2014, Prospect acquired, through its subsidiary, PCC, substantially all of the assets of CharterCARE Health Partners and its subsidiaries. PCC's operating subsidiaries include Prospect CharterCARE RWMC, LLC ("Roger Williams Medical Center"), Prospect CharterCARE SJHSRI, LLC ("St. Joseph Health Services of Rhode Island"), Prospect CharterCARE Elmhurst, LLC ("Elmhurst Extended Care"), and Prospect CharterCARE Physicians, LLC ("CharterCARE Physicians") which include hospitals, medical centers, multi-level elder care facilities, and a network of approximately 60 contracted primary care and specialist physicians located in Rhode Island with 785 licensed beds (collectively, "CharterCARE"). PCC is 85% owned by Prospect and 15% by CharterCARE Community Board (formerly known as CharterCARE Health Partners).

The Company's three community hospitals in Hollywood, Los Angeles and Norwalk offer a comprehensive range of medical and surgical services, including general acute care hospital services, pediatrics, obstetrics and gynecology, pediatric sub-acute care, general surgery, medical-surgical services, orthopedic surgery, and diagnostic, outpatient, skilled nursing and urgent care services. The Company's psychiatric hospital in Van Nuys provides acute inpatient and outpatient psychiatric services on a voluntary basis. The Company's hospital in Culver City ("SCH Culver City") offers a comprehensive range of inpatient and outpatient services: including general surgery, orthopedic, spine, cardiology, diagnostic outpatient, rehabilitation, psychiatric and detox services. In addition, SCH Culver City has an active emergency room that plays an integral part in providing emergency services to the West Los Angeles area.

Nix Health provides comprehensive service offerings at various locations throughout the greater San Antonio, Texas region. These locations include Nix Medical Center, which provides inpatient acute care, geriatric psychiatry services, and emergency room services; Nix Specialty Health Center, which provides a full range of behavioral health and rehabilitation services for children, adolescents, and adults, and a range of health clinics and provider based clinics throughout San Antonio, Texas; and Nix Community General Hospital ("Nix CGH"), which operates an inpatient acute hospital in Dilley, Texas and a medical clinic in Pearsall, Texas. Nix Health also opened a 73-bed behavioral health center during the year ended September 30, 2014, which provides psychiatric emergency services and a crisis intervention unit.

CharterCARE provides a comprehensive range of services at both Roger Williams Medical Center and St. Joseph's Health Services Rhode Island as well as multiple levels of elder care at Elmhurst Extended Care.

Admitting physicians are primarily practitioners in the local area. The hospitals have payment arrangements with Medicare, Medicaid (Medi-Cal in California) and other third party payers, including commercial insurance carriers, health maintenance organizations ("HMOs") and preferred provider organizations ("PPOs").

Medical Group Segment

The Medical Group segment is a healthcare management services organization that provides management services to affiliated physician organizations that operate as independent physician associations ("Medical Groups" or "IPAs"). The affiliated physician organizations enter into agreements with HMOs to provide HMO enrollees with a full range of medical services in exchange for fixed, prepaid monthly fees known as "capitation" payments. The Medical Groups contract with physicians (primary care and specialist) and other healthcare providers to provide enrollees with medical services. Prospect currently manages the provision of prepaid healthcare services for its affiliated physician organizations in Southern California, Texas and Rhode Island. The network consists of the following physician organizations as of September 30, 2015 (individually referred to as an "Affiliate"):

Prospect Medical Group, Inc. ("PMG")
Prospect Health Source Medical Group, Inc. ("PHS")
Prospect Professional Care Medical Group, Inc. ("PPCM")
Genesis HealthCare of Southern California, Inc. ("Genesis")
Prospect NWOC Medical Group, Inc. ("PNW")
StarCare Medical Group, Inc. ("PSC")
AMVI/Prospect Medical Group ("AMVI/Prospect")
Nuestra Familia Medical Group, Inc. ("Nuestra")
Upland Medical Group, a Professional Medical Group ("UMG")*
Pomona Valley Medical Group, Inc. ("PVMG")*

* PVMG and UMG are collectively referred to as the "ProMed Entities."

These Affiliates are managed by the following two medical management company subsidiaries that are wholly-owned by Prospect (collectively, "MSOs"):

Prospect Medical Systems, Inc. ("PMS")
ProMed Healthcare Administrators ("PHCA")

In addition to the Affiliates and MSOs, the Medical Group segment includes Prospect Health Services, TX, Inc. ("PHSTX") and Prospect Provider Group RI, LLC ("PPGRI"), both of which are indirect wholly-owned subsidiaries of the Company.

All of the Affiliates are wholly-owned by PMG, with the exception of Nuestra, which was 66.95% owned by PMG as of September 30, 2015 and 2014, and AMVI/Prospect which is a 50/50 Joint Venture between AMVI Care Health Network, Inc. ("AMVI") and PMG. The operations of all of these entities, with the exception of AMVI/Prospect, are consolidated in the accompanying consolidated financial statements. PMG is owned by a nominee physician shareholder pursuant to an assignable option agreement described below.

PMG's ownership in Nuestra increased from 62% to 66.95% during the year ended September 30, 2014. On October 7, 2013, Nuestra repurchased 109 shares from a physician shareholder that left Nuestra's group medical practice for a de minimis purchase price in accordance with Nuestra's Agreement Concerning Shares of the Company dated September 19, 1995. The repurchase increased the share percentage holdings of all remaining shareholders and PMG's percentage rose to 66.95% as of October 7, 2013.

The AMVI Joint Venture was formed for the sole purpose of combining enrollment in order to meet minimum enrollment levels required for participation in the CalOptima Medicaid (Medi-Cal in California) program in Orange County, California. The joint venture ownership is set at 50/50 to prevent either party from exerting control over the other; however, AMVI's and PMG's businesses are operated autonomously, and enrollees, financial results and cash flows are each separately tracked and recorded. In accordance with the joint venture partnership agreement, profits and losses are not split in accordance with the partnership ownership interest, but rather, are directly tied to the results generated by each separate portion of the business. Separate from any earnings the Company generates from PMG's portion of business within the joint venture, the Company also earns fees for management services PMS provides to PMG's partner in the joint venture. The Company accounts for PMG's interest in the joint venture partnership using the equity method of accounting. The Company includes in the consolidated financial statements only the net results attributable to those enrollees specifically identified as assigned to the Company, together with the management fee that PMS charges for managing those enrollees specifically assigned to the other joint venture partner.

PMS has entered into an assignable option agreement with PMG and the nominee physician shareholder of PMG. Under the assignable option agreement, Prospect has an assignable option, obtained for a nominal amount from PMG and the nominee shareholder to designate the purchaser (successor physician) for all or part of PMG's issued and outstanding stock held by the nominee physician shareholder (the "Stock Option") in its sole discretion. The Company may also assign the assignable option agreement to any person. The assignable option agreement has an initial term of 30 years and is automatically extended for additional terms of 10 years each, as long as the term of the related management services agreement described below (the "Management Agreement") is automatically extended. Upon termination of the Management Agreement with PMG, the related Stock Option would be automatically and immediately exercised. The Stock Option may be exercised for a purchase price of $1,000. Under these nominee shareholder agreements, Prospect has the unilateral right to establish or

effect a change of the nominee, at will, and without the consent of the nominee, on an unlimited basis and at nominal cost throughout the term of the Management Agreement. In addition to the Management Agreement with PMG, Prospect, through one of its management company subsidiaries, has a management agreement with each Affiliate. The term of the Management Agreements is generally 30 years. PMG is the sole shareholder of PHS, PPCM, Genesis, PNW, PSC, UMG, and PVMG. New Genesis Medical Associates, Inc. ("NGMA") is controlled through a nominee shareholder arrangement like the Stock Option structure utilized for PMG and discussed above.

The Company's Affiliates and NGMA have entered into Management Agreements with PMS or PHCA, as applicable (each of which is a wholly-owned subsidiary of Prospect). Each Affiliate has agreed to pay a management fee to PMS or PHCA, as applicable. The fee is based in part on the costs to the management company and on a percentage of revenues the Affiliate receives (i) for the performance of medical services by the Affiliate's employees and independent contractor physicians and physician extenders, and (ii) for all other services performed by the Affiliates. The revenue from which this fee is determined includes medical capitation (except for NGMA which provides professional and ancillary services), all sums earned from participation in any risk pools and all fee-for-service revenue earned. The management fee also includes a fixed amount for marketing and public relations services. Except in the case of Nuestra and AMVI/Prospect, the Management Agreements had initial terms of 30 years, renewable for successive 10-year periods thereafter, unless terminated by either party for cause. Effective September 1, 2013, the Managements Agreements for the ProMed Entities were consolidated under one new Management Agreement with PHCA. Effective October, 1, 2013, the Management Agreements for the rest of the Affiliates, other than Nuestra and AMVI/Prospect, were consolidated under one new Management Agreement with PMS. Those two new Management Agreements with PHCA and PMS include initial five year terms and are renewable for successive five year periods thereafter. In the case of Nuestra, its Management Agreement had an initial 10 year term renewable for successive one year terms, subsequently amended in January 15, 2009 to an initial 20 year term renewable for two 10 year periods. In the case of AMVI/Prospect, the Management Agreement has a one year term with successive one year renewal terms. The management agreement for NGMA was effective October 1, 2012 with an initial term of 30 years, renewable for successive 10-year periods thereafter, unless terminated by either party for cause. In return for payment of the management fee, Prospect (through PMS and PHCA) has agreed to provide financial management, information systems, marketing, advertising, public relations, risk management, and administrative support, including for utilization review and quality of care. At its cost, Prospect has assumed the obligations for all facilities, medical and non-medical supplies, and employment of non-physician personnel of its affiliated medical clinics.

The management fee earned by Prospect fluctuates based on the profitability of each Affiliate. Prospect is allocated a 50% residual interest in any profits after the first 8% of the profits. The remaining balance is retained by the Affiliates.

The Management Agreements are not terminable by the Affiliates except in the case of gross negligence, fraud or other illegal acts of Prospect, or bankruptcy of the Company.

Further, Prospect's rights under the Management Agreements are unilaterally saleable or transferable. Based on the provisions of the Management Agreements and the assignable option agreement with PMG, Prospect has determined that it has a controlling financial interest in the Affiliates, with the exception of AMVI/Prospect. Consequently, under applicable accounting principles, Prospect consolidates the revenues and expenses of all the Affiliates except AMVI/Prospect from the respective dates of execution of the Management Agreements. All significant inter-entity balances have been eliminated in consolidation. In the case of AMVI/Prospect, only that portion of the results which are contractually identified as Prospect's are recognized in the consolidated financial statements, together with the

management fee that the Company charges AMVI for managing AMVI's share of the joint venture operations.

Prospect has also entered into management agreements with unaffiliated third parties to manage services to their HMO enrollees. These management agreements do not have characteristics that give rise to the consolidation of the entities under current accounting literature.

The affiliated physician organizations provided medical services to a combined total of approximately 258,900 and 264,600 HMO enrollees as of September 30, 2015 and 2014, respectively. The enrollees include approximately 63,700 and 87,000 enrollees that the Company manages for the economic benefit of certain independent third parties, and for which the Company earns management fee income as of September 30, 2015 and 2014, respectively. The total paid member months including managed enrollees, for the fiscal years ended September 30, 2015 and 2014 was approximately 3,067,200 and 2,785,000, respectively.

On December 19, 2013, NGMA, an Affiliate of the Company, purchased stock of Chaparral Medical Group, Inc. ("CMG"), a California medical corporation. Consideration was composed of $1,100,000 in cash at the closing, $700,000 in future cash consideration to be used for the acquired company's general corporate purposes, and 3,750 shares of Ivy Holdings common stock issued at closing to the selling shareholders. As of December 19, 2013, NGMA owned 13.44% of the stock of CMG. During June 2015, CMG repurchased shares from a physician shareholder, which increased NGMA's ownership to 13.57%. After payment of the entire consideration, including the future cash consideration, NGMA will own 18.39% of the stock of CMG. Pursuant to the terms of the stock purchase agreement, NGMA will have the right and option to make additional stock investments at the same share valuations and prices and upon the same applicable terms and conditions as the initially acquired shares, to bring its aggregate ownership up to 50%. CMG is a multi-specialty group serving communities primarily in the Los Angeles and San Bernardino counties. The Company accounts for NGMA's interest in CMG using the equity method as the Company has the ability to exercise significant influence over the operating and financial policies of CMG.

Global Risk Management Segment

The Global Risk Management segment commenced operations during the year ended September 30, 2015 and entered into global capitation arrangements with certain unrelated third-party health plans. The Global Risk Management segment also manages the provision of care for members in coordination with the Hospital and Medical Group segments.

Corporate Segment

The Corporate segment reflects certain expenses incurred at the Parent Entity not specifically allocable to the Hospital Services, Medical Group, or Global Risk Management segments. These include, but are not limited to: salaries, benefits and other compensation for corporate employees; financing expenses; insurance expenses; rent; legal fees; and accounting fees. The Company does not allocate interest expense related to acquisition debt or income taxes to the other reporting segments.

2. Significant Accounting Policies

Basis of Presentation

The consolidated financial statements have been prepared in accordance with accounting principles generally accepted in the United States of America ("GAAP") and include the accounts of all controlled subsidiaries, of which control is effectuated through ownership of voting common stock or by other means, but do not include the accounts of the parent companies, Ivy Holdings and Ivy Intermediate Holding Inc. The Medical Group segment Affiliates and NGMA have been determined to be variable interest entities due to the existence of a call option under which the Company has the ability to require the holders of all of the voting common stock of the underlying subsidiaries to sell their shares at a fixed nominal price ($1,000) to another designated physician chosen by the Company. This call option agreement represents rights provided through a variable interest other than the equity interest itself that limits the returns that could be earned by the equity holders. In addition, the Company has management agreements with the Affiliates and NGMA and the holders of the voting common stock which allows the Company to direct the activities of the Affiliates and NGMA that most significantly impact their economic performance, retain the right to receive expected residual returns and assume the obligation to absorb losses. Although the Company has disproportionately few voting rights (based on the terms of the equity), the Company is considered to be the primary beneficiary of the activities of the Affiliates and NGMA. As a result, the Affiliates and NGMA are consolidated within the accompanying consolidated financial statements.

Operating results for CMG, FRMC and LACH Bellflower, PCC and the CharterCARE Physicians medical practices acquisitions are consolidated with the Company's financial statements from their acquisition dates or inception date in the case of LACH Bellflower (December 19, 2013, May 6, 2014, June 20, 2014, and various dates during the year ended September 30, 2015, respectively) (see Note 4). All significant intercompany balances and transactions have been eliminated in consolidation.

Reclassifications

Certain reclassifications were made to the 2014 consolidated financial statements in order to conform to the 2015 presentation.

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Revenues

Revenues by reportable segment are comprised of the following amounts (in thousands):

For the Years Ended September 30,	2015 *(a)*	2014 *(b)*
Net Hospital Services		
Inpatient	$ 736,340	$ 440,961
Outpatient	195,692	96,802
Capitation	98,993	70,077
Other	16,492	11,969
Total Hospital Services revenues	1,047,517	619,809
Less: Provision for bad debts	(44,087)	(32,945)
Total net Hospital Services revenues less provision for bad debts	1,003,430	586,864
Medical Group		
Capitation	312,031	244,573
Management fees	7,814	6,586
Other	13,393	2,821
Total Medical Group revenues	333,238	253,980
Global Risk Management		
Capitation	3,440	-
Other revenues	5,436	13,672
Total net revenues	$ 1,345,544	$ 854,516

(a) The revenues of various medical practices acquired by CharterCARE Physicians have been included in the accompanying consolidated financial statements from their various dates of acquisition during the year ended September 30, 2015.

(b) CMG, Bellflower and FRMC, and PCC revenues have been included in the accompanying consolidated financial statements for the period from acquisition or inception date in the case of LACH Bellflower, December 19, 2013, May 6, 2014, and June 20, 2014, respectively, through September 30, 2014.

Hospital Services Segment

Net Patient Service Revenues

Operating revenue of the Hospital Services segment consists primarily of net patient service revenue. The Company reports net patient service revenue at the estimated net realizable amounts from patients and third-party payers and others in the period in which services are rendered. The Company has agreements with third-party payers, including Medicare, Medicaid (Medi-Cal in California), managed care and other insurance programs that are paid at negotiated rates. These payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges and per diem payments, as further described below. Estimates of contractual allowances are based upon the payment terms specified in the related contractual agreements. The Company accrues for amounts that it believes may ultimately be due to or from the third-party payers. Normal estimation differences between final settlements and amounts accrued in previous years are reported as changes in estimates

in the current year. Outstanding receivables, net of allowances for contractual discounts and bad debts, are included in patient accounts receivable in the accompanying consolidated balance sheets.

The following is a summary of sources of patient service revenues (net of contractual allowances and discounts) before provision for bad debts:

September 30,	2015	2014
Medicare	$ 321,282	$ 224,984
Medicaid	379,821	189,668
Managed Care	168,553	95,853
Self Pay/Other	62,376	27,258
Capitation	98,993	70,077
Total patient service revenue	$ 1,031,025	$ 607,840

A summary of the payment arrangements with major third-party payers follows:

Medicare: Medicare is a federal program that provides certain hospital and medical insurance benefits to persons aged 65 and over, some disabled persons with end-stage renal disease and certain other beneficiary categories. Inpatient services rendered to Medicare program beneficiaries are paid at prospectively determined rates per discharge, according to a patient classification system based on clinical, diagnostic, and other factors. Outpatient services are paid based on a blend of prospectively determined rates and cost-reimbursed methodologies. The Company is also reimbursed for various disproportionate share and Medicare bad debt components at tentative rates, with final settlement determined after submission of the annual Medicare cost report and audit thereof by the Medicare fiscal intermediary. Normal estimation differences between filed settlements and amounts accrued are reflected in net patient service revenue.

Cost report settlement estimates are recorded based upon as-filed cost reports and are adjusted for tentative settlements, if any, and when a final Notice of Program Reimbursement ("NPR") is issued. The latest updated SSI ratios for 2013 were issued on May 14, 2015. To date, the Company has received final NPRs for SCH Culver City (formerly named Brotman Medical Center, Inc.) through 2012 for cost report years prior to its merger into the Alta Hollywood Hospitals, Inc. subsidiary, SCH Hollywood through 2010, Alta Los Angeles Hospitals through 2011, Nix Health through 2012, and Elmhurst through 2014. No NPR has been issued for Roger Williams Medical Center or St. Joseph's Health Services of Rhode Island.

The Company joined a second round of litigation relating to Medicare's settlement with providers relating to the manner in which the Centers for Medicare and Medicaid Services ("CMS") handled the budget neutrality adjustment associated with the rural floor wage index in setting the Medicare inpatient prospective system rates ("Rural Floor"). The Company entered into a settlement agreement with CMS and, as a result, Alta Los Angeles Hospitals, SCH Culver City, and CharterCARE recognized a net benefit of $2,495,000, $1,230,000, and $1,672,000, respectively, during the year ended September 30, 2014 related to the Rural Floor litigation.

Medicaid: Medicaid is a joint federal-state funded healthcare benefit program that is administered by states to provide benefits to qualifying individuals who are unable to afford care. The Company receives reimbursements under the Medicaid program at prospectively determined rates for both inpatient and outpatient services. Medi-Cal is the version of the federal Medicaid program that is

applicable to California residents. Inpatient services rendered to Medi-Cal fee-for-service program beneficiaries in California are in the process of a three-year transition to payment at prospectively determined rates based on diagnosis related groups from a contracted per diem rate. Outpatient services are paid based on prospectively determined rates per procedure provided. Inpatient and outpatient services rendered to Medi-Cal managed care beneficiaries in California are paid at either contracted rates or at the Medi-Cal fee-for-service rates.

The SCHS and Alta Los Angeles Hospitals are eligible to participate in the State of California Medi-Cal Disproportionate Share ("DSH") programs, under which medical facilities that serve a disproportionate number of low-income patients receive additional reimbursements. Eligibility is determined annually based on prescribed guidelines. The Company accrues revenue based on the expected total annual DSH awards. Differences between the estimated and the actual awards are recorded in the period they become known. DSH amounts are subject to retrospective revision prior to finalization and such revisions could lead to material retractions. The Company records retrospective retractions when they are estimable and probable. Retrospective additional DSH revenues are recorded when the amounts are received. The Medi-Cal DSH receivable as of September 30, 2015 and 2014 totaled approximately $13,787,000 and $9,094,000, respectively, and were included in due from government payers in the accompanying consolidated balance sheets. For the fiscal years ended September 30, 2015 and 2014, total Medi-Cal DSH payments received by the SCHS and Alta Los Angeles Hospitals were approximately $15,690,000 and $16,325,000, respectively, and total Medi-Cal DSH revenues recorded were approximately $19,005,000 and $20,475,000, respectively. Additionally, pursuant to an audit of Medi-Cal cost reports and notification sent to the Company, the Company accrued a cost report liability payable to Medi-Cal of $1,743,000 and $1,803,000 as of September 30, 2015 and 2014, respectively.

Certain of the Company's California hospitals also participate in *the California Hospital Fee Program* (see Note 10).

In Texas, the Medicaid program reimburses under prospectively determined rates for inpatient services and based on costs for outpatient services. Medicaid reimbursement may be subject to periodic adjustment, as well as to changes in existing payment levels and rates, based on the amount of funding available to the Medicaid program. Nix Health has also been receiving payments from the Texas Health and Human Services Commission under the Section 1115 Waiver ("the waiver") that was recently granted to the state of Texas by CMS. Under the first year of the waiver ending September 30, 2012, a transition payment was paid to Nix Health based upon prior levels of payment under the "Upper Payment Limit" ("UPL") program, which the waiver replaced. Payments for years two through five under the waiver are based upon two pools. One pool is for payments for uncompensated care ("UCC") which includes the shortfall in Medicaid reimbursement as compared to cost and the cost of providing services to uninsured patients. The other pool is the Delivery System Reform Initiative Payments ("DSRIP"), where approved programs and services are undertaken to improve access and services provided. Programs are established by regions and approved by the Texas Health and Human Services Commission and CMS. These programs are assigned a value and milestones are established to measure success and the timing and level of payment from the DSRIP funds. Nix Health recorded revenue related to the UCC pool of $10,962,000 and $12,366,000 for the years ended September 30, 2015 and 2014, respectively. Revenue recorded related to the DSRIP pool was $11,356,000 and $9,801,000 for the years ended September 30, 2015 and 2014, respectively. At September 30, 2015 and 2014, amounts receivable under the Section 1115 Waiver totaled $23,615,000 and $23,145,000, respectively.

Nix Health also recorded $12,000,000 and $5,746,000 during the years ended September 30, 2015 and 2014, respectively, in costs for rural community provision of services. No amounts payable related to the provision of such services were included in the consolidated balance sheets as of September 30, 2015 and 2014.

The CharterCARE hospitals are participants in the State of Rhode Island's DSH program, which was established in 1995 to assist hospitals that provide a disproportionate amount of uncompensated care. Under the program, Rhode Island hospitals, including the CharterCARE hospitals, receive federal and state Medicaid funds as additional reimbursement for treating a disproportionate share of low income patients. The CharterCARE hospitals recognized revenue related to DSH and Upper Payment Limit ("UPL") reimbursement of $16,636,000 and $3,965,000 during the year ended September 30, 2015 and the period from June 20, 2014 (acquisition date) through September 30, 2014, respectively. DSH and UPL payments received were $16,135,000 and $3,932,000 during the year ended September 30, 2015 and the period from June 20, 2014 (acquisition date) through September 30, 2014, respectively. The State of Rhode Island also assesses a license fee to all hospitals in Rhode Island based on each hospital's net patient revenue. The CharterCARE hospitals recorded $15,058,000 and $4,036,000 of expense during the year ended September 30, 2015 and from June 20, 2014 through September 30, 2014 as a result of the license fee.

Managed Care: The Company has also entered into payment agreements with certain commercial insurance carriers, HMOs, and PPOs. The basis for payment under these agreements is in accordance with negotiated contracted rates or at the Company's standard charges for services provided. Some of these payments are capitated, meaning that the Company receives an agreed amount per patient for providing an agreed range of services.

Self-Pay: Self-pay patients represent those patients who do not have health insurance and are not covered by some other form of third party arrangement. Such patients are evaluated, at the time of services or shortly thereafter, for their ability to pay based upon federal and state poverty guidelines, qualifications for Medicaid, as well as the Company's local hospital's indigent and charity care policy.

See "Concentrations of Credit Risks" below for discussion of revenues received from the Medicare and Medicaid programs.

Effective August 29, 2014, CMS provided a simplified process and timely partial payment to settle certain previously denied claims with dates of service prior to October 1, 2013 whereby such claims under appeal that had been retracted by CMS were settled with the provider receiving 68% of the face value. As a result, the Company recorded $3,887,000 in revenue during the year ended September 30, 2014 related to claims which were previously subject to ongoing Recovery Audit Contractor ("RAC") audits and other similar programs. As of September 30, 2015 and 2014, the Company accrued $262,000 and none, respectively, in due to government payors in the accompanying consolidated balance sheets related to such programs.

SCH Culver City Outlier Liability

Following the acquisition of a majority stake in SCH Culver City, effective April 14, 2009, the Company consolidated SCH Culver City's estimated liability to CMS arising out of outlier payments received for services provided by the hospital to Medicare eligible inpatients, primarily for the last four months of calendar year 2005 and all of calendar year 2006.

While SCH Culver City (formerly Brotman Medical Center, Inc.) reports financial statements on a fiscal year ending September 30, Medicare cost reports are filed on a calendar year basis. Acute care hospitals receive Medicare reimbursement payments pursuant to a prospective payment methodology primarily based on the diagnosis of the patient, but are entitled to receive additional payments, referred to as "outliers" for patients whose treatment is very costly. When Brotman Medical Center, Inc. acquired the hospital in 2005, CMS provided a ratio of cost to charges (the "RCC") based on the statewide average. Payments received by SCH Culver City on this basis were an interim estimate, subject to final determination upon audit of SCH Culver City's cost reports. SCH Culver City filed its Medicare cost reports, but determined that its outlier reimbursement for services provided in fiscal years 2005, 2006 and part of 2007 might be subject to adjustment based on certain outlier reconciliation rules.

On October 12, 2012, SCH Culver City received from its Medicare fiscal intermediary a proposed outlier adjustment for Medicare fiscal year 2006 in the amount of $12,785,000. SCH Culver City had previously been notified of an adjustment of $2,149,000 for 2005. As of September 30, 2015 and 2014, the Company accrued $13,834,000 of the estimated $14,934,000 liability to CMS included in the accompanying consolidated balance sheets. The difference between the $14,934,000 asserted by CMS and the $13,834,000 accrued by the Company relates to accrued interest of approximately $1,100,000. The Company does not agree, however, with the outlier reconciliation liability. Accordingly, in accordance with relevant literature related to accounting for contingencies, the Company recorded the lower end of the range of the liability.

The Company has also filed an appeal of the outlier issue with the Provider Reimbursement Review Board for the 2006 cost reporting period since it received a notice of program reimbursement for the 2006 cost report. Mediation was held with CMS and the U.S. Department of Justice in March 2015 for settlement of fiscal years 2005 and 2006. The terms of a final settlement have been approved by CMS and the Health and Human Services Office of the General Counsel. As the Company is waiting for final approval of the settlement by the U.S. Department of Justice, the settlement has not been recognized in the accompanying consolidated financial statements.

The following is a summary of due from and due to governmental payers at September 30 (in thousands):

September 30,	2015	2014
Due from government payers:		
Medi-Cal Disproportionate Share (DSH)	$ 13,787	$ 9,094
Medicare cost report settlements	3,953	10,279
Medi-Cal cost report settlements	231	-
Medicaid Section 1115 receivable	23,615	23,145
	$ 41,586	$ 42,518
Due to government payers:		
Outlier liability	$ 13,834	$ 13,834
Medicare cost report settlements	11,501	10,947
Medi-Cal cost report settlements	1,743	1,803
	$ 27,078	$ 26,584

The Company is not aware of any material claims, disputes, or unsettled matters with any payers that would affect revenues that have not been adequately provided for and disclosed in the accompanying consolidated financial statements.

Charity Care

The Company provides charity care to patients whose income level is below 300% of the Federal Poverty Level. Patients at the Company's California facilities with income levels between 300% and 350% of the Federal Poverty Level qualify to pay a discounted rate under the requirements of California State Assembly Bill 774 (AB 774) based on various government program reimbursement levels. Patients without insurance are offered assistance in applying for Medicaid and other programs they may be eligible for, such as state disability. Patient advocates from the Company's Medical Eligibility Program ("MEP") screen patients in the Hospital and determine potential linkage to financial assistance programs. They also expedite the process of applying for these government programs. The approximate cost of providing charity care was $1,683,000 and $2,029,000 for the years ended September 30, 2015 and 2014, respectively. The Company has estimated the cost of charity care based on a ratio of the cost to charges, with cost consisting of operating expenses, excluding depreciation, interest and management fees.

Provisions for Contractual Allowances and Bad Debts

Collection of receivables from third-party payers and patients is the Company's primary source of cash and is critical to its operating performance. The Company closely monitors its historical collection rates, as well as changes in applicable laws, rules and regulations and contract terms, to assure that provisions for contractual allowances are made using the most accurate information available. However, due to the complexities involved in these estimations, actual payments from payers may be materially different from the amounts management estimates and records. The Company's primary collection risks relate to uninsured patients and the portion of the bill which is the patient's responsibility, primarily co-payments and deductibles. Payments for services may also be denied due to issues over patient eligibility for medical coverage, the Company's ability to demonstrate medical necessity for services rendered and payer authorization of hospitalization.

Accounts receivable are reduced by an allowance for doubtful accounts. Valuation of the collectability of accounts receivable and provision for bad debts is based on historical collection experience, payer mix and the age of the receivables. Management routinely reviews accounts receivable balances in conjunction with these factors and other economic conditions which might ultimately affect the collectability of the patient accounts, and makes adjustments to the Company's allowances as warranted. For receivables associated with services provided to patients who have third-party coverage, management analyzes contractually due amounts and subsequently calculates an allowance for doubtful accounts and provision for bad debts once the age of the accounts reaches a specific age category based on historical experience. For receivables associated with self-pay patients, management records a significant provision for bad debts beginning in the period services were provided based on past experience that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The allowance for doubtful accounts as a percent of gross accounts receivable decreased from 29% at September 30, 2014 to 27% at September 30, 2015. The allowance for doubtful accounts was $52,707,000 and $49,727,000 for the years ended September 30, 2015 and 2014, respectively. The decrease in the allowance for doubtful accounts as a percent of gross accounts receivable was due primarily to a reduction in self pay patient admissions and patient dates at the CharterCARE hospitals. As a result of the shift in payor mix, the allowance for doubtful accounts as a

percent of gross accounts receivable decreased from 31% at September 30, 2014 to 20% at September 30, 2015 at the CharterCARE hospitals.

Legislation

All of the Company's hospital facilities are subject to the Emergency Medical Treatment and Active Labor Act ("EMTALA"). This federal law requires any hospital that participates in the Medicare program to conduct an appropriate medical screening examination of every person who presents to the hospital's emergency department for treatment and, if the patient is suffering from an emergency medical condition, to either stabilize that condition or make an appropriate transfer of the patient to a facility that can handle the condition. The obligation to screen and stabilize emergency medical conditions exists regardless of a patient's ability to pay for treatment. There are severe penalties under EMTALA if a hospital fails to screen or appropriately stabilize or transfer a patient or if the hospital delays appropriate treatment in order to first inquire about the patient's ability to pay. Penalties for violations of EMTALA include civil monetary penalties and exclusion from participation in the Medicare program. In addition, an injured patient, the patient's family or a medical facility that suffers a financial loss as a direct result of another hospital's violation of the law can bring a civil suit against that other hospital. The Company believes that it is in compliance with EMTALA and is not aware of any pending or threatened EMTALA investigations involving allegations of potential wrongdoing that would have a material effect on the Company's consolidated financial statements.

See Note 10 regarding the *Affordable Care Act*.

Other Revenues

Other revenues consist primarily of the CMS Rural Floor settlement recognized during the year ended September 30, 2014, meaningful use incentive payments, rental revenue from operating leases, and tuition revenue and totaled $5,436,000 and $13,672,000 for the years ended September 30, 2015 and 2014, respectively.

A summary of other revenues recorded during the years follows:

Rural Floor settlement: Certain of the Company's subsidiaries entered into a settlement agreement with CMS and recognized $6,091,000 of revenue during the year ended September 30, 2014 related to the Rural Floor litigation.

Meaningful Use incentives: The American Recovery and Reinvestment Act of 2009 ("ARRA") established incentive payments under the Medicare and Medicaid programs for certain professionals and hospitals that meaningfully use certified electronic health record ("EHR") technology or adopt or implement such technology. The Medicare incentive payments will be paid out to qualifying hospitals over four consecutive years on a transitional schedule. To qualify for Medicare incentives, hospitals and physicians must meet EHR "meaningful use" criteria that become more stringent over three stages.

Medicaid programs and payment schedules vary from state to state. The Medicaid programs require hospitals to register for the program prior to 2016, to engage in efforts to adopt, implement or upgrade certified EHR technology in order to qualify for the initial year of participation, and to demonstrate meaningful use of certified EHR technology in order to qualify for payment for up to three additional years.

For the years ended September 30, 2015 and 2014, the Company recorded revenues of $1,150,000 and $4,683,000, respectively, related to the Medicare and Medicaid programs in the consolidated statements of income. These incentives have been recognized following the grant accounting model, recognizing income ratably over the applicable reporting period as management becomes reasonably assured of meeting the required criteria. Subsequent changes to these estimates will be recognized in the consolidated statement of operations in the period in which additional information is available. Such estimates are subject to audit by the federal government, the state, or its designee.

Rental Revenue: Rental revenue from operating leases is recorded based on the fixed, minimum required rents (base rents) per the lease agreements. Rental revenue from base rents is recorded on the straight-line method over the terms of the related lease agreements. During the years ended September 30, 2015 and 2014, the Company recorded rental revenues of $2,417,000 and $2,220,000, respectively.

Tuition Revenue: St. Joseph Health Services of Rhode Island operates the St. Joseph School of Nursing and recorded tuition revenue of $1,639,000 and $471,000 during the year ended September 30, 2015 and the period from June 20, 2014 (acquisition date) through September 30, 2014, respectively.

Medical Group Segment

Medical Group Revenues

Operating revenue of the Medical Group segment consists primarily of payments for medical services procured by the Affiliates under capitated contracts with various managed care providers including HMOs. Capitation revenue under HMO contracts is prepaid monthly to the Affiliates based on the number of enrollees electing any one of the Affiliates as their health care provider. See "Concentrations of Credit Risks" below for revenues received from the five largest contracted HMOs.

Capitation revenue (net of capitation withheld to fund risk share deficits discussed below) is recognized in the month in which the Affiliates are obligated to provide services. Minor ongoing adjustments to prior months' capitation, primarily arising from contracted HMOs' finalizing of monthly patient eligibility data for additions or subtractions of enrollees, are recognized in the month they are communicated to the Company. Additionally, Medicare pays capitation using a "Risk Adjustment model," which compensates managed care organizations and providers based on the health status (acuity) of each enrollee. Health plans and providers with higher acuity enrollees will receive more and those with healthier enrollees will receive less. Under Risk Adjustment, capitation is determined based on health severity, measured using patient encounter data. Capitation is paid on an interim basis based on data submitted for the enrollee for the preceding year and is adjusted in subsequent periods (generally in the Company's fourth quarter) after the final data is compiled. Positive or negative capitation adjustments are made for Medicare enrollees with conditions requiring more or less healthcare services than assumed in the interim payments. Since the Company cannot reliably predict these adjustments, periodic changes in capitation amounts earned as a result of Risk Adjustment are recognized generally in the fourth quarter when those changes are communicated by the health plans to the Company. The Company received and recorded as additional revenue, approximately $17,503,000 and $8,889,000, respectively, in positive capitation risk adjustments for the Medical Group segment during the years ended September 30, 2015 and 2014, respectively.

HMO contracts also include provisions to share in the risk for hospitalization, whereby the Affiliate can earn additional incentive revenue or incur penalties based upon the utilization of hospital services. Typically, any shared risk deficits are not payable until and unless the Company generates future risk

sharing surpluses, or if the HMO withholds a portion of the capitation revenue to fund any risk share deficits. At the termination of the HMO contract, any accumulated risk share deficit is typically extinguished. Due to the lack of access to information necessary to estimate the related costs, shared-risk amounts receivable from the HMOs are only recorded when such amounts are known. Risk pools for the prior contract years are generally final settled in the third or fourth quarter of the following fiscal year. For the years ended September 30, 2015 and 2014, Medical Group revenues included approximately $8,402,000 and $2,406,000, respectively, of additional revenues due to favorable settlements on prior year risk-sharing arrangements. At September 30, 2015 and 2014, contingent liabilities for carry-forward risk-pool deficits expected to be forgiven, or offset against future surpluses were approximately $6,422,000 and $5,547,000, respectively, based on the available information from the health plans.

The Company also receives incentives under "pay-for-performance" programs for quality medical care based on various criteria. These incentives, which are included in other revenues within Medical Group revenues, are generally recorded in the third and fourth quarters of the fiscal year when such amounts are known. During the year ended September 30, 2015, the Company recognized $9,059,000 related to a shared savings incentive program with one health plan. Pay-for-performance revenues recorded during the years ended September 30, 2015 and 2014 were $11,387,000 and $1,886,000, respectively.

Management fee revenue is earned in the month the services are rendered. Management fee arrangements with unaffiliated entities provide for compensation ranging from 6.5% to 12% of revenues. Management fee revenues recorded during the years ended September 30, 2015 and 2014 were $7,814,000 and $6,586,000, respectively.

Medical Group Cost of Revenues

The cost of health care services consists primarily of capitation and claims payments, pharmacy costs and incentive payments to contracted providers. These costs are recognized in the period incurred, or when the services are provided. Claims costs also include an estimate of the cost of services which have been incurred but not yet reported to the Company. The estimate for accrued medical costs is based on projections of costs using historical studies of claims paid and adjusted for seasonality, utilization and cost trends. These estimates are subject to trends in loss severity and frequency. Although considerable variability is inherent in such estimates, management records its best estimate of the amount of medical claims incurred at each reporting period. Estimates are continually monitored and reviewed and, as settlements are made or estimates adjusted, differences are reflected in current operations. See Note 12 for changes in claims estimates during the years ended September 30, 2015 and 2014.

In addition to contractual reimbursements to providers, the Company also makes discretionary incentive payments to physicians, which are in large part based on the pay-for-performance and shared risk revenues and favorable senior capitation risk adjustment payments received by the Company. Since the Company records these revenues generally in the third or fourth quarter of each fiscal year when the incentives and capitation adjustments due from the health plans are known, the Company also finalizes the discretionary physician bonuses in the same periods. During the years ended September 30, 2015 and 2014, the Company recorded discretionary physician incentives expense totaling approximately $14,082,000 and $5,067,000, respectively. As of September 30, 2015 and 2014, physician bonus accruals of approximately $9,021,000 and $4,339,000, respectively, were included in accounts payable and other accrued liabilities.

The Company also periodically evaluates the need to establish premium deficiency reserves for the probability that anticipated future health care costs could exceed future capitation payments from HMOs under capitated contracts and, where appropriate, records a premium deficiency reserve.

The Company, for certain matters, maintains stop loss coverage for health care costs that are in excess of set thresholds.

Global Risk Management Segment

Global Risk Management Revenues

Operating revenue of the Global Risk Management segment consists primarily of payments for medical services procured under global capitation arrangements from third-party health plans. Capitation revenue under these global capitation contracts is prepaid monthly to the Global Risk Management segment based on the number of enrollees. Entities within the Global Risk Management segment entered into Management Services Agreements with our Hospital and Medical Group segments, under which 98% of capitation revenue received is transferred to these segments.

Similar to the Medical Group segment, capitation revenue is recognized in the month in which the Global Risk Management segment is obligated to provide services. Minor ongoing adjustments to prior months' capitation, primarily arising from contracted HMOs' finalizing of monthly patient eligibility data for additions or subtractions of enrollees, are recognized in the month they are communicated to the Company. Additionally, Medicare pays capitation using a "Risk Adjustment model," which compensates managed care organizations and providers based on the health status (acuity) of each enrollee. Health plans and providers with higher acuity enrollees will receive more and those with healthier enrollees will receive less. Under Risk Adjustment, capitation is determined based on health severity, measured using patient encounter data. Capitation is paid on an interim basis based on data submitted for the enrollee for the preceding year and is adjusted in subsequent periods (generally in the Company's fourth quarter) after the final data is compiled. Positive or negative capitation adjustments are made for Medicare enrollees with conditions requiring more or less healthcare services than assumed in the interim payments. Since the Company cannot reliably predict these adjustments, periodic changes in capitation amounts earned as a result of Risk Adjustment are recognized generally in the fourth quarter when those changes are communicated by the health plans to the Company. The Global Risk Management Segment did not have any capitation risk adjustments for the year ended September 30, 2015 as it was the segment's first year of operations.

Global Risk Management Cost of Revenues

The cost of health care services consists primarily of the transfer of capitation revenue to the Hospital and Medical Group segments under the Management Services Agreements, and capitation and claims payments. These costs are recognized in the period incurred, or when the services are provided. Claims costs also include an estimate of the cost of services which have been incurred but not yet reported to the Company. The estimate for accrued medical costs is based on projections of costs using historical studies of claims paid and adjusted for seasonality, utilization and cost trends. These estimates are subject to trends in loss severity and frequency. Although considerable variability is inherent in such estimates, management records its best estimate of the amount of medical claims incurred at each reporting period. Estimates are continually monitored and reviewed and, as settlements are made or estimates adjusted, differences are reflected in current operations.

The Company also periodically evaluates the need to establish premium deficiency reserves for the probability that anticipated future health care costs could exceed future capitation payments from HMOs under capitated contracts and, where appropriate, records a premium deficiency reserve.

The Company, for certain matters, maintains stop loss coverage for health care costs that are in excess of set thresholds.

Property, Improvements and Equipment

Property, improvements and equipment are stated on the basis of cost or, in the case of acquisitions, at their acquisition date fair values. Depreciation is provided using the straight-line method over the estimated useful lives of the assets, and amortization of leasehold improvements is provided using the straight-line basis over the shorter of the remaining lease period or the estimated useful lives of the leasehold improvements. Leasehold improvements are generally depreciated over five to ten years, buildings are depreciated over five to 28 years, equipment is depreciated over two to five years and furniture and fixtures are depreciated over two to seven years. Equipment capitalized under capital lease obligations are amortized over the lesser of the life of the lease or the useful life of the asset.

As more fully described in Note 10, the Company is required to comply with certain seismic standards as required by the state of California by January 1, 2020. The useful life of buildings subject to seismic retrofit requirements may be limited if the Company does not make the necessary upgrades by the required compliance date.

Goodwill and Other Intangible Assets

Goodwill totaled $162,296,000 and $158,864,000 at September 30, 2015 and 2014, respectively, and arose as a result of the ProMed, Alta, SCH Culver City, Nix Health (including Nix CGH), and Prospect CharterCARE Physicians medical practices acquisitions. Goodwill represents the excess of the consideration paid and liabilities assumed over the fair value of the net assets acquired, including identifiable intangible assets.

Goodwill is not amortized; rather it is reviewed annually for impairment for each reporting unit, or more frequently if impairment indicators arise. Impairment is the condition that exists when the carrying amount of goodwill exceeds its implied fair value. A two-step impairment test is used to identify potential goodwill impairment and to measure the amount of goodwill impairment loss to be recognized, if any. The Company has five reporting units with goodwill, consisting of the Alta Hospitals (which include SCH Hollywood, SCH Van Nuys, Los Angeles Community Hospital, and Norwalk Community Hospital), SCH Culver City, Nix Health, the MSOs and Medical Groups located in California ("California Medical Groups"), and CharterCARE. The California Medical Groups represent a change in reporting units during the year ended September 30, 2015; see Note 5.

The Company tests for goodwill impairment as of September 30 each year. In evaluating whether indicators of impairment exist, the Company considers adverse changes in market value, laws and regulations, profitability, cash flows, ability to maintain enrollment and renew payer contracts at favorable terms, among other factors. The goodwill impairment test is a two-step process. The first step consists of estimating the fair value of the reporting unit based on a weighted combination of (i) the guideline company method that utilizes revenue or earnings multiples for comparable publicly-traded companies, and (ii) a discounted cash flow model that utilizes expected future cash flows, the timing of those cash flows, and a discount rate (or weighted average cost of capital, which considers the cost of equity and cost of debt financing expected by a typical market participant) representing the time value

of money and the inherent risk and uncertainty of the future cash flows. If the estimated fair value of the reporting unit is less than its carrying value, a second step is performed to compute the amount of the impairment by determining the "implied fair value" of the goodwill, which is compared to its corresponding carrying value. The Company's impairment test related to goodwill during the years ended September 30, 2015 and 2014, resulted in no impairment charge.

Long-Lived Assets and Amortizable Intangibles

Amortizable intangible assets totaled $29,162,000 and $35,274,000, net of accumulated amortization at September 30, 2015 and 2014, respectively, and arose as a result of the ProMed, Alta, SCH Culver City, Nix Health, NGMA, PCC, and CharterCARE Physicians medical practices acquisitions. Intangible assets include customer relationships, trade names, favorable leasehold, and physician guarantees. The Company reviews long-lived assets for impairment whenever events or changes in circumstances indicate that the carrying value of such assets may not be recoverable. The Company considers assets to be impaired and writes them down to fair value if estimated undiscounted cash flows associated with those assets are less than their carrying amounts. Fair value is based upon the present value of the associated cash flows. Changes in circumstances (for example, changes in laws or regulations, technological advances or changes in strategies) may also reduce the useful lives from initial estimates. Changes in planned use of intangibles may result from changes in customer base, contractual agreements, or regulatory requirements. In such circumstances, management will revise the useful life of the long-lived asset and amortize the remaining net book value over the adjusted remaining useful life. There were no impairments recorded during the years ended September 30, 2015 and 2014.

Medical Malpractice Liability Insurance

The individual physicians who contract with the Affiliates carry their own medical malpractice insurance. In the Hospital Services segment, the Company's hospitals carry professional and general liability insurance to cover medical malpractice claims under claims-made policies. Under the policies, insurance premiums cover only those claims actually reported during the policy term. Should the claims-made policy not be renewed or replaced with equivalent insurance, claims related to occurrences during the policy term but reported subsequent to the policy's termination may be uninsured. Effective October 1, 2013, the Company's hospitals renewed the professional and general liability insurance under one consolidated policy with separate retentions for each entity. LACH Bellflower, FRMC, and CharterCARE were included under the consolidated policy from their respective dates of acquisition or inception (LACH Bellflower).

GAAP requires that a health care organization record and disclose the estimated costs of medical malpractice claims in the period of the incident of malpractice, if it is reasonably possible that liabilities may be incurred and losses can be reasonably estimated. The Company has recognized an estimated liability for incurred but not reported claims and the self-insured risks (including deductibles and potential claims in excess of policy limits) based upon an actuarial valuation of the Company's historical claims experience of the Company's hospitals. At September 30, 2015 and 2014, the total gross claims liability was $6,632,000 and $4,590,000 and insurance receivables were $1,406,000 and $618,000, respectively, and were estimated using a discount factor of 4%.

The claims reserve is based on the best data available to the Company. The estimate, however, is subject to a significant degree of inherent variability. The estimate is continually monitored and reviewed, and as the reserve is adjusted, the difference is reflected in current operations. While the ultimate amount of medical malpractice liability is dependent on future developments, management is of the opinion that the associated liabilities recognized in the accompanying consolidated financial

statements are adequate to cover such claims. Management is not aware of any potential medical malpractice claims whose settlement, if any, would have a material adverse effect on the Company's consolidated financial position, results of operations or cash flows.

Workers' Compensation Insurance

The workers' compensation coverage provides the statutory benefits required by law with a $250,000 deductible policy with limits of $1,000,000 per occurrence and aggregate for the hospitals located in California. Nix Health has opted out of the Texas Workers' Compensation system as a non-subscriber, and provides its employees with benefits for occupational injury or disease through an ERISA plan. Nix Health has an Employer's Excess Indemnity policy with a $25,000 deductible policy with limits of $10,000,000 per occurrence and $25,000,000 aggregate. CharterCARE was fully insured for workers' compensation claims with no deductible from June 20, 2014 through September 30, 2015. At September 30, 2015 and 2014, included in accrued salaries, wages and benefits are accruals for uninsured claims and claims incurred but not reported of approximately $8,766,000 and $7,210,000, respectively. The amounts are estimated based upon an actuarial valuation of their claims experience, using a discount factor of 4%.

The claims reserve is based on the best data available to the Company. The estimate, however, is subject to a significant degree of inherent variability. The estimate is monitored and reviewed, and as the reserve is adjusted, the difference is reflected in current operations. While the ultimate amount of the claims liability is dependent on future developments, management is of the opinion that the associated liabilities recognized in the accompanying consolidated financial statements are adequate to cover such claims. Management is not aware of any potential claims whose settlement, if any, would have a material adverse effect on the Company's consolidated financial position, results of operations or cash flows.

Asset Retirement Obligations

The Company recognizes the fair value of a liability for legal obligations associated with asset retirements in the period in which it is incurred, if a reasonable estimate of the fair value of the obligation can be made. Over time, the liability is accreted to its present value each period. Upon settlement of the obligation, any difference between the cost to settle the asset retirement obligation and the liability recorded is recognized as a gain or loss in the statement of operations. The Company has accrued $4,583,000 and $4,310,000 in other long-term liabilities related to asset retirement obligations for the CharterCARE hospitals as of September 30, 2015 and 2014, respectively.

Stock Options

On December 15, 2010, the Board of Directors (the "Ivy Board") of Ivy Holdings adopted the 2010 Stock Option Plan of Ivy Holdings Inc. (the "Ivy Plan") and, on December 16, 2010, the stockholders of Ivy Holdings adopted the Ivy Plan. The Ivy Plan provides that it shall be administered by the Compensation Committee of the Ivy Board. The Ivy Plan includes an Incentive Stock Option Agreement and a Non-Qualified Stock Option Agreement to be used in connection with the grant of options under the Ivy Plan. These options granted under the Ivy Plan are exercisable into Ivy Holdings stock and vest based on a number of criteria.

On June 30, 2015, the Board of Directors of Ivy Holdings adopted the First Amendment to the Ivy Plan and concurrently, on June 30, 2015, the stockholders of Ivy Holdings approved the First Amendment to the Ivy Plan (the "Amended Ivy Plan"). Pursuant to the Amended Ivy Plan, the Board of Directors

authorized the issuance of options exercisable for an additional 13,972 shares of common stock of Ivy Holdings to employees, certain consultants and independent members of the boards of directors of Ivy Holdings and its subsidiaries (including the Company and its subsidiaries). These options granted under the Amended Ivy Plan are exercisable into Ivy Holdings stock and vest based on a number of criteria, including the same criteria as options granted under the Ivy Plan as well as the occurrence of certain corporate transactions, including a change in control of Ivy Holdings, as defined in the Incentive Stock Option Agreements; see Note 9.

Compensation costs for option awards are measured and recognized in the consolidated financial statements based on their grant date fair value, net of estimated forfeitures over the awards' service period. Options subject to variable accounting treatment are subject to revaluation at the end of each reporting period. The Company uses the Black-Scholes option pricing model and a single option award approach to estimate the fair value of stock options granted. The fair value of restricted stock grants are determined on the date of grant, based on the number of shares granted and the quoted price or estimated fair market value of the Company's common stock. Equity-based compensation is classified within the same line items as cash compensation paid to employees. Compensation costs related to stock options that vest or are exercisable when certain corporate transactions occur, including a change in control, are recognized at the time that such an event occurs.

Cash and Cash Equivalents

The Company considers all highly liquid debt instruments with initial maturities of 90 days or less to be cash equivalents. Cash and cash equivalents are primarily comprised of deposits with banks. The Company maintains its cash at banks with high credit-quality ratings.

Restricted Cash

At September 30, 2015 and 2014, $2,000,000 was restricted to meet certain regulatory requirements for PHP. Prospect contributed $2,000,000 of restricted cash to PHP, which is not a guarantor of Prospect's long-term debt, in order for PHP to maintain compliance with tangible net equity requirements (see Note 10). $1,277,000 and $1,993,000 was restricted for research at CharterCARE hospitals as of September 30, 2015 and 2014, respectively. An additional $1,308,000 and $983,000 was restricted for various other purposes including workers' compensation insurance arrangements and various letters of credit as of September 30, 2015 and 2014, respectively.

Restricted Investments

The Company is required to keep restricted deposits by certain HMOs for the payment of claims. Such restricted deposits are classified as a current asset in the accompanying consolidated balance sheets, as they are restricted for payment of current liabilities. Investments also include certificates of deposit with maturity dates of more than 90 days when purchased.

Inventories

Inventories of supplies are valued at the lower of amounts that approximate the weighted average cost or market. Inventories consist primarily of medical and surgical supplies and pharmaceuticals.

Deferred Financing Costs

Deferred financing costs are amortized over the period in which the related debt is outstanding using the effective interest method.

Deferred financing costs at September 30, 2015 and 2014 are as follows (in thousands):

	2015			2014		
	Gross Book Value	Accumulated Amortization	Net Book Value	Gross Book Value	Accumulated Amortization	Net Book Value
Deferred financing costs	$14,398	$7,165	$7,233	$14,398	$4,941	$9,457

Income Taxes

Deferred income tax assets and liabilities are recognized for differences between financial and income tax reporting bases of assets and liabilities based on enacted tax rates and laws. To the extent a deferred tax asset cannot be recognized under the preceding criteria, allowances must be established. The impact on deferred taxes of changes in tax rates and laws, if any, are applied to the years during which temporary differences are expected to be settled and reflected in the financial statements in the period of enactment. The Company recognizes interest and penalties associated with income tax matters and unrecognized tax benefits in the income tax expense line item of the statements of operations. For the years ended September 30, 2015 and 2014, no interest and/or penalties related to incomes taxes were accrued and/or expensed.

An entity is required to evaluate its tax positions using a two-step process. First, the entity should evaluate the position for recognition. An entity should recognize the financial statement benefit of a tax position if it determines that it is more likely than not that the position will be sustained on examination. Next, the entity should measure the amount of benefit that should be recognized for those tax positions that meet the more-likely-than-not test.

Consolidated federal tax returns are filed, with the exception of PMG and NGMA, which file their own federal tax returns. The Company files separate state tax returns for California, Texas, and Rhode Island. The Company's filed tax returns are generally subject to examination by the IRS and state tax boards for 3 to 4 years.

Fair Value of Financial Instruments

Financial instruments consist primarily of cash and cash equivalents, restricted cash investments, patient and other accounts receivables, accrued salaries and benefits, accounts payable and accrued expenses, medical claims and related liabilities, amounts due to government agencies, notes receivable and payable, capital lease obligations, debt, and other liabilities. The carrying amounts of current assets and liabilities approximate their fair value due to the relatively short period of time between the origination of the instruments and their expected realization.

Fair Value Measurement

Relevant accounting guidance establishes a framework for measuring fair value and clarifies that fair value is an exit price, representing the amount that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants.

The guidance requires disclosure about how fair value is determined for assets and liabilities and establishes a hierarchy for which these assets and liabilities must be grouped, based on significant levels of inputs as follows: Level 1 quoted prices in active markets for identical assets or liabilities; Level 2 quoted prices in active markets for similar assets and liabilities and inputs that are observable for the asset or liability; or Level 3 unobservable inputs for the asset or liability, such as discounted cash flow models or valuations. The determination of where assets and liabilities fall within this hierarchy is based upon the lowest level of input that is significant to the fair value measurement.

The Company's Level 1 assets include cash and cash equivalents and investments (certificates of deposit and money market mutual funds). The inputs for fair value of goodwill and intangible assets (including long lived assets and intangible assets subject to amortization) would be based on Level 3 inputs as data used for such fair value calculations would be based on discounted cash flows that are not observable from the market, directly or indirectly.

Financial Items Measured at Fair Value on a Recurring Basis

The following table sets forth the Company's financial assets and liabilities measured at fair value on a recurring basis and where they are classified within the hierarchy (in thousands):

	Total	Level 1	Level 2	Level 3
As of September 30, 2015				
Certificates of deposit and money market mutual funds	$ 1,266	$ 1,266	$ -	$ -
As of September 30, 2014				
Certificates of deposit and money market mutual funds	$ 642	$ 642	$ -	$ -

The Company's investments are classified within Level 1 of the fair value hierarchy because they are valued using quoted market prices.

Nonfinancial Items Measured at Fair Value on a Nonrecurring Basis

Nonfinancial assets such as goodwill and identifiable intangible assets are measured at fair value when there is an indicator of impairment and recorded at fair value only when impairment is recognized. The Company performs an annual impairment test on the goodwill, and performs an impairment test on the intangibles when there are indications of impairment.

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Significant increases or decreases in the Company's weighted average cost of capital may result in a significantly lower or higher fair value measurement, respectively. Significant increases or decreases in the revenue growth rate and royalty rates in isolation may result in a significantly higher or lower fair value measurement, respectively. The fair values of the Company's current financial liabilities approximate their reported carrying amounts. The carrying values and the fair values of non-current financial liabilities that qualify as financial instruments under the guidance are as follows (in thousands):

	2015		2014	
September 30,	Carrying Amount	Fair Value	Carrying Amount	Fair Value
Liabilities:				
Long-term debt	$ 422,835	$ 445,269	$ 421,888	$ 457,620

The fair value of the Company's long-term debt was determined based on market prices.

Concentrations of Credit Risk

Cash and cash equivalents are maintained at financial institutions and, at times, balances may exceed federally insured limits of $250,000 per depositor of each financial institution. The Company has not experienced any losses to date related to these balances.

Financial instruments that potentially subject the Company to concentrations of credit risk consist of receivables due from Medicare, Medicaid (Medi-Cal in California), patients, and health plans including shared-risk arrangements.

The Company invests excess cash in liquid securities at institutions with strong credit ratings, following established guidelines relative to diversification and maturities to maintain safety and liquidity. These guidelines are periodically reviewed and modified to take into consideration trends in yields and interest rates and principal risk. Management attempts to schedule the maturities of the Company's investments to coincide with the Company's expected cash requirements. Credit risk with respect to receivables is limited since amounts are generally due from large HMOs within the Medical Group Management segment and from the Medicare and Medicaid (Medi-Cal in California) programs within the Hospital Services segment. Management reviews the financial condition of these institutions on a periodic basis and does not believe the concentration of cash or receivables results in a high level of risk.

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For the years ended September 30, 2015 and 2014, the Hospital Services segment received a total of 67% of its net patient revenues from Medicare and Medicaid programs, and the Medical Group segment received a total of 59% and 58%, respectively, of their capitation revenues from its five largest HMOs, as follows (in thousands):

Years Ended September 30,	2015	% of Total Revenue	2014	% of Total Revenue
Hospital Services:				
Government Payers:				
Medicare	$ 321,282	31%	$ 224,984	36%
Medicaid	379,821	36%	189,668	31%
Total	$ 701,103	67%	$ 414,652	67%
Medical Group:				
HMO A	$ 39,759	13%	$ 12,721	5%
HMO B	38,934	12%	33,784	14%
HMO C	37,900	12%	31,632	13%
HMO D	34,806	11%	31,481	13%
HMO E	32,239	11%	31,283	13%
Total	$ 183,638	59%	$ 140,901	58%

The Global Risk Management segment received 100% of their revenues from four health plans during the year ended September 30, 2015.

Use of Estimates

The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets, liabilities, revenues and expenses, and the disclosure of contingent assets and liabilities at the dates, and for the periods, that the consolidated financial statements are prepared. Actual results could materially differ from those estimates. Principal areas requiring the use of estimates include third party settlements, settlements under risk sharing programs, allowances for contractual discounts and doubtful accounts, accruals for medical claims, impairment of goodwill, long-lived assets and intangible assets, share-based payments, professional and general liability claims and workers' compensation claims, reserves for outcome of legislation and valuation allowances against deferred tax assets.

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New Accounting Pronouncements

In July 2013, the Financial Accounting Standards Board ("FASB") issued an Accounting Standards Update ("ASU") that requires an unrecognized tax benefit or portion of an unrecognized tax benefit to be presented as a reduction to a deferred tax asset for a net operating loss carryforward, a similar tax loss, or a tax credit carryforward except when certain conditions exist. The amendment is effective for the Company for fiscal years beginning after December 15, 2014, including interim periods in 2014. The Company is currently evaluating the effect of this guidance on its consolidated results of operations and consolidated financial position.

In May 2014, the FASB issued ASU No. 2014-09, "Revenue from Contracts with Customers (ASU 2014-09)," as amended by ASU 2015-14. The core principle of ASU 2014-09 is built on the contract between a vendor and a customer for the provision of goods and services, and attempts to depict the exchange of rights and obligations between the parties in the pattern of revenue recognition based on the consideration to which the vendor is entitled. To accomplish this objective, the standard requires five basic steps: (i) identify the contract with the customer, (ii) identify the performance obligations in the contract, (iii) determine the transaction price, (iv) allocate the transaction price to the performance obligations in the contract, (v) recognize revenue when (or as) the entity satisfies a performance obligation. Nonpublic entities will apply the new standard for annual periods beginning after December 15, 2018, including interim periods therein. Three basic transition methods are available – full retrospective, retrospective with certain practical expedients, and a cumulative effect approach. Under the third alternative, an entity would apply the new revenue standard only to contracts that are incomplete under legacy U.S. GAAP at the date of initial application (e.g. January 1, 2019) and recognize the cumulative effect of the new standard as an adjustment to the opening balance of retained earnings. That is, prior years would not be restated and additional disclosures would be required to enable users of the financial statements to understand the impact of adopting the new standard in the current year compared to prior years that are presented under legacy U.S. GAAP. Early adoption is permitted for fiscal years beginning after December 15, 2016. The Company is currently evaluating the effect of this guidance on its consolidated financial statements.

In August 2014, the FASB issued ASU No. 2014-15, "Presentation of Financial Statements - Going Concern: Disclosures of Uncertainties about an Entity's Ability to Continue as a Going Concern." This ASU provides guidance about management's responsibility to evaluate whether there is substantial doubt about an entity's ability to continue as a going concern and to provide related footnote disclosures. Specifically, this ASU provides a definition of the term substantial doubt and requires an assessment for a period of one year after the date that the financial statements are issued (or available to be issued). It also requires certain disclosures when substantial doubt is alleviated as a result of consideration of management's plans and requires an express statement and other disclosures when substantial doubt is not alleviated. The new standard will be effective for reporting periods beginning after December 15, 2016, with early adoption permitted. The Company will apply the provisions of this standard upon adoption.

In April 2015, the FASB issued ASU No. 2015-03, "Simplifying the Presentation of Debt Issuance Costs." This ASU amends existing guidance to require the presentation of debt issuance cost on the balance sheet as a deduction from the carrying amount of the related debt, instead of an asset. This ASU is effective for reporting periods beginning after December 15, 2015 and early adoption is permitted. The Company is currently evaluating the effect of this guidance on its consolidated financial statements.

In November 2015, the FASB issued ASU No. 2015-17, "Income Taxes (Topic 740), Balance Sheet Presentation of Deferred Tax Assets and Liabilities". This ASU amends existing guidance by simplifying the presentation of deferred income taxes on a net basis as non-current deferred tax assets or liabilities. ASU No. 2015-17 did not modify the requirement that deferred tax assets and liabilities of a tax-paying component of an entity be offset and presented as a single amount. This ASU is effective for reporting reports beginning after December 15, 2017 with earlier adoption permitted.

The Company elected early adoption of ASU No. 2015-17 effective October 1, 2013. The previous requirement to separate deferred income tax assets and liabilities into current and non-current amounts was not beneficial to the users of the consolidated financial statements as classification did not necessarily align with the time period in which the recognized deferred tax amounts were expected to be recovered or settled.

The following table discloses the impact of the adoption of ASU No. 2015-17 on the amounts previously reported in the consolidated balance sheet (in thousands):

Balance Sheet as of September 30, 2014	As Previously Reported	Impact of ASU No. 2015-17	As Reported
Deferred income taxes, net (current asset)	$ 68,304	$ (68,304)	$ -
Total current assets	$ 320,014	$ (68,304)	$ 251,710
Deferred income taxes, net (long-term asset)	$ -	$ 1,165	$ 1,165
Total assets	$ 761,317	$ (67,139)	$ 694,178
Deferred income taxes, net (long-term liability)	$ 70,447	$ (67,139)	$ 3,308
Total liabilities	$ 762,523	$ (67,139)	$ 695,384
Total liabilities and stockholder's equity	$ 761,317	$ (67,139)	$ 694,178

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3. Property, Improvements and Equipment

Property, improvements and equipment, consisted of the following (in thousands):

September 30,	2015	2014
Property, improvements and equipment:		
Land and land improvements	$ 53,416	$ 53,381
Buildings and improvements	136,137	119,163
Leasehold improvements	20,344	22,967
Equipment	107,785	87,249
Furniture and fixtures	6,891	7,187
	324,573	289,947
Less: accumulated depreciation	(84,236)	(60,473)
Property, improvements and equipment, net	$ 240,337	$ 229,474

Effective May 6, 2014, Prospect acquired the property, improvements, and equipment of Bellflower Medical Center, located in Bellflower, California, for cash consideration of $20 million. The assets, including land and building, were named Los Angeles Community Hospital at Bellflower. Bellflower Medical Center was closed in 2013 by its previous owner and was not operational when the Company purchased the related assets. The Company accounted for this transaction as an acquisition of assets. The primary factors influencing the determination that the acquisition should be accounted for in this manner included the complete closure of the hospital, the fact that there were no inputs and/or processes acquired, the requirement for significant additional capital expenditures and development efforts to reopen the hospital, and the lack of acquired workforce. Accordingly, the Company determined that this transaction lacked the key characteristics for business combination accounting. In addition to the $20 million purchase price, Prospect capitalized $546,000 of transaction costs directly related to the purchase of these assets. The purchase price and transaction costs were allocated to the assets acquired based on the relative fair value of the acquired assets.

At September 30, 2015 and 2014, the Company had assets under capitalized leases of approximately $20,299,000 and $19,294,000, respectively, and related accumulated depreciation of $14,356,000 and $11,465,000, respectively.

Depreciation expense was approximately $27,692,000 and $18,386,000 for the years ended September 30, 2015 and 2014, respectively.

4. Acquisitions

CharterCARE Physicians Medical Practices

During the year ended September 30, 2015, CharterCARE Physicians entered into asset purchase agreements to acquire 11 medical practices with primary care physicians as well as physicians with specialties in general surgery, bariatric surgery and urology. Total cash consideration for the medical practices was $3,865,000, with cash consideration for each practice ranging from $9,000 to $2,100,000.

The acquisitions of the medical practices were accounted for as a business combination using purchase accounting. Under the purchase accounting method, assets acquired and liabilities assumed are recorded based on their estimated fair values.

The following table summarizes the assets acquired and liabilities assumed in connection with the CharterCARE Physician medical practices acquisitions (in thousands):

	Purchase Price Allocation (Preliminary)
Inventory	$ 8
Improvements and equipment	328
Intangible assets	97
Goodwill	3,432
Net cash consideration	$ 3,865

As asset purchases, the goodwill and intangible assets acquired are deductible for tax purposes.

University Medical Group

Effective December 18, 2014, New University Medical Group ("New UNMG"), a wholly-owned subsidiary of RWMC, entered into an Asset Purchase Agreement, pursuant to which New UNMG will acquire substantially all of the assets of University Medical Group ("UNMG"), a physician medical practice with approximately 35 primary care and specialist physicians with various specialties. As consideration for the acquisition, New UNMG will assume certain liabilities of UNMG.

As of December 18, 2014, New UNMG acquired certain assets of the practice and assumed certain liabilities related to the administrative functions of UNMG ("Initial Close"). At a later date, New UNMG will acquire certain additional assets and assume certain additional liabilities ("Second Close"). Concurrent with the Initial Close, UNMG and New UNMG entered into an Interim Administrative Services Agreement, which is effective until the Second Close occurs. New UNMG also entered into the First Amendment to the Interim Administrative Services Agreement effective December 18, 2014. In addition, Prospect, RWMC and CharterCARE Physicians have receivables from various transactions of $4,345,000 due from UNMG as of September 30, 2015, which are included in other assets in the accompanying consolidated balance sheet.

Because Second Close had not occurred as of September 30, 2015, the acquisition of UNMG is not reported in the accompanying consolidated financial statements. As a result of the Asset Purchase Agreement, Interim Administrative Services Agreement (as amended), and various transactions, New UNMG has the obligation to absorb certain losses of UNMG and the right to receive certain benefits from UNMG. However, New UNMG does not have the power to direct the activities of UNMG which most significantly impact its performance based on the terms of the Interim Administrative Services Agreement (as amended) and the governance of UNMG. As a result, New UNMG is not the primary beneficiary of UNMG, and the results of UNMG are not consolidated in the accompanying consolidated financial statements.

Newport Specialty Hospital

Effective May 6, 2014, Prospect acquired substantially all of the assets of Newport Specialty Hospital (subsequently renamed Foothill Regional Medical Center) for cash consideration of $15 million. Newport Specialty Hospital, located in Tustin, California was substantially closed prior to acquisition, operating only its pediatric subacute unit as of the acquisition date.

The acquisition of Newport Specialty Hospital was accounted for as a business combination using purchase accounting. This transaction resulted in a bargain gain of $523,000, which is included in other income in the accompanying consolidated statements of income. The Company incurred $556,000 of transaction costs during the year ended September 30, 2014, which are included in General and Administrative expenses in the accompanying consolidated statements of income.

The following table summarizes the assets acquired and liabilities assumed in connection with the Newport Specialty Hospital acquisition, as of May 6, 2014 (in thousands):

	Purchase Price Allocation
Property, improvements and equipment	$ 15,523
Bargain purchase gain	(523)
Net cash consideration	$ 15,000

CharterCARE

Effective June 20, 2014, Prospect, through its newly formed subsidiary, PCC, acquired substantially all of the assets of CharterCARE Health Partners and its subsidiaries in exchange for a 15% interest in PCC, $43.3 million in cash and a commitment to invest at least $50 million in PCC and its subsidiaries for strategic business development and capital improvements over the next four years. As a result of the acquisition, PCC is owned 85% by Prospect and 15% by CharterCARE Health Partners (which was subsequently renamed CharterCARE Community Board).

PCC, through its subsidiaries, operates Roger Williams Medical Center, St. Joseph Health Services of Rhode Island, and Elmhurst Extended Care Facilities, Inc., which operate hospitals, medical centers and assisted living facilities located in Rhode Island with approximately 785 licensed beds.

The acquisition was accounted for as a business combination using purchase accounting. This transaction resulted in a bargain gain of $4,294,000 during the year ended September 30, 2014. Subsequent to September 30, 2014, PCC received $2,125,000 for a working capital adjustment, which is reflected in prepaid expenses and other current assets resulting in an increase in net assets acquired by Prospect and the non-controlling interest. The gain on bargain purchase was reduced by $319,000 during the year ended September 30, 2015, which is the non-controlling interest's 15% interest in the working capital adjustment. The gain on bargain purchase recognized during the years ended September 30, 2015 and 2014 are included in adjustment to (gain on) bargain purchase in the accompanying consolidated statements of income.

The following table summarizes the assets acquired and liabilities assumed in connection with the PCC acquisition, as of June 20, 2014 (in thousands):

	Purchase Price Allocation (Preliminary)	Purchase Price Allocation (Final)
Restricted cash	$ 1,739	$ 1,739
Patient accounts receivable and other receivables	34,264	34,264
Prepaid expenses and other current assets	8,777	10,902
Property, improvements and equipment	53,642	53,642
Intangible assets	8,590	8,590
Other long-term assets	4,698	4,698
Accounts payable and other liabilities	(44,656)	(44,656)
Capital leases	(1,315)	(1,315)
Long-term debt	(25)	(25)
Other long-term liabilities	(4,645)	(4,645)
Net assets acquired	61,069	63,194
Less: amount attributable to non-controlling interest	(9,160)	(9,479)
Net assets acquired by Prospect	51,909	53,715
Total purchase consideration	47,615	49,740
Bargain purchase gain	$ 4,294	$ 3,975

The change in prepaid expenses and other current assets from the preliminary to the final purchase price allocation was due to the working capital adjustment of $2,125,000. The total purchase consideration of $49,740,000 includes net cash consideration of $43,300,000 plus a long-term liability of $6,440,000, which represents the discounted fair value of the non-controlling interest's 15% interest in the $50 million future commitment of the Company to PCC as part of the Purchase Agreement.

During the year ended September 30, 2015, the Company partially satisfied its $50 million future commitment by contributing $9,637,000 to PCC, of which $1,446,000, or 15%, was attributed to the non-controlling interest in PCC. The Company incurred $2,145,000 of transaction costs during the year ended September 30, 2014, which are included in General and Administrative expenses in the accompanying consolidated statements of income.

5. Goodwill and Intangible Assets

As of September 30, 2015 and 2014, goodwill and intangible assets relate to the ProMed, Alta, SCH Culver City, Nix Health, NGMA, Nix CGH, CharterCARE Physicians medical practices acquisitions. The Company performed its annual goodwill impairment analysis for each reporting unit that constitutes a business for which 1) discrete financial information is produced and reviewed by management, and 2) services that are distinct from the other reporting units.

During the year ended September 30, 2015, the Company reorganized its reporting structure for the Medical Group segment due to changes in financial information produced and reviewed by management and the convergence of the economic characteristics of the MSOs and Medical Groups located in

California. Prior to the reorganization of the reporting structure, the Medical Group segment was comprised of two reporting units: PHCA and the ProMed Entities (collectively referred to as the "ProMed IPAs") as well as PMS and the other affiliated physician organizations, including NGMA (collectively, "Prospect IPAs"). As a result of the reorganization of reporting structure, the MSOs and Medical Groups located in California comprise a single reporting unit (collectively, "California Medical Groups").

For the Hospital Services segment, the reporting unit for the annual goodwill impairment analysis has been determined to be at the business unit level. Reporting units consist of Alta Hospitals, SCH Culver City, Nix Health, and CharterCARE.

The carrying value of goodwill by reporting unit is as follows (in thousands):

September 30,	2015	2014
Alta Hospitals	$ 106,539	$ 106,539
SCH Culver City	24,373	24,373
Nix Health	5,613	5,613
CharterCARE	3,432	-
California Medical Groups	22,339	22,339
	$ 162,296	$ 158,864

The following is a roll-forward of goodwill from October 1, 2013 to September 30, 2015 (in thousands):

	Amount
Balance, October 1, 2013	$ 158,864
Balance, September 30, 2014	158,864
Acquisition of CharterCARE Physicians medical practices (see Note 4)	3,432
Balance, September 30, 2015	$ 162,296

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Identifiable intangible assets are comprised of the following (in thousands):

	September 30, 2015						
	Alta	SCH Culver City	Nix Health	Charter CARE *(1)*	Prospect	Promed	Total
HMO membership	$ -	$ -	$ -	$ -	$ -	$ 25,200	$ 25,200
Trade names, net of impairment	10,310	1,320	2,740	8,590	-	9,450	32,410
Favorable leasehold	-	-	20	-	-	-	20
Physician guarantees	-	-	1,530	-	-	-	1,530
Customer relationships	-	-	-	-	350	-	350
Other	-	-	-	97	-	-	97
Gross carrying value	10,310	1,320	4,290	8,687	350	34,650	59,607
Accumulated amortization	(4,361)	(880)	(2,964)	(2,200)	(150)	(19,890)	(30,445)
Intangible assets, net	$ 5,949	$ 440	$ 1,326	$ 6,487	$ 200	$ 14,760	$ 29,162

(1) CharterCARE includes intangible assets related to the acquisitions of CharterCARE effective June 20, 2014 and various CharterCARE Physicians acquisitions effective on various dates during the year ended September 30, 2015 (see Note 4).

	September 30, 2014						
	Alta	SCH Culver City	Nix Health	Charter CARE	Prospect	Promed	Total
HMO membership	$ -	$ -	$ -	$ -	$ -	$ 25,200	$ 25,200
Trade names, net of impairment	10,310	1,320	2,740	8,590	-	9,450	32,410
Favorable leasehold	-	-	20	-	-	-	20
Physician guarantees	-	-	1,596	-	-	-	1,596
Customer relationships	-	-	-	-	350	-	350
Gross carrying value	10,310	1,320	4,356	8,590	350	34,650	59,576
Accumulated amortization	(3,670)	(440)	(2,171)	(482)	(100)	(17,439)	(24,302)
Intangible assets, net	$ 6,640	$ 880	$ 2,185	$ 8,108	$ 250	$ 17,211	$ 35,274

During the years ended September 30, 2015 and 2014, intangibles related to physician guarantees of $539,000 and $487,000, respectively, were fully amortized and removed from intangible assets.

Amortization is recognized on a straight-line basis (management's best estimate of the period of economic benefit) over the respective useful lives and expense for the years ended September 30, 2015 and 2014 was $6,682,000 and $5,194,000, respectively.

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Estimated amortization expense for each future fiscal year is as follows (in thousands):

Years ended September 30,	
2016	$ 6,312
2017	5,155
2018	4,635
2019	4,099
2020	2,813
Thereafter	6,148
Total	$ 29,162

The following table shows the estimated useful lives for each of the intangible assets:

	Estimated useful lives
HMO membership	14 years
Trade names	3 - 20 years
Favorable leasehold	6 years
Physician guarantees	2 to 3 years
Customer relationships	7 years
Other	5 years

The weighted-average remaining useful life for the intangible assets was 6.4 years as of September 30, 2015.

6. Related Party Transactions

Jeereddi Prasad, M.D., a shareholder of Ivy Holdings, a director of Ivy Holdings and the Company, and an officer of the ProMed Entities, has ownership interests in physician medical groups that provide medical services to ProMed members, including CMG. For the years ended September 30, 2015 and 2014, the ProMed Entities paid these groups approximately $18,170,000 and $12,677,000, respectively. As of September 30, 2015 and 2014, the Company had accounts payable and other accrued liabilities due to these related parties of $531,000 and none, respectively.

Pursuant to a Management Services Agreement, dated December 15, 2010 and amended on May 3, 2012 (the "LGP Management Agreement"), between the Company and Leonard Green & Partners, L.P. ("LGP"), a private equity fund with affiliated funds that collectively constitute the majority shareholder of Ivy Holdings, LGP provides to the Company, (a) certain investment banking services, (b) management, consulting and financial planning services and (c) financial advisory and investment banking services in connection with major financial transactions from time to time. In consideration for the services provided by LGP under the LGP Management Agreement, the Company pays LGP an annual fee of $1,000,000, payable in monthly installments, and reimburses LGP for its related expenses up to $50,000 annually. If approved by the unanimous consent of the Board of Directors of the Company, additional customary fees may be due to LGP pursuant to the terms of the LGP Management Agreement for services rendered in connection with major transactions from time to time. No amounts were payable related to these related party transactions as of September 30, 2015 or 2014.

The Company is a wholly-owned indirect subsidiary of Ivy Holdings. Therefore, Ivy Holdings is the parent of an affiliated group of corporations within the meaning of Section 1504(a) of the Internal Revenue Code of 1986. On December 15, 2010, Ivy Holdings, Ivy Intermediate and the Company entered into a Tax Sharing Agreement. The Tax Sharing Agreement allows the Company to make payments to Ivy Holdings as necessary to fund their payment of any required taxes incurred due to such parent status. During the years ended September 30, 2015 and 2014, the Company made payments under this arrangement of $24,977,000 and $5,703,000, respectively.

7. Income Taxes

The components of the income tax provision are as follows (in thousands):

For the years ended September 30,	2015	2014
Current:		
Federal	$ 35,445	$ 14,430
State	9,709	4,242
	45,154	18,672
Deferred:		
Federal	(12,957)	(4,529)
State	(1,051)	(3,582)
	(14,008)	(8,111)
Total:		
Federal	22,488	9,901
State	8,658	660
	$ 31,146	$ 10,561

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Temporary differences and carry forward items that result in deferred income tax balances as of September 30, are as follows (in thousands):

September 30,	2015	2014
Deferred tax assets:		
State tax benefit	$ 2,306	$ 2,593
Allowances for bad debts	7,889	5,119
Vacation accrual and other	4,800	5,440
Workers compensation	3,991	2,656
Accrued bonuses	4,837	3,898
Malpractice reserves	2,546	1,952
Deferred rent	139	107
Enterprise zone tax credit	1,261	2,433
Net operating losses	302	8,789
Partnership outside basis difference	8,323	-
Capital loss carryforward	-	2,274
Other	157	359
Deferred tax assets	36,551	35,620
Valuation allowance	(984)	(10,737)
Net deferred tax assets	35,567	24,883
Deferred tax liabilities:		
Intangible assets	(6,448)	(7,247)
Fixed assets	(17,035)	(17,664)
Deferred compensation	-	(112)
Partnership outside basis difference	-	(1,982)
Prepaid expenses	-	(21)
Other	(219)	-
Deferred tax liabilities	(23,702)	(27,026)
Net deferred tax assets (liabilities)	$ 11,865	$ (2,143)

Deferred tax assets and liabilities reflect the effect of temporary differences between the assets and liabilities recognized for financial reporting purposes and the amounts recognized for income tax purposes.

As of September 30, 2014, the Company had a valuation allowance of $10,737,000 related to deferred tax assets. Certain deferred tax assets, including carryforwards of net operating losses and capital losses, were written off due to the inability to use certain carryovers as a result of IRC 382 limitations, as well as due to the carry over expiration during the year ended September 30, 2015. However, such removal had no impact on the income tax provision because of the corresponding impact of the change in the valuation allowance. As of September 30, 2015, the Company maintains a valuation allowance of $984,000 on a certain portion of the California Enterprise credit and net operating losses of non-consolidated and separately filed entities for federal and state purposes, as it is more likely than not that the deferred tax asset will not be realized.

As of September 30, 2015, the Company has $1,261,000 of California Enterprise Zone credit carryforwards which can be carried over indefinitely. The Company has approximately $483,000 and $1,506,000 of net operating loss carryforwards for federal and California which expire through September 30, 2036 and September 30, 2026, respectively.

The Company is currently undergoing an IRS examination for fiscal year 2012. Additionally, the Company received a notice of review from the Franchise Tax Board of California for refunds claimed on its California returns reflecting additional Enterprise tax credits.

Generally, the Company's tax years 2011 through 2014 are open for state tax examination. As of September 30, 2015, the Company does not have material unrecognized tax benefits. The Company believes that it is reasonably possible that an increase in unrecognized tax benefits may be necessary within the coming year, and these unrecognized tax benefits would primarily impact deferred taxes and taxes payable, and the expected range of potential increase in the unrecognized tax benefits is not expected to be material to the balance sheet nor the income statement.
The FASB issued ASU No. 2015-17, which requires entities to offset deferred tax assets and liabilities for each tax paying jurisdiction within each tax paying component. The deferred taxes must be reported as non-current. The Company elected early adoption of the ASU (see Note 2 under New Accounting Pronouncements).

The differences between the income tax provision at the federal statutory rate and that reflected in the accompanying consolidated statements of operations are summarized as follows:

For the years ended September 30,	**2015**	2014
Tax provision at statutory rate	**35%**	35 %
State taxes, net of federal benefit	**7%**	6 %
Enterprise zone tax credits	**0%**	(7)%
Other	**6%**	2 %
	48%	36 %

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8. Long-Term Debt

Long-term debt consists of the following (in thousands):

September 30,	2015	2014
Prospect's debt:		
Senior secured notes		
2019 Notes	$ 325,000	$ 325,000
Less: discount, net	(4,950)	(6,339)
	320,050	318,661
Additional 2019 Notes	100,000	100,000
Plus: premium, net	1,110	1,419
	101,110	101,419
	421,160	420,080
Nix Health's debt:		
Mortgage debt	1,675	1,801
Other debt:	-	7
Total Debt:	422,835	421,888
Less: current maturities	(135)	(133)
Long-term debt, net of current maturities	$ 422,700	$ 421,755

Prospect's Debt:

Senior Secured Notes

On May 3, 2012, the Company closed the offering of $325 million in 8.375% senior secured notes due May 1, 2019 ("PMH 2019 Notes"). Interest is payable semi-annually in arrears on May 1 and November 1, commencing on November 1, 2012. The offering was executed in accordance with Rule 144A and Regulation S under the Securities Act of 1933. The terms of the PMH 2019 Notes are governed by an indenture among the Company, certain of its subsidiaries and affiliates (as "Guarantors"), and U.S. Bank National Association (as trustee) (the "Indenture"). The Indenture contains certain covenants that, among other things, limit the Company's ability, and the ability of its restricted subsidiaries (as such term is defined in the Indenture) to: retire and pay dividends or distributions on capital stock or equity interests, prepay subordinated indebtedness or make other restricted payments; incur additional debt; make investments; create liens on assets; enter into transactions with affiliates; engage in other businesses; sell or issue capital stock of restricted subsidiaries; merge or consolidate with another company; transfer and sell assets; create dividend and other payment restrictions affecting subsidiaries; and designate unrestricted subsidiaries. The Credit Agreement (defined below), executed in connection with the PMH Senior Secured Credit Facility (discussed below), contains a number of customary covenants as well as covenants requiring the Company to maintain a maximum consolidated secured leverage ratio and limiting the amount of capital expenditures.

Concurrent with the issuance of the PMH 2019 Notes, the Company entered into a five year $50 million revolving senior secured credit facility (the "PMH Senior Secured Credit Facility") which replaced the existing senior secured credit facility. The PMH Senior Secured Credit Facility provides, among other things, for borrowings up to the amount of the facility with sublimits of up to (i) $20 million to be available for the issuance of letters of credit and (ii) $10 million to be available for swingline loans. The commitment under the facility may be increased by up to $10 million upon the Company's request at the discretion of the lenders and subject to certain customary requirements. The interest rate per annum applicable to loans under the PMH Senior Secured Credit Facility will be, at the Company's option, either a rate per annum equal to (i) LIBOR plus 3.50% or (ii) an alternate base rate, which will be the higher of the administrative agent's prime rate, the federal funds rate plus 0.50%, and the 1-month LIBOR rate plus 1.00%, plus in each case, 2.50%. In August 2013, the PMH Senior Secured Credit Facility limit was increased to $60 million. As of September 30, 2015 and 2014, the Company had $20 million outstanding debt related to the PMH Senior Secured Credit Facility. As of September 30, 2015, the interest rate for the PMH Senior Secured Credit Facility was 3.95%.

The PMH 2019 Notes and the PMH Senior Secured Credit Facility are jointly and severally guaranteed on a senior secured basis by all of the Company's subsidiaries (as such term is defined in the Indenture) other than AMVI/Prospect Medical Group, Nuestra, PHP and certain immaterial subsidiaries. The PMH 2019 Notes are secured pari passu with the PMH Senior Secured Credit Facility by first-priority Liens and security interests on substantially all of the tangible and intangible assets of the Guarantors, including, but not limited to, the accounts receivable, inventories, other personal property, real property, fixtures and equipment, in each case now owned or hereafter acquired by the Company and the Subsidiary Guarantors, with certain exceptions. The PMH 2019 Notes are effectively senior to all of the Guarantors' existing and future Indebtedness.

The terms of the PMH Senior Secured Credit Facility are governed by the Credit Agreement, dated as of May 3, 2012, (as amended in connection with the Company's November 2012 offering of additional PMH 2019 Notes - see below) among the Company, Morgan Stanley Senior Funding, Inc. (as administrative agent), Royal Bank of Canada and Credit Suisse AG, Cayman Islands Branch (as co-syndication agents) and the lenders party thereto (the "Credit Agreement").

The Company, at its option, may redeem all or part of the notes at a redemption price equal to 106.281%, 104.188%, 102.094% and 100.0% on or after May 1, 2015, 2016, 2017 and 2018, respectively. Prior to May 1, 2015, the Company, at its option, may (i) redeem up to 35% of the original principal amount of the notes with the proceeds of certain equity offerings at a redemption price of 108.375% (ii) redeem up to 10% of the original principal amount of the PMH 2019 Notes during each 12-month period, commencing on May 1 in each of 2012, 2013 and 2014, at a redemption price of 103.0% of the principal amount thereof (this redemption option was terminated in connection with the Company's November 2012 offering of additional PMH 2019 Notes) or (iii) redeem the PMH 2019 Notes, in whole, but not in part, at a redemption price of 100.0% of the aggregate principal plus a make-whole premium. There are no required principal payments on the PMH 2019 Notes until maturity.

On November 16, 2012, the Company closed the offering of $100 million in aggregate principal amount of 8.375% senior secured notes due 2019 (the "Additional 2019 Notes") at a price equal to 102% of the principal amount of the Additional 2019 Notes. The Additional 2019 Notes were issued in a private placement to qualified institutional buyers and form a part of the same series as the PMH 2019 Notes issued on May 3, 2012.

The Additional 2019 Notes were issued under the Indenture, dated May 3, 2012 and described above, as supplemented by two supplemental indentures entered into in connection with the issuance of the

Additional 2019 Notes (the "Supplemental Indentures"). The Additional 2019 Notes are treated as a single series with the previously issued PMH 2019 Notes for all purposes under the Indenture, including, without limitation, restrictive covenants, waivers, amendments, redemptions and offers to purchase. Prior to closing the issuance of the Additional 2019 Notes, the Company was required to obtain the consent of the majority in interest of its PMH 2019 Notes issued on May 3, 2012 to certain amendments to the Indenture contained in the first Supplemental Indenture. The Company obtained such consent from the holders of approximately $324 million in aggregate principal amount of outstanding PMH 2019 Notes and paid an aggregate consent fee of approximately $8.9 million. The Company determined that the transaction represents a debt modification under the applicable accounting guidance and capitalized the consent fee and recorded it as a debt discount during the year ended September 30, 2013, which is being amortized over the term of the Additional 2019 Notes using the effective interest method.

In connection with the issuance of the Additional 2019 Notes, the Company entered into an amendment of its Credit Agreement governing the PMH Senior Secured Credit Facility that waived and amended certain provisions of the Credit Agreement, including certain restrictive covenants.

As of September 30, 2015 and 2014, the Company was in compliance with the financial covenants of the Indenture and Credit Agreement.

Demand Notes

During the year ended September 30, 2012, the Company obtained a commitment from a bank for a $9.3 million equipment leasing facility to finance various equipment at the Company's hospital facilities. During January 2014, the commitment was increased to $15.0 million. As of September 30, 2015 and 2014, $11.5 million and $10.7 million, respectively, were drawn under the facility and are classified as capital lease arrangements. Draws represent demand notes until conversion to capital leases, and interest accrues on such draws at the bank prime rate plus 1.5% with a floor of 4.5% and payable monthly.

Nix Health's Debt:

Mortgage Debt

In connection with the Nix Health acquisition, Nix SPE, LLC ("Nix SPE") executed a Loan Assumption Agreement, effective as of February 29, 2012, pursuant to which Nix SPE assumed the obligations of the sellers of Nix Health under a mortgage loan facility provided by The Ohio National Life Insurance Company on December 27, 1999. Nix SPE assumed the obligation to pay the outstanding principal amount of the mortgage loan and interest accruing thereafter. The outstanding balance of the mortgage loan as of September 30, 2015 and 2014 was $1,675,000 and $1,801,000, respectively.

Prospect Hospital Holdings, LLC, the parent company of Nix SPE, has provided a guaranty of the obligations of Nix SPE under the loan. The obligations under the loan facility are secured by a deed of trust on a neighborhood medical center known as Nix Alamo Heights. The loan is subject to a 7.0% interest rate and requires monthly installment payments of $21,000, with a balloon payment on the maturity date of November 1, 2019. Prepayment is subject to a fee and the loan contains customary covenants.

Note Payable

Nix Health entered into a note payable during September 2012 due in March of 2014 for $141,000. Interest accrued on this note at 8.96% and was payable monthly. The note payable was repaid during the year ended September 30, 2014.

Scheduled payments under the Company's current and long-term debt as of September 30, 2015 are as follows (in thousands):

Years ending September 30,	
2016	$ 135
2017	145
2018	155
2019	421,326
2020	1,074
	$ 422,835

9. Stockholder's Equity (Deficit)

Equity Based Compensation Plans

Effective December 15, 2010, the Board of Directors of Ivy Holdings adopted the Ivy Plan that authorized the issuance of options exercisable for up to 155,110 shares of the common stock of Ivy Holdings ("Initial Options") to employees, certain consultants and independent members of the boards of directors, of Ivy Holdings and its subsidiaries (including the Company and its subsidiaries). During the years ended September 30, 2015 and 2014, the Compensation Committee of the Board of Directors of Ivy Holdings ("Compensation Committee") granted 37,814 and 4,113 options, respectively, to certain members of the Company's management and employees. These options are exercisable into Ivy Holdings stock and vest based on a number of criteria, including time, Company and Business Unit performance based on EBITDA targets and CEO and Compensation Committee discretion. Since the Ivy Holdings stock options were granted to Company employees for their services related to the Company, the related compensation cost has been recorded in the Company's consolidated financial statements.

Effective June 30, 2015, the Board of Directors of Ivy Holdings adopted the First Amendment to the Ivy Plan, pursuant to which the Board of Directors authorized the issuance of options exercisable for an additional 13,972 shares of common stock of Ivy Holdings ("New Options") to employees, certain consultants and independent members of the boards of directors of Ivy Holdings and its subsidiaries (including the Company and its subsidiaries). Concurrently, the Compensation Committee granted 13,972 options to certain members of the Company's management and employees. The New Options are exercisable into Ivy Holdings stock and vest based on a number of criteria, including the same criteria as the Initial Options however, they only become exercisable on the occurrence of certain corporate transactions, including a change in control of Ivy Holdings, as defined in the Incentive Stock Option Agreements ("Corporate Transaction"). Because the occurrence and timing of a Corporate Transaction is not determinable as of September 30, 2015, no compensation cost has been recorded in the Company's consolidated financial statements.

Under the terms of the Ivy Plan, the exercise price of an incentive stock option ("ISO") may not be less than 100% of the fair market value of the Company's common stock on the date of grant and, if granted

to a shareholder owning more than 10% of the Company's common stock, then not less than 110%. Stock options granted under the Ivy Plan have a maximum term of 10 years from the grant date, and are exercisable at such time and upon such terms and conditions as determined by the Compensation Committee. Stock options granted to employees generally vest over four years, subject to continued service, performance, and other criteria. In the case of an ISO, the amount of the aggregate fair market value of common stock with respect to which the ISO grant is exercisable, for the first time by an employee during any calendar year, may not exceed $100,000.

Stock Options Activity

The following table summarizes information about Ivy Holdings stock options outstanding as of September 30, 2015 and 2014 and activity during the years then ended for the Initial Options and the New Options:

	Shares Subject to Options	Weighted Average Exercise Price	Weighted Average Aggregate Intrinsic Value	Weighted Average Remaining Contractual Term (Months)
Outstanding as of September 30, 2013 *(1)*	118,277	$ 43.44	$ 76.56	95.8
Granted	4,113	120.00	–	–
Exercised	–	–	–	–
Canceled/Forfeited	(6,915)	58.71	–	–
Outstanding as of September 30, 2014	115,475	45.37	74.63	84.1
Granted *(2)*	51,786	176.00	–	–
Exercised	(12,620)	31.38	–	–
Canceled/Forfeited	(3,808)	46.24	–	–
Outstanding as of September 30, 2015	150,833	$ 91.42	$ 436.51	88.2

(1) The number of options at September 30, 2013 includes 100,611 options modified in connection with the Repricing (see below).
(2) The options granted include 37,814 Initial Options and 13,972 New Options.

The aggregate intrinsic value is calculated as the difference between the exercise price of the underlying awards and the estimated fair value of the Company's common stock for those awards that have an exercise price currently below the estimated fair value. As of September 30, 2015, the aggregate intrinsic value of outstanding shares was approximately $60,000,000. As of September 30, 2015, there were 106,078 options that are exercisable at a weighted average exercise price of $55.08.

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A summary of Ivy Holdings non-vested options and the changes during the fiscal years ended September 30, 2015 and 2014 is presented as follows for the Initial Options and New Options:

	Shares	Weighted Average Grant Date Fair Value
Ivy Holdings Stock Options:		
Nonvested at September 30, 2013 *(3)*	43,192	$ 86.99
Granted	4,113	63.81
Vested	(28,797)	92.00
Canceled/Forfeited	(4,871)	85.15
Nonvested at September 30, 2014	13,637	70.47
Granted	51,786	72.03
Vested	(19,267)	73.60
Canceled/Forfeited	(1,401)	88.08
Nonvested at September 30, 2015	44,755	$ 70.38

(3) The number of non-vested options at September 30, 2013 includes 29,930 options modified in connection with the repricing (see below).

On April 5, 2013, the Compensation Committee approved the repricing of the exercise price of all outstanding stock options as of that date. Pursuant to such resolution of the Ivy Holdings Compensation Committee, as of the effective date, all of the previously granted options were exchanged for new options with a lower exercise price granted on a one-for-one basis. As a result of this repricing, the Company repriced 49,380 vested options and 59,748 unvested options from an original exercise price of $100.00 per share to a new exercise price of $30.00 per share. Other than the exercise price, all other terms of the repriced options, such as vesting and contractual life, remained the same. The Company has accounted for the repricing as a modification and recorded any net incremental fair value related to vested awards as compensation expense on the date of modification. In addition, the Company is recording the incremental fair value related to the unvested awards, together with unamortized stock-based compensation expense associated with the unvested awards, over the remaining requisite service period of the option holders. In connection with the repriced options, the Company recorded stock compensation expense of $1,454,000 on the date of the modification. Incremental compensation cost resulting from the modification was $113,000 and $1,097,000 during the years ended September 30, 2015 and 2014, respectively.

The original fair value of the options granted ranged from $50.73 to $98.65 per option. In connection with the repricing, the stock compensation expense related to the stock options granted prior to April 5, 2013 is calculated based on a fair value of $97.75. The fair value was determined using the Black-Scholes option pricing model.

Fair value of the repriced options was estimated with the following assumptions for Ivy Holdings:

For the year ended September 30,	2013
Weighted average fair value of repriced options	$97.75
Estimated fair market value of the Company's common stock on the date of grant	$120.00
Weighted average expected life of the options	8.2 years
Risk-free interest rate	1.7%
Weighted average expected volatility	45.9%
Dividend yield	0.0%

Stock-Based Compensation Expense

Stock-based compensation expense for all share-based payments in exchange for employee services (including stock options and restricted stock) is measured at fair value on the date of grant, estimated using an option pricing model and is recognized in the consolidated financial statements, net of estimated forfeitures over the awards requisite service period.

The Company uses the Black-Scholes option pricing model and a single option award approach to estimate the fair value of options granted. Estimated forfeitures will be revised in future periods if actual forfeitures differ from the estimates and will impact compensation cost in the period in which the change in estimate occurs. The determination of fair value using the Black-Scholes option-pricing model is affected by the Company's estimated stock price as well as assumptions regarding a number of complex and subjective variables, including expected stock price volatility, risk-free interest rate, expected dividends and projected employee stock option exercise behaviors.

Fair value for options granted during the years ended September 30, 2015 and 2014 was estimated with the following assumptions for Ivy Holdings:

For the years ended September 30,	2015	2014
Weighted average fair value of option grants	$ 98.65	$ 63.81
Estimated fair market value of the Company's common stock on the date of grant	$ 176.00	$ 120.00
Weighted average expected life of the options	9.8 years	8.0 years
Risk-free interest rate	1.8%	2.7%
Weighted average expected volatility	45.0%	45.0%
Dividend yield	0.00%	0.00%

Expected Term - The expected term of options granted represents the period of time that they are estimated to be outstanding.

Risk-Free Interest Rate - The Company bases the risk-free interest rate on the implied yield in effect at the time of option grant on U.S. Treasury zero-coupon issues with equivalent remaining terms.

Expected Volatility - The Company estimates the volatility of the common stock at the date of grant based on the average of the historical volatilities of a group of peer companies. The Company has identified a group of comparable companies to calculate historical volatility from publicly available data for sequential periods approximately equal to the expected terms of the option grants. In

selecting comparable companies, Management considered several factors including industry, stage of development, size and market capitalization.

Forfeitures—Share-based compensation is recognized only for those awards that are ultimately expected to vest. Compensation expense is recorded net of estimated forfeitures. Those estimates are revised in subsequent periods if actual forfeitures differ from those estimates. The Company used data since December 2010 to estimate pre-vesting option forfeitures.

Stock-based compensation expense for the Ivy Holdings stock options recognized by the Company during the years ended September 30, 2015 and 2014 was $1,184,000 and $2,673,000 (including the impact of the option repricing noted above), respectively. At September 30, 2015, there were 44,755 unvested options, which could potentially vest over the next three fiscal years, subject to meeting the vesting requirements noted above. The remaining maximum estimated stock compensation expense to be amortized to expense in future periods is approximately $3,000,000. Options which are expected to vest based on CEO and Compensation Committee discretion are treated as variable stock options and are subject to revaluation at each reporting period. Management determined the fair value of the discretionary vested options using a Black Scholes calculation but determined that the change in compensation expense was not material to the consolidated financial statements for the years ended September 30, 2015 and 2014.

10. Commitments and Contingencies

Leases

The Company leases various office facilities and equipment from third parties under non-cancelable operating and capital lease arrangements expiring at various dates through 2026. Certain operating leases contain rent escalation clauses and renewal options, which have been factored into determining rent expense on a straight-line basis over the lease terms. Capital leases bear interest at rates ranging from 2% to 11% per annum.

The future minimum annual lease payments (net of anticipated sublease income) required under leases in effect at September 30, 2015, are as follows (in thousands):

For the Years ending September 30,	Capital Leases	Operating Leases
2016	$ 3,913	$ 4,157
2017	2,589	3,395
2018	1,725	2,693
2019	1,414	2,210
2020	1,274	2,175
Thereafter	6,434	932
Total minimum lease payments	17,349	$ 15,562
Less: amounts representing interest	(5,148)	
	12,201	
Less: current portion	(2,905)	
	$ 9,296	

Rent expense for the years ended September 30, 2015 and 2014 was approximately $15,258,000 and $9,615,000, respectively. Sublease rental income of approximately $107,000 and $271,000, for the years ended September 30, 2015 and 2014, respectively, was recorded as a reduction to rental expense.

Litigation

The Company is subject to a variety of claims and suits that arise from time to time in the ordinary course of its business, acquisitions, or other transactions. While the Company's management currently believes that resolving all of these matters, individually or in the aggregate, will not have a material adverse impact on the Company's consolidated financial position or results of operations, the litigation and other claims that the Company faces are subject to inherent uncertainties and management's view of these matters may change in the future. Should an unfavorable final outcome occur, there exists the possibility of a material adverse impact on the Company's consolidated financial position, results of operations and cash flows for the period in which the effect becomes probable and reasonably estimable.

Following the acquisition of the Company in August 2010, two putative class action complaints were filed against the Company, each of the Company's special committee members, Ivy Holdings, LGP, and certain other parties. These complaints, which were consolidated into a single action, allege generally that defendants breached their fiduciary duties, or aided and abetted others' breaches of their fiduciary duties, in connection with the transaction with the Company by, among other things, authorizing the transaction for what plaintiffs claim to be inadequate consideration and pursuant to what plaintiffs claim to be an inadequate process and with inadequate disclosures.

On December 30, 2010, another lawsuit was filed in Delaware Chancery Court by Terrier Partners and five related entities against the same defendants identified above. The complaint alleges generally that the consideration offered to shareholders in connection with the transaction with the Company was inadequate in light of the revenue received under AB 1383 (see California Hospital Fee Program below), and that defendants breached their fiduciary duties, or aided and abetted others' breaches of their fiduciary duties by not obtaining a higher price in light of this additional revenue.

In May 2012, the Court of Chancery granted motions to consolidate the Terrier Partners case and the class action cases and certified a class as a non-opt out class. On June 11, 2012, plaintiffs filed their Verified Consolidated Third Amended Class Action Complaint. On July 26, 2012, the director defendants answered the Third Amended Complaint. That same day, Prospect moved to dismiss itself as a party to the Third Amended Complaint. The Court granted the motion to dismiss the Company as a defendant, leaving only the individuals as defendants in the case.

The parties subsequently engaged in discovery, and following mediation, have agreed to settle the dispute as to all parties and all claims. Pursuant to the terms of the Settlement Agreement, Prospect and its insurers have agreed to contribute $6.5 million as a settlement amount, which will be used to pay all claims to the class as well as fees for plaintiffs' class counsel. All defendants will be released from all claims in return for entry into the settlement. The settlement is subject to approval by the Delaware Chancery Court, which has scheduled a hearing for January 21, 2016 to consider the proposed settlement and determine, among other things, whether the settlement is fair, reasonable, and adequate to the class and should be approved by the Court. Notice has been sent out advising class members of the settlement, the date of the hearing and their right to object. Because it is a non-opt-out class, if the settlement is approved it should fully dispose of the claim as to all potential plaintiffs. The Company has no reason to believe that the settlement will not be approved by the Court, since it has been stipulated to by all parties and multiple counsel for plaintiffs; however, if the Court rejects

the settlement or for some other reason the settlement is not consummated, the defendants will vigorously defend the lawsuit.

Seismic Standards

Our SCHS Hospitals, Alta Los Angeles Hospitals, and FRMC are required to comply with California's Alfred E. Alquist Hospital Facilities Seismic Safety Act (the "Alquist Act"), which regulates the seismic performance of all aspects of hospital facilities in California. The Alquist Act imposes near-term and long-term compliance deadlines for seismic safety assessment, submission of corrective plans, and the retrofitting or replacement of medical facilities to comply with current seismic standards. The Alquist Act also requires that the California Building Standards Commission adopt earthquake performance categories, seismic evaluation procedures, standards and timeframes for upgrading certain facilities, and seismic retrofit building standards. These regulations require hospitals to meet seismic performance standards to ensure that they are capable of providing medical services to the public after an earthquake or other disaster. The Building Standards Commission completed its adoption of evaluation criteria and retrofit standards in 1998.

The Alquist Act requires that within three years after the Building Standards Commission had adopted evaluation criteria and retrofit standards:

- Hospitals in California must conduct seismic evaluation and submit these evaluations to the Office of Statewide Health Planning and Development ("OSHPD"), Facilities Development Division for its review and approval;
- Hospitals in California must identify the most critical nonstructural systems that represent the greatest risk of failure during an earthquake and submit timetables for upgrading these systems to the OSHPD, Facilities Development Division for its review and approval; and
- Hospitals in California must prepare a plan and compliance schedule for each regulated building demonstrating the steps a hospital will take to bring the hospital buildings into substantial compliance with the regulations and standards.

The Company was required to conduct engineering studies at its hospitals to determine whether and to what extent modifications to the hospital facilities will be required. Management believes that SCH Culver City meets all current requirements; however, it may be required to make significant capital expenditures in the future to comply with the seismic standards, which could impact its earnings. The cost at September 30, 2015, is unknown at this time but could be material. In addition, such modifications to the hospital facilities could potentially result in environmental remediation liabilities which may be material to the Company.

The OSHPD has a voluntary program to re-evaluate the seismic risk of hospital buildings classified as Structural Performance Category ("SPC") 1. These buildings are considered hazardous and at risk of collapse in the event of an earthquake and they were required to be retrofitted, replaced or removed from providing acute care services by 2013, unless granted an extension. OSHPD is using HAZARDS U.S. ("HAZUS"), a state-of-the-art methodology, to reassess the seismic risk of SPC-1 buildings and those that are determined to pose a low seismic risk may be reclassified to SPC-2. The SPC-2 buildings would have until 2030 to comply with the structural seismic safety standards. Participation in the HAZUS program is optional for hospital owners wishing to have their SPC-1 building(s) re-evaluated. Applications for a HAZUS re-evaluation of the seismic risk were submitted for SCH Hollywood, SCH Culver City and Los Angeles Community Hospital, but there is no assurance they will result in extensions.

In addition, in 2011, the California Legislature enacted Senate Bill 90, which permitted some hospitals to apply for up to an additional seven year extension to the seismic retrofit deadlines, not to extend beyond January 1, 2020. SB 90 also permits OSHPD to extend until January 1, 2018 the date by which the hospitals must obtain a building permit and commence the required retrofit project.

SCH Culver City and Los Angeles Community Hospitals both applied for the SB 90 extension from OSHPD. Three of the buildings owned by SCH Culver City were granted SB 90 extensions until January 2019 or July 2019. Also, the facility operated by Los Angeles Community Hospital received an SB 90 extension until January 2019.

OSHPD has discretion to approve or disapprove SB 90 extension requests, and to determine the length of the extension (up to the maximum seven years), based on eligibility factors including seismic risks associated with the affected buildings (which can be impacted by the updated HAZUS findings), community access to essential hospital services in the area and financial hardships facing the applicant.

Effective May 6, 2014, Prospect acquired the hospital facilities FRMC and LACH Bellflower (see Note 4). The Company is in the process of pursuing Non-Structural Performance Category ("NPC") 2 classification and the extension of the compliance deadlines that would result for FRMC. LACH Bellflower is not currently subject to the requirements of SB90 as the facility currently only provides psychiatric services.

These requirements can result in significant operational changes and capital outlays. Management is continuing to assess its options and the methods of financing the required retrofits. Based on management's evaluation, the costs of renovation needed to comply with the California seismic safety standards for its acute-care facilities, including asbestos abatement, are not estimable at this time.

Legislation and HIPAA

The healthcare industry is subject to numerous laws and regulations of federal, state and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government healthcare program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Government activity has continued with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed.

The Company believes that it is in compliance with fraud and abuse regulations as well as other applicable government laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time.

The Health Insurance Portability and Accountability Act ("HIPAA") assures health insurance portability, reduces healthcare fraud and abuse, guarantees security and privacy of health information, and enforces standards for health information. The Health Information Technology for Economic and Clinical Health Act ("HITECH Act") expanded upon HIPAA in a number of ways, including establishing notification requirements for certain breaches of protected health information. In addition to these federal rules, California has also developed strict standards for the privacy and security of health information as well as for reporting certain violations and breaches. The Company may be subject to significant fines and penalties if found not to be compliant with these state or federal provisions.

Affordable Care Act

The Patient Protection and Affordable Care Act ("PPACA") will substantially reform the United States health care system. The legislation impacts multiple aspects of the health care system, including many provisions that change payments from Medicare, Medicaid and insurance companies. Starting in 2014, the legislation requires the establishment of health insurance exchanges, which will provide individuals without employer-provided health care coverage the opportunity to purchase insurance. It is anticipated that some employers currently offering insurance to employees will opt to have employees seek insurance coverage through the insurance exchanges. It is possible that the reimbursement rates paid by insurers participating in the insurance exchanges may be substantially different than rates paid under current health insurance products. Another significant component of the PPACA is the expansion of the Medicaid program to a wide range of newly eligible individuals. In anticipation of this expansion, payments under certain existing programs, such as Medicare disproportionate share, will be substantially decreased. Each state's participation in an expanded Medicaid program is optional.

California Hospital Fee Program

The State of California enacted Assembly Bill 1383 ("AB 1383") effective January 1, 2010, as amended by Assembly Bill 1653 (collectively, the "Program"), to provide supplemental payments to certain hospitals such as the hospitals owned and operated by the Company's subsidiaries. The Program requires participating hospitals to pay fee assessments into a pool of funds to which the federal government contributes matching funds. Most of these funds, including the federal matching funds, are then distributed to qualifying hospitals. In addition, on April 13, 2011 SB 90 was signed into law and provided for a six-month extension of the Hospital Fee Program for dates of service from January 1, 2011 through June 30, 2011. CMS granted final approval of SB 90 on December 29, 2011, at which point the revenue and expense was recognized for the retroactive period. In September 2011, the State of California enacted Senate Bill 335 ("SB 335") which provides a 30-month hospital fee program for dates of service from July 1, 2011 through December 31, 2013. The elements of SB 335 related to the fee for service payments were approved by CMS on June 22, 2012. The payments due under the managed care component are scheduled to be made in three cycles. The first two cycles were previously approved by CMS, and the third cycle was approved by CMS during the year ended September 30, 2015. Certain technical changes to the legislation required by CMS are included in Senate Bill 920.

Governor Brown signed Senate Bill 239 ("SB 239") in October 2013, which enacted a hospital fee program for the period January 1, 2014 through December 31, 2016. SB 239 provides that the hospital fee program will continue through December 31, 2022 in three year cycles and will require authorization of each cycle by the California legislature. The fee for service component of SB 239 was approved by CMS during December 2014, and the first cycle of the managed care component from January 2014 through June 2014 was approved by CMS during July 2015.

For the years ended September 30, 2012 and 2011, SCH Culver City received invoices for fee assessments under AB 1383 and SB 90 of approximately $6,310,000 and $19,000,000, respectively, following payment of which, SCH Culver City was scheduled to receive approximately $5,236,000 and $15,000,000, respectively. Management of SCH Culver City estimated that SCH Culver City would be a "net" payer under the Program, since the fee assessments on SCH Culver City exceeded the supplemental payments by approximately $1,074,000 and $4,000,000, respectively. Accordingly, on October 6, 2010, the Company notified the California Department of Healthcare Services ("DHCS") that SCH Culver City was opting out of the Program.

SCH Culver City did not pay the required fee assessments under the Program. Beginning February 14, 2011, the DHCS began withholding against amounts otherwise due SCH Culver City, in the amount of $65,000 per week indicating that withholdings would continue for 108 weeks and would total approximately $7,000,000. Through September 30, 2012, a total of approximately $2,986,000 had been withheld against SCH Culver City's Medi-Cal fee-for-service payments. As of September 30, 2012, SCH Culver City recorded a liability of approximately $5,494,000, representing the accrued loss above, as well as deferred recognition of payments received from managed care plans. On November 15, 2012 the Company entered into a settlement agreement with DHCS with regards to SCH Culver City's liability under AB 1383, SB 90 and SB 335, as discussed above. Under the terms of the agreement, the DHCS agreed to forgive approximately $2,000,000 of the fees due under AB 1383, which was recorded by the Company during the year ended September 30, 2013. The remaining liability due to DHCS of $4,605,000 will be repaid by the Company monthly over a 10-year period without interest or penalties. The Company recorded a net liability of $3,233,000 as of the settlement date, which represents the net present value of the liability due to DHCS discounted at an effective interest rate of 7.5%. As of September 30, 2015 and 2014, the unamortized balance of the liability amounted to $2,547,000 and $2,806,000, respectively. The DHCS will no longer withhold against any other amounts due to SCH Culver City unless the Company is delinquent on payments owed under the agreement.

As of September 30, 2015, the Company had a receivable related to the California Hospital Fee Program of $32,285,000 in the accompanying consolidated balance sheets. The Company did not have a receivable related to the California Hospital Fee Program as of September 30, 2014. As of September 30, 2015 and 2014, the Company had a liability related to the California Hospital Fee Program of $15,022,000 and $2,806,000, respectively, in the accompanying consolidated balance sheets.

Total California Hospital Fee program revenues and expenses recognized during the years ended September 30, 2015 and 2014 were as follows (in thousands):

Years Ended September 30,	2015	2014
Hospital services revenues	$ 134,604	$ 11,884
Hospital operating expenses	91,325	5,863
Net pre-tax impact	$ 43,279	$ 6,021

Collective Bargaining Agreements

A small group of employees at SCH Hollywood, which is one of the hospitals under the consolidated group of Alta Hospitals System, LLC, and Service Employees International Union, United Healthcare Workers-West ("SEIU") are currently negotiating a new collective bargaining agreement. This agreement expired on May 3, 2015. In addition, approximately 84% of the employees of SCH Culver City are part of a collective bargaining agreement with the SEIU or the California Nurses Association ("CNA"). SCH Culver City and CNA are currently parties to a collective bargaining agreement that expires on December 21, 2015. The parties have commenced negotiations for a new agreement. SEIU and SCH Culver City are currently parties to a three-year term agreement that expires on April 27, 2017.

As of September 30, 2014, approximately 25% of the employees at Our Lady of Fatima Hospital ("Fatima") are subject to a collective bargaining agreement with United Nurses and Allied Professionals ("UNAP"), which expires July 31, 2016. An additional 1% are subject to a collective bargaining agreement with the Federation of Nurses and Health Professionals ("FNHP"), which expires April 30,

2016. During April 2015, a hospital unit consisting of approximately 400 service employees of Fatima elected to be represented by UNAP. Negotiations over a first collective bargaining agreement for this unit are ongoing.

Tangible Net Equity ("TNE") Requirement

The Company's affiliated physician organizations and PHP must comply with a minimum working capital requirement, Tangible Net Equity ("TNE") requirement, cash-to-claims ratio and claims payment requirements prescribed by the California Department of Managed Health Care ("DMHC"). Additionally, PHP has a TNE requirement as prescribed by the California Department of Managed Health Care. TNE is defined as net assets, less intangibles and amounts due from affiliates, plus subordinated obligations. At September 30, 2015, PHP was in compliance with these regulatory requirements.

The California DMHC determined that, as of March 31, 2015, PMG, on a consolidated basis with its subsidiaries, was not in compliance with the California DMHC's positive TNE requirement for a Risk Bearing Organizations ("RBO"). As a result, the California DMHC required PMG to develop and implement a six-month corrective action plan ("CAP") for such deficiency. Such six-month period has expired, and PMG believes that it has fully complied with all related requirements. As of the date of this report, PMG has not yet received the California DMHC's official release of the CAP.

The Company contributed $2,000,000 of Restricted Cash and $300,000 of Restricted Investments to PHP in conjunction with PHP's commencement of operations during the year ended September 30, 2015 (see Note 2 regarding Restricted Cash and Restricted Investments).

Employee Health Plans

Effective January 1, 2013 the Company offered self-insured EPO/HMO and PPO plans to all eligible employees. The CharterCARE hospitals had a separate low-deductible employee health plan from the date of acquisition through December 31, 2014. Effective January 1, 2015, the CharterCARE hospitals changed to self-insured EPO/HMO and PPO plans for all eligible employees.

Employee health benefits are administered by a third party claims administrator, based on plan coverage and eligibility guidelines determined by the Company, as well as by collective bargaining agreements (as reflected above). Commercial insurance policies cover per occurrence losses in excess of $275,000 for the CharterCARE hospitals, $250,000 for all other hospitals and $175,000 for the Medical Group and Corporate segments. An actuarially estimated liability of approximately $3,850,000 and $1,828,000 for incurred but not reported claims has been included in accrued salaries, wages, and benefits as of September 30, 2015 and 2014, respectively.

Provider Contracts

Many of the Company's payer and provider contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of medical services. Such differing interpretations may not come to light until a substantial period of time has passed following contract implementation. Liabilities for claims disputes are recorded when the loss is probable and can be estimated. Any adjustments to reserves are reflected in current operations.

11. Defined Contribution Plan

The Company sponsors two defined contribution plans covering substantially all employees who meet certain eligibility requirements. Under these plans, employees can contribute up to 50% of their compensation up to the IRS deferred annual maximum. There is currently no company match offered under the plans, except at Nix Health and PCC, for which the expense for the employer match was $1,865,000 and $576,000 for the years ended September 30, 2015 and 2014, respectively. Total expenses under the plan were approximately $480,000 and $197,000 during the years ended September 30, 2015 and 2014, respectively.

12. Accrued Medical Claims and Other Healthcare Costs Payable

The following table presents the roll-forward of incurred but not reported ("IBNR"), claims reserves (Medical Group segment, Global Risk Management segment, and full risk contracts) as of and for each of the fiscal years ended September 30, 2015 and 2014 (in thousands):

September 30,	2015	2014
IBNR as of beginning of year	$ 39,314	$ 30,352
Claim expenses incurred during the year:		
Related to current year	203,400	161,088
Related to prior year	1,606	(3,571)
Total incurred	205,006	157,517
Claims paid during the year:		
Related to current year	(156,485)	(124,393)
Related to prior year	(34,304)	(24,162)
Total paid	(190,789)	(148,555)
IBNR as of end of year	$ 53,531	$ 39,314

Following is a table showing the details of the Medical Group and Global Risk Management segments cost of revenues per the consolidated statements of operations (in thousands):

Years Ended September 30,	2015	2014
Capitation expense	$ 93,340	$ 85,754
Fee-for-service claims expense	118,529	94,749
Other physician compensation	14,082	5,066
Other cost of revenues	1,196	(227)
Total cost of revenues	$ 227,147	$ 185,342

13. Joint Ventures and Unconsolidated Equity Investments

AMVI

The Company (through Prospect Medical Group, Inc.) and an unrelated third party, AMVI Care Health Network, Inc. ("AMVI") are partners in a joint venture initially formed to service Medi-Cal members under the CalOptima program in Orange County, California. Healthy Families and OneCare members were subsequently added to the joint venture arrangement. Effective January 1, 2013, all Healthy Family participants were transferred to the Company's Medi-Cal line of business and therefore no longer part of the joint venture. The Company does not consolidate the joint venture. The Company includes in its consolidated financial statements only the net results attributable to those enrollees specifically identified as assigned to it, together with the management fee that it charges the joint venture partner for managing those enrollees specifically assigned to AMVI. Costs incurred by the Company in managing the joint venture are included in general and administrative expenses in the accompanying consolidated financial statements. As of September 30, 2015 and 2014, the net liability balances of the Company investment in the joint venture under the equity method were approximately $1,944,000 and $1,594,000, respectively, and were included in accounts payable and other accrued liabilities in the accompanying consolidated financial statements.

Summarized unaudited financial information for the unconsolidated joint venture as of and for each of the years ended September 30, 2015 and 2014 is as follows (in thousands):

September 30,	2015	2014
Cash	$ (96)	$ 1,753
Receivables	2,344	2,232
Total assets	$ 2,248	$ 3,985
Accrued medical claims	$ 1,652	$ 1,658
Other payables	158	1,470
Other partner's capital	437	856
Prospect's capital	1	1
Total liabilities and partner's capital	$ 2,248	$ 3,985

Years Ended September 30,	2015	2014
Revenues	$ 19,817	$ 19,289
Income before income taxes	$ 4,532	$ 2,915
Prospect's equity income	$ 5,867	$ 3,295
Management fees earned by Prospect	$ 1,106	$ 1,141

RWRT and SNERCC

Roger Williams Medical Center and an unrelated third party are owners of Roger Williams Radiation Therapy ("RWRT") and Southern New England Regional Cancer Center, LLC ("SNERCC"), which provide radiation therapy services. As of September 30, 2014, RWMC owned 29% of RWRT and 20% of SNERCC. On January 6, 2015, RWMC sold a 9% interest in RWRT for $1,233,000, reducing its ownership in RWRT from 29% to 20%. Also on January 6, 2015, RWMC increased its investment in SNERCC by $1,600,000 in

connection with SNERCC's acquisition of a radiation oncology business. RWMC's interest in SNERCC remained at 20% after the additional investment as RWMC's additional investment was its pro rata portion of the radiation oncology business purchase price. Roger Williams accounts for these investments using the equity method of accounting.

RWMC is not liable for any obligations insured by RWRT or SNERCC nor is it obligated to make any further capital contributions or lend funds to RWRT or SNERCC. As of September 30, 2015 and 2014, RWMC's investments in RWRT and SNERCC under the equity method were approximately $4,217,000 and $3,522,000 respectively, and are included in equity method investments in the accompanying consolidated balance sheets. For the year ended September 30, 2015, the Company recognized approximately $455,000 as its share of the financial results of RWRT and SNERCC and received $423,000 in distributions. For the period from June 20, 2014 (Roger Williams Medical Center inception) through September 30, 2014 and for the year ended September 30, 2015, the Company recognized $132,000 as its share of the financial results of RWRT and SNERCC and received no distributions.

Summarized combined unaudited financial information for RWRT and SNERCC as of September 30, 2015 and 2014 and for the year ended September 30, 2015 and for the period from June 20, 2014 (inception) through September 30, 2014 is as follows (in thousands):

September 30,	2015	2014
Cash	$ 1,299	$ 1,165
Receivables	1,547	1,130
Other current assets	274	372
Total current assets	3,120	2,667
Property, improvements and equipment, net	7,432	6,715
Goodwill	7,142	629
Intangible assets	943	-
Other long-term assets	1,663	1,756
Total assets	$ 20,300	$ 11,767
Accounts payable and accrued liabilities	$ 1,618	$ 1,070
Other long-term liabilities	345	336
Equity	18,337	10,361
Total liabilities and partner's capital	$ 20,300	$ 11,767

Years ended September 30,	2015	2014
Revenues	$ 14,626	$ 3,175
Net income	$ 2,000	$ 455
Roger Williams Medical Center's income from equity method investments	$ 455	$ 132

14. Segment Information

The Company's operations are organized into four reporting segments: (i) Hospital Services – which is comprised of the Alta Hospitals, SCH Culver City, Nix Health, and PCC reporting units, owns 13 hospitals and extended care facilities – Los Angeles Community Hospital, Norwalk Community Hospital, Los Angeles Community Hospital at Bellflower, Foothill Regional Medical Center, SCH Hollywood, SCH Van Nuys, SCH Culver City, Nix Medical Center, Nix Specialty Health Center, Nix CGH, Roger Williams Medical Center, Saint Joseph's Health Services of Rhode Island, and Elmhurst Extended Care; (ii) Medical Group – which is comprised of entities which provide management services to affiliated physician organizations that operate as independent physician associations or medical practice groups and certain unaffiliated independent physician associations; (iii) Global Risk Management - which is comprised of PHP, PHSTX and PHSRI which manage the provision of care for its members under global capitation arrangements in coordination with our Hospital and Medical Group segments and (iv) Corporate, which represents expenses incurred in Prospect Medical Holdings, Inc., that were not allocated to the other reporting segments.

The accounting policies of the reporting segments are the same as those described in the summary of significant accounting policies (see Note 2). The Company evaluates financial performance and allocates resources primarily based on earnings from operations before interest expense, interest income, income taxes, depreciation and amortization, as well as income or loss from operations before income taxes, excluding infrequent or unusual items.

The reporting segments are strategic business units that offer different services within the healthcare industry. Business in each reporting segment is conducted by one or more direct or indirect wholly-owned subsidiaries of the Company and certain affiliated physician organizations controlled through assignable option agreements and management services agreements. The Company voluntarily discloses the following table which summarizes certain information for each of the reporting segments regularly provided to and reviewed by the chief operating decision maker (in thousands):

	As of and for the Year Ended September 30, 2015					
	Hospital Services *(3)*	Medical Group *(2)*	Global Risk Management	Corporate *(1)*	Intersegment Eliminations	Consolidated
Revenues from external customers	$ 1,008,866	$ 333,238	$ 3,440	$ -	$ -	$ 1,345,544
Intersegment revenues	-	1,762	16,661	-	(18,423)	-
Total revenues	1,008,866	335,000	20,101	-	(18,423)	1,345,544
Depreciation and amortization	31,148	3,178	-	48	-	34,374
Operating income (loss)	63,413	66,142	(3,163)	(18,332)	-	108,060
Other (income) expense	2,240	(271)	-	42,926	(2,283)	42,612
Income (loss) before income taxes	61,173	66,413	(3,163)	(61,258)	2,283	65,448
Provision for income tax	-	10,600	-	20,546	-	31,146
Net income (loss)	$ 61,173	$ 55,813	$ (3,163)	$ (81,804)	$ 2,283	$ 34,302
Identifiable segment assets	$ 655,540	$ 96,289	$ 6,725	$ 24,297	$ -	$ 782,851
Segment capital expenditures, net of dispositions	$ 35,332	$ 981	$ -	$ 202	$ -	$ 36,515
Segment goodwill	$ 139,957	$ 22,339	$ -	$ -	$ -	$ 162,296

	As of and for the Year Ended September 30, 2014				
	Hospital Services *(3)*	Medical Group *(2)*	Corporate *(1)*	Intersegment Eliminations	Consolidated
Revenues from external customers	$ 600,536	$ 253,980	$ -	$ -	$ 854,516
Intersegment revenues	-	1,039	-	(1,039)	-
Total revenues	600,536	255,019	-	(1,039)	854,516
Depreciation and amortization	20,694	2,846	40	-	23,580
Operating income (loss)	57,748	29,080	(20,676)	-	66,152
Other (income) expense	(3,037)	(26)	38,480	1,622	37,039
Income (loss) before income taxes	60,785	29,106	(59,156)	(1,622)	29,113
Provision for income tax	-	5,765	4,796	-	10,561
Net income (loss)	$ 60,785	$ 29,106	$ (69,717)	$ (1,622)	$ 18,552
Identifiable segment assets	$ 599,516	$ 75,605	$ 19,057	$ -	$ 694,178
Segment capital expenditures, net of dispositions	$ 49,181	$ 924	$ 2	$ -	$ 50,107
Segment goodwill	$ 136,525	$ 22,339	$ -	$ -	$ 158,864

(1) Prospect files consolidated tax returns, with the exception of PMG and NGMA, which file their own federal tax returns, and allocates costs for shared services and corporate overhead to each of the reporting segments. With the exception of Nix Health and PCC, all debt, including debt related to the Medical Group and Hospital Services segment, is recorded at the Parent Entity level. The Company does not allocate interest expense related to acquisition debt to the operating segments.

(2) Prospect Medical Group, Inc. (which serves as a holding company for the other affiliated physician organizations) files consolidated tax returns.

(3) The Hospital Services segment includes the results for LACH Bellflower and FRMC, CharterCARE, and the CharterCARE Physicians medical practices from the acquisition dates of May 6, 2014, June 20, 2014, and various dates during the year ended September 30, 2015, respectively, through September 30, 2015. Included in revenues from external customers are $5,436,000 and $13,672,000 of other revenues related primarily to the CMS Rural Floor settlement, meaningful use incentive payments and rental revenue from operating leases for the years ended September 30, 2015 and 2014, respectively.

15. Subsequent Event (Unaudited)

The Company has evaluated subsequent events through December 10, 2015, the date the Company's consolidated financial statements were available for issuance.

Effective December 1, 2015, NGMA entered into a Stock Purchase Agreement to acquire all issued and outstanding shares of Primary and Multi-Specialty Clinics of Anaheim, Inc. ("PMCA"). PMCA operates a medical practice consisting of primary and multi-specialty clinics in Orange County, California. Concurrent with the Stock Purchase Agreement, NGMA entered into a Promissory Note payable to the former shareholders of PMCA for $3,288,000, for which principal shall be payable on December 8, 2015.

The purchase price consists of $4,445,000 due December 8, 2015, less certain liabilities and certain other adjustments as specified in the Stock Purchase Agreement ("Initial Payment") and an additional $1,080,000 due on December 1, 2016. The Promissory Note represents a portion of the Initial Payment.